

County of Los Angeles  
Department of Health Services

# cultural and linguistic competency standards

Developed by DHS Cultural and Linguistic  
Competency Standards Work Group

Edited by  
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## SECTION I: INTRODUCTION

### **Los Angeles County Department of Health Services (DHS) Vision:**

DHS will improve the provision of culturally-sensitive patient/consumer service in collaboration with the community, labor unions, and our public private partners. The workforce will reflect cultural diversity and demonstrate language and cultural competence. (1996)

### **DHS Diversity Mission:**

...DHS is committed to delivering quality health care services and improving the health care status of the people of Los Angeles County.

DHS understands that a key quality of care issue for culturally diverse populations and persons with limited English proficiency is the provision of culturally and linguistically appropriate services.

In the delivery of health care, all patients have the same rights regardless of race, ethnicity, national origin and limited English proficiency. DHS will establish systems that promote diversity and maintain cultural competency in the workplace; and will strive to create an environment that understands that staff, patient and community cultures, values and beliefs are vital to the provision of accessible, quality health care... (2003)

## **A. DHS Introduction**

### **Message from Dr. Thomas L. Garthwaite, M.D., Director and Chief Medical Officer for the Los Angeles County Department of Health Services**

The Department is pleased to present our new Cultural and Linguistic Standards. These standards will guide and enhance the quality of care we are able to offer to our culturally and linguistically diverse patients. Improving patient-provider communications is critical to improving health outcomes, and reports demonstrating the link between culturally and linguistically sensitive services and better health outcomes are referenced throughout this document.

There are ambitious goals embodied within these standards. It is the link to patient outcomes that adds urgency to our need to meet these standards. To be successful, we must create a cooperative environment within the department, and with our external partners to support this effort.

These standards reflect the thoughtful work of many and I especially commend the DHS Cultural and Linguistic Standards Work Group, and the Project Edit Team for their hard work and commitment.

### **Message from Fred Leaf, Chief Operating Officer for Los Angeles County Department of Health Services**

The DHS Cultural & Linguistic Standards articulate what is required, and what is the right thing for DHS to do in providing services for one of the most diverse patient populations in the nation. These standards reflect the efforts of a diverse work group made up of DHS facility and program managers and clinicians, cultural and linguistic specialists, legal and language rights advocates, and other stakeholders committed to improving services to culturally and linguistically diverse patients. This will be an important and ongoing process that will help DHS become one of the leading public health systems in the provision of culturally and linguistically sensitive health services.

## B. Purpose

These cultural and linguistic competency standards are established to assist the DHS and its entities in creating a health system that is responsive and accessible to our patient populations. These standards are in accord with all existing state and federal regulations. Some standards, however, exceed the existing requirements and demonstrate DHS' commitment to improving access to diverse populations. However, implementation of these standards within the current environment of declining revenues will be incremental and will take place in phases over the next several years, and is anticipated to be an ongoing process. Key performance indicators and measures for the standards will be developed in the next, implementation phase.

DHS cultural and linguistic policies will be integrated into a comprehensive plan that includes needs assessment, training, monitoring, and language service provision, including oral interpreting services and written translations of materials, guided by specific standards. This will ensure that the policies are consistently followed throughout DHS and that patients can be assured of receiving appropriate care at every point of contact. A summary of the DHS Cultural & Linguistic Standards will be made available in a user-friendly form.

In 1999 the Director of Health Services established as a department goal the improvement of the effectiveness of the health care delivery system, and the establishment of systems that promote diversity and cultural and linguistic competency. This commitment is highlighted in the six departmental goals for 2002-3 of the current Director, Dr. Thomas Garthwaite, one of which is to reduce disparities in the provision of care and enhance cultural sensitivity across DHS.

## C. Background

Los Angeles County, with over 9.5 million residents, is the most diverse and populous county in the United States and home to nearly a third of California's residents. The Los Angeles County Department of Health Services (DHS) is the second largest public health system in the Nation and is governed by the Los Angeles County Board of Supervisors. DHS provides health care services for county residents and serves as the major open door provider for the more than 1.7 million uninsured, of which over 300,000 are children. DHS treats some 800,000 patients annually; an estimated 600,000 which are uninsured. DHS provides 15% of all emergency visits in the County; and 50% of all trauma visits.

The challenges before the County include an increasing demand for services in the face of diminishing resources. However, DHS remains committed to protecting the health of, and providing quality health care to all County residents regardless of race, ethnicity, national origin, ability to speak English, or ability to pay. Recognizing the diverse cultures and languages of its patient population, DHS acknowledges that a key quality of care issue is the provision of culturally and linguistically appropriate services. A framework of organizational, structural, and clinical cultural competence interventions, including minority recruitment into the health professions, development of interpreter services and language-appropriate health educational materials, and provider education on cross-cultural issues can facilitate the elimination of disparities and improve care<sup>1</sup>. The capacity to identify the current and potential patient population, and to strategically direct resources and target culturally and linguistically appropriate outreach and services for these communities, and to make DHS managers accountable for individual and organizational performance in cultural competence, will be vital to DHS' survival and ultimate success.

## DHS Response to Cultural & Linguistic Diversity Issues

The Director of Health Services appointed 23 DHS staff and community leaders with expertise in this field to form a Cultural and Linguistic Standards Work Group in 1999 (*for membership, see Appendix J, page 61*). The Work Group was co-chaired by the Director of the Binational/Border Health Program, Dr. Patricia Hassakis, and the Director of the Office of Women's Health, Kathleen Torres. The Work Group began meeting in October 1999, and was subsequently chaired by the Director of the Office of Diversity Programs, Miya Iwataki, in 2002. In completing its assigned task, the group studied existing published cultural and linguistic standards and definitions, and current research, and considered the particular demographic and health needs of residents within Los Angeles County. The group also reviewed current

laws and emergent legislation, and the requirements of state and federal funding and accreditation agencies. Finally, the Work Group reviewed current DHS policies relating to the cultural and linguistic needs of its diverse population. The Work Group developed a set of guiding principles for the development of cultural and linguistic competency standards, and a suggested process for implementation. These guidelines have been incorporated into the present Standards and process steps. *(These guiding principles appear in Appendix B on page 26.)* This document presents the recommendations of the Work Group for cultural and linguistic competency standards for the Los Angeles County Department of Health Services. Several department wide review periods have been conducted, as well as a public comment period during which the draft was made available on the DHS Office of Diversity Programs (ODP) website.

By recognizing the diverse DHS constituency which makes up the service population, and integrating this knowledge into a new health care delivery system, DHS is positioning itself to address cultural and linguistic issues comprehensively and innovatively, in patient care and in its diverse workforce. If fully implemented, these Standards will provide an opportunity for LA County to develop national leadership in addressing cultural and linguistic competency in healthcare, a critical issue in most urban centers across the country.

In June, 2002, the Los Angeles County Board of Supervisors instructed the Director of Health Services to finalize and integrate the Cultural and Linguistic Competency Standards within the Department's redesigned system. *(The full text of the motion appears in Appendix C on page 27.)*

A grant from the Center for the Health Professions of the University of California, San Francisco in 2003 made this document possible, allowing for the final editing of the standards and attachments. The editing team consisted of Niels Agger-Gupta, Ph.D., an independent consultant, as the principle editor, and Karin Wang, Esq., Vice President of Program Administration for the Asian Pacific American Legal Center, and Miya Iwataki, Director of the Office of Diversity Programs, LA County Department of Health Services.

## **Impact of Cultural Competency on Health Outcomes**

Non English speaking patients in the USA are less likely to receive appropriate care; less likely to understand care instructions; have increased risk of medical errors; have reduced quality of care; have increased risk of unethical care; and are less satisfied with their care.<sup>2-8</sup>

Cultural and linguistic issues impact quality of care and health outcomes on many levels. In 1998, President Clinton's "One America" Race Initiative identified six areas of racial and ethnic disparities in health in which the potential exists to prevent disease and disability: cancer screening and management, cardiovascular disease, child and adult immunizations, diabetes, HIV infection/AIDS, and infant mortality. Represented in the Los Angeles service population are large numbers of the specific populations in which the federal government has noted the greatest health disparities. For example, infant mortality is highest among African Americans with 13.1 deaths per 1,000 live births, more than double of deaths per 1,000 live births of Hispanics, Asian Americans and whites.

The National Academies Institute of Medicine (IOM) in its report, *Unequal treatment: Confronting Racial and Ethnic Disparities in Health Care*, found racial and ethnic disparities in health care even when insurance status, income, age, and severity of conditions were comparable.<sup>9</sup> One example is in the area of cardiovascular care. Several studies cited noted differences in treatment regimen following coronary angiography, and higher mortality among African Americans in receipt of coronary revascularization procedures. Additionally, significant racial differences in the receipt of appropriate cancer diagnostic tests (e.g., McMahon et al., 1999<sup>10</sup>), treatments (e.g. Imperato et al., 1996<sup>11</sup>), and administration of analgesics (e.g. Bernabei et al, 1998<sup>12</sup> and Todd, 1993<sup>13</sup>,) were also cited. The IOM found, "As is the case for cardiovascular disease, evidence suggests that disparities in cancer care are associated with higher death rates among minorities."<sup>9</sup>

Evidence of racial and ethnic disparities in health care is, with few exceptions, remarkably consistent across a range of illnesses and health care services.<sup>9</sup> Increasing awareness of racial and ethnic disparities in health care among the general public and key stakeholders is recommended as one strategy to address this issue. The IOM concludes, "because death rates from cancer, heart disease, and diabetes are significantly higher in racial and ethnic minorities than in whites, these disparities are unacceptable."<sup>9</sup>

The study also recognizes that minorities experience a range of access barriers, including “barriers of language, geography, and cultural familiarity.” It explains that language barriers pose a significant problem because it may affect “the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision making, or ethical compromises.”

A commentary in the Los Angeles Times notes that “Los Angeles is the country’s living laboratory for understanding the link between culture and health.”<sup>14</sup> Therefore, the Director of Health Services and the Board of Supervisors have a unique opportunity to provide leadership for the nation by becoming the first county health department to develop and implement comprehensive cultural and linguistic competency standards across its extensive healthcare system of hospitals, clinics, and contracting agencies. By successfully integrating cultural and linguistic competency into its vast health care delivery system, LA County will serve as a model for other areas.

Implementation of cultural and linguistic standards will require investment in staff, facility and community resources, however, new research and analysis indicates delivery of effective and culturally appropriate health care can improve health outcomes, as well as, prove cost-effective in the goals of DHS and structuring health care delivery towards patient care. The resulting public health system should prove that the small initial investment is well worth the long term advances in increased access and improved health care for all of LA County’s residents.

*(A larger overview of key studies relating to language barriers in health care appears in Appendix H on page 53.)*

## **The Business Case for Culturally Competent Services**

A study report issued by the National Health Law Program and the Henry J. Kaiser Family Foundation, has found that language barriers can cause doctors to rely on extensive, costly, often unnecessary tests, causing treatment to take 25-50% longer than treatment for English-speaking patients.<sup>15</sup>

The US Office of Management and Budget benefit-cost report on E.O. 13166 discusses the benefits of providing language services, including possible decreases in the number and severity of misdiagnoses or other medical errors.<sup>16</sup> Medical errors can be extremely costly (estimated between \$17 and \$29 billion annually).<sup>17</sup> Provision of language services to limited English-speaking patients could help reduce medical errors by increasing the quality of information a provider obtains regarding their patient’s condition. It could also increase adherence to medical instructions.

Overall, research has shown that culturally and linguistically competent services contribute to:

**Decrease in medical errors:** A study published in 2003 showed that errors in medical interpreting in the pediatric setting are common and have potential clinical consequences. Ad hoc interpreters are more likely to make errors that can lead to clinical consequences.<sup>18</sup>

**Increased patient satisfaction:** Language barriers have a negative impact on patient satisfaction<sup>18-42</sup>

**Improved Primary and preventative care:** Access to primary and preventative care has been shown to be related to better health outcomes. (eg. HEDIS scores). This area will support DHS’s goal of improved primary and preventive care and away from episodic and emergent care to a continuity of care. In a study of Harvard Pilgrim Health Care in Boston, one researcher found that when a trained interpreter became available, primary and preventive care increased, and ER use decreased significantly.<sup>43</sup>

**Decreased medical costs:** Unnecessary emergency room usage decreases with an increase in outpatient visits. When an ER visit does occur, the presence of a language barrier increases the range and cost of diagnostic tests that are necessary and increases the time that a patient remains in ER.<sup>44</sup> The presence of a language barrier also results in an increased probability of admission into the hospital, but that increased probability is significantly reduced (but does not disappear) with the presence of an interpreter.<sup>45</sup> A study in 2000 by Bernstein and colleagues at Boston Medical Center followed patients for 30 days following an initial ER visit and found that LEP patients who received a trained interpreter in the Emergency Department had fewer costs and received more preventative care

than even English speaking patients. Patients with no trained interpreters or who used family members costs the least, at the initial visit, but were most likely to have subsequent ER visits, since their medical complaint was not appropriately addressed initially.<sup>46</sup>

**Improved patient comprehension of informed consent for treatment:** Without effective use of a trained interpreter, the physician-patient relationship is seriously impaired. Patients cannot make an informed choice about treatment if they lack a basic understanding of what is, or is possibly, occurring with their health. The clinician is severely limited if he/she is unable to take a thorough medical history because they lack the knowledge and language skills to take the cultural health beliefs of the patient into consideration in the diagnosis and treatment options phases of their interaction. A lack of language concordance between patient and clinician greatly increases the risk of the patient not comprehending the diagnosis or treatment options and leading to an invalid informed consent for treatment.<sup>22, 47-51</sup> It also increases the likelihood that treatment plans, including medications, will not be adhered to at home.<sup>23, 50, 52-56</sup>

**Improved communication between healthcare professionals and patients:** Misunderstanding can occur even when an interpreter is accurately converting English words into the second language, because a patient's cultural beliefs about health and illness may make communication difficult.<sup>57, 58</sup> In order to communicate meaningfully with patients, physicians must have an appropriate understanding of the cultures they serve. The IOM report (2002) recommends "programs aimed at current and future health professionals should integrate cross-cultural education into the training."<sup>9</sup> The physician is placed at a significant disadvantage when they do not have some basic cultural knowledge to guide their questions to determine their patient's explanation of their cultural health beliefs, and therefore may not be appropriately meeting patients' needs. Effective provider-patient communication is the key to establishing trust and rapport as well as providing information that will lead to an accurate diagnosis of symptoms, increasing compliance with recommended treatments and improving health outcomes.

**Improved marketing to a major consumer demographic segment:** Furthermore, in an increasingly competitive health care environment, consumers have the option to choose their health care providers. An increasing number of consumers are from racially and ethnically diverse populations. As diverse communities continue to grow, it makes economic sense for providers to incorporate marketing strategies that will increase the recruitment and retention of these consumers.

## Demographics

The population of L.A. County is larger than that of 44 states and 147 countries. Its vibrant and dynamic diversity is unmatched by any other major metropolitan region in the United States. While ethnic minorities make up a substantial share of the population in many metropolitan areas, they are a demographic majority in L.A. County. For the past twenty years, the County has been the epicenter of an ever-changing amalgam of ethnicities, languages, cultural and religious beliefs, lifestyles, health care practices, and diverse family structures. With the rapid growth of immigrant and minority populations in L.A. County, diverse economic and social patterns have also emerged.<sup>a</sup>

The size and scale of L. A. County dwarfs all other urban areas with more than 80 nationalities and up to 63 racial/ethnic/multiracial groups (2000 Census), 83 languages plus numerous dialects spoken in the home (L.A. Unified School District 1999) contributing to perhaps the most dynamic and complex County in the U.S.; and with far-reaching implications for health care. MediCal has identified 11 threshold languages for Los Angeles County – the highest of all counties in the state.<sup>b</sup>

Foreign-born make up 33% of the Los Angeles County's estimated 9.5 million residents. More Mexicans, Central Americans, Asians and Middle Easterners live in L.A. County than any other metropolitan area in the United States. The 2000 Census found that 36.2% of those in L.A. County were born in another country. Nearly half (49.2%) of the county's households speak a language other

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<sup>a</sup> Please see Appendix I on page 55

<sup>b</sup> A chart of MediCal Threshold Languages by County appears in Appendix K on page 62.

than English at home.<sup>59</sup> Of these, 477,729 households are linguistically isolated – that is, no one 14 years of age or older speaks English. In 1998, 35% of all Los Angeles County public school students (K-12) were non- English speaking.<sup>59</sup> The largest language groups represented among limited English-proficient (LEP) students are Spanish (87%), Armenian, Korean, Cantonese, Cambodian and Vietnamese. Twenty-six percent of Hispanics, 24.4% of African Americans, about 14% of Asian/Pacific Islanders, and 8.5% of whites have incomes that are below the 100% federal poverty level.(2000 US census)

With the rapid growth of immigrant and minority populations, the Los Angeles County landscape has become a multicultural mosaic in which English is a second language for a significant segment of the population.

The ability to communicate and work effectively across these substantial cultural and linguistic differences is critical to improving the quality of health care in Los Angeles County. The Director of Health Services is committed to enhancing cultural sensitivity across DHS and reducing disparities in care.

## **D. Summary of Relevant Laws, Policies and Accreditation Requirements**

Health programs and services are required to provide culturally and linguistically competent care under numerous statutory, regulatory, contract and accreditation authorities. Many of these requirements have been in effect for years; other requirements have arisen more recently, driven by the continuing diversification of the U.S. and California populations. The laws, policies and requirements most relevant to DHS are listed below. *(A detailed summary of each may be found in Appendix D on page 29).*

### **Federal Laws, Policies and Enforcement**

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000 et seq.)
- U.S. Department of Health and Human Services (HHS) Title VI regulations (45 C.F.R. § 80 et seq.)
- Presidential Executive Order 13166 (65 Fed. Reg. 50121 (Aug. 16, 2000))
- HHS Office for Civil Rights, Title VI LEP Guidance (68 Fed. Reg. 47311 (Aug. 8, 2003))
- Hill-Burton Act (42 U.S.C. § 291 et seq.)
- Medicaid, State Children’s Health Insurance Program (SCHIP) and Medicare statutes and regulations
- Federal categorical grant program requirements

### **National Standards On Culturally And Linguistically Appropriate Services In Health Care**

- HHS Office of Minority Health, National Standards on Culturally and Linguistically Appropriate Services in Health Care (65 Fed. Reg. 80865-79 (Dec. 22, 2000))

### **California Laws and Policies**

- Government Code § 11135
- Kopp Act (Health & Safety Code § 1259)
- Dymally-Alatorre Bilingual Services Act (Gov’t.Code § 7290 et seq.)
- California Department of Health Services, Medi-Cal Managed Care Division, Medi-Cal Managed Care Contract Requirements
- Managed Risk Medical Insurance Board, Healthy Families Contract Requirements

### **Health Accreditation Requirements**

- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Standards
- National Committee for Quality Assurance (NCQA) Standards

Healthcare professionals, including physicians, nurses, psychologists, and medical educators, among many, have also adopted standards for their members for cultural and linguistic competent care.

*(See Appendix F.3.b on page 46)*

## SECTION II: CULTURAL AND LINGUISTIC STANDARDS

### Definition of Cultural & Linguistic Competency in Health Care for Organizations & Individuals

A working definition is one that addresses concrete steps to be taken in our daily work. Within this framework, the following definitions are offered:

#### Cultural Competency

Refers to a set of congruent behaviors, attitudes, policies, practices and beliefs that create and foster a professional and organizational culture that enables health care providers and organizations to:

- Recognize and acknowledge the diverse groups within the service population;
- Understand the role of diverse values, norms, practices, attitudes and beliefs about disease and treatment in program and policy development and health services planning;
- Enhance accessibility to services by diverse groups by improving cultural and linguistic competencies and availability;
- Take a holistic view of health, inclusive of cultural health beliefs and practices, and the physical, mental and emotional aspects of diverse groups;
- Respect and support the dignity and perspectives of the client, patient, family and staff to best address the health interests of the patient;
- Ensure systems of recruitment, evaluation, staff development and retention that support an organizational culture and staff that are better able to provide health services that meet the cultural and linguistic needs of the community;
- Measurably improve the health status of the populations and communities served.

#### Linguistic Competency

A key component of cultural competency is linguistic competency, which refers to the health care organization's ability to provide its non- and limited English speaking patients with timely, accurate and confidential interpreting services, and quality, culturally-appropriate translated materials.

## A. CULTURAL & LINGUISTIC ORGANIZATIONAL STANDARDS

### STANDARD 1: CULTURAL COMPETENCY

**STANDARD:** The Department of Health Services (DHS) is committed to diversity as an integral component of its mission and values and to cultural competence as an organizational standard, and promotes the development of cultural competency skills within its workforce. As an organization, DHS will ensure that cultural competence is included where appropriate in policy and/or program planning, implementation and evaluation. Cultural competency will be a Performance Evaluation component for all DHS programs and managers.

DHS strives towards the principles of universal respect and dignity for all who enter its facilities and participate in its programs, and fosters an attitude of openness to perspectives that are new or different.

DHS recognizes the integral relationship between cultural and linguistic competency and clinical effectiveness, improved health outcomes, patient /clinician rapport, and may potentially reduce overall costs of providing health services to LA County's diverse populations.

## STANDARD 2: ORGANIZATIONAL ACCOUNTABILITY

**STANDARD:** The DHS commitment to cultural and linguistic competence is system-wide and articulated by written DHS policies, practices, procedures and programs. DHS leadership models and promotes cultural competence as an active part of the DHS organizational culture, and will develop and/or provide the necessary professional development training to staff in these areas.

DHS leadership, including all managers, is accountable to the public in matters of legal compliance and accreditation requirements, and for the department's policy on cultural and linguistic competence.<sup>c</sup> DHS leadership is committed to ensuring that cultural and linguistic policies are administered and implemented consistently across the department with guidance from the Office of Diversity Programs.

DHS leadership will involve diverse sectors of the community in the planning, ongoing feedback and evaluation of programs and services. *(For Suggested Program Steps, please see Section III, page 17.)*

## STANDARD 3: EXPECTATIONS OF DHS EMPLOYEES & CONTRACTORS

**STANDARD:** All individuals working at DHS facilities and programs, Public Private Partners, and other contracting entities providing health care services should aspire to carry out their duties in a manner consistent with the definitions and organizational expectations for cultural and linguistic competency. These expectations seek to clarify the knowledge, skills, attitudes, and practices as tools for staff to provide culturally and linguistically competent health care services to the diverse patient population of Los Angeles County and to work effectively with other staff in the workplace.

Staff should have opportunities for continual skills building, including a range of professional development workshops, trainings, and new staff orientation including the mission, vision and values of DHS.

### **In brief:**

**Knowledge** includes demographics, disease patterns, health beliefs and cultural patterns, religious preferences and differences pertaining to culture, basic self-awareness of one's own cultural beliefs and communication patterns, available community resources and relevant laws relating to cultural and linguistic access.

**Skills** includes ability to respectfully elicit relevant cultural information and work from the perspective of the other culture, creating a welcoming environment, identify and appropriately work with cultural and linguistic differences, and use interpreter services and other culturally appropriate services and resources.

**Attitudes** includes valuing cultural competence and patient and staff diversity, conveying compassion and caring, demonstrating a willingness to learn about other cultures and perspectives, respect for other beliefs, and an obligation to stand up against intolerance.

*(For Suggested Program Steps, please see Section III, page 16. Expectations of knowledge, skills, attitudes and practices are set forth in Appendix G, page 49.)*

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<sup>c</sup> See Appendix D: Relevant Laws, Policies & Accreditation Requirements, on page 29; and Appendix C: Current DHS Cultural and Linguistic Policies, on page 27

## B. SYSTEMS FOR ENSURING LINGUISTIC ACCESS

### STANDARD 4: ASSESSING LANGUAGE NEEDS

**STANDARD:** Each DHS facility or program will ask patients for their preferred written and spoken language, and whether they need an interpreter at any point where the patient presents for patient care, including telephone calls. The patient's primary/preferred language will then be recorded in the patient's medical record, with this data maintained as a required field in the facility information system.

When facility or program staff place or receive a telephone call and cannot determine what language the person on the line is speaking, bilingual staff, onsite interpreters or a telephone interpreting service will become involved in making an expedient determination.

*(For Suggested Program Steps for Language Assessment please refer to Section III, page 17)*

### STANDARD 5: COMMITMENTS FOR INTERPRETER SERVICES

**STANDARD:** All LEP patients seeking services at DHS facilities are entitled to qualified oral interpreting at no cost, regardless of language. Each DHS facility will maintain sufficient interpreter resources such as bilingual staff, staff interpreters, contracted interpreters from outside agencies, telephone interpreting services, and credentialed volunteers, to ensure a timely response when interpreters are needed. Minors may not be used to provide interpreting services except in life-threatening situations. Clinicians will receive professional development coaching on how to work effectively with a qualified interpreter.

**Signage:** The facility will post and maintain a sign, similar in size and legibility to the Hill-Burton Community Service notices supplied by HHS under the provisions of 42 C.F.R. '124.604(a), informing the public of the availability of interpreter services at all points of contact. The sign, in at least the threshold languages for Medi-Cal Managed Care, will say: "You have the right to an interpreter at no cost to you. Ask at the front desk." A "Point to Your Language" card in, at least, the MediCal threshold languages will be maintained at the points of contact. *(For Suggested Protocol, please see Section III, page 17.)*

### STANDARD 6: QUALIFICATIONS FOR INTERPRETER SERVICES

#### Staff Interpreters:

**STANDARD:** All staff providing interpreting services to patients will be qualified, trained, tested and monitored by a DHS approved program to determine competency to provide interpreter services in health care settings. A qualified group of stakeholders including experts within the field of medical interpreting services, key DHS staff, and a union representative will advise on the development of this program which will include a curriculum for training bilingual staff in the role of interpreters. Recruitment and placement of interpreters and translators should be based on resource availability of qualified interpreters. *(For Suggested Protocol please see Section III, page 17.)*

#### Non-staff Interpreters:

**STANDARD:** Non-staff interpreters may include outside interpreting services or telephone interpreting services. The facility should investigate and use those services whose standards, protocols, evaluation and training is similar to that expected of staff.<sup>d</sup> When staff at the facility, or the LEP person, has reason to believe that an interpreter is hampering effective communication, staff shall obtain another interpreter.

<sup>d</sup> See Appendix D: Relevant Laws, Policies & Accreditation Requirements, on page 29; and Appendix C: Current DHS Cultural and Linguistic Policies, on page 27

## STANDARD 7: WRITTEN TRANSLATIONS

**STANDARD:** All DHS vital documents should be translated into the identified Medi-Cal **threshold languages**<sup>e</sup> for Los Angeles County. DHS staff responding to LEP persons making inquiries regarding English language documents should access bilingual staff or request an interpreter for assistance.

Vital documents requiring translation include, but may not be limited to:

- Signage and way-finding directions
- Patient intake forms
- Consent forms for, but not limited to, the following examples: medical treatment, surgery, anesthesia, inpatient psychiatric treatment, and diagnostic tests
- Advance directives
- Patient complaint forms
- Letters and notices pertaining to the reduction, denial or termination of services or benefits
- Letters or notices that require a response from the beneficiary or client
- Documents that advise of free language assistance
- Information on emergency health issues
- Patient rights and responsibilities
- Billing and financial information
- General information on current clinical trials being conducted within the facility and opportunities to participate
- Applications for federal/state health and social services programs, including financial assistance
- Consents to release medical information
- Appointment reminder notices
- Key Health education materials
- HIPAA Privacy Notice.

Other written materials will be translated when it is determined that a printed translation is needed for effective communication. If there is no translation for an English language document, or the LEP patient/client cannot read the translated version, a qualified interpreter will orally sight translate<sup>f</sup> the document for the LEP individual whenever possible.

An Interpreter Attestation Form must be completed when an interpreter is interpreting a discussion between a patient and a physician relating to a medical procedure, particularly for the purpose of obtaining an informed consent for treatment, and/or the sight/oral translation of the written information contained on the informed consent form in the presence of the healthcare provider. This form will be signed by the interpreter verifying that the information was interpreted. The signed Form will be attached with the consent to the medical record.<sup>g</sup>

English language documents not deemed vital will include a notice written in the MediCal threshold languages to contact the facility if reading assistance is needed.

*(For Suggested Program Steps and Protocol see page 17 in Section III.)*

## C. CULTURAL & LINGUISTIC OPERATIONAL STANDARDS

### STANDARD 8: CULTURAL/LANGUAGE ACCESS MONITORING AND RECORD KEEPING

**STANDARD:** DHS and its entities will monitor the implementation of the DHS Cultural and Linguistic policies on an on-going basis, and maintain updated records of patients' race/ethnicity, primary/preferred language, and the interpreting provided. All facilities and programs will report patient /client cultural and linguistic data as a standard part of their DHS reporting.<sup>h</sup> The reporting system will be standardized among DHS entities using compatible data and reporting format. The monitoring of cultural and language access will require interdepartmental cooperation; maintaining program and facility records will be coordinated by the LEP Administrators with overall coordination by the Office of Diversity Programs (ODP). *(For Suggested Protocol see page 17 in Section III.)*

<sup>e</sup> See definition on page 25.

<sup>f</sup> See definition of "sight translation" on page 25.

<sup>g</sup> See page 28 in Appendix C for a copy of the Interpreter Attestation Form, referring to DHS Policy 314.2.

<sup>h</sup> See Standard 4, Assessing Language Needs, on page 17

## STANDARD 9: CULTURAL & LINGUISTIC COMPETENCY TRAINING

**STANDARD:** DHS will provide the necessary tools, skills and knowledge to support and improve culturally competent practices. This includes creating a workplace environment that empowers staff to work comfortably and effectively across the cultural and linguistic boundaries presented by patients/clients and with other DHS staff.<sup>i</sup>

DHS should develop and provide training opportunities for staff and senior management, as well as to physicians, nurses, allied technologists and other clinicians and providers, on diversity and cultural and linguistic competency. These trainings should include the linkage between cultural and linguistic care and improved health outcomes, legal requirements and policies including the DHS Standards, quality of care issues, and the importance of the skilled use of qualified interpreters, and information about the programs and services of the ODP. DHS staff, at all levels, have the responsibility to avail themselves of training programs and practices that promote culturally competent care. *(For Suggested Program Steps see Section III, page 17.)*

## STANDARD 10: HEALTH FACILITY STAFFING

**STANDARD:** DHS will work to build a workforce able to address the cultural and linguistic needs of our patients, and to provide appropriate and effective services as required by federal, state and local laws, regulations and policies. DHS will promote a system of recruitment and retention of qualified staff from diverse backgrounds who understand their patient cultures and communities in order to support an organizational culture that can better serve the community. Training opportunities to increase cultural and linguistic competency skills will be made available to assist staff with responsibilities for direct patient care.

DHS will annually assess the organization's progress in recruitment, hiring and retention of qualified bilingual and bicultural employees. Human Resource managers within DHS should assess and report on employee promotions, terminations and resignations, including the use of exit interviews, to evaluate how well the organization is doing in the promotion and retention of a diverse work force. *(See page 17 in Section III for suggested program steps.)*

## STANDARD 11: COMPLAINT/GRIEVANCE PROCESS

**STANDARD:** DHS will develop and implement a process to ensure a prompt and equitable resolution of complaints or grievances addressing its provision of culturally and linguistically appropriate services, and will monitor such complaints and their resolution. As part of its patient satisfaction efforts, DHS provides various complaint/grievance mechanisms to facilitate communication and problem resolution within its organization.

DHS entities will maintain a log of cultural and language complaints and the record of complaint resolution. This will be included in the facility's required complaint report issued quarterly and sent to the DHS Quality Improvement (QI) with a copy to the ODP. Aggregate data submitted to Quality Improvement and the ODP will be subject to an annual review. An annual report of all cultural and language access complaints will be prepared by the LEP Administrators and provided to the ODP and QI which will prepare a department-wide annual report, using aggregated, de-identified data to safeguard patient confidentiality.

*(A suggested protocol for resolution of cultural or language access complaints, including external options, such as the State DHS Medi-Cal Managed Care Ombudsman and the U.S. Department of Health & Human Services Office of Civil Rights, may be found on page 17 in Section III.)*

<sup>i</sup> A listing of the broad range of knowledge, skills, attitudes and tools helpful in working with a diverse population of patients and co-workers appears on page 17 in Section III.



## SECTION III: SUGGESTED PROTOCOLS FOR STANDARDS IMPLEMENTATION

### **Standard 2 – Organizational Accountability**

#### **Suggested Program Steps:**

1. Establishment of DHS policies, practices, procedures, and programs that reflect the commitment to cultural and linguistic competence. This will include the development of system-wide procedures to incorporate cultural competency as a component of performance evaluations and in the recruitment, hiring, promotion, retraining and retention of a healthy and relevant workforce.
2. An evaluation system should be designed and implemented to monitor and provide ongoing feedback on the effectiveness of diversity and cultural and linguistic competency programs and strategies, including employee training sessions.
3. The DHS Director will appoint 12 individuals to form an advisory body of stakeholders to meet on a quarterly basis to facilitate community input and support in implementing and evaluating the cultural and linguistic competency standards.
4. DHS will continue to disseminate updated regulatory policies, regulations and accreditation guidelines relating to requirements guiding issues of language and culture matters to all facilities and programs.

### **Standard 3 – Expectations of DHS Employees and Contractors**

#### **Suggested Program Steps:**

1. Information updates on demographics, disease patterns, legal mandates, and health care beliefs and needs of population being served will be made available to employees in patient care by DHS.
2. Information on how to access tools such as interpreter services, resource library, community resources and the DHS web site should be provided by DHS to all facilities.
3. DHS staff will attend trainings on diversity and cultural competency, which will also include the US DHHS Office for Civil Rights Guidelines on Title VI and the DHS Cultural & Linguistic standards.
4. A cultural competency self-assessment tool should be developed and made available to all DHS staff and contractors. Completed self-assessments will be discussed with staff.
5. Training should be developed and provided on how to assess C& L issues, including working with cultural and linguistic differences, complaints, eliciting relevant cultural information and finding best practice resources. *(Note: A listing of Knowledge, Skills, Attitudes, Practices and Tools related to cultural and linguistic competency may be found in Appendix G, Section II on page 49)*

### **Standard 4 – Assessing Language Needs**

#### **Suggested Program Steps:**

1. At the first point of contact, each facility will assess a person's preferred language.
2. If a patient indicates or states they need or want an interpreter, he/she will be deemed to be Limited English-Proficient (LEP). If any patient, parent of a minor or person legally responsible for the patient is assessed as LEP, he/she shall be informed of their right to have an interpreter at no cost to them with a posted notice in writing in at least the Medi-Cal threshold languages.<sup>j</sup>

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<sup>j</sup> See definition in Appendix A: Definitions, on page 23

3. To further assist the LEP patient, the facility could use a “point-to card” to immediately access telephonic interpreters or bilingual staff to verbally inform him or her of the availability of qualified oral interpreter services at no cost to them.
4. The Primary/Preferred language of the LEP patient will be a required field in the facility information system for patient intake.
5. Management Meeting reports should include patient language assessment data.
6. Reports identifying language needs/preferences of the facility patients should be generated on a quarterly basis. (See Standard 8, on page 14)

## **Standard 5 – Commitments for Interpreter Services**

### **Suggested Protocol:**

If the LEP person objects to or declines the facility's interpreter services and requests the use of a family member or friend, the patient may have that person (but not a minor) interpret, “if the use of such a person would not compromise the effectiveness of services or violate the LEP person’s confidentiality. The facility should document the offer and declination in the patient’s file. Even if an LEP person elects to use a family member or friend, the facility should suggest that a trained interpreter sit in on the encounter to ensure accurate interpretation.”<sup>k</sup> The trained interpreter in this situation stays discreetly in the background and only speaks when interpreting provided by the family member is inaccurate or incomplete.

It is recommended that when discussing complex medical situations, such as treatment alternatives with different risks and potentially different outcomes, or obtaining informed consent, that the importance of a trained, no-cost interpreter be repeated. The facility will monitor these interactions and continue to offer interpreter services if it appears there are problems with the arrangement. The facility shall document in the patient's record the name of the interpreter providing services, or that an offer for an interpreter was made and refused along with the reason, and the name of the person serving as an interpreter at the patient's request, and the purpose of the visit. However, when possible, the facility should have its own trained interpreter present to ensure that accurate communication is being provided to the LEP person(s) and to the provider(s).

## **Standard 6 – Qualifications for Interpreter Services**

### **Suggested Protocol:**

1. Interpreter training should include, but is not limited to, basic medical terminology, cultural and linguistic competency; interpreter ethics including confidentiality, accuracy, completeness and ethical decision-making; and interpreter intervention techniques, roles, protocols and procedures. Established interpreter standards, the California Standards for Healthcare Interpreters: Ethics, Protocols, and Guidance on Roles and Intervention, by the California Healthcare Interpreters Association should serve as the recommended protocol for DHS interpreters. <sup>l</sup> Language proficiency testing, interpreter training, and an evaluation process and tools should be established, approved, and administered centrally for DHS.
2. Bilingual staff in the role of an interpreter should be assessed for their language fluency and provided with basic training in interpreter standards and protocols. ODP will continue to offer Medical Interpreter Training programs to bilingual/bicultural staff that have direct patient contact.
3. Bilingual clinicians who work directly with patients in their non-English language without an interpreter present should possess the appropriate language proficiency qualifications.

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<sup>k</sup> quoted from, health and Human Services Office for Civil Rights Guidance<sup>60</sup>

<sup>l</sup> See page 53, Appendix H, for the executive summary of the CHIA interpreter standards.

### Suggested Program Steps:

1. Appropriate evaluation tools and assessments will be developed for all DHS staff used as interpreters.
2. Interpreter training will be developed and provided for all DHS staff passing the qualifying assessments.
3. In addition, a train the trainer program for medical interpreter training should be developed and implemented; as well as a workshop to coach clinicians on how to successfully work with a trained interpreter. *(See page 49 and Appendix G for the full range of training and topics)*
4. The ODP together with LEP Administrators should maintain an updated list of translation and interpretation service agencies and vendors and their qualifications; as well as a standardized glossary of terms and a list of languages spoken in each SPA.

### Standard 7 – Written Translations

#### Protocol:

1. Department-wide Translation Policies should be updated to include guidelines and protocol in the DHS Cultural & Linguistic Standards.
2. For any document written only in English, including all correspondence to patients, the following notice will be included in the Medi-Cal threshold languages: “Important: This document about your health care is important. If you need help reading it, ask facility staff for an interpreter to help you.” DHS staff responding to LEP persons making inquiries regarding English language correspondence should access bilingual staff or request an interpreter for assistance.  
DHS will develop and implement a train the trainer program for interpreter training. A workshop will be developed to coach clinicians on how to successfully work with a trained interpreter. *(See also Standard 9 on page 15 for the full range of ODP training.)*
3. For quality assurance, the process for all complex translated documents should include review by a second qualified translator to ensure accuracy and the equivalency of the translation to the original document’s **register**.<sup>m</sup> Community field testing of translated vital documents is recommended.
4. Use of computer translation for patient care documents, is strongly discouraged. Computer translation in other areas should be used with caution.

### Suggested Program Steps:

1. A system to coordinate, centralize (where appropriate), and make vital translated materials available to all DHS facilities and programs should be established for to ensure cost savings and efficiency.
2. Evaluation and assessment tools for all DHS staff translating documents will be developed. Training for translators should be developed and provided for all DHS staff passing the qualifying assessments.
3. The DHS Webmaster, LEP Administrators and ODP should develop a centralized database on the DHS/ODP Intranet/Internet website to make standardized translated vital documents accessible to facilities and programs and partners.
4. As a rule, DHS English-language documents should be tested for appropriate literacy level and readability wherever possible.

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<sup>m</sup> See definition on page 25

## **Standard 8 – Cultural & Language Monitoring and Record-Keeping**

### **Suggested Protocol:**

1. DHS will enhance the data collection system to capture patient culture and language information, and develop a reporting system that assures ready availability of data. On a quarterly basis, the following standardized reports will be compiled with a copy sent to the ODP:
  - (a) Race/ethnicity and primary/preferred language of all patients in collaboration with DHS facilities and programs, Information Systems and Data Warehousing, (and the Office of Health Assessment and Epidemiology-when needed);
  - (b) Monitoring of complaint logs on cultural and linguistic access (collaboration with DHS Quality Improvement; and
  - (c) Records of all cultural competency training participation and evaluations will be compiled with a copy sent to the ODP.
2. Patient/client cultural and language data will be included in DHS patient-related reports.
3. DHS facilities and programs should include the reports on cultural and language access data and the complaint log in its management and performance improvement meetings to discuss cultural and language issues, identify patterns or trends, address the status of unresolved complaints, and seek resolution through quality improvement efforts. Facilities and programs should incorporate feedback on cultural and linguistic matters from its Local Diversity Operations Council and/or community advisory board into its reports.
4. The ODP should meet at least annually with DHS facilities and programs to review the reports they submit, and to determine if the language and cultural access needs of DHS patients are currently being met by the resources provided by the organization. DHS review and monitoring of its cultural and linguistic services must have a direct link to its quality improvement process.
5. The ODP, working with DHS Quality Improvement and LEP Administrators, will prepare a written summary of the status of DHS language access services, based on the quarterly reports and annual review, submitted to the DHS Director and Chief Operating Officer.
6. A system should be developed to efficiently capture and report (a) the number of LEP patients, by language group, for whom interpreter services were used and the source of the interpreting provided; and (b) Documentation in medical records when LEP patients reject DHS interpreter services.<sup>n</sup>

## **Standard 9 – Cultural & Linguistic Competency Training**

### **Suggested Program Steps:**

1. ODP, with its partners, should expand and enhance training workshops on cultural competency offered on an on-going basis to all staff at DHS facilities and programs.
2. ODP, with its partners, will develop, and Human Resources will subsequently implement and maintain a training module on the need for language and cultural services, to be provided for new staff orientations. An updated mandatory employee training on Diversity and Cultural and Linguistic Competency will be developed by ODP and its partners.
3. Training opportunities for senior management, including clinicians and administrators, should emphasize the linkage between culturally and linguistically competent care and improved health outcomes and should include relevant legal and regulatory information on cultural and linguistic competency matters, particularly as they relate to fiscal, epidemiological, and quality of care issues; and current cultural and demographic information on the patient population. In addition, clinicians should be provided with opportunities to learn how to work effectively with a trained interpreter.

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<sup>n</sup> Also see Standard 11, Complaint / Grievance Protocol, on page 15

4. With appropriate support, the DHS/ODP website should be developed into a centralized site for diversity and cultural and linguistic resources. The site could include resources such as a listing of all DHS training on diversity, cultural and linguistic competence and interpreter standards and protocols opportunities, a translation database, and links to a resource library that will be established and maintained that includes best practices, videos, and community resource directories.
5. The website will also have a section on legal and regulatory information regarding cultural and linguistic competency matters, available to DHS staff, clinicians and consumers. DHS facilities and entities sponsoring or holding such trainings separately from the ODP should, at a minimum, notify the ODP that such activities are planned, and provide an annual report of workshop content and participation.
6. DHS Diversity and Cultural and Linguistic Competency Training Components, and Training Methodologies. *(for a suggested list of training topics for clinicians please refer to Appendix G: Cultural Competency Training Topics, page 49.)*
7. Training Components:  
Systematic training should include but is not limited to:
  - The importance of effective communications with patients in the medical setting;
  - The organization's legal obligation to provide language services as part of county, state and federal laws, regulations and accreditation requirements related to cultural and linguistic access issues;
  - Updated information about the patient populations, including demographics.  
*[See Appendix I on page 55];*
  - The impact of ethnicity, health beliefs, cultural norms and family values on health-seeking, decision-making and health behavior, and the importance of clinician awareness of these elements in the provision of health care;
  - Information about health status disparities in ethnic and racial populations and their root causes.
  - Epidemiological patterns of disease for the communities being served;
  - Awareness of one's own cultural biases and framework;
  - Orientation on these DHS cultural and linguistic standards, policies and procedures;
  - Assessing a patient's need for interpreter services;
  - Knowledge of how to access in-house, contracted, volunteer, or telephone service interpreters; the importance of trained interpreters, and how to work effectively with an interpreter;
  - How to utilize telephone interpreting equipment or conference calls with a telephonic interpreter;
  - How to assess when a different interpreter or a different mode of interpretation is appropriate; and,
  - The role of DHS senior management in the cultural and linguistic compliance.

These tools and skills can be developed to evaluate, on both the individual and organization levels, DHS participation in and the effectiveness of ODP diversity and cultural competency training and marketing. The evaluation system, including performance measures, will be developed, implemented with appropriate resource support, baselines determined, and longitudinal assessments made on an annual basis. *(A more complete listing of training topics for clinicians, as well as individual knowledge, skills and attitudes, appears in Appendix G on page 49)*

## **Standard 10 – Health Facility Staffing**

### **Suggested Program Steps:**

1. DHS will develop a plan to recruit sufficient bilingual /bicultural staff to meet the needs of culturally diverse and LEP patients.
2. The plan should include how DHS plans to recruit bilingual/bicultural linguistically qualified staff from potential labor pools such as community colleges, State University and University of California colleges, high schools, local E.D.D. offices, non-profit and for profit employee training agencies, and other community-based, ethnic-serving organizations.
3. All recruitment communication efforts will include the use of the ethnic media. DHS Human Resources (HR) will work with Public Information to maintain an updated list of all ethnic media to assist with recruitment efforts. This includes radio, television, cable, ethnic and targeted neighborhood newspapers.

## **Standard 11 – Grievance Process**

### **COMPLAINT PROCESS – EXTERNAL OPTIONS:**

The State DHS Medi-Cal Managed Care Ombudsman is available to provide assistance in investigating and resolving any grievances involving a Medi-Cal recipient. A patient may call the Ombudsman Program toll free at 1-888-452-8609. The patient has the right to request a fair hearing from the California Department of Social Services by contacting the Public Inquiry and Response Unit at 1-800-952-5253, TDD 1-800-952-8349. The patient should also be informed that he/she may file a complaint with the U.S. Health & Human Services Office for Civil Rights by calling 1-800-368-1019. Complaints about interpreter services can also be registered with the State DHS Licensing and Certification, Orange County District at 1-800-228-5234, TDD 1-800-735-2929.

### **Options for resolution of cultural or language access complaints:**

DHS complaint forms will include a “cultural/linguistic complaint” check box. Upon request, a patient will be provided with a Patient Complaint/Grievance form. The patient can fill out this form, or request the assistance of a DHS staff representative to complete the form on their behalf and/or provide an oral interpreter or other method of language assistance. The Patient Complaint Form will be considered the formal documentation of the complaint. Whenever possible, the designated facility complaint staff will attempt to resolve the complaint on the day it is received.

Complaints/grievance pertaining to patients enrolled in the Healthy Families and Medi-Cal programs will be forwarded to contracted health plans according to the timelines required by the program/contracted entity.

The designated DHS staff member and/or the complaint staff will acknowledge receipt of a patient’s grievance orally or in writing within 7 working days, and will include the name and contact information for the LEP Administrator who may be contacted to discuss the case. In consultation with the LEP Administrator, appropriate action will be initiated to address and/or resolve the patient’s cultural and/or linguistic complaint/grievance and the patient will be contacted with a response within 30 days. The facility senior manager should consult with the LEP Administrator and the facility’s Grievance/Complaint Coordinator to determine if referral to DHS Quality Improvement is needed if no resolution has taken place within this time.

A patient has the right to be accompanied by an advocate, a friend, or other spokesperson during this internal grievance process. The patient may request interpreting assistance and/or documents pertinent to his/her complaint as permitted by applicable law. If a patient feels that no satisfactory resolution is possible, the patient may request a referral to another facility or provider for their medical care.

## SECTION IV: APPENDICES

### APPENDIX A: DEFINITIONS / GLOSSARY

There are many definitions of cultural and linguistic competence and related terminology. Los Angeles County Department of Health Services offers the following definitions for the implementation of standards contained in this document.

**Access:** the degree to which services are readily obtainable – determined by the extent to which needed services are available, information about these services is provided, the responsiveness of the system to individual cultural and linguistic needs, and the convenience and timeliness with which services are obtained.

**Back Translation:** a written translation conducted by a Qualified Translator other than the original translator who translates from the target language back to the source language. If it is a complex or legal document, a Back Translation is desirable.

**Cultural Awareness:** the development of sensitivity and understanding of another racial/ethnic group. It usually involves changes within an individual toward others in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that a person develops in relation with others. Cultural awareness must be supplemented with cultural knowledge.

**Cultural Competence:** a set of congruent behaviors, attitudes, policies and practices which creates and fosters an organizational culture that enables health care providers and organizations to:

- Recognize and acknowledge diverse groups within the service population;
- Understand the role of diverse values, norms, practices, attitudes and beliefs about disease, treatment and prevention in program and policy development and health services planning;
- Enhance accessibility to services to diverse groups by improving cultural and linguistic competencies and availability;
- Take a holistic view of health, inclusive of cultural health beliefs and practices, and the physical, mental and emotional aspects of diverse groups;
- Respect and support the dignity and perspective of the client, patient, family and staff, to best address the health interest of the patient;
- Ensure systems of recruitment, evaluation, staff development and retention that support an organizational culture and staff that are better able to provide health services that meet the cultural and linguistic needs of the community;
- Improve the health status of the populations and communities served.

**Cultural Diversity:** a constellation of people consisting of distinctive ethnic groups, colors and races, languages, customs, styles, values, beliefs, gender, ages, education, knowledge, skills, abilities, functions, practices, religions, socioeconomic status, sexual orientation and geographic areas.

**Cultural Responsiveness:** A measure of the knowledge, skill and sensitivity of healthcare professionals and their organizations to become aware of the individual and systemic needs of culturally diverse populations, and their subsequent receptivity and openness in developing, implementing and evaluating culturally-appropriate individual and institutional responses to these needs. (California Standards for Healthcare Interpreters, CHIA, 2002)

**Cultural Sensitivity:** recognition and respect for customs and cultural norms different from one's own.

**Culture:** the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people. Culture is a vital factor in both how clinicians deliver services and how patients respond to medical services and preventive interventions. Culture is determined not only by ethnicity but by factors such as geography, age, language, religion, gender, sexual orientation, physical ability and socioeconomic status.

**Department of Health Services (DHS) Entities:** includes DHS in-patient and outpatient facilities, programs, Public Private Partners (PPPs) and other contracting entities.

**Department of Health Services (DHS) facilities and programs:** DHS hospitals, comprehensive health centers, public health centers and public health programs.

**Interpreter, qualified:** A qualified healthcare interpreter is one who has, 1) been trained in healthcare interpreting, 2) adheres to the professional code of ethics and protocols of healthcare interpreters (such as CHIA's California Standards for Healthcare Interpreters), 3) is knowledgeable about medical terminology, and 4) can accurately and completely render communication from one language to another. Ideally, a qualified healthcare interpreter will have been tested for their competency in the languages in which they interpret. A healthcare interpreter may include a bilingual or multilingual provider or medical staff. Minor children are disqualified from being considered an interpreter because they lack the interpreter training, skills, vocabulary, and maturity, and are therefore ethically inappropriate to be given the responsibility for the task of healthcare interpreting, except in extremely rare emergency situations.

**Interpreting:** involves conveying both the literal meaning and connotations of spoken and unspoken communication (e.g. body language, mannerisms) from one language into another to the health practitioner and the patient. *(CHIA: The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account (ASTM, 2000). The purpose of interpreting is to enable communication between two or more individuals who do not speak each other's languages.)*

**Interpretation:** While the two words have the same meaning in the context of oral/signed communication, the term interpreting is preferred, because it emphasizes process rather than product and because the word interpretation has so many other uses outside the field of translation and interpreting. (National Council on Interpreting in Health Care)

**Limited English Proficient (LEP):** an LEP individual is a person who is unable to speak, read, write or understand the English language at a level that permits him/her to interact effectively with health and social service agencies and providers.

**LEP Administrator:** a designated administrator at each facility and program responsible for managing limited and non-English speaking services, issues and resources.

**Linguistic Competency:** the health care organization's ability to provide its non and limited English speaking patients with timely, accurate and confidential interpretation services, and quality, culturally appropriate translated materials; a key component of cultural competency.

**Multicultural:** consisting of cultural characteristics representative of one or more ethnic groups. Multicultural individuals may acquire the norms, attitudes and behavior patterns of their own and one or more ethnic and/or cultural groups.

**Public Private Partners (PPPs):** Private, community-based clinics the County contracts with to provide primary care and some specialty services in order to expand access to ambulatory care for uninsured patients under the 1115 Waiver.

**Preferred Language:** refers to the language an individual is most proficient in and uses most frequently to communicate with others inside and outside the family system.

**Qualified Translator:** One who is able to read, write, and understand both the target language(s) and English; has had training in medical interpreting and translation, has knowledge of medical terminology, and has knowledge and experience with the culture(s) of the intended audience.

**Register:** A speaker's pronunciation and choice of vocabulary and grammar which contribute to the speaker's perceived level of literacy, education or social class. Register is also a component of readability in written documents; translations should be in the identical register of the original, including vocabulary and complexity of ideas and sentence structure.

**Sight translation:** The process of a qualified interpreter reading a document written in one language, and orally describing the content of the document in the language of the patient or the clinician.

**SPA:** Service Planning Area. Eight (8) geographic regions for planning, information-sharing and data gathering were agreed upon to move towards more integrated and comprehensive services across Los Angeles County. In 1993, the Board of Supervisors adopted these 8 SPAs as a framework for cross-agency, cross-jurisdictional planning for children and families. *(See Appendix I, page 55)*

**Threshold Language:** A language that meets Medi-Cal qualifications for translation under the Kopp Act (Health and Safety Code 1259). Current Medi-Cal regulations require services and information to be provided in the person's primary/preferred language if the person is in a mandatory Medi-Cal eligible population of 3,000 in a proposed Service Area (L.A. County) or 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes. According to the California Department of Health Services, Medi-Cal Managed Care Division, the threshold languages for Los Angeles County are: Armenian, Chinese, English, Khmer (Cambodian), Russian, Spanish and Vietnamese. *(See Appendix K, on page 62, for a comparison of threshold languages in California Counties)*

**Translation:** The rendering, in writing, of a written text from one language into a written text in a second language. Accuracy is often checked on a translation's accuracy by having a second qualified translator "back translate" the translated document into the original language (English), for comparison with the original document. In this document, the standard for complex documents is that a qualified translator will simply "check" the accuracy of complex translations.

**Transparency, or Transparent interpreting:** The idea that the interpreter keeps both parties in the interpreting session fully informed of what is happening, who is speaking, and what the interpreter is doing, is known as "transparency." Whenever interpreters intervene by voicing their own thoughts and not the interpreted words of one of their clients, it is critical that they ensure that a) the message is conveyed to all parties and b) everyone is aware that the message is from the interpreter. (as for example, "...the interpreter would like to say,...") (CHIA)

## **APPENDIX B: WORK GROUP GUIDING PRINCIPLES for DHS CULTURE & LINGUISTIC STANDARDS**

The following guiding principles were developed by the Work Group (1999-2001), and have been incorporated into the Standards & Process Steps:

- That the cultural and linguistic standards adopted by the Board of Supervisors for DHS reflect the regulations, requirements and recommendations of state and federal law as well as accreditation agencies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA);
- That the DHS Cultural and Linguistic Standards are established to improve the ability of DHS and its entities to fully communicate with the various cultures for whom we provide services, and thereby to improve health outcomes;
- That DHS commitment to cultural and linguistic competence will be system wide and articulated by written DHS cultural and linguistic policies, practices, procedures and programs; and to the extent possible, will include sufficient allocation of resources, necessary staffing and other support needed to implement these standards;
- That DHS adopt a definition of cultural and linguistic competency that can be operationalized through cost-effective quality services;
- That DHS approach cultural competency as both an organizational and individual employee responsibility: DHS will support its staff by providing appropriate training and tools for the delivery of cultural and linguistically competent services; individual staff will be expected to avail themselves of the training and tools and operationalize them in the care they provide;
- That there will be accountability throughout all levels of the organization;
- That the achievement of cultural and linguistic competency be considered a developmental process in which implementation will be guided by clear standards and evaluated by measurable objectives;
- That these competencies be need-driven -- that is, that they are supported by an assessment of the diverse populations served and their health care needs;
- That DHS will utilize opportunities to enroll patients in existing programs to increase revenue to the County for patients being served by working with community based organizations, community clinics, and hospitals;
- That DHS develop a mechanism to assure community input on the cultural and linguistic needs of communities within the organization's service areas; and
- That department-wide implementation of the cultural and linguistic competency standards will be centrally coordinated through the DHS Office of Diversity Programs and provided the necessary resources and authority.

## APPENDIX C: SUMMARY OF CURRENT DHS CULTURAL & LINGUISTIC POLICIES

Motion by Los Angeles County Supervisor Zev Yaroslavsky, unanimously carried on June 26, 2003:

The Department of Health Service's plan to balance the budget and establish a unified healthcare system does not refer to the issue of cultural and linguistic diversity in relation to public access to County health services. Given the diversity and multilingual complexity of the County population, it is important to acknowledge these factors as access issues in the plans for the future health system.

In Los Angeles County approximately 33% of the ten million residents are foreign-born and over 100 language and dialects are spoken. Population diversity in Los Angeles County poses additional challenges in the delivery of health services.

Access to healthcare service and the effectiveness of care are greatly affected by the cultural and linguistic competency of the healthcare delivery system. For this reason, the DHS has drafted Cultural and Linguistic Competency Standards to be implemented in every County healthcare facility. I believe the County healthcare system must incorporate the skills, attitudes, behaviors, policies, and procedures that meet the needs of Los Angeles County's diverse community, particularly the non-English and limited English-speaking populations.

I THEREFORE MOVE that the Board of Supervisors instruct the Director of Health Services to finalize and integrate the Cultural and Linguistic Competency Standards with the Department's redesigned system.

Existing DHS cultural and linguistic policies include providing non- and limited English proficient (LEP) patients with language assistance to ensure meaningful access, including free oral interpreting services for any LEP person requiring health care services from the County. The County also operates a Bilingual Bonus program in which employees whose positions require fluency in English and at least one foreign language on a frequent and continuing basis receive additional compensation. Additional policies will be developed from the Cultural & Linguistic Standards which reflect the County's commitment to cultural and linguistically appropriate health care services.

### **DHS Policy 731 – Bilingual Bonus Plan (Effective 1975)**

The Bilingual Bonus Program is a countywide program mandated by the Board of Supervisors and defined in County Code Section 6.10.140 and in Memorandums of Understanding between the County and labor unions. The Bilingual Bonus Program provides a qualified employee with compensation of \$50 per pay period or \$100 per month.

### **DHS Policy No. 321 – Fair and Equal Treatment of All County Patients (Effective 1975)**

All persons seeking medical treatment shall be treated fairly and equitably, and no preferential treatment shall be afforded to any patient or prospective patient. It is the responsibility of personnel in the Department to adhere to this policy.

### **DHS Policy No. 322 – Patients' Bill of Rights (Effective 1976)**

All Department hospitals shall comply with State legal and regulatory mandates providing for patients' rights while under treatment.

### **DHS Policy 405 – Translation of Written Material (Effective 1992)**

To assure the correct translation of written material, each facility is responsible for developing the wording directly relating to its operation.

### **DHS Policy 318 – Non-English and Limited English Proficiency (Effective September 2000)**

All departmental facilities and programs will provide interpreter assistance at no cost to non-English and limited English speaking patients to ensure meaningful access to services. Resources to be available include employees on Bilingual Bonus, medical interpreter, qualified volunteers, telephone interpreter services, and Sign language.

**DHS Policy 314.2 - Documenting Use of Interpreter Services During Informed Consent Discussions (Effective December 15, 2001)**

An Interpreter Attestation Form must be completed when an interpreter is required to interpret the discussion between a patient and physician as it relates to a medical procedure for the purpose of obtaining an informed consent and/or the oral interpretation of information contained on the informed consent.

○	○	○	○	○
COUNTY OF LOS ANGELES	<b>INTERPRETER ATTESTATION DURING INFORMED CONSENT</b>			DEPARTMENT OF HEALTH SERVICES
<b>Complete one or more of the section(s) below:</b>				
<b>I. ORAL COMMUNICATION</b>				
This is to certify that I, _____ have completely and accurately				
<small>Name of Interpreter</small>				
orally interpreted, in the patient's or patient's legal representative's language, all of the information told to				
_____ by _____,				
<small>Name of Patient</small>		<small>Name of Health Care Provider</small>		
and have completely and accurately orally interpreted all communication between the patient and/or legal representative with the above named health care provider. I have asked the patient and/or legal representative if he/she understood all the terms and conditions and he/she acknowledged consent to the procedure by signing the consent form in my presence.				
_____		_____		_____
<small>Signature of Interpreter</small>		<small>Title or State Relationship to Patient</small>		<small>Date</small>
<b>II. ORAL INTERPRETATION OF CONSENTS/DOCUMENTS</b>				
The document(s) for the signature of the patient is(are) in a language other than the native/spoken language of the patient.				
I, _____, certify that I have accurately and completely				
<small>Name of Interpreter</small>				
Check one: <input type="checkbox"/> READ <input type="checkbox"/> INTERPRETED THE PROVIDER'S EXPLANATION of				
_____ to the patient and/or legal				
<small>Name of Consent and/or Any Other Documents</small>				
representative in _____, which is the native/spoken language of the patient				
<small>Language</small>				
and/or legal representative. He/she understood all of the terms and conditions and acknowledged his/her agreement thereto by signing the document(s) in my presence.				
_____		_____		_____
<small>Signature of Interpreter</small>		<small>Title or State Relationship to Patient</small>		<small>Date</small>
<b>III. TELEPHONE INTERPRETATION SERVICE</b>				
Interpretation of information and/or consent documents was provided in _____				
<small>Language</small>				
by Telephone Operator ID # _____ ; _____ and _____.				
<small>Number</small>		<small>Date</small>	<small>Time</small>	
IMPRINT PATIENT'S I.D.				
<b>INTERPRETER ATTESTATION DURING INFORMED CONSENT</b>				
<small>HS-1001 (8/02)</small>		<small>DISTRIBUTION: MEDICAL RECORD</small>		

## APPENDIX D: RELEVANT LAWS, POLICIES AND ACCREDITATION REQUIREMENTS

Health programs and services are required to provide culturally and linguistically competent care under numerous statutory, regulatory, contract and accreditation authorities. Many of these requirements have been in effect for years; other requirements have arisen more recently, driven by the continuing diversification of the U.S. and California populations. The laws, policies and requirements most relevant to DHS are summarized below.<sup>o</sup>

### FEDERAL LAWS AND POLICIES

The most important federal law governing language accessibility in health care is Title VI of the Civil Rights Act of 1964, but there are other key statutory and regulatory bases at the federal level, including the Hill-Burton Act as well as requirements under Medicaid, the State Children’s Health Insurance Program (SCHIP), Medicare and federal categorical grant programs. Recently, the federal government has also issued a number of federal LEP guidelines on complying with civil rights laws, indicating the federal government’s strong interest in encouraging federally funded programs and services to better serve LEP populations.

#### 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 grounds 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.”<sup>p</sup> Nearly every health care provider is subject to Title VI, because federal funding of health care is almost universal. Federal financial assistance for health care includes Medicare, Medicaid, SCHIP, and block grants to health and welfare agencies, among other sources.<sup>q</sup>

As a recipient of federal financial assistance, DHS and all of its facilities and operations are subject to Title VI and to the U.S. Department of Health and Human Services (HHS) Title VI regulations and guidelines.<sup>r</sup> Title VI and the HHS regulations and guidelines prohibit discrimination on the basis of race, color, or national origin in any federally funded program or activity.<sup>s</sup> Federal courts and agencies have consistently interpreted Title VI protections to extend to limited English proficient (LEP) persons.<sup>t</sup>

#### Presidential Executive Order 13166

In August 2000, President Clinton issued Executive Order (EO) 13166, entitled Improving Access to Services for Persons with Limited English Proficiency.<sup>u</sup> EO 13166, which applies to all “federally conducted and federally assisted programs and activities,” has two main requirements: (1) each federal agency providing federal funding must issue LEP guidance specially tailored to its recipients;

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<sup>o</sup> For a comprehensive review of laws and policies governing culturally and linguistically competent health care, see *National Health Law Program (NHeLP), ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES (August 2003)* (available from The California Endowment, [www.calendow.org](http://www.calendow.org), and NHeLP); Perkins, Jane, *ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: AN OVERVIEW OF CURRENT LEGAL RIGHTS AND RESPONSIBILITIES (August 2003)* (available from the Kaiser Family Foundation, [www.kff.org](http://www.kff.org) or (800) 656-4533). Significant sections of this appendix are taken from these NHeLP publications.

<sup>p</sup> 42 U.S.C. § 2000d.

<sup>q</sup> 45 C.F.R. § 80 app. A.

<sup>r</sup> 42 U.S.C. § 2000d-4a.

<sup>s</sup> 45 C.F.R. § 80 et seq.

<sup>t</sup> See *Lau v. Nichols*, 414 U.S. 563 (1974) (finding that a school system violated Title VI by failing to take assist non-English speaking students.)

<sup>u</sup> 65 Fed. Reg. 50121 (Aug. 16, 2000)

and (2) all federal agencies (whether or not they provide federal financial assistance) must develop and implement their own plans to improve linguistic access to their federally conducted programs.<sup>v</sup> EO 13166 designates the U.S. Department of Justice (DOJ) as the lead agency with the responsibility for providing technical assistance to other federal agencies. It incorporates by reference contemporaneously issued DOJ general guidance and instructs all federal agencies to issue LEP guidance consistent with DOJ policies.

### **HHS Office for Civil Rights and Title VI LEP Guidance**

The U.S. Department of Health and Human Services, through its Office for Civil Rights (OCR), enforces Title VI for federally funded health care programs and services. OCR monitors and enforces compliance with Title VI primarily through responding to complaints received.<sup>w</sup> Over the years, OCR has handled hundreds of complaints and initiated numerous compliance reviews regarding discrimination against national origin minorities due to linguistic barriers. OCR also provides technical assistance to federal fund recipients seeking to make their programs and services accessible to LEP persons. The responsibility for investigations, compliance reviews and technical assistance fall on the ten regional OCR offices, located throughout the country. California is in Region IX, which has a regional office in San Francisco but also a field office in Los Angeles, which focuses on civil rights enforcement in health care in the Southern California area.

A review of OCR Title VI LEP decisions by the National Health Law Program identified certain elements common to programs or services that comply with Title VI:<sup>x</sup>

- Developing a written plan for providing LEP services;
- Designating a staff person to coordinate Title VI compliance;
- Providing information and training to staff on these policies;
- Posting translated notices regarding the availability of no cost interpreters;
- Maintaining effective interpreter services by emphasizing in-person interpretation and, to the extent possible, minimize telephone interpretation;
- Providing translation of important forms and documents
- Collecting, analyzing, and maintaining data to determine if interpreter services are adequately provided; and
- Monitoring subcontractors and including a nondiscrimination clause in all contracts for services.

Subsequent to the release of EO 13166, OCR issued LEP guidance on August 30, 2000, the first federal agency to do so.<sup>y</sup> Following the DOJ's request for federal guidances to be coordinated and reissued, OCR has subsequently reissued its guidance. The current version, entitled "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (Guidance), was issued on August 8, 2003.<sup>z</sup>

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<sup>v</sup> HHS released its plan on December 14, 2001. See U.S. Department of Health and Human Services, *Strategic Plan to Improve Access to HHS Programs and Activities by Limited English Proficient (LEP) Persons* (Dec. 14, 2001), available at <http://www.hhs.gov/gateway/language/languageplan.html>.

<sup>w</sup> 45 C.F.R. § 80.8.

<sup>x</sup> Perkins, Jane, *ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: AN OVERVIEW OF CURRENT LEGAL RIGHTS AND RESPONSIBILITIES* (August 2003) at pp. 13-14.

<sup>y</sup> 65 Fed. Reg. 52762 (Aug. 30, 2000).

<sup>z</sup> 68 Fed. Reg. 47311 (Aug. 8, 2003).

The Guidance states HHS' intent that federal fund recipients take reasonable steps to ensure that LEP persons have meaningful access to programs and activities. Adopting a "flexible and fact-dependent" approach articulated by DOJ, the Guidance asks all fund recipients to assess the following four factors:

- Number or proportion of LEP persons eligible or likely to be served, directly affected, or encountered by the program, using program-specific data along with census, school, state and local, and community-based data from the relevant service area
- Frequency with which LEP individuals have or should have contact with the program, activity, or service
- Nature and importance of the program or service to people's lives
- Resources available to the fund recipient and costs.<sup>aa</sup>

HHS notes that the four-factor analysis necessarily implicates the "mix" of language services, that is, whether oral interpretation and/or written translation services will be offered.<sup>ab</sup> The correct mix should be based on what is both necessary and reasonable in light of the four factors. HHS notes that, depending on the circumstances, the assistance may need to be expedited while in other situations, "pursuant to an agreement, where there is no discriminatory intent, the purpose is beneficial and will result in better access for LEP persons, it may be appropriate for a recipient to refer the LEP beneficiary to another recipient."<sup>ac</sup> For example, if a physician knows that a nearby physician's office can provide linguistically appropriate services to an LEP patient and the offices have a custom/practice of referring patients between each other, it may be appropriate to refer the patient to the other physician.

The Guidance provides specific information about oral interpretation. It describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines,<sup>ad</sup> and using community volunteers. It notes that interpreters need to be competent, though not necessarily formally certified. The Guidance allows the use of family members and friends as interpreters but clearly states that an LEP person may not be required to use a family member or friend to interpret. HHS says recipients should make the LEP person aware that they have the "option" of having the recipient provide an interpreter without charge. "Extra caution" should be taken when the LEP person chooses to use a minor to interpret. Recipients are asked to verify and monitor the competence and appropriateness of using the family member or friend to interpret, particularly in situations involving administrative hearings; child or adult protective investigations; life, health, safety or access to important benefits; or when credibility and accuracy are important to protect the individual. Moreover, if the fund recipient determines that the family member or friend is not competent or appropriate, the recipient should provide competent interpreter services in place of or, if appropriate, as a supplement to the LEP person's interpreter.<sup>ae</sup>

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<sup>aa</sup> *Id.* at 47314-15.

<sup>ab</sup> *Id.* at 47315.

<sup>ac</sup> *Id.*

<sup>ad</sup> *Previous guidance cautioned federal recipients that telephone interpreters should not be the sole language assistance option, unless other options were unavailable. See 67 Fed. Reg. 4968 (Feb. 1, 2002) at 4975.*

<sup>ae</sup> *68 Fed. Reg. at 47317-18.*

With respect to written translation, HHS says it will determine compliance on a case-by-case basis, taking into account the totality of the circumstances (the four factors test).<sup>af</sup> However, like the DOJ guidance, the HHS guidance designates “safe harbors” that, if met, will provide strong evidence of compliance with respect to written translations:

- The recipient provides written translations of “vital” documents (e.g., intake forms with the potential for important consequences, consent and complaint forms, eligibility and service notices) for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally; or
- If there are fewer than 50 persons in a language group that reaches the five percent trigger, above, the recipient provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of vital written materials, free of cost.<sup>ag</sup>

According to HHS, after the four factors have been applied, fund recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Fund recipients may choose to develop a written plan as a means of documenting compliance with Title VI.<sup>ah</sup> If so, the following five elements are suggested for designing such a plan:

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

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<sup>af</sup> *Id.* at 47319. The previous guidance called for the review to include the nature of the service, the size of the recipient, the size of the LEP language groups in the service area, the nature and length of the document, the objectives of the program, total resources available to the recipient, the frequency with which translated documents are needed, and the cost of translation. See 67 Fed. Reg. at 4973.

<sup>ag</sup> 68 Fed. Reg. at 47319. The Guidance makes it clear that the safe harbors only apply to translation of written materials. Previous guidance established different safe harbors, calling for (a) translation of written materials, including vital documents, for each eligible LEP language group that constituted 10 percent or 3,000, whichever is less, of the eligible population to be served; (b) for LEP language groups that did not meet the above threshold, but constituted five percent or 1,000, whichever is less, of the population to be served, the recipient ensured that, at a minimum, vital documents are translated, with oral translation of other documents, if needed; and (c) notwithstanding the above, a recipient with fewer than 100 persons in a language group did not translate written materials but provided written notice in the primary language of the patient of the right to receive competent oral interpretation of written materials. See 67 Fed. Reg. at 4973.

<sup>ah</sup> 68 Fed. Reg. at 47319. The Guidance recognizes additional benefits that a written plan can provide to recipients in the areas of training, administration, planning, and budgeting. It further notes that absence of a written plan does not obviate the need to comply with Title VI, and the recipient may want to consider alternative ways to articulate how it is providing meaningful access in compliance with Title VI. *Id.*

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

HHS also notes that an effective plan will set clear goals and establish management accountability. Recipients may want to provide opportunities for community input and planning throughout the process.<sup>aj</sup>

The August 2003 Guidance notes that systems will evolve over time, and HHS will look favorably on intermediate steps taken that are consistent with the Guidance. HHS repeatedly states its interest in working with fund recipients to disseminate examples of model plans, best practices, and cost saving approaches.<sup>ak</sup>

### **The Hill-Burton Act**

Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers.<sup>al</sup> In return for receiving Hill-Burton funds, recipients agreed to comply with a “community service obligation,” which requires the recipient to make services available to all persons residing in the service area without discriminating on the basis of race, color, creed, or national origin.<sup>am</sup> OCR, which enforces the Hill-Burton Act, has consistently interpreted this to require the provision of language assistance to those in need of such services.<sup>an</sup> This obligation lasts in perpetuity.<sup>ao</sup> Hill-Burton facilities are also required to post non-discrimination notices in English, Spanish and other languages that represent ten percent or more of the households in the service area.<sup>ap</sup>

Past OCR decisions have required hospitals to:

- Develop lists of bilingual interpreters;
- Establish procedures for communicating with LEP patients at all hours of a facility’s operation;
- Notify patients that interpretive services are available; and
- Treat migrant workers and undocumented immigrants who live in a facility’s service area.<sup>aq</sup>

### **Medicaid, Schip and Medicare**

Medicaid, SCHIP and Medicare are government funded health insurance programs that are accepted by DHS entities. Medicaid is a federal-state program that provides health insurance coverage to indigent aged, blind and disabled persons; children; and pregnant women.<sup>ar</sup> A number of Medicaid provisions require state Medicaid agencies and participating Medicaid providers to assure that services are culturally and linguistically appropriate. For example, the Centers for Medicaid and Medicare Services (CMS, formerly the Health Care Financing Administration) states in its primary Medicaid guidance that states must communicate orally and in writing in a language understood by the beneficiary and provide interpreters at Medicaid hearings.<sup>as</sup>

The State Children’s Health Insurance Program (SCHIP) is a federal-state program that provides health insurance to uninsured children. HHS regulations governing the implementation of SCHIP programs address language access (e.g., the regulations address the collection of primary language data of applicants and enrollees<sup>at</sup> ).

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<sup>aj</sup> 68 Fed. Reg. at 47321.

<sup>ak</sup> *Id.* at 47321-22.

<sup>al</sup> Hill-Burton is the popular name for the Hospital Survey and Construction Act of 1946, Title VI of the Public Health Services Act, 42 U.S.C. § 291 et seq. (1995).

<sup>am</sup> 42 C.F.R. § 124.603(a) (1996).

<sup>an</sup> See U.S. Department of Health and Human Services, Office for Civil Rights, *GUIDE TO PLANNING THE HILL-BURTON COMMUNITY SERVICE COMPLIANCE REVIEW* at 16, 27 (June 30, 1981).

<sup>ao</sup> 42 U.S.C. § 291c(e), 300s-1(b)(1)(k) (1995); 42 C.F.R. §§ 124.601, 124.603 (1996).

<sup>ap</sup> 42 C.F.R. § 124.504(a)-(b) (1996).

<sup>aq</sup> See NHeLP, *ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES*, at pp. 2.29-2.30.

<sup>ar</sup> 42 U.S.C. § 1396 (1992); 42 C.F.R. § 430 (1994).

<sup>as</sup> U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services, *STATE MEDICAID MANUAL* §§ 2900.4, 2902.9 (Mar. 1990).

<sup>at</sup> See 66 Fed. Reg. 33810, 33816 (June 25, 2001).

Medicare is the federal health insurance program for persons 65 years or older and certain disabled persons under 65. CMS addresses linguistic accessibility in its Medicare policies. For example, Medicare-participating hospitals may seek reimbursement for the costs incurred for providing bilingual services to inpatients to the extent that the costs are “reasonable in amount and in relationship to the need.”<sup>au</sup> Bilingual services include the costs of interpreters for communication between the provider and patients, printed provider informational material to be distributed to patients, and special personnel recruitment efforts designed to recruit bilingual employees.

### Federal Categorical Grant Programs

Federal categorical grant programs intended to increase health services for poor, disabled and older Americans also include linguistic access requirements. HHS makes grants to plan, develop and operate community health centers that serve medically underserved populations and areas suffering health staff shortages.<sup>av</sup> HHS also provides grants for clinics serving migratory and seasonal agricultural workers, and their families.<sup>aw</sup> Federal law requires these health centers to:

- Develop plans and arrange to provide services “to the extent practicable in the language and cultural context most appropriate to such individuals;”<sup>ax</sup>
- Identify an individual on staff “who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences;”<sup>ay</sup>
- Provide language-appropriate outreach;<sup>az</sup>
- Have governing boards with majorities consisting of clients served by the facility that, as a group, represent the individuals being served in terms of demographic factors such as race, ethnicity, and sex.<sup>ba</sup>

## NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE

In December 2002, the U.S. Department of Health and Human Services Office of Minority Health (OMH) issued National Standards on Culturally and Linguistically Appropriate Services in Health Care (“CLAS Standards”).<sup>bb</sup> Issued by OMH after a lengthy development and public comment period, the CLAS Standards were promulgated to “correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers.”<sup>bc</sup> Since their release, the CLAS Standards have served as an important model for other efforts to improve cultural and linguistic competence in health care, including the development of these DHS Standards.

The 14 CLAS Standards are organized into three areas: culturally competent care (standards 1-3); language access services (standards 4-7); and organizational supports for cultural competence (standards 8-14). The “language access services” standards are considered mandates, as they are based on the legal requirements of Title VI. The other standards are not required per se but OMH strongly recommends their adoption and implementation. Appendix C provides a detailed summary of the CLAS Standards.

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<sup>au</sup> U.S. Department of Health and Human Services, *Health Care Financing Administration, MEDICARE PROVIDER MANUAL § 2147* (Aug. 1979).

<sup>av</sup> 42 U.S.C. § 254c et seq. (1996).

<sup>aw</sup> *Id.*

<sup>ax</sup> 42 C.F.R. §§ 51c.303 (l) (community health centers), 56.303(l), 56.603(j) (migrant health centers) (2003).

<sup>ay</sup> 42 C.F.R. §§ 51c.303 (l), 56.303(l) (2003).

<sup>az</sup> 42 U.S.C. §§ 254c(a)(5), 254b(a)(1)(G) (1995).

<sup>ba</sup> 42 C.F.R. §§ 51c.304 (b) (1), 56.304 (b)(1) (1996).

<sup>bb</sup> 65 Fed. Reg. 80865-79 (Dec. 22, 2000), reprinted at <http://www.omhrc.gov/clas>.

<sup>bc</sup> *Id.* at 80873.

## CALIFORNIA LAWS AND POLICIES

State laws and policies provide other sources of protection for LEP persons. California, in particular, has strong statutes, regulations and policy requirements.<sup>bd</sup>

### Government Code § 11135

Similar to Title VI, California law prohibits discrimination in programs and services funded by the state. However, California Government Code § 11135 is more expansive than federal law because it includes more protected categories and applies to the state itself. In relevant part, the statute states: “No person in the state of California shall, on the basis of race, national origin, ethnic group identification, religion, age, sex, color, or disability be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under any program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state.”<sup>be</sup> The implementing state regulations define “ethnic group identification” to mean the “possession of the racial, cultural or linguistic characteristics common to a racial, cultural or ethnic group or the country or ethnic group from which the person or his or her forebears originated.”<sup>bf</sup> The regulations also address language-based discrimination specifically – for example, one section states that it is a discriminatory “to fail to take appropriate steps to ensure that alternative communication services are available to ultimate beneficiaries.”<sup>bg</sup> “Alternative communication services” means the method used or available for purposes of communicating with a person unable to read, speak or write in English, including providing a multilingual employee or an interpreter, or written translated materials in a language other than English.<sup>bh</sup>

### Kopp Act (Health & Safety Code §1259)

Passed in 1983, the Kopp Act requires acute care hospitals to take numerous steps to serve LEP patients, including:

- Adopt and annually review language assistance service policies;
- Ensure availability of interpreter services either on site or by telephone, “to the extent possible as determined by the hospital,” 24 hours-a-day to patients who are part of a language group that comprises at least five percent of the population of the geographic area served by the hospital;
- Post multi-lingual notices of the availability of interpreters and how to obtain an interpreter, and directions on how to complain to state authorities about interpreter services;
- Identify and record patients’ primary/preferred languages in hospital records;
- Prepare and maintain a list of qualified interpreters;
- Notify employees of the requirement to provide interpreters to all patients who request them;
- Review standardized forms to determine which should be translated;
- Consider providing non-bilingual staff with picture and phrase sheets for communication with LEP patients;
- Consider establishing community liaison groups to LEP communities.<sup>bi</sup>

The Kopp Act defines interpreters as individuals who are fluent in English and a second language, who can accurately speak, read and readily interpret a second language, and who have the ability to translate the names of body parts and describe symptoms and injuries competently in both languages.<sup>bj</sup> As the state agency that licenses hospitals, the California Department of Health Services is responsible for compliance.<sup>bk</sup>

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<sup>bd</sup> For a detailed review of California laws and policies governing culturally and linguistically competent health care, see Wong, Doreena, and Jane Perkins, *ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS IN CALIFORNIA: LEGAL RIGHTS AND RESPONSIBILITIES* (2003) (available from The California Endowment, [www.calendow.org](http://www.calendow.org), and NHeLP).

<sup>be</sup> CAL. GOV'T CODE § 11135(a).

<sup>bf</sup> 22 CAL. CODE REGS. Tit. 22 § 98210(b) (2001).

<sup>bg</sup> *Id.* § 98101.

<sup>bh</sup> *Id.* § 98210(a).

<sup>bi</sup> CAL. HEALTH & SAFETY CODE § 1259(c)(1)-(9).

<sup>bj</sup> *Id.* § 1259(b)(1).

<sup>bk</sup> *Id.* § 1259.5(d).

### **Dymally-Alatorre Bilingual Services Act (Government Code § 7290 et seq.)**

Passed in 1973, the Dymally-Alatorre Bilingual Services Act requires all state agencies and their local offices that furnish information or render services to the public to provide oral interpretation and translated materials. Among other things, agencies must:

- Employ sufficient numbers of qualified bilingual persons in public contact positions to ensure access for non-English speaking persons;<sup>bl</sup>
- Translate materials explaining their services;<sup>bm</sup>
- Distribute translated materials or provide alternative translation assistance if the written materials request, require or provide information or the information requested, required or provided affects the individuals' rights or duties;<sup>bn</sup>
- Conduct bi-annual surveys of local offices to determine the number of bilingual employees and the number and percentage of non-English speaking persons served by each office, broken down by language.<sup>bo</sup>

The law requires bilingual staffing and translation for limited-English speaking groups comprising five percent or more of the people served<sup>bp</sup> and implementation "to the extent that local, state or federal funds are available."<sup>bq</sup> The State Personnel Board (SPB) is responsible for monitoring and educating agencies.<sup>br</sup> Efforts to strengthen the Dymally-Alatorre Act resulted in a budget bill (AB 3000), signed by the Governor in 2002, requiring state agencies to develop long-term implementation plans to come into compliance and providing the SPB with limited enforcement powers.<sup>bs</sup>

### **Other State Statutes and Regulations**

Numerous other California statutes and regulations also protect LEP individuals who obtain health care in specific settings and contexts.<sup>bt</sup> For example:

- Health care entities must post notice of patients' rights in English and other languages – for example, hospitals (Spanish);<sup>bu</sup> general acute care hospitals and skilled nursing facilities (Spanish);<sup>bv</sup> adult day health centers (any other predominant language of the community).<sup>bw</sup>
- Counties must provide public notice of availability of county funded emergency, urgent care, and non-urgent clinical services in Spanish and English.<sup>bx</sup>
- Local health departments must make family planning pamphlets and circulars available in languages spoken by ten percent or more of the county's population.<sup>by</sup>

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<sup>bl</sup> CAL. GOV'T CODE §§ 7292, 7293.

<sup>bm</sup> *Id.* §§ 7295, 7295.2.

<sup>bn</sup> *Id.* § 7295.4.

<sup>bo</sup> *Id.* § 7299.4.

<sup>bp</sup> *Id.* § 7296.2.

<sup>bq</sup> *Id.* § 7299.

<sup>br</sup> *Id.* §§ 7299.2, 7299.4, 7299.6.

<sup>bs</sup> A multi-year effort to strengthen and clarify provisions of the Dymally-Alatorre Act resulted in SB 987, which was passed in 2002 by the California legislature but was vetoed by the Governor.

<sup>bt</sup> For a comprehensive list of California statutes and regulations addressing language and cultural competency in health care, see *NHeLP, ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES* .at Appendix D; Wong, Doreena, and Jane Perkins, *ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS IN CALIFORNIA: LEGAL RIGHTS AND RESPONSIBILITIES* at Attachment 4.

<sup>bu</sup> 22 CAL. CODE REGS. § 70707(b).

<sup>bv</sup> *Id.* §§ 70577, 72453.

<sup>bw</sup> *Id.* § 78437(b).

<sup>bx</sup> CAL. WELF. & INST. CODE § 16946(h)(1)(D).

<sup>by</sup> *Id.* § 124300.

- Physicians are required to inform a patient by written consent of possible alternatives to hysterectomy in a language she understands.<sup>bz</sup> Physicians and surgeons must inform patients being treated for any form of breast cancer of alternative treatment methods by providing the patient with a written summary in a language understood by the patient.<sup>ca</sup>
- Community-based, low-income perinatal health care providers must have staff that reflect, to the maximum extent feasible, the cultural, linguistic, ethnic and other social characteristics of the community served.<sup>cb</sup>

### Medi-Cal Managed Care Contract Requirements

The Medi-Cal Managed Care Division (MMCD) of the California Department of Health Services contracts with health plans to serve Medi-Cal recipients and requires, as part of the contract, that plans build systems that meet the needs of the diverse Medi-Cal population. In April 1999, the MMCD released Policy Letters 99-01 to 99-04 and All Plan Letter 99005 clarifying contract requirements of Medi-Cal Managed Care Plans. Noting the “inextricabl[e] link” between culture, language and health,<sup>cc</sup> these policy letters provide guidelines for culturally and linguistically competent health care. Key requirements from the contracts and policy letters include:

- Assessing health education as well as cultural and linguistic needs of members and identifying resources which will enable the plan to provide culturally and linguistically competent care;<sup>cd</sup>
- Providing 24-hour access to interpreter services for members;<sup>ce</sup>
- Providing interpreter services at “key points of contact” if the number of LEP mandatory eligibles living in the service area exceed quantified thresholds;<sup>cf</sup>
- Not requiring or suggesting that LEP members provide their own interpreters;<sup>cg</sup>
- Developing and implementing standards and performance requirements for the provision of linguistic services and monitoring performance of persons providing services;<sup>ch</sup>
- Maintaining “community linkages” through the formation of community advisory committees, with demonstrated participation of consumers and traditional safety net providers;<sup>ci</sup>
- Ensuring that informing materials are available in the threshold languages and that they are accurate and complete.<sup>cj</sup>

One key Medi-Cal Managed Care contract requirement is the adoption of a numerical instead of a percentage threshold. MMCD Policy Letter 99-03 states: “Threshold languages in each county ... are primary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible beneficiaries residing in a county. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single zip code

<sup>bz</sup> CAL. HEALTH & SAFETY CODE § 1691.

<sup>ca</sup> *Id.* § 109275.

<sup>cb</sup> *Id.* § 123515.

<sup>cc</sup> California Department of Health Services, Medi-Cal Managed Care Division (MMCD), POLICY LETTER (April 2, 1999) at p. 4 (regarding conducting needs assessments).

<sup>cd</sup> *Id.* at p. 1.

<sup>ce</sup> California Department of Health Services, MMCD, POLICY LETTER 99-03 (April 2, 1999) at p. 2 (regarding the provision of linguistic services).

<sup>cf</sup> *Id.* at p. 3. “Key points of contact” include medical encounters with providers (e.g., telephone or face-to-face) and non-medical contact (e.g., membership services, orientation, appointments). *Id.*

<sup>cg</sup> *Id.* at p. 2. However, a family member or friend may be used if requested by the LEP member and after they are informed of their right to free language assistance. *Id.*

<sup>ch</sup> *Id.* at p. 4.

<sup>ci</sup> California Department of Health Services, MMCD, POLICY LETTER 99-01 (April 2, 1999) (regarding establishing a community advisory committee).

<sup>cj</sup> California Department of Health Services, MMCD, POLICY LETTER 99-04 (April 2, 1999) at pp. 1, 3 (regarding the provision of translated written materials). “Informing documents” are those that provide essential information to all members regarding access to and usage of plan services; examples include evidence of coverage booklet, member services guide, disclosure forms, provider listings, and form letters. *Id.* at p. 2.

or 1,500 in two contiguous zip codes, are also considered threshold languages for a county.”<sup>ck</sup> The advantage of the numerical threshold is that it covers a significant proportion of the non-English speaking population that would not benefit from a percentage threshold.

### HEALTHY FAMILIES CONTRACT REQUIREMENTS

The Healthy Families program is administered by the Managed Risk Medical Insurance Board (MRMIB), which seeks to improve the health of Californians by increasing access to affordable, comprehensive, quality health care coverage. In December 1999, MRMIB adopted model contract requirements, including the following:

- Improve linguistic services by providing 24-hour access to interpreters; developing and implementing interpreter services, policies and procedures; avoiding unreasonable delay in providing interpreters; recording the language needs of patients; prohibiting the use of minors to interpret except in the most extraordinary circumstances; informing patients of the availability of linguistic services; and requiring demonstrated bilingual proficiency by providers who list their bilingual capabilities;
- Provide translated written materials, in Spanish and any language comprising the lesser of 5 percent or 3,000 of the contractor’s enrollment, and ensuring quality translated materials;
- Conduct cultural and linguistic group needs assessment, including the input of subscribers; and
- Operationalize cultural and linguistic competency by providing cultural competency trainings to staff, improving internal systems to meet cultural and linguistic needs of subscribers, and reporting annually regarding the contractor’s linguistic and cultural services.<sup>cl</sup>

The Healthy Families contract language includes many of the Medi-Cal Managed Care contract requirements (e.g., 24-hour access to interpreter services) – however, the Healthy Families contracts have several key additional requirements: prohibiting the use of minors except in emergencies; annual reporting on culturally and linguistically supportive services; and inclusion of race, ethnicity and primary language data in all standard measures of assessment.<sup>cm</sup> In addition, the threshold triggering the provision of written materials is also different.<sup>cn</sup>

### HEALTH ACCREDITATION AGENCIES

Private accrediting agencies play an important role in shaping the delivery of health care. Many health facilities voluntarily undergo review and certification from these agencies. High marks from accrediting agencies can give providers an advantage in the market. State and federal agencies use private accrediting agencies to set standards for care and determine compliance with those standards,<sup>co</sup> and loss of accreditation can result in the loss of government funding. Courts also have considered the standards and findings of accrediting agencies when deciding whether a provider has committed malpractice.<sup>cp</sup>

The largest and most-used accrediting agencies are the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions, and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations. Both have adopted standards that require cultural and linguistic competency.

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<sup>ck</sup> *MMCD POLICY LETTER 99-03 (April 2, 1999)*, at p. 3.

<sup>cl</sup> *Managed Risk Medical Insurance Board, Healthy Families Program, HEALTH PLAN MODEL CONTRACT, 2000-2003 (2000)* at 9-17.

<sup>cm</sup> *Id.*

<sup>cn</sup> *Id.*

<sup>co</sup> *Claudia Schlosberg and Shelly Jackson, "Assuring Quality: The Debate Over Private Accreditation and Public Certification of Health Care Facilities," 30 CLEARINGHOUSE REV. 699 (Nov. 1996).*

<sup>cp</sup> *See NHeLP, ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES*, at p. 5.1.

## a) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards

JCAHO standards establish the accreditation requirements for various health care organizations. The standards are organized into eight sections<sup>ca</sup> and cultural and linguistic competency are addressed or encompassed in most of these sections. The standards vary for each type of health care organization, so the most relevant types of organizations – hospitals and ambulatory care facilities – are discussed below.<sup>cr</sup>

### (1) Hospitals

- Rights, Responsibilities and Ethics (RI): JCAHO requires hospitals to address ethical issues in patient care. This includes establishing and maintaining structures to support patient rights that address both patient care and organizational ethical issues. Also, a patient has a right to care that is considerate and respectful of their personal values and beliefs. Standard RI.1.2 states that patients must be involved in all aspects of their care. JCAHO recognizes that spiritual and cultural values affect how patients respond to care and that hospitals must allow patients and their families to express their spiritual beliefs and cultural practices as long as these practices do not harm others or interfere with treatment. According to JCAHO, hospitals must also address care at the end of life, including respecting the patient's values and responding to the spiritual and cultural concerns of the patient and the family.<sup>cs</sup> Further, patients have the right to appropriate assessment and management of pain. Hospitals should communicate that pain management is an important part of care, taking into account cultural, spiritual, and/or ethnic beliefs of the patient and family.<sup>ct</sup>

This standard also requires hospitals to demonstrate respect for patient communication needs.<sup>cu</sup> The hospital must have a way to provide effective communication for each patient; effective communication is defined as "any form of communication (for example, writing or speech) that leads to demonstrable understanding."<sup>cv</sup> If a patient's care requires restriction of access to communication, the communication restrictions must be explained in a language the patient understands.

Finally, upon admission, hospitals must provide each patient with a written copy of the hospital's statement of patient's rights.<sup>cw</sup> This must be appropriate to the patient's age, understanding, and language. If a patient does not understand the written communication, the patient must be informed of her rights in a manner that they can understand.<sup>cx</sup>

- Education (PF): A hospital's patient education activities must consider cultural characteristics of the patients being taught.<sup>cy</sup> In determining the resources necessary for achieving patient educational objectives, the hospital must include other community resources to do the teaching, if needed, and referrals to other programs, special devices, interpreters or other aids to meet specialized needs.<sup>cz</sup>
- Leadership (LD): Hospital leaders, and, as appropriate, community leaders must collaborate to design services responsive to community needs.<sup>da</sup> The scope of care and level of care provided throughout the hospital must satisfy accepted standards of practice.<sup>db</sup> Further, the hospital's priority setting must be sensitive to emerging needs in the community such as those identified through data collection and assessment. This could include changes in demographics that increase the need for oral interpretation and written translation.<sup>dc</sup>

<sup>ca</sup> The eight sections are: Rights, Responsibilities and Ethics (abbreviated RI); Education (PF); Leadership (LD); Management of Human Resources (HR); Assessment (PE); Continuum of Care (CC); Health Promotion and Disease Prevention (PS); and Care (TX).

<sup>cr</sup> JCAHO accredits 17,000 health care organizations, including hospitals, ambulatory care organizations, behavioral health care organizations, health care networks, home care agencies, and long-term care organizations.

<sup>cs</sup> Joint Commission on Accreditation of Healthcare Organizations, *Hospital Standards at RI.1.1.*

<sup>ct</sup> *Id.* at RI.1.2.9.

<sup>cu</sup> *Id.* at RI.1.3.6.

<sup>cv</sup> *Id.*

<sup>cw</sup> *Id.* at RI.1.4.

<sup>cx</sup> *Id.*

<sup>cy</sup> *Id.* at PF.1.

<sup>cz</sup> *Id.* at PF.1.1.

<sup>da</sup> *Id.* at LD.1.3.1.

<sup>db</sup> *Id.* at LD.1.3.2.

<sup>dc</sup> *Id.* at LD.1.4.

- Management of Human Resources (HR): JCAHO recognizes that a hospital's ability to fulfill its mission and provide for its patients is directly related to its ability to provide a qualified, competent staff.<sup>dd</sup> In projecting staffing needs, the hospital should consider the case mix of patients served as well as the expectations of the hospital, its patients, and other customers. Further, the hospital should orient its staff and regularly collect and analyze data to assess staff competence and training needs.<sup>de</sup> Data may be collected from performance reports, staff surveys or other needs assessment. Hospital policies and procedures must specify those aspects of patient care which might conflict with staff members' cultural values or religious beliefs and whether these values or beliefs are sufficient to grant a request of a provider not to participate in care. The hospital must have policies and procedures in place to allow a provider to request not to participate in care and to ensure that granting such a request will not negatively affect a patient's care.<sup>df</sup>

## (2) Ambulatory Health Care Organizations

- Rights, Responsibilities and Ethics (RI): The same standards for RI that apply to hospitals also apply to ambulatory health care organizations. Ambulatory health care standards specifically require: that patients' rights be respected and supported;<sup>dg</sup> that patients be involved in all aspects of care;<sup>dh</sup> that patients' cultural, psychological, spiritual and personal values be respected;<sup>di</sup> and that the organization demonstrate respect for a patient's communication needs. JCAHO provides example of implementing the communication standard that states that the needs of patients who have difficulty communicating might be addressed by offering translation services for non-English-speaking patients. The explanation also states that documents such as consent forms, patient rights and responsibilities statements, and educational materials should be available in the primary languages of the common populations served.
- Assessment (PE): The assessment standards discuss conducting an initial assessment of a patient.<sup>dj</sup> Explaining its intent, JCAHO says that the initial assessment should take into account the patient's needs, including culture. The explanation recognizes that a patient's cultural and family contexts and individual background are important factors in responding to illness and treatment. Further, when an ambulatory care facility serves a large, culturally distinct population, patient assessment and education information should be appropriately modified and information about the culture should be shared with staff.
 

Ambulatory care assessment standards provide that data collected at an initial assessment should include information about cultural or religious practices that may affect care as well as the patient's and family's educational needs, abilities, motivation and readiness to learn.<sup>dk</sup> In addition, when nutritional status is assessed, patients at high nutritional risk should be assessed for cultural, ethnic, and personal food preferences.<sup>dl</sup>
- Education (PF): These standards mirror those of hospitals.<sup>dm</sup>
- Leadership (LD): Under leadership standards, ambulatory care organizations must define their scope of services in writing and have them approved by their leaders. The intent of this standard is to ensure that the needs of different types of patients are addressed. JCAHO suggests that planning documents describe the languages in which consent documents are written for the patient population served.<sup>dn</sup>

<sup>dd</sup> *Id. at HR.1.*

<sup>de</sup> *Id. at HR.4-4.3.*

<sup>df</sup> *Id. at HR.6-6.2.*

<sup>dg</sup> *Joint Commission on Accreditation of Healthcare Organizations, Ambulatory Health Care Standards at RI.1.1.*

<sup>dh</sup> *Id. at RI.1.2.*

<sup>di</sup> *Id. at RI.1.2.1.*

<sup>dj</sup> *Id. at PE.1.*

<sup>dk</sup> *Id.*

<sup>dl</sup> *Id. at PE.1.2.*

<sup>dm</sup> *Id. at PE.1.*

<sup>dn</sup> *Id. at LD.1.3.5.*

- Management of Human Resources (HR): Ambulatory care organizations are expected to conduct ongoing data collection about staff competence patterns and trends to respond to staff learning needs.<sup>do</sup> The ambulatory care organization, like a hospital, should have policies and processes to define which specific aspects of patient care will not be performed due to conflict with a staff member's values, ethics, or religious beliefs. This includes processes to ensure that staff refusals will not compromise patient care. A staff member's ongoing performance evaluation may consider whether a staff member's refusal is legitimately justified by cultural values or ethics.<sup>dp</sup>

### National Committee for Quality Assurance (NCQA) Standards

NCQA provides accreditation for managed care organizations (MCOs).<sup>dq</sup> In addition, it produces a highly influential set of performance measures, which are used by many purchasers to judge the MCO's performance.

#### Accreditation Standards

NCQA's accreditation process involves 60 standards and one specific standard focuses on "Translation Services."<sup>dr</sup> Each MCO must provide translation services within its member services telephone function based on the linguistic needs of its members. NCQA explains that this requires organizations to consider data about the population needs of its members. If the organization serves individuals whose principle written and spoken language is not English, the organization must have a mechanism in place to provide language services (oral and/or written). Examples of actions that could satisfy this requirement include contracting with translation/interpreter services and hiring staff who speak languages prevalent in the population.<sup>ds</sup>

#### Health Plan Employer Data and Information Set (HEDIS)

NCQA also developed and maintains the Health Plan Employer Data and Information Set (HEDIS), which is the most widely used set of performance measures in the managed care industry. NCQA requires all participating plans to report HEDIS results as part of the accreditation process; in addition, the federal Centers of Medicaid and Medicare Services (CMS) requires all Medicare + Choice plans to use HEDIS, and some state Medicaid and SCHIP agencies use HEDIS to evaluate their managed care plans.

HEDIS consists of two parts: technical specifications for measuring performance and a consumer survey. The technical specifications include reporting measures related to language access.

One HEDIS 2003 measure requires MCOs that serve Medicare or Medicaid members to report on the availability of language services. MCOs must complete a table on the number of MCO practitioners (primary care, OB/GYN and prenatal care, behavioral health care, and dental) and member services staff who speak languages other than English.<sup>dt</sup> MCOs must also provide a description of out-of-MCO interpreter services secured during the year for Medicaid, commercial and Medicare members. MCOs are asked to identify up to 30 languages for which interpreter services were secured, prioritized by the most relevant languages.<sup>du</sup> The required information includes the source of the interpreter service provided (e.g., in person or by telephone), the type of interpreter service agreement (e.g., formal written contract), and any restrictions on availability of services (e.g., time of day).<sup>dv</sup> If no interpreter services were secured during the year, the MCO must state this and document the reason.<sup>dw</sup> HEDIS 2003 also requires reporting on diversity of membership by Medicaid participating MCOs. Although not mandating a specific reporting format, NCQA does provide a reporting table<sup>dx</sup> which asks for the number and percentage of unduplicated members by race, Hispanic origin and spoken language.<sup>dy</sup>

<sup>do</sup> *Id.* at HR.4.2.

<sup>dp</sup> *Id.* at HR.6.1-2.

<sup>dq</sup> NCQA has reviewed almost half of the nation's HMOs, covering 75% of all HMO enrollees.

<sup>dr</sup> E-mail from Cynthia Martin, National Committee for Quality Assurance, to Mara Youdelman, National Health Law Program (Dec. 27, 2002, 14.32) (on file with NHeLP).

<sup>ds</sup> *Id.*

<sup>dt</sup> National Committee for Quality Assurance, HEDIS 2003 TECHNICAL SPECIFICATIONS, at Vol. 2, 144-45, Tbl. A5a-1/3 (Health Plan Practitioners and Member Services Staff Serving Members Who Speak Languages Other Than English) (2002).

<sup>du</sup> *Id.* at 145-46.

<sup>dv</sup> *Id.* at 146, Tbl. A5B-1/2/3 (Out-of-MCO Interpreter Services Secured During the Measurement Year).

<sup>dw</sup> *Id.* at 146.

<sup>dx</sup> See *id.* at 278, Tbl. D7-1 (Diversity of Medicaid Membership).

<sup>dy</sup> *Id.* at 278-79.

## **b) Health Profession Organizations Cultural and Linguistic Standards**

The bodies representing health professionals have also integrated cultural and linguistic competencies into their standards of practice and ethical codes. The following section is reprinted from. Resources in Cultural Competence Education for Health care Professionals, edited by Jean Gilbert, PhD, published by The California Endowment and available online at <http://www.calendow.org>.<sup>62</sup>

1. Accreditation Council for Graduate Medical Education Outcome Project: General Competencies. [Outcomes@acgme.org](mailto:Outcomes@acgme.org). Patient Care is made up of the following: (1) A commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse population; and (2) Sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
2. 2001 American Academy of Family Physicians (AAFP). Cultural Proficiency Guidelines. The guidelines were approved by the AAFP Board of Directors in March, 2001. For more information, contact AAFP at 11400 Tomahawk Creek Parkway, Leawood, KS 66211 or call 913-906-6000. Web site: [www.aafp.org](http://www.aafp.org).

### **Cultural Proficiency Guidelines**

The AAFP believes in working to address the health and educational needs of our many diverse populations. A list of issues to consider in preparing informational or continuing medical education material and programs has been developed to ensure cultural proficiency and to address specific health related issues as they relate to special populations of patients and providers. The list, while perhaps not complete, is meant as a dynamic template to assist those developing Academy material and programming for patients and physicians.

Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Care. Like, R, Steiner, P, & Rubel, A. Family Medicine, Vol. 28 (4).

3. 2001 American College of Emergency Physicians. Cultural Competence and Emergency Care. Approved by the ACEP Board of Directors, October. For more information, contact ACEP at 1125 Executive Circle, Irving, TX 75038- 2522 or call 800-798-1822.  
"The American College of Emergency Physicians believes that: o Quality health care depends on the cultural competence as well as the scientific competence of physicians; o Cultural competence is an essential element of the training of healthcare professionals and to the provision of safe, quality care in the emergency department environment; and o Resources should be made available to emergency departments and emergency physicians to assure they are able to respond to the needs of all patients regardless of the respective cultural backgrounds."
4. 1998 The American College of Obstetricians and Gynecologists (ACOG) Committee on Health Care for Underserved Women. Committee Opinion, No. 201, March. Copyright Clearance Center Danvers, MA 01923. Call 978-750-8400. For more information, contact ACOG at 409 12th Street, SW, PO Box 96920, Washington, D.C. 20090-6920.  
"During every health care encounter, the culture of the patient, the culture of the provider, and the culture of medicine converge and impact upon the patterns of health care utilization, compliance with recommended medical interventions and health outcomes. Often, however, health care providers may not appreciate the effect of culture on either their own lives, their professional conduct or the lives of their patients (3). When an individual's culture is at odds with that of the prevailing medical establishment, the patient's culture will generally prevail, often straining provider-patient relationships (4). Providers can minimize such situations by increasing their understanding and awareness of the culture(s) they serve. Increased sensitivity, in turn, can facilitate positive interactions with the health care delivery system and optimal health outcomes for the patients served, resulting in increased patient and provider satisfaction."
5. American Nurses Association. Position Statements: Cultural Diversity in Nursing Practice. <http://www.nursingworld.org/readroom/position/ethics/etcldv.htm> "Knowledge of cultural diversity is vital at all levels of nursing practice. Ethnocentric approaches to nursing practice are

ineffective in meeting health and nursing needs of diverse cultural groups of clients. Knowledge about cultures and their impact on interactions with health care is essential for nurses, whether they are practicing in a clinical setting, education, research or administration. Cultural diversity addresses racial and ethnic differences, however, these concepts or features of the human experience are not synonymous. The changing demographics of the nation as reflected in the 1990 census will increase the cultural diversity of the U.S. population by the year 2000, and what have heretofore been called minority groups will, on the whole constitute a national majority (Census, 1990). Knowledge and skills related to cultural diversity can strengthen and broaden health care delivery systems. Other cultures can provide examples of a range of alternatives in services, delivery systems, conceptualization of illness and treatment modalities. Cultural groups often utilize traditional health care providers, identified by and respected within the group. Concepts of illness, wellness and treatment modalities evolve from a cultural perspective or worldview. Concepts of illness, health and wellness are part of the total cultural belief system.”

6. 1990 American Psychological Association (APA). APA Guidelines for Culturally Diverse Populations: (Approved by the APA Council of Representatives) For more information, write to 750 First Street, NE, Washington, DC 20002. Tel. 202-336-5500. [www.apa.org/pi/guide.html](http://www.apa.org/pi/guide.html). This public interest directorate consists of guidelines, illustrative statements and references. The guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations. There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs and cultural expectations have been introduced into educational, political, business and health care systems by the physical presence of these groups. The issues of language and culture impact on the provision of appropriate psychological services.
7. 1998 Association of American Medical Colleges. Teaching and Learning of Cultural Competence in Medical School. Contemporary Issues in Medical Education, Feb; Vol. 1(5). Division of Medical Education, AAMC, Washington, DC.
8. 2000 CLAS Culturally and Linguistically Appropriate Services in Managed Care Organizations. (US Department of Health & Human Services, Office of Minority Health) <http://www.omhrc.gov/clas/>. National standards for culturally and linguistically appropriate services in health care posted on Federal Register. Based on an analytical review of key laws, regulations, contracts and standards currently in use by federal and state agencies and other national organizations, these standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guideline’s relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.
9. 1999 Committee on Pediatric Workforce and the American Medical Association Advisory Committee on Minority Physicians. Culturally Effective Pediatric Care: Education and Training Issues. American Academy of Pediatrics, Jan; Vol. 103 (1):167-170. This policy statement defines culturally effective health care and describes its importance for pediatrics. The statement also defines cultural effectiveness, cultural sensitivity and cultural competence, and describes the importance of these concepts for training in medical school, residency and continuing medical education. The statement is based on the premise that culturally effective care is important and that the knowledge and skills necessary for providing culturally effective health care can be taught and acquired through 1) educational courses and other formats developed with the expressed purpose of addressing cultural competence and/or cultural sensitivity, and 2) educational components on cultural competence and/or cultural sensitivity that are incorporated into medical school, residency and continuing education curricula.

10. 1997. New York State Cultural and Linguistic Competency Standards. New York State Office of Mental Health. For information, contact Design Center, 44 Holland Avenue, Albany, NY 12229. Tel. 518-473-2684. The methods and strategies employed are discussed and the team members introduced. The scope of the project is presented along with a review of the five domains, or standards for cultural competency in mental health services.
11. Liaison Committee on Medical Education. Standard on Cultural Diversity. Full text of LCME Accreditation Standards (from Functions & Structure of a Medical School, Part 2). [www.lcme.org](http://www.lcme.org) "Faculty & students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness & respond to various symptoms, diseases, & treatments. Medical students should learn to recognize & appropriately address gender & cultural biases in health care delivery, while considering first the health of the patient."
12. National Association of Social Workers (NASW). <http://www.naswdc.org/diversity/default.asp#top> NASW is committed to social justice for all. Discrimination and prejudice directed against any group are damaging to the social, emotional and economic well-being of the affected group and of society as a whole. NASW has a strong affirmative action program that applies to national and chapter leadership and staff. It supports three national committees on equity issues: the National Committee on Women's Issues, National Committee on Racial and Ethnic Diversity and the National Committee on Gay, Lesbian and Bisexual Issues. The information contained in their web site reflects some of NASW's material and work on diversity and equity issues.
13. Society for Public Health Education (SOPHE). Code of Ethics for the Health Education Profession. <http://www.sphe.org/> (click on "About SOPHE" and then click "Ethics.")  
"The Health Education profession is dedicated to excellence in the practice of promoting individual, family, organizational, and community health. Guided by common ideals, Health Educators are responsible for upholding the integrity and ethics of the profession as they face the daily challenges of making decisions. By acknowledging the value of diversity in society and embracing a cross-cultural approach, Health Educators support the worth, dignity, potential, and uniqueness of all people. The Code of Ethics provides a framework of shared values within which Health Education is practiced. The Code of Ethics is grounded in fundamental ethical principles that underlie all health care services: respect for autonomy, promotion of social justice, active promotion of good, and avoidance of harm. The responsibility of each health educator is to aspire to the highest possible standards of conduct and to encourage the ethical behavior of all those with whom they work. Regardless of job title, professional affiliation, work setting, or population served, Health Educators abide by these guidelines when making professional decisions."
14. WICHE Western Interstate Commission for Higher Education. Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; U.S. Department of Health and Human Services. "The standards are designed to provide readers with the tools and knowledge to help guide the provision of culturally competent mental health services within today's managed care environment. This document melds the best thinking of expert panels of consumers, mental health service providers, and academic clinicians from across the four core racial/ethnic populations: Hispanics, American Indians/Alaska Natives, African Americans, and Asian/Pacific Islanders. Developed for states, consumers, mental health service providers, educators and organizations providing managed behavioral health care, the volume provides state-of-the-science cultural competence principles and standards – building blocks to create, implement and maintain culturally competent mental health service networks for our diverse population." The site provides educators, policymakers and legislators with data and issues-oriented analysis by subject matter.<sup>dz</sup>

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<sup>dz</sup> <http://www.mentalhealth.org/publications/allpubs/SMA00-3457/default.asp>

## **APPENDIX E: NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE (CLAS)**

In December 2002, the U.S. Department of Health and Human Services Office of Minority Health (OMH) issued National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). The 14 CLAS Standards were organized into three areas: culturally competent care (standards 1-3); language access services (standards 4-7); and organizational supports for cultural competence (standards 8-14).

### **Culturally Competent Care**

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.
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.
3. Healthcare organizations should ensure that staffs at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

### **Language Access Services**

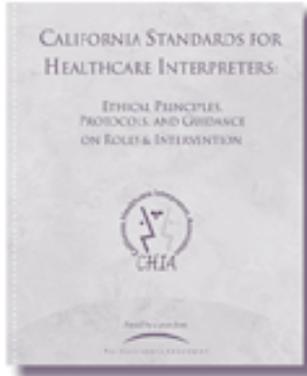
4. Health care organization must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations 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. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
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.

### **Organizational Supports for Cultural Competence**

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. Health care organizations should conduct initial and ongoing organization 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. 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. Health care organizations should maintain a current demographic cultural and epidemiological profile of the community as well as a need assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of 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. 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. 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.

## APPENDIX F: California Standards For Healthcare Interpreters: In Summary

The California Healthcare Interpreters Association (CHIA) promotes and advocates for the healthcare interpreter profession; advocating for culturally and linguistically appropriate services; and providing education and training to interpreters and healthcare professionals.



### Objective:

The goal of these standards is to standardize healthcare interpreting practices by providing a set of ethical principles, interpreting protocols, and guidance on roles particular to the specialty of healthcare interpreting. CHIA's hope is that increased availability of quality interpreting will result in better access to healthcare for limited English proficient (LEP) patients.

The standards were designed for a number of target audiences: healthcare interpreters, bilingual workers, administrators, providers, interpreter trainers, community advocates, legislators and government agencies, foundations, policy-makers, and researchers and others in the academic community. The Standards will serve as a reference for all healthcare interpreters, and will be the basis for job descriptions, performance evaluations, and organizational policies and procedures that will ultimately contribute to quality control. The standards also form the foundation of a number of training curricula developed by educational institutions, such as City College of San Francisco, and community-based and interpreter service organizations. This document can serve as the basis for the development of tests for California state accreditation, certification, or licensure. The result could lead to increased state reimbursement for healthcare interpreter services. Ultimately, these standards of practice will contribute to the recognition and acceptance of the value of healthcare interpreting as a profession.

### Overview:

The document's three main sections guide interpreters through the complex tasks of healthcare interpreting. Interpreter training will be essential to help interpreters put into practice the ethical principles in Section 1, the protocols in Section 2, and the complex roles outlined in Section 3. The view reflected throughout this document is that healthcare interpreters, as members of the team of healthcare professionals working with the patient, have a responsibility to support the health and well-being of patients.

### Section 1: Ethical Principles

Section 1 consists of the ethical principles that guide the actions of healthcare interpreters. Each ethical principle has an underlying value description followed by a set of performance measures which demonstrate how the interpreter's actions follow the principle. The principles are followed by a section on an ethical decision-making process to help interpreters address the frequent ethical conflicts and dilemmas that arise for interpreters. Dilemmas occur when any action in support of one or more ethical principles conflicts with one or more other ethical principles. This process is also helpful for making decisions about interpreter roles.

Each of the following ethical principles is to be considered in the context of the health and well-being of the patient.

#### Confidentiality

Interpreters treat all information learned during the interpreting as confidential.

#### Impartiality

Interpreters are aware of the need to identify any potential or actual conflicts of interest, as well as any personal judgments, values, beliefs or opinions that may lead to preferential behavior or bias affecting the quality and accuracy of the interpreting performance.

### **Respect for individuals and their communities**

Interpreters strive to support mutually respectful relationships between all three parties in the interaction (patient, provider and interpreter), while supporting the health and well being of the patient as the highest priority of all healthcare professionals.

### **Professionalism and integrity**

Interpreters conduct themselves in a manner consistent with the professional standards and ethical principles of the healthcare interpreting profession.

### **Accuracy and completeness**

Interpreters transmit the content, spirit and cultural context of the original message into the target language, making it possible for patient and provider to communicate effectively.

### **Cultural responsiveness**

Interpreters seek to understand how diversity and cultural similarities and differences have a fundamental impact on the healthcare encounter. Interpreters play a critical role in identifying cultural issues and considering how and when to move to a cultural clarifier role. Developing cultural sensitivity and cultural responsiveness is a life-long process that begins with an introspective look at oneself.

We believe the addition of an ethical decision-making process for healthcare interpreters is a critical contribution. These steps assist interpreters in determining a course of action in ethical dilemmas, when actions to support one or more ethical principles may conflict with one or more other ethical principles. Appendix B gives an example of how this ethical decision-making process is used in practice. The steps to the process are:

- Ask questions to determine whether there is a problem.
- Identify and clearly state the problem, considering the ethical principles that may apply and ranking them in applicability.
- Clarify personal values as they relate to the problem.
- Consider alternative actions, including benefits and risks.
- Choose the action and carry it out.
- Evaluate the outcome and consider what might be done differently next time.

## **Section 2: Protocols**

Section 2 describes procedures standardizing how interpreters work with patients and providers in the healthcare encounter before, during and after their interaction or session. The protocols specifying interpreter actions are seen as a direct consequence of the Ethical Principles. This section also includes recommendations to the employers of interpreters on how to provide support to healthcare interpreters in their often stressful work.

### **Protocol 1: Pre-Encounter, Pre-Session, or Pre-Interview**

This protocol outlines information interpreters should provide in pre-session introductions to assure confidentiality and gain the cooperation of patient and providers for a smooth interpreted encounter. The protocol also allows for a pre-encounter briefing of the interpreter or provider as necessary.

### **Protocol 2: During the Encounter, Session, or Interview**

Interpreting practices to support the patient-provider relationship during the medical encounter are presented in this section. This includes encouraging direct patient-provider communication through practices such as positioning, verbal reminders or gesturing for patient and providers to address each other directly, and use of first person interpreting. This protocol addresses the need to manage the flow of communication and facilitate or seek clarification of messages as well as how to conduct more active interventions when necessary. This section also flags the importance of interpreters to clearly identify when they intervene and speak on their own behalf, and describes how this may be done.

### **Protocol 3: Post-Encounter, Post-Session or Post-Interview**

This protocol addresses steps interpreters take to provide closure to the interpreted session. This ranges from ensuring that the encounter has ended and no other questions or concerns are outstanding, to facilitating follow-up appointments and scheduling of interpreter services, as necessary, and debriefing with the provider or interpreter's supervisor as needed.

### **Section 3: Guidance on Interpreter Roles and Intervention**

Section 3 identifies communication barriers LEP patients experience in the healthcare setting. CHIA recognizes these barriers create a need for multiple roles for healthcare interpreters. This section defines these multiple roles and describes performance strategies to facilitate communication and assist the interpreter to set appropriate boundaries for the benefit of all parties in an encounter.

Four roles are discussed:

#### **Message Converter**

In this role, interpreters listen, observe body language, and convert the meaning of all messages from one language to another without unnecessary additions, deletions, or changes in meaning.

#### **Message Clarifier**

In this role, interpreters are alert for possible words or concepts that might lead to misunderstanding and identify and assist in clarifying possible sources of confusion for the patient, provider, or interpreter.

#### **Cultural Clarifier**

The cultural clarifier roles goes beyond message clarification to include a range of actions that typically relate to an interpreter's ultimate purpose of facilitating communication between parties not sharing a common culture. Interpreters are alert to cultural words or concepts that might lead to misunderstanding and act to identify and assist the parties to clarify culturally-specific ideas.

#### **Patient Advocate**

In this role, interpreters actively support change in the interest of patient health and well-being. Interpreters require a clear rationale for the need to advocate on behalf of patients, and we suggest the use of the ethical decision-making process to facilitate this decision.

CHIA stresses that the complex patient advocate role is an optional role which must be left to the careful judgment of trained, experienced interpreters to decide whether to pursue in a given situation. The patient advocate role has not previously been clearly defined, and the guidelines here are intended to assist interpreters better understand the ethical thinking process required and suggest appropriate actions for this role. We anticipate feedback and suggest an ethical advisory committee be established to provide feedback on case studies.

### **Section 4: Appendices in the CHIA California Standards:**

**Appendix A** includes a brief overview of language barriers and health outcomes; **Appendix B**, an example of an ethical dilemma and the application of the ethical decision-making process; **Appendix C**, a discussion of group advocacy (outside of the role of the individual interpreter); **Appendix D**, a glossary of bolded and italicized words used throughout the document; and **Appendix E**, references for all citations.

The complete Standards document is available in spiral bound format from CHIA and from The California Endowment (<http://www.calendow.org>). The document is also available on the CHIA website (<http://www.chia.ws>). in Adobe PDF format.

## APPENDIX G: CULTURAL COMPETENCY TRAINING TOPICS

(Source: Recommendations from the California Task Force on Culturally Competent Physicians and Dentists, developed by Albert Gaw, M.D., Medical Director, Mental Health Rehabilitation Facility in San Francisco, a member of the Task Force co-chaired by Kathleen Hamilton – Director, Department of Consumer Affairs and Diana Bonta – Director, Department of Health Services, Spring, 2003)

### I. Recommended topics for Cultural Competency Training and Continuing Education Programs for Physicians and Dentists include but are not limited to the following topics:

- Understanding the application and concept of culture in clinical care.
- Elicitation of pertinent cultural information in interviews to make a diagnosis and formulate a treatment plan.
- How to work with an interpreter and interpreter ethics.
- Eliciting basic ethnic and cultural information necessary for needs assessment and data collection: language and dialect spoken, degree of English-speaking skills, key informants, and key decision-maker in family, etc.
- Effects of diets and herbs on drugs
- Cross-Cultural Pharmacology: Pharmacokinetic, Pharmacogenetic, Pharmacodynamic findings that may affect drug actions and metabolisms and drug/drug interaction.
- Cultural aspects of Physician/Dentist - Patient relationship.
- Cultural aspects of diagnostic categories.
- Cultural factors in the expression of illnesses.
- Cultural factors of family responses to illness in members of family.
- Cultural and community responses to illness.
- Cultural factors in healing experience.
- Aspects of symbolic healing.
- Role of indigenous healers in healing system.
- Alternative Medicine: Facts and Myths.
- Role of traditional medical systems, classical and popular, in contemporary health care system.
- Cultural factors in the bio-psycho-social paradigm in diagnosis and treatment.
- Health beliefs, food beliefs, and concepts of illness.
- Historical background of immigrants groups.
- General Physical and Psychiatric Sequelae of Trauma, Dislocation and Severe Culture Shock of immigrant groups.
- Epidemiology of diseases/disorders of various ethnic groups.
- Culture-Bound Syndromes.
- Use of Cultural Formulation in Psychiatric and Medical Care.
- How to use cultural information in life-long learning.
- Basic manners, linguistic, and social interaction of various ethnic groups and their pertinence to provider/consumer interaction.
- Cultural aspects of medication adherence/non-adherence, and psychotherapy.
- Racial disparities in health.
- Access to health care.

## **II. Knowledge, Skills, Attitudes, Tools and Practices for all DHS employees & individuals working with DHS entities.**

### **Knowledge**

Including:

- Demographics of the community your facility serves.
- Disease patterns and health care needs of the cultural groups your facility serves and cross-cultural factors that influence disparities in health status.
- Patient core health beliefs, practices and traditions specific to the kinds of care your facility provides and their impact on disease patterns and outcomes, access to care and treatment compliance.
- Patients' culture-based health beliefs, behaviors and communication patterns as they affect access and responsiveness to care and treatment.
- Culture as dynamic and evolving, and that differences occur within cultural groups.
- The impact of one's own values, attitudes, beliefs and biases on service delivery.
- How to access available agency and community tools and resources to assist in providing culturally competent and linguistically accessible services to patients and families.
- Federal, state and county laws, regulations and accreditation requirements related to cultural and linguistic services.

### **Skills**

Staff, particularly those with patient/client contact, should be aware of and be able to use five kinds of skills:

1. Interpersonal skills;
2. Clinical skills;
3. Advocacy skills;
4. Skills relating to utilization of resources; and
5. Management and leadership skills.

#### **1. Interpersonal Skills:**

- Create a welcoming environment (décor and ambiance) for all patients.
- Understand and go beyond one's own prejudices by effectively suspending judgment in considering points of view other than one's own. (Allowing oneself to fully and fairly understand and consider someone else's perspective does not mean you must agree with the other perspective.)
- Identify, negotiate and manage cultural differences and diversity-related conflicts with other staff and with patients.

#### **2. Clinical Skills:**

- Respectfully elicit relevant cultural information from patients. (For example, "What do these symptoms mean to you?" "Is there something that you should traditionally do when you get these symptoms?")
- Understand there may be cultural beliefs about any particular illness that limit the ability or the willingness of the patient to describe symptoms, understand bio-medical explanations, and adhere to any treatment plan that does not take their cultural health beliefs and practices into account. Shifting the frame of reference from the bio-medical model to the patient's own cultural health practices by asking respectful questions may help clinicians uncover and perhaps better understand culturally-based resistance and obstacles to health education and treatment.

#### **3. Advocacy Skills:**

- Effectively intervene with staff and/or patients who display inappropriate or culturally insensitive behavior.
- Identify, negotiate and manage cultural differences and diversity-related conflicts with other staff and with patients.

#### **4. Skills in Utilization of Resources:**

Appropriately use interpreter services, resource information, policies and procedures and other available tools and resources.

## 5. Management And Leadership Skills:

For managers and supervisors, maximize the cultural resources that exist within your facility (e.g. bicultural teams and work assignments, allocation of staff resources).

For all staff, demonstrate initiative in identifying opportunities for new and innovative ways of working which improve the relationships with the diverse communities and fellow staff, across all diversities.

### Attitudes

#### DHS staff:

- Values cultural competence in self and others.
- Values diversity of staff and patients and their valuable contributions to the organization — even if you don't agree or completely understand their perspectives.
- Conveys compassion, caring and openness to all patients.
- Demonstrates a willingness to learn about and understand other cultures, from their perspective as well as one's own.
- Is non-judgmental about and respects the practices and beliefs of other cultural groups as legitimate for those groups as demonstrated by willingness to respect and acknowledge other culture-based reasons for behaviors without judging the individual.
- Acknowledges the strengths of other cultures and respects their traditional healing systems, practitioners and practices, and different ways of coping with health issues.
- Respects the multi-faceted nature and individuality of people—views individuals within all their cultural contexts.
- Is willing to accept the moral and ethical obligation to challenge intolerance.

### Tools

#### Cultural & Linguistic tools include:

- Interpreter services.
- Client feedback and satisfaction survey results.
- TDD for hearing and speech impaired patients/clients.
- Policies and procedures relating to cultural and linguistic competency.
- Appropriate diversity-related training.
- Other staff and community agencies as cultural consultants.
- ODP website (to be developed).
- Indicators and measures (to be developed).

### Practices – How Skills & Knowledge Apply to Work:

#### Staff will:

- Incorporate cross cultural communication skills, knowledge and insights into patient history taking, assessment and treatment where appropriate.
- Provide safe medical care through the recognition, understanding and management of healing traditions and practices and, where appropriate, integrate traditional healing practices into medical treatment plan.
- Acknowledge strengths and legitimacy of other cultures' beliefs whether medically correct or not, and respectfully and non-judgmentally inform patients of cultural practices that could be detrimental to their health.
- Take the initiative to pursue understanding of patient cultures and seek information that enhances learning.
- Flexibly adapt communication, interactions and clinical approaches to the needs of different cultural situations.
- Follow policies and procedures that support delivery of culturally competent services.
- Make appropriate use of and referrals to community resources.
- Apply new skills and knowledge and share what's learned with other staff.
- Identify, respectfully handle, and, where appropriate, resolve C&L issues, complaints and grievances.

### **III. Training Components from Standard 9 Cultural & Linguistic Competency Training – Suggested Program Steps, Section III, page 25**

#### **Training shall include but is not limited to:**

- Importance of effective communications with patients in the medical setting;
- The organization's legal obligation to provide language services;
- The importance of ethnic and cultural awareness in the provision of health care;
- Awareness of one's own cultural biases and framework;
- Orientation on the cultural and linguistic standards, policies and procedures;
- Assessing a patient's need for interpreter services;
- Knowledge of how to access in-house, contracted, volunteer, or telephone service interpreters; the importance of utilizing, and how to properly utilize an interpreter;
- How to utilize telephone interpretation equipment or conference calls;
- How to assess when a different interpreter or a different mode of interpretation is appropriate; the role of DHS senior management in the cultural and linguistic compliance.

#### **These tools and skills can be offered through:**

- Cultural competence, awareness and skills training programs for all health care professionals and staff at all levels;
- Negotiation skills workshops;
- Updated information of the patient population including demographics. [See Appendix I on page 3]
- Epidemiological patterns of disease for the communities being served;
- Sharing knowledge on how health beliefs, norms and family values may affect client's health behavior;
- The impact of ethnicity and culture on health-seeking and decision-making;
- Health status disparities in ethnic and racial populations and their root causes.
- Access to cultural competence resources such as: a) best practices; b) resource library; c) videos; d) community resource directories; d) web site.
- Opportunities for self-assessment and staff satisfaction with cultural competence issues.
- Incorporating information on county, federal and state laws, regulations and accreditation requirements related to cultural and linguistic services into training.
- A system to evaluate DHS participation on both the individual and organization levels will be developed to evaluate the success and effectiveness of ODP diversity and cultural competency training, marketing, implementation and support will be developed, a baseline determined and annually and implemented on an annual basis.

## APPENDIX H: RESEARCH ON LANGUAGE BARRIERS IN HEALTHCARE

The following are but a small fraction of studies of language barriers and health outcomes. A report in March 2002 by the Institute of Medicine provides an extensive review of the research, strongly concluding that a need for trained interpreters exists.<sup>9</sup> A more complete treatment of this topic may be found in the book, *Language Barriers in Health Care Settings: An Annotated bibliography of the Research Literature*, by Elizabeth Jacobs, Niels Agger-Gupta, Alice Hm Chen, Adam Piotrowski, and Eric Hardt<sup>63</sup>. This document is available on The California Endowment website (<http://www.calendow.org>).

- A survey commissioned by the Robert Wood Johnson Foundation in 2001 found that one-fifth of Spanish-speaking Latinos living in communities with fast-growing Latino populations report not seeking medical treatment due to language barriers<sup>2</sup>. The survey found that both patients and providers agree that language barriers significantly compromise healthcare quality. Patients said language barriers made it much harder to explain symptoms, ask questions, and follow through with filling prescriptions, and caused them to doubt their physician's understanding of their medical needs. Ninety-four percent of providers said communication is a top priority in delivering quality care, identifying language barriers as a major challenge to delivering that care. Seventy three percent of providers said the aspect of care most compromised by language barriers is a patient's understanding of treatment advice and of their disease, 72 % said that barriers can increase the risk of complications when the provider is unaware of other treatments, and 71% percent said barriers make it harder for patients to explain their symptoms and concerns.
- The same study found that 51% of providers surveyed enlisted interpreting help from staff who speak Spanish, including clerical and maintenance staff. Another 29 % of providers said they rely on family members or friends of the patient to interpret. Patients said these practices often leave them feeling embarrassed, that their privacy has been compromised, and that information has been omitted. These concerns cause patients not to talk about personal issues when interpreters are present. Only 1% of providers actually used trained interpreters.
- A study in 2000 by Bernstein and colleagues at Boston Medical Center followed patients for 30 days following an initial ER visit and found that LEP patients who received a trained interpreter in the Emergency Department had fewer costs and received more preventive care than even English speaking patients. Patients with no trained interpreters or who used family members cost the least but were most likely to have subsequent ER visits, since their medical complaint was not appropriately addressed initially.<sup>46</sup>
- A 1996 study by Baker and associates conducted in an emergency department in Los Angeles found 87% of Spanish-speaking patients with limited English who saw providers with limited Spanish were not given an interpreter when they felt one should have been used.<sup>64</sup>
- A 1997 survey of 495 primary care physicians in the San Francisco Bay Area by Hornberger and associates showed 21% of visits were with non-English-speaking (NES) patients and that trained interpreters were used in only 6% of the encounters.<sup>65</sup> The other 94% of NES patients were "interpreted" by bilingual providers (27% of the time), untrained staff members (20% ) and family members (36%), with no interpreter present in the remainder (11%).
- Jacobs and her colleagues found that LEP patients used more preventive services, rather than emergency services, once a professional interpreter service was instituted in 1999 at Harvard Pilgrim Health Care in the Boston area.<sup>43</sup>

- Woloshin and colleagues found French-speaking women in Canada in 1997 were less likely to receive mammograms and breast exams compared to patients who spoke English, even after controlling for socioeconomic factors.<sup>5</sup>
- Todd and his colleagues found Hispanics were less likely to receive pain medication in the emergency department for long-bone fractures, a risk they thought to be related to non-English-speaking status.<sup>13</sup>
- Carrasquillo et. al. reported data from the emergency department of five urban teaching hospitals suggesting that LEP patients were less satisfied with care and less likely to return.<sup>8</sup>
- Hampers and his associates reported pediatric Emergency Department visits in a Chicago pediatric hospital involving a language barrier were more expensive, took more time, and resulted more often in admission than visits without a language barrier.<sup>44</sup>
- Andrulis and his colleagues found greater dissatisfaction and more problems among LEP patients at safety-net hospitals who needed but did not receive an interpreter.<sup>3</sup>

These are but a few studies. A full bibliography of research relating to health outcomes, language status and healthcare interpreting is in development and will be available through The California Endowment website (<http://www.calendow.org>) in 2003.<sup>63</sup>

## APPENDIX I: LOS ANGELES COUNTY LANGUAGE and CULTURAL DATA BY SERVICES PLANNING AREAS (SPAs)

	Census 2000 Summary File 1				Male				Female				Total
					0-17	18-64	65 over	Total	0-17	18-64	65 over	Total	
LA County	Latino	785,371	1,279,417	74,811	2,139,599	749,608	1,240,370	112,636	2,102,614	4,242,213			
	White	272,084	977,895	214,840	1,464,819	256,269	939,764	298,762	1,494,795	2,959,614			
	African American	134,703	250,962	33,719	419,384	130,475	299,272	52,341	482,088	901,472			
	Asian/Pacific Islander	128,745	367,082	51,449	547,276	120,263	411,519	68,776	600,558	1,147,834			
	American Indian/Alaska Native/Other	6,710	14,397	1,350	22,457	6,453	14,827	1,807	23,087	45,544			
	Two or more races (excluding Latino)	39,308	64,191	7,071	110,570	37,987	64,993	9,111	112,091	222,661			
										<b>9,519,338</b>			
SPA 1	Latino	19,973	24,944	1,285	46,202	18,845	24,129	1,731	44,705	90,907			
	White	23,849	51,304	7,728	82,881	22,669	50,361	10,145	83,175	166,056			
	African American	8,172	10,850	812	19,834	7,716	10,956	1,040	19,712	39,546			
	Asian/Pacific Islander	1,441	3,332	363	5,136	1,369	3,742	554	5,665	10,801			
	American Indian/Alaska Native/Other	388	979	69	1,436	425	812	74	1,311	2,747			
	Two or more races (excluding Latino)	2,188	1,901	150	4,239	2,065	2,038	208	4,311	8,550			
										<b>318,607</b>			
SPA 2	Latino	128,066	218,733	10,478	357,277	122,814	210,816	16,317	349,947	707,224			
	White	95,564	301,271	64,099	460,934	90,071	296,504	87,579	474,154	935,088			
	African American	9,679	23,895	1,390	34,964	9,073	22,867	1,821	33,761	68,725			
	Asian/Pacific Islander	21,823	58,039	5,979	85,841	20,151	67,379	8,508	96,038	181,879			
	American Indian/Alaska Native/Other	1,346	2,948	236	4,530	1,264	3,133	313	4,710	9,240			
	Two or more races (excluding Latino)	11,123	20,256	2,163	33,542	10,526	19,765	2,765	33,056	66,598			
										<b>1,968,754</b>			
SPA 3	Latino	138,212	221,090	15,959	375,261	133,190	223,305	23,568	380,063	755,324			
	White	43,209	142,925	36,695	222,829	40,573	142,771	54,628	237,972	460,801			
	African American	12,515	23,395	2,878	38,788	11,780	26,938	4,456	43,174	81,962			
	Asian/Pacific Islander	46,925	125,643	17,244	189,812	43,482	138,611	21,759	203,852	393,664			
	American Indian/Alaska Native/Other	1,208	2,191	239	3,638	1,032	2,375	310	3,717	7,355			
	Two or more races (excluding Latino)	6,814	9,577	1,092	17,483	6,606	9,789	1,270	17,665	35,148			
										<b>1,734,254</b>			
SPA 4	Latino	104,138	203,711	11,673	319,522	98,972	183,801	18,283	301,056	620,578			
	White	13,747	101,340	18,405	133,492	12,889	79,183	25,011	117,083	250,575			
	African American	6,215	27,112	2,789	36,116	5,945	21,898	4,034	31,877	67,993			
	Asian/Pacific Islander	15,856	56,768	10,771	83,395	15,088	61,632	15,425	92,145	175,540			
	American Indian/Alaska Native/Other	787	1,999	170	2,956	731	1,723	232	2,686	5,642			
	Two or more races (excluding Latino)	2,903	8,019	1,092	12,014	2,788	7,548	1,405	11,741	23,755			
										<b>1,144,083</b>			
SPA 5	Latino	13,588	32,398	2,249	48,235	12,660	33,938	3,475	50,073	98,308			
	White	27,121	133,367	27,930	188,418	25,879	133,553	36,835	196,267	384,685			
	African American	4,285	12,975	1,161	18,421	3,912	15,193	1,685	20,790	39,211			
	Asian/Pacific Islander	3,726	23,976	2,326	30,028	3,592	29,453	3,126	36,171	66,199			
	American Indian/Alaska Native/Other	398	1,176	87	1,661	385	1,246	113	1,744	3,405			
	Two or more races (excluding Latino)	3,108	6,782	649	10,539	2,915	7,146	783	10,844	21,383			
										<b>613,191</b>			
SPA 6	Latino	119,043	167,583	5,663	292,289	113,038	156,582	8,381	278,001	570,290			
	White	2,018	8,838	1,510	12,366	1,951	8,067	2,338	12,356	24,722			
	African American	49,292	79,352	17,769	146,413	48,915	106,535	29,181	184,631	331,044			
	Asian/Pacific Islander	1,166	5,093	1,176	7,435	1,146	5,269	1,605	8,020	15,455			
	American Indian/Alaska Native/Other	601	910	149	1,660	637	1,163	238	2,038	3,698			
	Two or more races (excluding Latino)	1,514	2,430	395	4,339	1,600	3,238	668	5,506	9,845			
										<b>955,054</b>			
SPA 7	Latino	161,808	254,665	19,580	436,053	154,315	256,520	29,139	439,974	876,027			
	White	24,176	73,932	21,936	120,044	22,616	73,001	32,003	127,620	247,664			
	African American	6,359	9,972	622	16,953	5,847	11,413	864	18,124	35,077			
	Asian/Pacific Islander	12,791	32,632	4,499	49,922	11,767	35,957	5,868	53,592	103,514			
	American Indian/Alaska Native/Other	819	1,689	191	2,699	829	1,753	259	2,841	5,540			
	Two or more races (excluding Latino)	3,410	4,764	581	8,755	3,328	4,562	743	8,633	17,388			
										<b>1,285,210</b>			
SPA 8	Latino	100,543	156,293	7,924	264,760	95,774	151,279	11,742	258,795	523,555			
	White	42,400	164,918	36,537	243,855	39,621	156,324	50,223	246,168	490,023			
	African American	38,186	63,411	6,298	107,895	37,287	83,472	9,260	130,019	237,914			
	Asian/Pacific Islander	25,017	61,599	9,091	95,707	23,668	69,476	11,931	105,075	200,782			
	American Indian/Alaska Native/Other	1,163	2,505	209	3,877	1,150	2,622	268	4,040	7,917			
	Two or more races (excluding Latino)	8,248	10,462	949	19,659	8,159	10,907	1,269	20,335	39,994			
										<b>1,500,185</b>			

## LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH

Universe: Population 5 years and over

	SPA 1	%	SPA 2	%	SPA 3	%	SPA 4	%	SPA 5	%	SPA 6	%	SPA 7	%	SPA 8	%	LAC	%
Total population 5 and over	280,962		1,838,685		1,608,423		1,061,323		584,633		860,254		1,173,328		1,383,488		8,791,096	
Speak only English	206,825		897,120		684,865		315,969		381,403		359,746		403,573		783,113		4,032,614	
Speak Spanish	60,014	100.0	574,574	100.0	543,322	100.0	519,749	100.0	82,905	100.0	479,165	100.0	663,128	100.0	408,078	100.0	3,330,935	100.0
Speak English "very well"	33,245	55.4	258,545	45.0	274,440	50.5	196,088	37.7	44,187	53.3	179,410	37.4	315,405	47.6	184,251	45.2	1,485,571	44.6
Speak English "well"	13,483	22.5	141,082	24.6	118,938	21.9	119,852	23.1	18,785	22.7	112,002	23.4	145,507	21.9	97,277	23.8	766,926	23.0
Speak English "not well"	9,152	15.2	114,228	19.9	98,287	18.1	126,094	24.3	15,027	18.1	109,880	22.9	124,679	18.8	85,145	20.9	682,492	20.5
Speak English "not at all"	4,134	6.9	60,719	10.6	51,657	9.5	77,715	15.0	4,906	5.9	77,873	16.3	77,537	11.7	41,405	10.1	395,946	11.9
Speak other Indo-European lang.:	5,708	100.0	201,767	100.0	45,766	100.0	69,107	100.0	65,445	100.0	5,448	100.0	24,876	100.0	41,275	100.0	459,392	100.0
Speak English "very well"	4,295	75.2	112,814	55.9	31,964	69.8	32,692	47.3	44,636	68.2	4,062	74.6	16,179	65.0	29,064	70.4	275,706	60.0
Speak English "well"	910	15.9	49,314	24.4	9,036	19.7	17,354	25.1	13,823	21.1	1,001	18.4	5,531	22.2	8,265	20.0	105,234	22.9
Speak English "not well"	414	7.3	28,657	14.2	3,804	8.3	13,580	19.7	5,659	8.6	321	5.9	2,460	9.9	3,280	7.9	58,175	12.7
Speak English "not at all"	89	1.6	10,982	5.4	962	2.1	5,481	7.9	1,327	2.0	64	1.2	706	2.8	666	1.6	20,277	4.4
Speak Asian & Pacific Island lang.:	6,643	100.0	132,688	100.0	321,719	100.0	145,046	100.0	41,672	100.0	11,442	100.0	75,560	100.0	140,745	100.0	875,515	100.0
Speak English "very well"	4,062	61.1	71,193	53.7	126,258	39.2	55,343	38.2	23,892	57.3	5,291	46.2	37,298	49.4	69,541	49.4	392,878	44.9
Speak English "well"	1,799	27.1	37,028	27.9	99,732	31.0	39,458	27.2	11,792	28.3	3,350	29.3	21,365	28.3	40,476	28.8	255,000	29.1
Speak English "not well"	676	10.2	21,018	15.8	74,842	23.3	38,085	26.3	5,419	13.0	2,223	19.4	14,185	18.8	26,274	18.7	182,722	20.9
Speak English "not at all"	106	1.6	3,449	2.6	20,887	6.5	12,160	8.4	569	1.4	578	5.1	2,712	3.6	4,454	3.2	44,915	5.1
Speak other language:	1,772	100.0	32,536	100.0	12,751	100.0	11,452	100.0	13,208	100.0	4,453	100.0	6,191	100.0	10,277	100.0	92,640	100.0
Speak English "very well"	1,177	66.4	22,073	67.8	8,586	67.3	6,557	57.3	9,360	70.9	2,976	66.8	3,912	63.2	7,181	69.9	61,822	66.7
Speak English "well"	433	24.4	7,153	22.0	2,807	22.0	2,746	24.0	2,572	19.5	847	19.0	1,418	22.9	2,022	19.7	19,998	21.6
Speak English "not well"	110	6.2	2,702	8.3	1,049	8.2	1,269	11.1	995	7.5	267	6.0	633	10.2	884	8.6	7,909	8.5
Speak English "not at all"	52	2.9	608	1.9	309	2.4	880	7.7	281	2.1	363	8.2	228	3.7	190	1.8	2,911	3.1

## HOUSEHOLD LANGUAGE BY LINGUISTIC ISOLATION

Universe: Households: A household in which no person 14 years old and over speaks only English and no person 14 years old and over who speaks a language other than English speaks English "very well" is classified as "linguistically isolated." (Census 2000 SF3, U.S. Census Bureau)

	SPA 1	%	SPA 2	%	SPA 3	%	SPA 4	%	SPA 5	%	SPA 6	%	SPA 7	%	SPA 8	%	LAC	%
Total households	95,594		680,378		524,822		414,981		280,430		256,249		357,722		526,103		3,136,279	
English	67,910		356,888		225,007		145,277		184,475		126,997		122,585		312,925		1,542,064	
Spanish:	20,736	100.0	176,678	100.0	165,675	100.0	168,779	100.0	34,894	100.0	119,327	100.0	195,652	100.0	132,152	100.0	1,013,893	100.0
Linguistically isolated	4,259	20.5	52,005	29.4	35,957	21.7	72,302	42.8	7,613	21.8	43,482	36.4	52,365	26.8	39,499	29.9	307,482	30.3
Not linguistically isolated	16,477	79.5	124,673	70.6	129,718	78.3	96,477	57.2	27,281	78.2	75,845	63.6	143,287	73.2	92,653	70.1	706,411	69.7
Other Indo-European lang.:	3,254	100.0	81,984	100.0	21,836	100.0	34,783	100.0	34,003	100.0	3,050	100.0	10,962	100.0	23,149	100.0	213,021	100.0
Linguistically isolated	231	7.1	20,660	25.2	3,126	14.3	13,320	38.3	5,938	17.5	344	34.4	2,069	18.9	3,394	14.7	49,082	23.0
Not linguistically isolated	3,023	92.9	61,324	74.8	18,710	85.7	21,463	61.7	28,065	82.5	2,706	88.7	8,893	81.1	19,755	85.3	163,939	77.0
Asian or Pacific Island lang.:	2,899	100.0	50,297	100.0	107,101	100.0	60,557	100.0	20,020	100.0	4,773	100.0	25,984	100.0	52,927	100.0	324,558	100.0
Linguistically isolated	412	14.2	12,991	25.8	42,365	39.6	28,654	47.3	5,310	26.5	1,881	39.4	7,138	27.5	15,098	28.5	113,849	35.1
Not linguistically isolated	2,487	85.8	37,306	74.2	64,736	60.4	31,903	52.7	14,710	73.5	2,892	60.6	18,846	72.5	37,829	71.5	210,709	64.9
Other language:	795	100.0	14,531	100.0	5,203	100.0	5,585	100.0	7,038	100.0	2,102	100.0	2,539	100.0	4,950	100.0	42,743	100.0
Linguistically isolated	119	15.0	2,247	15.5	671	12.9	1,553	27.8	1,009	14.3	350	16.7	470	18.5	897	18.1	7,316	17.1
Not linguistically isolated	676	85.0	12,284	84.5	4,532	87.1	4,032	72.2	6,029	85.7	1,752	83.3	2,069	81.5	4,053	81.9	35,427	82.9

## RECENT IMMIGRATION BY RACE AND SPA

Total foreign born (% immigrated since 1995)

Race / Ethnic	Total foreign born SPI	% immigr. since 1995	Total foreign born SP2	% immigr. since 1995	Total foreign born SP3	% immigr. since 1995	Total foreign born SP4	% immigr. since 1995	Total foreign born SP5	% immigr. since 1995	Total foreign born SP6	% immigr. since 1995	Total foreign born SP7	% immigr. since 1995	Total foreign born SP8	% immigr. since 1995	Total foreign born LAC	% immigr. since 1995
African American	855	6.7%	1,033	21.6%	1,653	23.5%	3,030	25.4%	2,213	24.0%	11,549	15.3%	684	20.0%	7,502	20.0%	42,193	19.8%
Asian	1,572	10.0%	90,344	16.8%	268,133	19.3%	115,994	20.5%	29,961	26.7%	3,096	49.8%	57,274	14.4%	101,746	16.2%	787,467	18.5%
Hispanic	31,072	13.1%	365,959	18.1%	305,060	15.9%	361,462	20.6%	43,187	18.4%	319,492	18.0%	387,102	14.6%	249,213	17.3%	2,085,813	17.3%
White	5,877	10.1%	180,151	13.5%	38,931	12.6%	64,162	20.7%	69,464	15.4%	664	34.3%	17,458	7.7%	37,988	12.4%	483,202	14.6%
Total FB	46,710	12.5%	725,891	16.8%	649,770	17.2%	585,236	20.7%	172,987	19.2%	347,941	18.2%	485,481	14.4%	434,506	16.5%	3,449,444	17.4%

Source: Census 2000 SF4 • Analysis of recent immigration by race and SPA based on tracts with 100+ persons in each category • Draft date: September 26, 2003

## LANGUAGE SPOKEN AT HOME BY AGE

Universe: Population 5 years and over

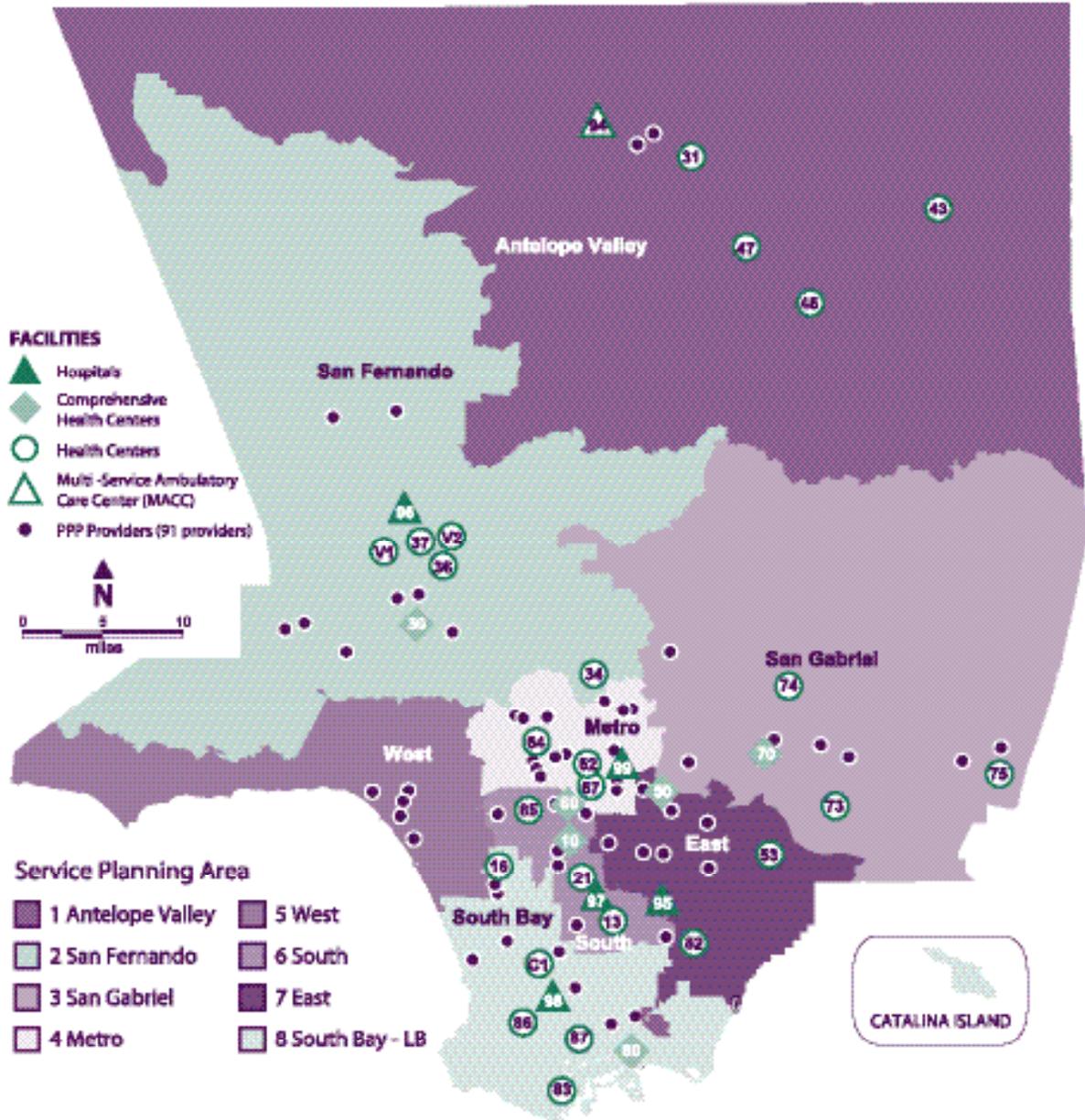
	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8	LAC
Total pop. 5 & over	280,962	1,838,685	1,608,423	1,061,323	584,633	860,254	1,173,328	1,383,488	8,791,096
Speak only English	206,825	897,120	684,865	315,969	381,403	359,746	403,573	783,113	4,032,614
African languages	317	1,719	2,038	2,267	1,984	2,534	892	3,864	15,615
Arabic	971	12,776	8,668	2,305	3,958	395	4,067	4,008	37,148
American	517	100,393	9,252	20,968	1,322	140	4,116	1,307	139,015
Chinese	763	15,038	193,196	29,613	12,993	2,477	15,811	17,833	287,724
French Creole	169	287	262	152	75	632	96	384	2,057
French*	982	9,506	4,235	6,574	8,951	1,443	1,996	5,265	38,952
German	1,152	7,249	4,770	3,505	5,051	476	1,945	4,854	29,002
Greek	98	2,290	988	895	795	10	10,33	1,346	7,455
Gujarathi	199	1,897	2,376	220	832	250	2,374	1,038	9,186
Hebrew	103	11,164	393	3,184	4,980	158	155	825	20,962
Hindi	217	3,787	2,579	781	2,279	513	1,459	1,630	13,245
Hungarian	154	3,401	876	1,373	1,346	21	401	666	8,238
Italian	513	5,614	3,528	2,709	2,821	211	1,557	4,135	21,088
Japanese	377	7,626	11,113	7,250	9,445	1,146	3,156	19,772	59,885
Korean	637	36,604	23,046	54,732	7,644	1,676	21,000	19,809	165,158
London	83	243	1,291	449	77	86	453	962	3,644
Nhoo, Hmong	0	0	84	7	36	4	56	262	449
Non-White, Cambodian	36	1,193	3,331	2,452	190	822	3,513	17,620	29,117
Nunup	15	52	47	58	12	66	24	62	336
Other and unspecified langs.	164	3,279	590	2,090	830	1,161	532	698	9,344
Other Asian languages	346	3,019	4,036	885	1,880	190	1,128	1,359	12,843
Other Ind. languages	287	6,560	4,131	2,518	1,346	264	1,893	2,451	19,450
Other Indo-European langs.	163	3,366	1,217	1,974	1,198	422	1,240	1,258	10,838
Other Indo-Euro. langs.	48	145	139	175	98	118	120	154	997
Other Pac. Island languages	578	3,329	6,652	2,148	1,501	2,012	2,267	9,249	27,736
Other Sinitic languages	239	2,170	578	1,097	835	19	315	967	6,220
Other West Germanic langs.	326	1,595	1,976	577	834	48	1,009	1,193	7,558
Persian (Farsi)	303	28,639	2,967	3,461	26,002	393	999	5,428	68,192
Polish	145	2,323	782	1,015	1,216	40	357	853	6,731
Portuguese or Port. Creole	29	2,097	957	890	2,088	66	2,372	1,613	10,112
Russian	95	16,702	1,578	18,550	4,720	223	997	1,183	44,048
Samoan languages	143	1,560	1,063	563	1,672	75	213	1,209	6,498
Santo-Croton	63	1,770	874	724	775	39	260	3,167	7,672
Spanish or Spanish Creole	60,014	574,574	543,322	519,749	82,905	479,165	663,128	408,078	3,330,935
Tepaling (Tepino)	3,150	47,022	39,572	38,622	5,049	1,827	21,303	39,126	195,671
Thai	244	7,213	4,962	3,573	707	419	2,314	2,192	21,624
Urdu	68	2,004	1,495	302	1,380	163	542	1,805	7,759
Vietnamese	429	11,401	34,436	5,315	2,190	783	4,549	12,561	71,664
Yiddish	0	1,958	158	1,632	1,253	21	103	189	5,314

\*Includes Pidgin and Cajun

All highlighted languages have been identified by the State of California as the Medi-Cal Threshold Languages for Los Angeles County. • Data Sources: Census 2000 Summary File 3 prepared by the U. S. Census Bureau, 2002 (www.census.gov)  
 • Summary File 3 (SF 3) presents in-depth population and housing data collected on a sample basis (generally 1-in-6 persons and housing units) from the Census 2000 long form questionnaire. • Tables P19. AGE BY LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH FOR THE POPULATION 5 YEARS AND OVER [67] • Universe: Population 5 years and over; P20 HOUSEHOLD LANGUAGE BY LINGUISTIC ISOLATION [14] Universe: Households; PCT0 - AGE BY LANGUAGE SPOKEN AT HOME FOR THE POPULATION 5 YEARS AND OVER [83] Universe: Population 5 years and over



**DEPARTMENT OF HEALTH SERVICES**  
Hospitals, CHCs, HCs By Service Planning Area



**FACILITIES**

- Hospitals
- Comprehensive Health Centers
- Health Centers
- Multi-Service Ambulatory Care Center (MACC)
- PPP Providers (91 providers)



**Service Planning Area**

- 1 Antelope Valley
- 2 San Fernando
- 3 San Gabriel
- 4 Metro
- 5 West
- 6 South
- 7 East
- 8 South Bay - LB

**HOSPITALS**

- 95 Rancho Los Amigos National Rehabilitation Center
- 96 Olive View/UCLA Medical Center
- 97 MILK/Drw Medical Center
- 98 H/UCLA Medical Center
- 99 LAC + USC Medical Center

**COMPREHENSIVE HEALTH CTR**

- 10 HUH/Humphrey CHC
- 30 Valleycare Mid-Valley CHC
- 50 Edward R. Roybal CHC
- 60 H. Claude Hudson CHC
- 70 El Monte CHC
- 80 Long Beach CHC

**MULTI-SERVICE AMBULATORY CARE CENTER (MACC)**

- 94 High Desert MACC

**HEALTH CENTERS**

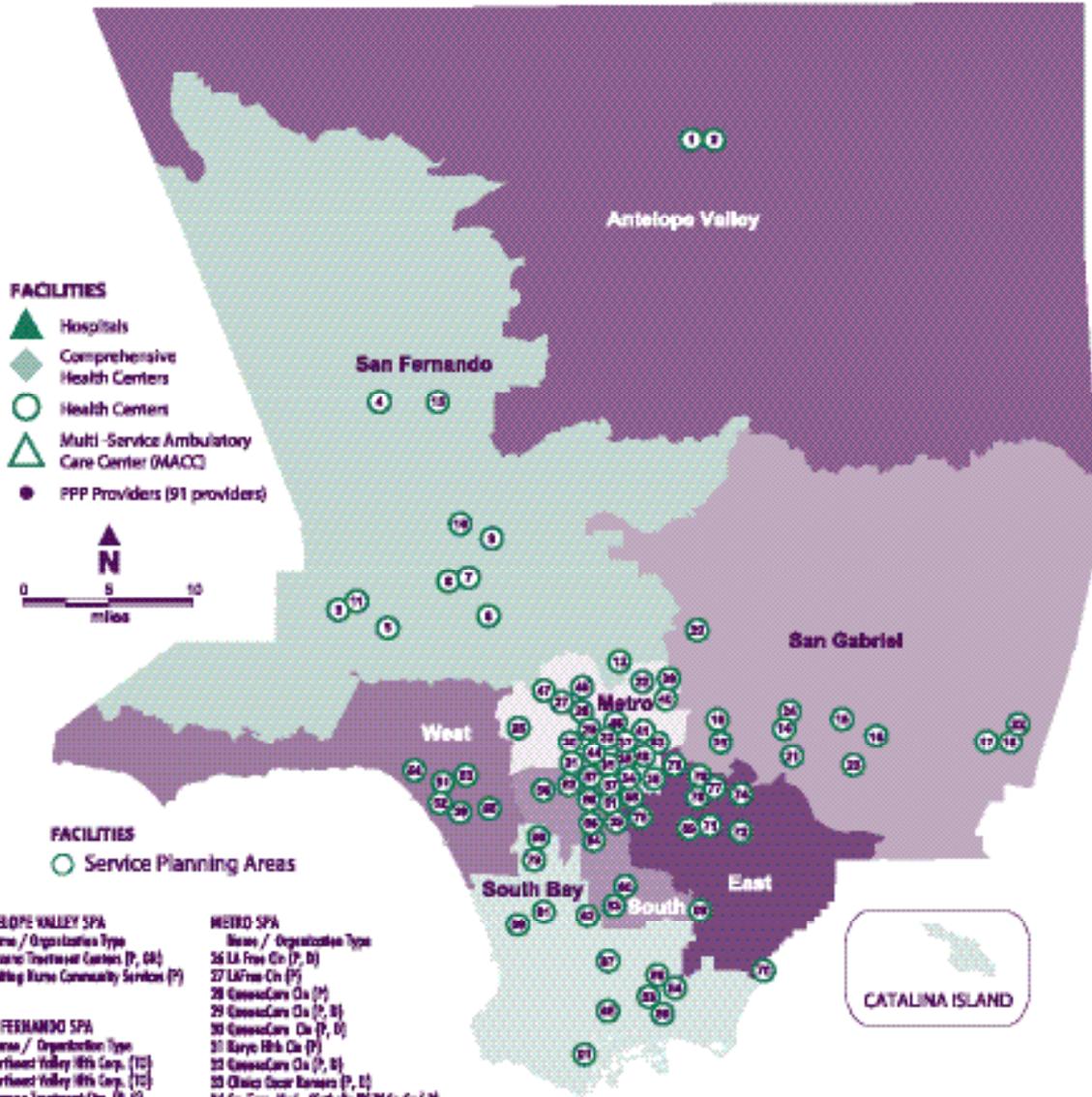
- 13 Dollarhide
- 16 Curtis R. Tucker
- 21 South
- 31 Antelope Valley HC
- 34 Glendale HC
- 36 Pacoima HC
- 37 San Fernando HC
- 43 Lake Los Angeles Clinic
- 46 Littlerock Community Clinic
- 47 South Antelope Valley HC
- 53 Whittier HC
- 62 Central HC
- 64 Hollywood-Wishnie HC
- 65 Ruth Temple HC
- 67 Weingart Medical Clinic
- 73 La Puente HC
- 74 Monrovia HC
- 75 Pomona HC
- 82 Bellflower HC
- 83 Harbor HC
- 86 Torrance HC
- 87 Wilmington HC
- C1 Gardena HS Based Clinic
- V1 Kennedy School Based Clinic
- V2 Vaughn School Based Clinic

Note: Boundary files are based upon Census 2000. List of facilities provided by Office of Planning as of 5/03.

September 19, 2003



**DEPARTMENT OF HEALTH SERVICES**  
Public Private Partnership Facilities By Service Planning Area



- FACILITIES**
- Hospitals
  - Comprehensive Health Centers
  - Health Centers
  - Multi-Service Ambulatory Care Center (MACC)
  - PPP Providers (91 providers)



- FACILITIES**
- Service Planning Areas

**ANTELOPE VALLEY SPA**  
Name / Organization Type  
1 Torrance Treatment Centers (P, GR)  
2 Valley Home Community Services (P)

**SAN FERNANDO SPA**  
Name / Organization Type  
3 Northwest Valley HHs Corp. (TC)  
4 Northwest Valley HHs Corp. (TC)  
5 Torrance Treatment Ctr. (P, GR)  
6 Mission City Community Network (P)  
7 El Progreso del Norte (P)  
8 Valley Community Clinic (P)  
9 Northwest Ys  
10 Northeast Valley HH (P, G)  
11 El Progreso del Norte (P)  
12 Broadway Fam. Med. Ctr (GR)  
13 Sexual Abuse Fam. HHs Ctr. (P)

**SAN GABRIEL SPA**  
Name / Organization Type  
14 Alhambra Health Services Corp (P)  
15 Rosemead Health Plan Medical Group (P)  
16 East Valley Care HHs Ctr (P, GR)  
17 East Valley Care HHs Ctr (P, GR)  
18 Pasadena Valley Medical Center (P)  
19 La Cima Medical Group (P)  
20 Care, HHs Alliance (P, G)  
21 Duarte Fam. Care Med. (P)  
22 Pasadena Valley Med. Ctr. (P)  
23 Bay Area Addiction Res. & Treat (P)  
24 The Church of Our Saviour (P)  
25 Sleep H. Clinic, M.D. Inc (P)

**METRO SPA**  
Name / Organization Type  
26 LA Free Ctr (P, R)  
27 LAFree Ctr (P)  
28 QueensCare Ctr (P)  
29 QueensCare Ctr (P, R)  
30 QueensCare Ctr (P, G)  
31 Bayco HHs Ctr (P)  
32 QueensCare Ctr (P, R)  
33 Clinica Oscar Barrios (P, G)  
34 Co. Fam. Med. /Catholic BK W So Co (P)  
35 Esser Pod. & Fam.Med. Ctr. (P, G)  
36 FACH Institute, Inc (P)  
37 Okinawan Service Center (P)  
38 East Los Angeles Health Task Force (GR)  
39 Northeast Community Clinic (P)  
40 Arroyo Vista Fam. HHs Focal (P, G)  
41 Arroyo Vista Fam. HH Focal (P)  
42 Asian Pacific Health Care Network (P)  
43 Alhambra Health Services Corp (GR)  
44 Diamond Business Medical Ctr (GR)  
45 Mission City Community Network (P)  
46 Bay Area Addiction Res. & Treat. (GR)  
47 Bay Area Addiction Res. & Treat. (GR)  
48 Good Samaritan Health Foundation, Inc (P)  
49 Rainbow HH, Educ., Inform., & Res. (P)

**WEST SPA**  
Name / Organization Type  
50 Yerdon Family Clinic (P, GR)  
51 Westside Family Health Center (P)  
52 Yerdon Family Clinic (P, GR)  
53 Yerdon Family Clinic (P, GR)  
54 Yerdon Family Clinic (G)  
55 Yerdon Family Clinic (P)

**SOUTH SPA**  
Name / Organization Type  
56 T.A.L.S. Clinic, Inc (P)  
57 St. John's Well Child Center (P, G)  
58 South Central Family HHs Ctr. (P)  
59 Central City Community HHs Ctr. (P)  
60 St. John's Well Child Center (P)  
61 Bay Area Addiction Res. & Treat. (P)  
62 Co. Fam. Med. /Catholic BK W So Co (P)  
63 Complex Central Health Inc (P)  
64 HarborCare Health Plan (P)  
65 UHMA Free Ctr (P)  
66 Co. Fam. Med. /Catholic BK W So Co (P)  
67 Central Blvd Med. (P)  
68 Soquel Heart Ctr. (P)

**EAST SPA**  
Name / Organization Type  
69 Children Foundation (P)  
70 Family Health Care Centers (P)  
71 Family Health Care Centers (P)  
72 Alhambra Health Services Corp (P, GR)  
73 QueensCare Family Clinics (P)  
74 El Dorado Care, Sec. Ctr (P)  
75 Alhambra Health, Inc.  
76 Alhambra Health Services Corp (GR)  
77 Miramonte Children's Ctr. (P)  
78 South Alhambra Medical Gr. (P)

**SOUTH BAY SPA**  
Name / Organization Type  
79 El Dorado Care, Sec. Ctr. (P)  
80 South Bay Fam. HC Ctr. (P, G)  
81 El Dorado Care, HC - Lumbria (P)  
82 South Bay Fam. HC Ctr. (P)  
83 Westside Neighborhood Ctr (P)  
84 The Children's Clinic (P)  
85 Wilmington Care, Clinic (P)  
86 Avoca Mountain Hosp & Ctr (P)  
87 Little Company of Mary (P)  
88 Children's Dental Health Ctr (P)  
89 The Children's Clinic (P)  
90 South Bay Family HC Ctr. (P)  
91 Harbor Free Clinic (P)

- Service Planning Area**
- 1 Antelope Valley
  - 2 San Fernando
  - 3 San Gabriel
  - 4 Metro
  - 5 West
  - 6 South
  - 7 East
  - 8 South Bay - LB

Note: Boundary lines are based upon Census 2000. List of facilities provided by Office of Planning as of 4/23. Organization Type = Primary Care (P), Dental (D), Tobacco (TC), General/Helth (GR)

## **APPENDIX J: DEPARTMENT OF HEALTH SERVICES CULTURAL & LINGUISTIC STANDARDS WORK GROUP**

In 1999 the following DHS staff and community leaders with expertise in cultural and linguistic issues and services were appointed by the Director of Health Services to the DHS Cultural and Linguistic Standard Work Group to develop recommended cultural and linguistic competency standards for the Department of Health Services. The members were:

**Margaret Avila, R.N.P., M.S.N.**  
Nursing Director, Public Health  
L.A. County Department of Health Services

**Monica Benitez**  
Director, Statewide Health Care Outreach  
Mexican American Legal Defense & Educational Fund  
(MALDEF)

**Jennifer Cho**  
Cultural and Linguistic Specialist  
L.A. Care Health Plan

**José Cosío, M.P.H.**  
Cultural and Linguistic Services Specialist  
Health Net

**Monette Cuevas, Pharm.D.**  
Pharmacist  
L.A. County Department of Health Services

**Kate Edmundson**  
Associate Director, Corporate Office of Human Resources  
Management  
L.A. County Department of Health Services

**Hector Flores, M.D.**  
Co-Director  
Family Practice Residency Program  
White Memorial Medical Center

**Heng Foong**  
Program Director  
Pacific Asian Language Services (PALS) for Health

**Lark Galloway-Gilliam**  
Executive Director  
Community Health Councils, Inc.

**Jean Gilbert, Ph.D.**  
Director of Cultural Competence  
Kaiser Permanente

**Amy Gutierrez, Pharm.D.**  
Director of Pharmacy  
King/Drew Medical Center

**Patricia C. Hassakis, M.D., M.P.H.,**  
Former Co-Chair  
Director, Office of Binational/Border Health  
L.A. County Department of Health Services

**Miya Iwataki, Chair**  
Director, Office of Diversity Programs  
L.A. County Department of Health Services

**Sally Jue, MSW**  
Independent Cultural & Linguistic Competency Consultant

**Margaret Lee, Ph.D.**  
Director, Special Projects  
L.A. County Department of Health Services

**Christina L. Perez, MN, WHC-CFNP**  
Regional Minority Health Consultant  
Region IX, Office of Minority Health  
U.S. Dept. of Health & Human Services

**Jane Perkins, J.D., M.P.H.**  
Director of Legal Affairs  
National Health Law Program (NHeLP)

**Irene Recendez, R.N.P.**  
Director, Medical/Surgical Services  
LAC+USC Medical Center

**Phillip Rocha**  
Director, Office of Equal Employment Opportunity  
Compliance  
L.A. County Department of Health Services

**Pauline Rodriguez, R.N.**  
Interim Director, Office of Managed Care  
L.A. County Department of Health Services

**Satwant Sidhu, M.D.**  
Medical Director  
Mid-Valley Comprehensive Health Center

**Kathleen A. Torres, M.P.H.**  
Former Co-Chair  
Director, Office of Women's Health  
L.A. County Department of Health Services

**Karin H. Wang, Esq.**  
Deputy Regional Manager, Region IX  
Office for Civil Rights  
U.S. Department of Health & Human Services

In 2002, the following members were appointed to the Cultural and Linguistic Work Group by the Acting Director of the Department of Health Services:

**Wesley Ford**  
Head, Surveys Integration Support Division  
L.A. County Department of Health Services

**Kazue Shibata, Executive Director**  
Asian Pacific Health Care Venture, Inc.  
President, Community Clinic Association of L.A. County

**Sylvia Drew Ivie**  
Executive Director  
T.H.E. Clinic, Inc.

**Beatriz Solis**  
Director, Cultural and Linguistic Services  
L.A. Care Health Plan

**Dennis Kao**  
Policy Director  
Asian Pacific American Legal Center

**Sissy Trinh**  
Policy Advocate  
Asian Pacific American Legal Center

**D. Tyler Ross**  
Field Representative  
SEIU Local 660

**Doreena Wong**  
Staff Attorney  
National Health Law Program

**Staff:**

**Yealanda Charles\***  
Assistant Program Specialist  
Public Health Programs & Services  
L.A. County Department of Health Services

**Nina Vassilian, M.P.H.**  
Office of Diversity Programs  
L.A. County Department of Health Services

**Abel Martinez, M.P.H.\***  
Diversity Analyst  
Office of Diversity Programs  
L.A. County Department of Health Services

**Jessica St. John\***  
Special Projects Manager  
Office of Women’s Health  
L.A. County Department of Health Services

**Edenn Sarino, M.P.H.\***  
Director of Communications & Outreach  
Health Consumer Center of Los Angeles SFV  
Neighborhood Legal Services

**Andrea Welsing, M.P.H.\***  
Senior Policy Analyst  
Office of Women’s Health  
L.A. County Department of Health Services

\* Former Workgroup Staff

**APPENDIX K: MediCal THRESHOLD LANGUAGES BY COUNTY**

**MEDI-CAL BENEFICIARIES (July 2002) • PRIMARY LANGUAGE THRESHOLDS**

(3,000 residing in a county or 1,000 beneficiaries in a zip code or 1,500 beneficiaries in two contiguous zip codes)

Counties with Two or More Threshold Languages

Language	Alameda	Fresno	Los Angeles	Sacramento	San Francisco	San Joaquin	Sutter/ Yuba	Yolo
Spanish	X	X	X	X	X	X	X	X
Vietnamese	X		X	X	X			
Cantonese	X		X	X	X			
Mandarin			X					
Other Chinese			X					
Armenian			X					
Russian			X	X				X
Cambodian			X			X		
Hmong		X		X			X	
Tagalog			X					
Korean			X					
Farsi			X					

[http://www.medi-cal.ca.gov/Medi-Cal\\_Thresh\\_Lang.htm](http://www.medi-cal.ca.gov/Medi-Cal_Thresh_Lang.htm) (accessed September 9, 2003)

## SECTION V: REFERENCES

1. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong On. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep.* Jul-Aug 2003;118(4):293-302.
2. Wirthlin Worldwide. *Hablamos Juntos / Survey of Interpreter Need*. Washington, D.C.: Robert Wood Johnson Foundation; December 12, 2001 2001. available online at: [http://www.hablamosjuntos.org/mediacenter/press\\_conference.asp](http://www.hablamosjuntos.org/mediacenter/press_conference.asp). Accessed 3/30/03.
3. Andrulis D, Goodman N, Pryor C. *What a difference an interpreter makes: Health care experiences of uninsured with limited English proficiency*. Boston, Massachusetts: The Access Project, a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University; 2002.
4. Gandhi TK, Burstin HR, Cook EF, et al. Drug complications in outpatients. *Journal of General Internal Medicine.* 2000;15:149-154.
5. Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services? *Journal of General Internal Medicine.* 1997;1997(12):472-477.
6. Diehl AK, Westwick TJ, Badgett RG, Sugarek NJ, Todd KH. Clinical and sociocultural determinants of gallstone treatment. *The American Journal of the Medical Sciences.* 1993 Jun;305(6):383-386.
7. Haffner L. Translation is not enough -- Interpreting in a Medical Setting. *Western Journal of Medicine.* 1992;157(3 (special issue on Cross-cultural Medicine: A Decade Later)):255-259.
8. Carrasquillo O, Orav EJ, Brennan TA, Burstin HR. Impact of language barriers on patient satisfaction in an emergency department. *Journal of General Internal Medicine.* 1999;1999(14):82-87.
9. Smedley BD, Stith AY, Nelson AR, eds. *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: Institute of Medicine, National Academy Press; 2002.
10. McMahan LF, Jr., Wolfe RA, Huang S, Tedeschi P, Manning W, Jr., Edlund MJ. Racial and gender variation in use of diagnostic colonic procedures in the Michigan Medicare population. *Medical care.* Jul 1999;37(7):712-717.
11. Imperato PJ, Nenner RP, Will TO. Radical prostatectomy: lower rates among African-American men. *Journal of the National Medical Association.* Sep 1996;88(9):589-594.
12. Bernabei R, Gambassi G, Lapane K, et al. Management of pain in elderly patients with cancer. SAGE Study Group. Systematic Assessment of Geriatric Drug Use via Epidemiology. *JAMA : the journal of the American Medical Association.* Jun 17 1998;279(23):1877-1882.
13. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. *Journal of the American Medical Association.* 1993;1993(269):1537-1539.
14. Hayes-Bautista DE. *The secret of L.A.'s public health*. Los Angeles: Los Angeles Times; August 6 2000.
15. Perkins J, Simon H, Cheng F, Olson K, Vera Y. *Ensuring linguistic access in health care settings: Legal rights and responsibilities* (Revised August 2003). Los Angeles, California: National Health Law Program and Henry J. Kaiser Family Foundation. (available from The California Endowment, [www.calendow.org](http://www.calendow.org) and <http://www.NHeLP.org>); 2003, 1998.
16. Office of Management and Budget. Assessment of the total benefits and costs of implementing executive order No. 13166: Improving access to services for persons with limited English proficiency (Report to Congress). Washington, D.C. March 14 2002.
17. National Academy of Sciences. *To err is human: Building a safer health system: Report to National Academy of Sciences*. Washington, DC: National Academy Press; 1999.
18. Flores G, Barton-Laws M, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics.* 2003;111(1):6-14.
19. Baker DW, Hayes R, Fortier JP. Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care.* 1998;36((10)):1461-1470.
20. Bauer HM, Rodríguez MA, Szkupinski-Quiroga S, Flores-Ortiz YG. Barriers to health care for abused Latina and Asian immigrant women. *Journal of Health Care for the Poor & Underserved.* 2000;11(1):33-44.
21. Carrasquillo O, Orav EJ, Brennan TA, Burstin HR. Impact of language barriers on patient satisfaction in an emergency department. *Journal of General Internal Medicine.* 1999;14:82-87.

22. Crane JA. Patient comprehension of doctor-patient communication on discharge from the emergency department. *Journal of Emergency Medicine*. 1997;15((1)):1-7.
23. David RA, Rhee M. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *The Mount Sinai Journal of Medicine*. 1998;65(5-6):393-397.
24. Drennan G. Counting the costs of language services in psychiatry. *South African Medical Journal*. 1996;86(4):343-345.
25. Elderkin-Thompson V, Silver RC, Waitzkin H. When nurses double as interpreters: A study of Spanish-speaking patients in a U.S. primary care setting. *Social Science and Medicine*. 2001;52:1343-1358.
26. Eytan A, Bischoff A, Loutan L. Use of interpreters in Switzerland's psychiatric services. *Journal of Nervous and Mental Disease*. 1999;187:190-192.
27. Fox SA, Stein JA. The effect of physician-patient communication on mammography utilization by different ethnic groups. *Medical Care*. 1991;29:1065-1082.
28. Free C, White P, Shipman C, Dale J. Access to and use of out-of-hours services by members of Vietnamese community groups in South London: A focus group study. *Family Practice*. 1999;16:369-374.
29. Freeman GK, Rai H, Walker JJ, Howie JGR, Heaney DJ, Maxwell M. Non-English speakers consulting with the GP in their own language: A cross-sectional survey. *British Journal of General Practice*. 2002;52:36-38.
30. Garrett CR, Treichel CJ, Ohmans P. Barriers to health care for immigrants and non-immigrants: A comparative study. *Minnesota Medicine*. 1998;81:52-55.
31. Ghandi TK, Burstin HR, Cook EF, et al. Drug complications in outpatients. *Journal of General Internal Medicine*. 2000;15:149-154.
32. Hornberger JC, Gibson CD, Wood W, et al. Eliminating language barriers for non-English-speaking patients. *Medical Care*. 1996;34(8):845-856.
33. Kline F, Acost FX, Austin W, Johnson Jr RG. The misunderstood Spanish-speaking patient. *American Journal of Psychiatry*. 1980;137(12):1530-1533.
34. Leman P. Interpreter use in an inner city accident and emergency department. *Journal of Accident and Emergency Medicine*. 1997;14:98-100.
35. Marin BVO, Marin G, Padilla A, de la Rocha C. Utilization of traditional and non-traditional sources of health among Hispanics. *Hispanic Journal of Behavioural Sciences*. 1983;5(1):65-80.
36. Mazor SS, Hampers LC, Chande VT, Krug SE. Teaching Spanish to pediatric emergency physicians. *Archives of Pediatric Adolescent Medicine*. 2002;156:693 - 695.
37. Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine*. 1999;14:409-417.
38. Perez-Stable EJ, Napoles-Springer A, Miramontes JM. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care*. 1997;35:1212-1219.
39. Roberts GW. Nurse/patient communication within a bilingual health care setting. *British Journal of Nursing*. 1994;3(2):60-67.
40. Shapiro J, Saltzer E. Cross-cultural aspects of physician-patient communications patterns. *Urban Health*. 1981(December):10 - 15.
41. Small R, Rice PL, Yelland J, Lumley J. Mothers in a new country: The role of culture and communication in Vietnamese, Turkish, and Filipino women's experiences of giving birth in Australia. *Women and Health*. 1999;28(3):77 - 101.
42. Weech-Maldonado R, Morales LS, Spritzer K, Elliott M, Hays RD. Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. *Health Services Research*. 2001;36(3):575-594.
43. Jacobs EA, Lauderdale DS, Meltzer DO, Shorey JM, Levinson W, Thisted RA. Impact of interpreter services on delivery of health care to limited-English-proficient patients. *J Gen Intern Med (Journal of general internal medicine : official journal of the Society for Research and Education in Primary Care Internal Medicine)*. 2001;16(July (7)):468-474.

44. Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE. Language barriers and resource utilization in a pediatric emergency department. *Pediatrics*. 1999;103(6 Pt 1):1253-1256.
45. Lee ED, Rosenberg CR, Sixsmith DM, Pang D, Abularrage J. Does a physician-patient language difference increase the probability of hospital admission? *Academic Emergency Medicine*. 1998;5(1):86-89.
46. Bernstein J, Bernstein Edward, Dave A, et al. Trained medical interpreters in the emergency department: effects on services, subsequent charges, and follow-up. *Journal of Immigrant Health*. 2002;Volume 4(Issue 4; October 2002):171-176.
47. Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. Use and effectiveness of interpreters in an emergency department. *Journal of the American Medical Association*. 1996;275:783-788.
48. Cooke MW, Wilson S, Cox P, Roalfe A. Public understanding of medical terminology: Non-English speakers may not receive optimal care. *Journal of Accident and Emergency Medicine*. 2000;17:119-121.
49. Seijo R, Gomez J, Freidenberg J. Language as a communication barrier in medical care for Hispanic patients. *Hispanic Journal of Behavioral Sciences*. 1991;13(4):363 - 375.
50. Shaw J, Hemming MP, Hobson JD, Nieman P, Naismith NW. Comprehension of therapy by non-English-speaking hospital patients. *Medical Journal of Australia*. 1977;2(13):423 - 327.
51. Wardin K. A comparison of verbal evaluation of clients with limited English proficiency and English speaking clients in physical rehabilitation settings. *American Journal of Occupational Therapy*. 1996;50(10):816 - 825.
52. Enguidanos ER, Rosen P. Language as a factor affecting follow-up compliance from the emergency department. *The Journal of Emergency Medicine*. 1997;15(1):9-12.
53. Jeremiah JP, O'Sullivan MS, Stein MD. Who leaves against medical advice? *Journal of General Internal Medicine*. 1995;10:403-405.
54. Lipton RB, Losey LM, Giachello A, Mendez J, Girotti MH. Attitudes and issues in treating Latino patients with Type 2 diabetes: Views of health care providers. *The Diabetes Educator*. 1998;24(1):67-71.
55. Manson A. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. *Medical Care*. 1988;26(12):1119 -1128.
56. Sarver J, Baker DW. Effect of language barriers on follow-up appointments after an emergency department visit. *Journal of General Internal Medicine*. 2000;15:256-264.
57. Kleinman A. *Patients and healers in the context of culture*. Los Angeles, CA: University of California Press; 1980.
58. Kleinman A, M.D. *Rethinking psychiatry: from cultural category to personal experience*. 1st ed. New York: The Free Press, A Division of Macmillan, Inc.; 1988.
59. Waldinger R, Bozorgmehr M. *Ethnic Los Angeles*. New York, New York: Russell Sage Foundation; 1996.
60. Campanelli RM. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. Washington, D.C.: US Department of Health & Human Services Office for Civil Rights (published in the Federal Register, 68 Fed. Reg. 47311); Aug. 8, 2003. (on-line at: <<http://www.hhs.gov/ocr>>); 2003.
61. Roat CE. How to choose a language agency: A guide for health and social service providers who wish to contract with language agencies. Woodland Hills, California: The California Endowment (available online at: <http://www.calendow.org>); 2003.
62. Gilbert J, ed. *Resources in cultural competence education for health care professionals*. Woodland Hills, California: The California Endowment (available on <http://www.calendow.org>); 2002.
63. Jacobs EA, Agger-Gupta N, Chen AH, Piotrowski A, Hardt E. *Language barriers in health care settings: An annotated bibliography of the research literature*. Woodland Hills, California: The California Endowment; 2003.
64. Baker DW, Parker RM, Williams MV, Coates WC, Pitken K. Use and Effectiveness of Interpreters in an Emergency Department. *Journal of the American Medical Association*. 1996;275(10):783-788.
65. Hornberger J, Itakura H, Wilson SR. *Bridging language and cultural barriers between physicians and patients*. Public Health Rep. 1997;112(5):410-417.