Law and the Public's Health

REDUCING DISCRIMINATION AFFECTING PERSONS WITH LIMITED ENGLISH PROFICIENCY: FEDERAL CIVIL RIGHTS GUIDELINES UNDER TITLE VI OF THE 1964 CIVIL RIGHTS ACT

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This installment of *Law and the Public's Health* examines guidelines issued in August 2003 by the U.S. Department of Health and Human Services (DHHS) Office for Civil Rights (OCR). The purpose of the guidelines is to outline the obligations that recipients of federal financial assistance have to persons with limited English proficiency (termed "LEP persons").[1] These guidelines are of great importance to public health policy and practice, given the size of the non-English speaking population in the U.S. (46 million persons, more than 17% of the U.S. population, speak a primary language at home other than English), the reach of Title VI of the 1964 Civil Rights Act in the case of federally supported health services, and the importance of patient communication to health care quality.

The column begins with a brief overview of Title VI and its application to issues of language. It then reviews key elements of the guidelines and considers their implications for public health. (Additional explanatory resources can be found at the website maintained by DHHS/OCR,[2] and the Kaiser Family Foundation has prepared excellent explanatory materials that can be found at its website.[3])

TITLE VI AND ITS APPLICATION TO LANGUAGE

Title VI of the 1964 Civil Rights Act (§601) provides that no person shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." This prohibition against the investment of federal funds in entities that engage in discriminatory practices is one of the fundamental tenets of the 1964 Civil Rights Act, a landmark in U.S. civil rights law.

Discrimination in health care was a key consideration in the enactment of Title VI. At the time of its passage, the legal segregation of hospitals and other health care facilities had only recently ended, and the vestiges of pervasive discrimination remained (and experts would argue that many remain today).[4,5] Consistent with Congressional intent that the prohibitions under Title VI be broadly interpreted and applied, federal regulations promulgated immediately following enactment interpreted the law as prohibiting not only intentional acts of discrimination (e.g., the intentional exclusion or segregation of minority patients), but also the use of seemingly neutral "criteria or methods of administration" which "have the effect of subjecting individuals to discrimination because of their race, color or national origin, or have the effect of defeating or substantially impairing" accomplishment of the purposes of Title VI.[6] Thus, Title VI reaches both intentional and *de facto* (i.e., discriminatory impact) conduct. (However, in *Alexander v. Sandoval* 532 U.S. 275 (2001), the continued viability of the *de facto* discrimination standard was called into question by the Court in a case which made it far more difficult for individuals to sue to protect their rights under the rules. [*Sandoval* involved the Alabama Motor Vehicle Administration's failure to provide driving tests in Spanish.]) Because of this bar against certain types of private litigation under the *de facto* rules, the federal government can be thought of as assuming particularly important enforcement responsibilities.[7]

In *Lau v. Nichols*, a 30-year-old U.S. Supreme Court decision interpreting the reach of Title VI and its regulations, the Court clarified that discrimination on the basis of national origin (either intentional or *de facto*) included discrimination on the basis of language.[8] *Lau* involved the failure to provide effective education services to non-English speaking children, but the decision was understood as applying to all federally assisted programs and activities covered by Title VI.

As is the case with much of Title VI, comprehensive guidance interpreting *Lau* never materialized. In 2000, however, President Clinton issued an Executive Order directing all federal agencies to promulgate LEP guidelines.[9] Following extensive comments regarding the Clinton Administration's guidance,[10] the Bush Administration reissued the guidelines in 2002 and finalized them in 2003.[11] Thus, across two administrations, the federal government's commitment to removing language barriers in federally assisted health and human services programs has remained constant.

CRITICAL ELEMENTS OF THE 2003 GUIDELINES

The guidelines (which include an appendix containing a series of helpful questions and answers) state that their purpose is not to impose new standards, but to clarify existing obligations. As with all legal documents of this magnitude, however, in their clarification of the law, the 2003 guidelines effectively breathe new meaning into Title VI. Most importantly, the guidelines contain extensive commentary on the obligations of health providers receiving federal financial assistance; indeed, health care represents a principal focus of the guidance.

Who is covered by Title VI obligations?

The guidelines clarify that they apply to *all* recipients of "federal financial assistance," not merely public agencies. Thus, the guidelines apply to private hospitals and health care facilities, managed care organizations participating in federal programs and their subcontractors, and both public clinics and private physicians. The term "federal financial assistance" includes grants, training, equipment, donations of surplus property, and other assistance.[12] It also includes Medicare Part A payments to hospitals and Medicaid and The State Children's Health Insurance Program (SCHIP). However, the term does not include Medicare Part B payments. (The Medicare Part B exemption adopted by the Bush Administration—not included in the original Clinton Administration guidelines—is a relic of a decision by the Johnson Administration in 1965 to informally exempt Part B from the reach of civil rights enforcement in order to quell opposition by Southern members of Congress over the potential reach of the non-discrimination laws as a result of physician participation in Medicare. There is no statutory exemption from Title VI for the Medicare program.) Therefore, health care professionals who participate only in Part B—and only as independent practitioners (and not as Medicare+Choice contractors)—would not be considered to receive federal financial assistance and therefore would not be affected by the guidelines.

Who is an LEP individual protected by Title VI?

LEP persons are defined as persons who "do not speak English as their primary language and who have a limited ability to read, write, speak or understand English."[13] These individuals may be eligible to receive "language assistance" with respect to benefits, services, and health care encounters. LEP persons seeking health and health-related services, as well as participants in health promotion activities, are specifically identified as eligible for language assistance.[14]

How do recipients of federal financial assistance determine the extent of their language assistance obligations?

All recipients of federal financial assistance have LEP obligations, but the *extent* of the obligation may vary in relation to certain factors. DHHS indicates that it considers the *extent* of any recipient's obligation to turn on four factors: (*1*) the number or proportion of LEP persons served or encountered in the service population as a whole; (*2*) the frequency with which LEP persons come into contact with the recipient's services or program; (*3*) the nature and importance of the program, activity, or service; and (*4*) the resources available to recipients and the cost of adaptation.[15]

Thus, for example, a large urban hospital or public health clinic located in and serving a community with a large and varied non-English-speaking population would be viewed by OCR as having obligations that are quite different from those incurred by a rural health clinic that treats relatively few Medicaid patients and that covers a service area with few non-English-speaking residents. In short, the extent of the obligation is relevant to the extent of the presence of LEP persons, the importance of the service, and the cost of adaptation in relation to prevalence.

As with many legal standards, the LEP standard is fact-specific and relative to the context in which it applies. Specifically, the standard is what is considered "both necessary and reasonable in light of the four-factor analysis."[16] Thus, the key question becomes *what level of investment in language assistance a recipient of federal financial assistance must reasonably and necessarily make from an objective point of view, given the totality of the circumstances.*

Language assistance is defined to include both oral and written assistance. The range of required reasonable assistance, and the speed with which it is given, will vary depending on the particular situation. For example, in some situations a hospital may need to maintain on-call expert interpreters with immediate access capabilities, while in others, the facility may be able to respond more slowly and with written materials. The guidance recognizes cost factors, but also notes that "[l]arge entities and those entities serving a significant number or proportion of LEP persons should ensure that their resource limitations are well-substantiated before using this factor as a reason to limit language assistance."[17]

The "reasonable and necessary" standard implies that OCR will examine the totality of circumstances in order to determine whether a covered entity acted reasonably in designing its language support services

under particular circumstances. Attention to compliance can perhaps be expected to be particularly great in health and health care, because of the intimate link between effective provider/patient communication and fundamental notions of health quality.[18]

Selecting language assistance services

The guidelines clarify that covered entities can select among both oral and written assistance. Although the guidelines note that OCR will accord substantial flexibility in measuring compliance, the agency also indicates that it will consider whether the mix of assistance is sufficient to "avoid serious consequences to the LEP person and the recipient [of federal financial assistance].[19] The guidelines address standards for both oral interpreters (i.e., listening in one language and translating into another) and translators (i.e., the interpretation of written documents). Competency in both interpretation and translation is to be measured in relation to language competency, contextual competency (e.g., sufficient skill to be a competent health care interpreter or translator), and timeliness. With respect to written translation, the guidelines anticipate the translation of "vital written materials into the language of each frequently encountered LEP group eligible to be served and/or likely to be affected by the recipient's program." [20]

Elements of effective plans for LEP persons and voluntary compliance

Recipients (other than those who serve "very few" LEP persons) are expected to conduct assessments of compliance need in light of the four-factor test and to develop written compliance plans that are periodically updated. The guidelines describe steps to design and develop plans, which include identifying LEP persons, identifying the types of services to be furnished, training staff, providing notice to LEP persons regarding the availability of services, and monitoring and updating the plan. OCR stresses its commitment to voluntary compliance and to supporting recipients in plan development and self-monitoring.

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

The LEP guidelines are a testament to the importance of reducing language barriers to federally assisted services. The guidelines offer considerable compliance flexibility but nonetheless contemplate that virtually all federally assisted health services, whether preventive and population-based or urgent and patient-specific, will be accessible to LEP persons. OCR notes that full compliance and true language access is a long-term goal but anticipates steady progress.

In addition to measuring and adapting language access in their own services, public health agencies and policy makers may wish to identify the most important health services in their communities that are utilized by LEP populations in order to determine the progress being made in these settings toward planning for adaptation, identifying technical assistance that may be needed, and assuring context-specific patient and user access to appropriate materials and services. In the case of certain key public health services, public health agencies may wish to develop uniform materials for dissemination, as well as offer training for interpreters and translators in communicating key public health concepts and information. For example, more intensive public health agency involvement may be particularly important in the case of public health programs aimed at furnishing essential physical and mental health services or the detection and control of infectious disease and other community health threats.

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