



# CALIFORNIA RURAL LEGAL ASSISTANCE, INC.

September 30, 2013

VIA ELECTRONIC SUBMISSION: [www.regulations.gov](http://www.regulations.gov)

Department of Health and Human Services  
Office for Civil Rights  
Attention: RIN 0945-AA02  
Hubert H. Humphrey Building, Room 509F  
200 Independence Avenue, SW  
Washington, D.C. 20201

## **Re: Request for Information on Nondiscrimination in Certain Health Programs or Activities**

Dear Director Rodriguez,

California Rural Legal Assistance, Inc. (CRLA) is a legal services organization founded in 1966, with 19 offices throughout rural and agricultural California. CRLA serves over 39,000 low-income individuals a year through litigation, outreach and legal education on housing, employment, education, workplace safety, discrimination, income maintenance, and health care access.

We are submitting this letter in response to the Request for Information (RFI) to inform the U.S. Department of Health and Human Services' rulemaking for Section 1557 of the Affordable Care Act (FR Doc # 2013-18707). The information we provide in this letter is based on our experiences representing low-income individuals in rural communities who are subject to discrimination and face substantial obstacles to obtaining meaningful access to health care and government programs. CRLA has represented numerous limited English proficient (LEP) individuals with limited access to health care and government services, so our comments will focus specifically on language access concerns.

The following comments are presented in response to the specific questions asked in the Federal Register Notice as indicated below.

### **Understanding the Current Landscape**

#### **1. Examples of discrimination in health programs and activities**

##### **(a) Race, color, or national origin discrimination**

Discrimination against LEP persons, including the failure to provide meaningful access to the same benefits and services as English speakers, is a form of national origin discrimination prohibited under Title VI. Lau v. Nichols, 414 U.S. 563 (1974). Failure to

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### **Regional Offices**

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provide appropriate language services (interpretation and translation) is a bar to LEP persons' meaningful access to health programs and services.

CRLA's Indigenous Program has served indigenous Mexican clients who face language discrimination in health care. The indigenous are Mexico's equivalent to Native Americans, and many speak indigenous languages that are totally unrelated to Spanish. The indigenous population in California has increased dramatically over the last two decades. Among the most common indigenous Mexican languages spoken in California are Mixteco, Triqui, Zapoteco, and Purepecha.

The following examples of the absence of language access in health care describe the barriers confronted by our clients on obtaining adequate care and treatment.

One CRLA client, an LEP, Triqui-speaking farm worker from Mexico, was sent to a local hospital after she collapsed in the field. She was admitted to the hospital for several days, underwent an unknown cardiac procedure, was discharged, and went to a follow up appointment in her cardiologist's office, all without ever receiving interpretation in her language. When she came to CRLA's office after her first follow up appointment to ask for help understanding her medical bills, she still did not know what her diagnosis was or what procedure had been performed; she knew only that she had a scar on her chest and some papers that might say whether and when she would have to go back to her doctor. We were able to assist her in understanding her follow up instructions and appointment information, but the shocking nature of this example tells us that the hospital could not have provided this patient with adequate health care. If medical staff could not communicate with their patient, obtain information about her reactions to treatment, ensure that they had appropriate medical history and medical allergies, they were severely limited in their ability to tend to the needs of a patient with an obviously very serious health condition.

Another Triqui-speaking CRLA client was a patient in a rural California clinic that serves a significant Triqui and Mixteco population. She had been going to the clinic for monthly prenatal appointments and never had been provided a Triqui interpreter. Clinic staff repeatedly refused her requests for an interpreter, offering only Spanish-speaking staff and asking that she bring a friend or family member to interpret for her. After multiple requests, clinic staff gave the patient a document to sign – in Spanish, which she does not read – stating that she waived her right to an interpreter for her appointments at the clinic. The patient signed the document without understanding what it meant, because she believed she had to sign in order to continue to be seen by the clinic. A family member or friend not only should not have access to a patient's most personal details, but well might not understand the terms used by a health care provider in treating a patient. The refusal to provide interpreters, absence of any effort to do so, lack of sensitivity to the patient's need for privacy and confidentiality, resulting inability to communicate effectively with the patient and possibly consequential substandard health treatment are only some of the concerns raised by this example.

Another case CRLA's Indigenous Program staff learned of involved a Mixteco-speaking woman who was treated by a health care provider who had required her to contract and pay for her own interpreter. This raises concerns about privacy, confidentiality, and interpreter competence, but more importantly, it suggests that health care would be provided to this LEP community only if they could afford to pay for an interpreter.

We have seen numerous other examples like these, where LEP indigenous-speaking individuals have been discriminated against based on race and national origin through failure of health care providers to provide appropriate language services.

The language access issues confronted by CRLA's clients have not been limited to indigenous language speakers. CRLA staff assisted a Spanish-speaking LEP individual who was a patient in a private doctor's office that serves a large Spanish-speaking patient population. The office consistently failed to provide the patient with services in Spanish, and a few weeks prior to a scheduled surgery, the office staff asked the patient to bring an interpreter to his appointments. CRLA's advocacy resulted in an agreement by the office to provide interpreter service to LEP Spanish speakers, but the interpreter's skills and qualifications are unknown. Cases such as this raise the specter of improper medical treatment and basic health care services due to language barriers.

### 3. Impacts of discrimination: Possible consequences of unequal access to health programs and services

The consequences of health care providers' failure to ensure language access for LEP persons can be serious and potentially life-threatening. The lack of adequate interpretation and translation can lead to improper diagnosis because of failure to communicate about symptoms and medical history. Patients who cannot understand their health care providers may be unable to give informed consent for medical treatment. LEP patients' confidentiality may be violated if they are forced to use friends or family as interpreters. They may misunderstand diagnoses and doctors' instructions, contributing to mistrust of health care providers and reluctance to seek necessary medical care. The negative consequences of this lack of access for the indigenous farmworker population in particular have been documented in detail.<sup>1</sup>

### 4. LEP Access

#### (a) (2) Best practice standards for oral interpretation

Quality in-person interpretation is always preferable to telephonic interpretation, because in-person interpreters can pick up and convey nonverbal cues that telephone interpreters cannot. It

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<sup>1</sup> See Mines, Richard et al., *Final Report of the Indigenous Farmworker Study (IFS) To the California Endowment*, January 2010, available at [www.indigenousfarmworkers.org](http://www.indigenousfarmworkers.org). "The inability to communicate breeds distrust, avoidance of seeking care and non-compliance with prescribed treatments. As a Mixteco woman in Fresno put it, 'I don't think they prescribe the right medicine for what we have because they don't understand what we're saying.'"

is therefore generally accepted<sup>2</sup> that telephone interpreter services should be used only as a last resort.

(a) (3) Best practice standards for competence

The most effective means for ensuring interpreter competence is for health programs themselves to provide training and evaluation for interpreters, particularly for the less common languages we encounter. A language access coordinator within the institution would be best situated to evaluate and monitor interpreter competence and ensure initial and ongoing training for interpreters, whether staff members or outside contractors.

(c) Experiences of LEP individuals who speak less-common languages

The examples we provided above illustrate that LEP individuals often face tremendous barriers to accessing health care services. The experiences of our indigenous Mexican clients demonstrate the even greater barriers faced by individuals who speak less common non-English languages. Although the indigenous population has been growing in California over the last two decades, the following still present serious difficulties for indigenous language speaking LEP patients:

- **Providers fail to identify or misidentify the patient's language.** Providers erroneously assume that all immigrants from Mexico speak Spanish, or that indigenous languages are dialects of Spanish, so a Spanish interpreter will suffice.
- **Variation of dialects leads to interpreter mismatch.** The linguistic variation within indigenous languages (large number of regional dialects) also leads to interpreter mismatch. An interpreter and a patient may both speak Mixteco, but because they are from different regions and speak different dialects of Mixteco, they do not understand each other.
- **Confidentiality concerns when interpreters come from the same small community.** Groups of people who speak a less common non-English language often live in small immigrant communities where many or most community members know each other. This increases the likelihood that a patient may know his or her interpreter, or have acquaintances or family in common. Even if the interpreter respects the LEP person's confidentiality, this may contribute to his or her unease and unwillingness to divulge sensitive personal information. Family members and friends should not be privy to details about patients' conditions or treatment. Interpreters must be professional and bound by confidentiality agreements.
- **Telephone interpreter services do not have interpreters in the needed language, and providers do not make alternate arrangements.** Many health care providers rely exclusively on telephone interpreter services for all but the most commonly spoken languages. Our experience shows that many telephone interpreter services do not provide

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<sup>2</sup> See, e.g., *Best Practice Recommendations for Hospital-Based Interpreter Services*, Executive Office of Health and Human Services, Massachusetts Department of Public Health

interpretation in less common languages spoken by our clients, particularly the many regional variants of indigenous languages. Providers erroneously believe that having a contract for telephonic interpretation is enough to comply with their obligations to LEP patients and do not take additional steps to ensure language access for those individuals whose languages are not covered by telephone interpreter services.

- **Frequent reliance on friends or family members.** Speakers of less common non-English languages are more often asked to provide their own interpreter, such as a friend or family member, perhaps due to the greater effort involved in finding interpreters in these languages. This is inappropriate for all of the reasons described above. A patient, moreover, well might fail to reveal essential information due to embarrassment or fear of disclosure.
- **Use of interpreters who lack formal training.** The providers that offer in-person interpretation for indigenous language LEP patients often rely on interpreters with little or no formal training, likely due limited availability of trained interpreters. Our experience has shown that many providers do not have quality controls in place, and very few offer opportunities for individuals to acquire the necessary training.
- **More frequent use of relay interpreting.** Many indigenous language interpreters are fluent only in Spanish and their indigenous language. Thus, if a provider only speaks English, he or she must rely on a relay system, where one person interprets between the indigenous language and Spanish, and the other interprets between Spanish and English. There is greater potential for inaccuracy and miscommunication in these circumstances, so the importance of using skilled interpreters is even greater.

#### (e) Language access plans

Health care providers must be required to assess and periodically reassess the language needs in their communities, understand the scope and nature of the communities and the number of languages spoken in those communities. In assessing the language needs of the population in their service areas, providers should not rely solely on Census data, which may fail to reflect the size and diversity of LEP populations, especially speakers of less common non-English languages. Providers should seek input from community groups, local and regional refugee and immigrants' organizations, and other community based service providers to ensure they have a more complete understanding of their community's language needs and can plan accordingly.

Each health care provider should be required to develop and implement a language access plan that includes, at a minimum, the following elements: a community wide language assessment, the guarantee of interpretation services for all LEP individuals, training and evaluation of interpreters, competent translation and vetting of vital documents, prohibition on the use of family members (especially children), friends and community members as interpreters, and regular cultural competency training for staff.

#### (f) Translation of vital documents

Any document related to treatment, prescription, diagnosis, authorization of treatment, releases or waivers of any rights, and all required notices, must be translated and explained, and the responsible person should certify who did it and when.

7. (a) Effectiveness of enforcement mechanisms

CRLA has submitted several administrative complaints to the Department's Office for Civil Rights (OCR) on behalf of LEP clients who were not provided with appropriate language services by their health care providers. The effectiveness of OCR's complaint procedure is hampered by the extremely limited remedies it can impose. When a recipient is found to be in violation of Title VI, the only coercive power the agency has is to entirely cut off HHS funding to the recipient, an authority which it almost never uses. Enhancing OCR's authority, including granting the power to assess civil penalties for violations of Title VI, would greatly increase the effectiveness of its administrative complaint process. OCR's procedures also should guarantee direct involvement for the complainant in the investigation and resolution of all complaints.

A private right of action for all individuals suffering from language discrimination in addition to a more robust administrative complaint procedure involving direct input from the complainant would contribute powerfully to ensuring full language access for all LEP persons. The existing requirement, that an individual must show intentional discrimination, also allows the vast majority of Title VI language access violations to persist without resolution and weakens the deterrent effect of the law because many policies and practices have a discriminatory effect but might not be intentional. A private right of action with no requirement of discriminatory intent would give LEP individuals who have suffered concrete harms access to remedies – including money damages – currently unavailable to them in the vast majority of cases. It would also avail them of the injunctive power of the courts to ensure future compliance of health programs and activities with language access obligations.

Thank you for the opportunity to provide our comments and for the Department's interest in improving equal access to health for all.

Sincerely,  
CALIFORNIA RURAL LEGAL ASSISTANCE, INC.

A handwritten signature in black ink, appearing to read 'M. E. K.', with a long horizontal flourish extending to the right.

Maureen Keffer  
Indigenous Program Director