Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

GUIDANCE AND STANDARDS ON LANGUAGE ACCESS SERVICES: MEDICARE PROVIDERS

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Inspector General

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EXECUTIVE SUMMARY

OBJECTIVES

1. To determine the extent to which Medicare providers conducted the four-factor assessment recommended by the Office for Civil Rights' (OCR) guidance when determining what language access services to offer.
2. To determine the extent to which Medicare providers offered language access services consistent with the Office of Minority Health's (OMH) Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards on language access services.
3. To determine the extent to which Medicare providers realized benefits, including savings, and encountered obstacles to providing language access services.
4. To describe costs of providing language access services.

BACKGROUND

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that the Office of Inspector General (OIG) conduct a study examining Medicare provider and plan compliance with (1) OCR's *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (hereinafter referred to as OCR guidance) and (2) OMH's CLAS standards. The MIPPA also requires that OIG describe the costs or savings related to the provision of language access services.

Because OCR guidance and CLAS standards are not mandatory, OIG assessed Medicare providers' voluntary compliance as indicated by the extent to which providers conducted the four-factor assessment recommended by OCR guidance and offered language access services consistent with CLAS standards. A companion report, *Guidance and Standards on Language Access Services: Medicare Plans* (OEI-05-10-00051), provides the same assessment for Medicare plans.

OCR guidance and CLAS standards address the provision of language access services. OCR guidance recommends a four-factor assessment to help determine what language access services to offer. These factors are (1) the number or proportion of Limited English Proficient (LEP) persons eligible to be served or likely to be encountered in the provider's service population; (2) the frequency with which LEP persons come in

contact with the provider; (3) the importance, nature, and urgency of the program, activity, or service to people's lives; and (4) the resources available to the provider and costs for offering language access services.

OMH's CLAS standards can help providers become responsive to the cultural and linguistic needs of diverse populations. Four of the fourteen CLAS standards focus on the provision of language access services. These standards are (1) providing language access services during all business hours, (2) providing verbal offers and written notices of the rights to language access services, (3) assuring the competence of language assistance provided by staff, and (4) providing written materials and signage translated into appropriate languages.

Language access services are designed to promote effective communication between LEP persons and non-LEP persons. LEP persons do not speak English as their primary language and have a limited ability to read, write, speak, or understand English. Language access services can include oral interpretation; written translation; and other provisions that enhance communication, such as translated signs.

To conduct this review, we administered a survey in 2009 to 140 randomly selected Medicare providers located in counties with a high percentage of LEP persons.

FINDINGS

Sixty-nine percent of providers conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer. Sixty-nine percent of providers conducted all four factors of the recommended assessment. Further, most providers reported completing some of the factors; 84 percent completed at least three of the four factors and 97 percent completed at least one of the factors. The percentages of providers that completed each factor ranged between 78 percent and 94 percent. The factor completed most frequently was assessing available resources. Providers that conducted the assessment were more likely to be familiar with OCR guidance than providers that did not.

Only 33 percent of providers offered services consistent with all four CLAS standards on language access services. Ninety-eight percent of providers reported offering some language access services, but only 33 percent offered services consistent with all four CLAS standards on language access services. The percentages of providers that offered services consistent with each standard ranged

between 52 percent and 86 percent. Providers were most likely to offer language access services consistent with the standard regarding assuring the competence of language assistance provided by staff. Providers that offered language access services consistent with all four CLAS standards were more likely to be familiar with them.

Seventy-three percent of providers reported benefits to providing language access services and half reported obstacles. The four most frequently reported benefits were (1) improved communication, (2) improved adherence to treatment regimen, (3) improved diagnosis and treatment, and (4) fewer complaints. The three most frequently reported obstacles were (1) a lack of training resources for staff, (2) costs of providing language access services, and (3) the broad range of languages spoken in the providers' communities.

Few providers reported data on the costs of providing language access services and the data provided were not comparable. Because of the overall lack of reporting and the inability to compare data, we were unable to make any determinations about cost data related to providing language access services. Of the 119 providers that responded to the survey, only 49 providers responded to the request for cost data. In addition, provider comments indicated different approaches to calculating costs; therefore, we were unable to compare cost data.

RECOMMENDATIONS

The MIPPA requires OIG to make recommendations on improving compliance with and enforcement of CLAS standards. However, in keeping with our assessment of voluntary compliance, we make recommendations to increase the percentage of providers that voluntarily offer services consistent with all four CLAS standards on language access services.

Providers that offered language access services consistent with the CLAS standards were more likely to be familiar with them. Therefore, to improve Medicare providers' awareness and implementation of CLAS standards, we recommend that:

- **OCR inform providers about OMH's CLAS standards.**
- **OMH increase outreach to providers to familiarize them with CLAS standards.**

In addition, to help Medicare providers offer language access services, we recommend that:

- **OMH offer model translated written materials and signs to providers.**

AGENCIES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OCR and OMH concurred with our recommendations. OMH stated that it will take the lead in developing specific marketing strategies to inform providers of the CLAS standards. CMS indicated that it did not have any substantive comments. However, it did provide technical comments that we incorporated as appropriate.

TABLE OF CONTENTS

INTRODUCTION

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Because OCR guidance and CLAS standards are not mandatory, OIG could not assess compliance or make recommendations on the enforcement of CLAS standards. Instead, OIG assessed Medicare providers' voluntary compliance as indicated by the extent to which providers conducted the four-factor assessment recommended by OCR

[1] Although the OCR guidance was signed by the then-Director of OCR, it was issued on behalf of the Secretary of Health & Human Services (HHS) and applies to all entities receiving funds from HHS.

[2] P.L. 110-275 § 187 (July 15, 2008), 42 U.S.C. § 1395cc note.

guidance and offered language access services consistent with CLAS standards.

This report is one of two issued in response to the MIPPA provision. This report focuses on Medicare providers, such as hospitals and nursing homes, which directly supply heath care services to beneficiaries. A companion report, *Guidance and Standards on Language Access Services: Medicare Plans* (OEI-05-10-00051), focuses on Medicare plans. Medicare plans are private companies that contract with the Centers for Medicare & Medicaid Services (CMS) to provide health insurance or prescription drug coverage to Medicare beneficiaries.

Language Access Services for Limited English Proficient Persons

Language access services are designed to promote effective communication between Limited English Proficient (LEP) persons and non-LEP persons.[3] LEP persons do not speak English as their primary language and have a limited ability to read, write, speak, or understand English.[4] According to the U.S. Census Bureau, approximately 18 percent of the U.S. population in 2000 spoke languages other than English at home. Further, 8 percent of the U.S. population, or approximately 21 million people, spoke English less than "very well."[5]

Language access services may include oral interpretation; written translation; and other provisions that enhance communication, such as translated signs.[6] In providing oral interpretation, providers may choose, for example, to hire bilingual staff, contract with interpreters, or use telephone interpreter lines. When providing written translation, providers have discretion over which materials are translated. However, some materials are more critical than others.[7, 8] These

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[3] OMH, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*, p. 1. Accessed at http://minorityhealth.hhs.gov on January 15, 2010.

[4] OCR, *Guidance,* pt. IV, 68 Fed. Reg. 47311, 47313 (Aug. 8, 2003). Accessed at http://www.hhs.gov/ocr on October 21, 2009.

[5] U.S. Census Bureau, *Profile of Selected Social Characteristics: 2000.* Accessed at http://factfinder.census.gov on January 15, 2010.

[6] OMH, *Patient-Centered Guide,* loc. cit.

[7] OCR, *Guidance,* pt. VI at 47316.

[8] OMH, *National Standards on Culturally and Linguistically Appropriate Services in Health Care Final Report*, March 2001, p. 78. Accessed at http://minorityhealth.hhs.gov on February 12, 2010.

include, but are not limited to, patients' rights information; medication directions; and screening, diagnosis, or treatment explanations.[9, 10]

The lack of language access services enables language barriers to persist between LEP persons and non-LEP persons. The inability to communicate with a provider can lead to ineffective care because providers are unable to elicit an LEP person's symptoms, making it difficult to render a proper diagnosis and course of treatment.[11] Research indicates that LEP persons are more likely than non-LEP persons to report being in fair or poor health, defer medical care, miss followup appointments, and experience drug complications.[12, 13] LEP patients are also more likely than non-LEP patients to experience adverse events because of a communication failure.[14]

Title VI of the Civil Rights Act

Title VI of the Civil Rights Act of 1964, as amended, provides that no person in the United States shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[15] The Supreme Court has interpreted the Title VI implementing regulation to find that conduct with a disproportionate effect on LEP persons had a discriminatory impact on the basis of national origin.[16]

OCR Oversight of Title VI Compliance

OCR is the civil rights law enforcement agency for HHS. As such, it ensures that all recipients of Federal financial assistance through HHS operate their programs in compliance with Federal civil rights laws.

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[9] OCR, *Guidance,* pt. VI at 47316.

[10] OMH, *National Standards*, loc. cit.

[11] Leighton Ku and Glenn Flores, "Pay Now Or Pay Later: Providing Interpreter Services in Health Care," *Health Affairs*. March/April 2005. Vol. 24, No. 2. Accessed at http://content.healthaffairs.org on February 26, 2010.

[12] Bradford Kirkman-Liff and Delfi Mondragón, "Language of Interview: Relevance for Research on Southwest Hispanics," *American Journal of Public Health*. November 1991. Vol. 81, No. 11. Accessed at http://ajph.aphapublications.org/ on February 26, 2010.

[13] Glenn Flores et al., "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics & Adolescent Medicine*. November 1998. Vol. 152. Accessed at http://archpedi.ama-assn.org/ on February 26, 2010.

[14] The Joint Commission, *Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study*, February 2010. Accessed at http://www.jointcommission.org on February 22, 2010.

[15] P.L. 88-352 § 601; 42 USC § 2000d.

[16] Lau v. Nichols. 414 U.S. 563 (1974).

Federal financial assistance includes grants, training, use of equipment, donation of surplus property, and other assistance. It does not include Medicare Part B payments to physicians.[17]

OCR conducts civil rights reviews of all new Medicare provider applicants that receive Federal financial assistance. OCR also conducts these reviews when there is a change of ownership. During these reviews, OCR certifies that providers have plans in place to operate their programs in accordance with, among other laws, Title VI.[18] According to OCR staff, OCR completed 2,385 civil rights reviews in fiscal year (FY) 2009. Alternatively, corporations with multiple facilities may enter into corporate agreements with OCR. In these cases, OCR conducts reviews of the corporate policies that apply to all corporate facilities rather than reviewing each facility. OCR had 24 corporate agreements in effect in 2009.

In addition, OCR investigates complaints of discrimination. According to OCR staff, of the 17 complaints concerning LEP persons received in FY 2009, 6 complaints involved Medicare providers. If OCR investigates and determines that discrimination has occurred, a provider usually has 60 days to correct the violation or provide OCR with a plan of correction.[19] OCR staff stated that they strive for voluntary compliance and resolution in all cases as required by Title VI. Accordingly, complaints are often voluntarily resolved through an exchange of letters containing requirements for improvement.

Further, OCR encourages compliance with Title VI by providing technical assistance and training.[20] OCR provided technical assistance and training to more than 95,000 individuals in FY 2009.[21] This technical assistance included telephone consultations, written correspondence, and in-person presentations at conferences, as well as meetings with advocacy groups and organizations receiving HHS financial assistance. In addition, OCR collaborates with organizations, such as the American Hospital Association and the Joint Commission,

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[17] 45 CFR § 80, App. A.; 45 CFR § 80.2.

[18] OCR, *Nondiscrimination Laws, Regulations, and Standards*. Accessed at http://www.hhs.gov/ocr/ on February 25, 2010.

[19] OCR, *How Does OCR Investigate a Civil Rights Complaint?* Accessed at http://www.hhs.gov/ocr on February 25, 2010.

[20] OCR, *Guidance*, pt. VIII at 47321.

[21] OCR, *Fiscal Year 2011 Online Performance Appendix.* Accessed at http://www.hhs.gov/ocr/ on April 12, 2010.

to develop training materials to help providers respond to LEP persons' communication needs.

OCR Guidance for Determining What Language Access Services To Offer

In August 2000, OCR, on behalf of the Secretary of HHS, issued guidance specifically concerning discrimination affecting LEP persons.[22] The guidance was issued in response to an August 2000 Executive Order requiring Federal agencies to clarify and publish guidance on Title VI requirements.[23] The original guidance was republished in February 2002, seeking public comment.[24] In 2003, after receiving public comments and subsequent guidance from the U.S. Department of Justice, OCR issued revised guidance.[25]

OCR guidance applies to all providers receiving HHS financial assistance, including hospitals, nursing homes, and home health agencies, among others. It does not apply to physicians solely reimbursed for services under Medicare Part B, per Title VI regulations.[26]

OCR guidance is meant to assist recipients of HHS financial assistance in ensuring meaningful access for LEP persons to critical services while not imposing an undue burden. OCR guidance does not carry the force of law and is not mandatory.[27]

OCR guidance recommends that each recipient of HHS financial assistance determine what language access services to offer by conducting a four-factor assessment. The four factors are:[28]

(1) the number or proportion of LEP persons eligible to be served or likely to be encountered in the recipient's service population;

(2) the frequency with which LEP persons come in contact with the recipient;

(3) the importance, nature, and urgency of the program, activity, or service to people's lives; and

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[22] 65 Fed. Reg. 52762 (Aug. 30, 2000).

[23] Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," 65 Fed. Reg. 50121 (Aug. 16, 2000).

[24] 67 Fed. Reg. 4968 (Feb. 1, 2002).

[25] OCR, *Guidance,* introduction at 47311.

[26] Ibid., pt. III at 47313.

[27] Ibid., pt. III at 47313, footnote 2.

[28] Ibid., pt. V at 47314.

(4) the resources available to the recipient and costs for offering language access services.

After conducting the four-factor assessment, recipients have discretion to determine what language access services to offer. In some cases, offering language access services may not be necessary to comply with Title VI.[29] However, this discretion does not diminish, and should not be used to minimize, recipients' obligation to address the needs of LEP persons.[30]

OMH's CLAS Standards

In 2001, OMH created the CLAS standards to provide consistent and comprehensive guidance to promote cultural and linguistic competence in health care. As is OCR guidance, the CLAS standards are not mandatory.[31]

OMH divided the standards into three categories: Culturally Competent Care (standards 1–3), Language Access Services (standards 4–7), and Organizational Supports for Cultural Competence (standards 8–14).[32] For a list of all 14 CLAS standards, see Appendix B.

The four Language Access Services standards are:[33]

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

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

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff.

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[29] OCR, G*uidance,* pt. V at 47314.

[30] Ibid.

[31] According to OMH officials, the four Language Access Services standards are not mandatory despite language stating that they are Federal requirements and that health care organizations "must" provide the services noted in each of the four standards.

[32] OMH, *Standards,* p. 3.

[33] Ibid., pp. 10–13.

Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

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

OMH staff offer training and educational resources related to CLAS standards to providers through the Center for Cultural and Linguistic Competence in Health Care (the Center).[34] Established in FY 1995, the Center was OMH's response to the Disadvantaged Minority Health Improvement Act of 1990 and encouragement from Congress to establish a center to develop and evaluate models, conduct research, and provide technical assistance to providers on removing language barriers to health care services.[35]

Through the Center, OMH offers training and educational resources related to the provision of language access services. This includes accredited training programs for physicians, nurses, and disaster personnel on cultural competency through e-learning programs. OMH also publishes *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*, which was designed to help health care administrators and organizations comply with Title VI and implement the CLAS standards.[36] In addition, OMH distributes an e-newsletter that is geared toward all persons interested in cultural competency in health care settings.

Reimbursement for Language Access Services

Limited reimbursement is available for language access services. Medicare does not reimburse providers for language access services. On the other hand, State Medicaid Programs and Children's Health Insurance Programs can, as an optional benefit, access Federal matching funds to reimburse for language access services.[37] In 2009,

[34] OMH, *About the Center for Cultural and Linguistic Competence in Health Care*. Accessed at http://minorityhealth.hhs.gov/ on March 8, 2010.

[35] H.R. Rep. No. 103-553, at 54 (1994).

[36] OMH, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. Accessed at http://www.thinkculturalhealth.org on February 1, 2010.

[37] 42 U.S.C. § 1396b(a)(2)(E); 42 U.S.C. § 1397ee(a)(1)(D).

13 States and the District of Columbia used this optional benefit to reimburse providers or interpreters.[38] In addition, a national survey of hospitals in the United States found that only 3 percent of hospitals receive reimbursement for providing language access services.[39]

Related Work

In 2007, the Joint Commission found that there was still a gap between current practice and the CLAS standards among a purposive sample of hospitals selected for their advanced provision of culturally and linguistically appropriate care. Ninety percent of sampled hospitals cited funding services as a challenge to providing language access services.[40]

METHODOLOGY

To conduct this review, we collected information, in 2009, through a survey of randomly selected Medicare providers located in counties with a high percentage of LEP persons. OCR and OMH staff provided additional context through structured interviews.

Scope

The MIPPA mandates that OIG report on Medicare providers' and plans' compliance with OCR guidance and CLAS standards. However, because OCR guidance and CLAS standards are not mandatory, HHS lacks authority to enforce them. Therefore, we assessed providers' voluntary compliance as indicated by the extent to which they conducted the four-factor assessment recommended by OCR guidance and offered language access services consistent with CLAS standards. This study focused on CLAS Standards 4–7, which OMH designated as the Language Access Services standards.

This study focused on the types of Medicare providers uniformly subject to Title VI. For this reason, we excluded Medicare Part B providers. We also limited our analysis to providers located in counties with a high percentage of LEP persons to increase the likelihood that sampled

[38] Families USA, *Improving Language Access: CHIPRA Provides Increased Funding For Language Services*. Accessed at http://www.familiesusa.org on March 15, 2010.

[39] The Health Research and Educational Trust, *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Study,* October 2006. Accessed at http://www.hret.org on February 12, 2010.

[40] The Joint Commission, *Hospitals, Language, and Culture: A Snapshot of the Nation*, 2007. Accessed at http://www.jointcommission.org on February 12, 2010.

providers needed to offer language access services. Medicare plans are covered in a companion report.

Finally, we broadened the definition of costs and savings to include nonfinancial obstacles and benefits.

Sample

Provider sampling frame. We created a sampling frame of providers located in counties with a high percentage of LEP persons. To do this, we used 2000 decennial Census data and demographic data contained in CMS's Online Survey Certification and Reporting (OSCAR) system as of October 2009.[41, 42] First, we used the Census data to rank counties by the percentage of residents who answered anything other than "very well" when asked how well they speak English. We selected the 10 percent of counties with the highest percentage of these LEP persons. Together, the 313 selected counties, representing 37 States, contained 72 percent of LEP persons residing in the United States. These LEP persons represented between 9 percent and 51 percent of all county residents in each of the selected counties. Then, we used the OSCAR data to identify Medicare providers located in the selected counties. We identified 16,853 providers in the sampling frame.

Sample selection. After creating the sampling frame of 16,853 providers, we selected a simple random sample of 145 providers.[43] The sample consisted of 14 provider types, including hospitals, skilled nursing facilities, and home health agencies. After selecting the sample, we excluded one provider because of an ongoing OIG investigation and four additional providers because they were no longer in business. The final sample consisted of 140 providers.

Data Collection

Survey. We mailed the survey to the sample of 140 providers in December 2009. We made at least two followup attempts by telephone and one by signature-required certified mail. Data collection lasted

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[41] The U.S. Census Bureau's 2000 decennial Census has the most recent data on all counties for the same year.

[42] OSCAR contains survey results from certification and complaint surveys for all Medicare providers receiving Federal financial assistance. As such, it contains location information on all of these providers.

[43] This sample design enabled us to estimate the percentage of providers with certain characteristics with +/- 10-percent precision at the 95-percent confidence level assuming a 75-percent response rate and assuming that 7 percent would be excluded because of ongoing OIG investigations.

through January 2010. Of the 140 providers, 119 responded to the survey, for an overall response rate of 85 percent. However, providers did not always answer every question; therefore, item response rates may be lower. No item response rate was less than 79 percent.

Structured interviews. In January 2010, we conducted separate structured interviews with OCR and OMH staff to obtain background information. We interviewed OCR staff about their role and activities related to Title VI enforcement, OCR guidance, and the types of technical assistance OCR provided for language access services. We interviewed OMH staff about their activities related to CLAS standards.

Data Analysis

To analyze providers' survey responses, we calculated response category frequencies for the key questions related to whether providers conducted the four-factor assessment recommended by OCR guidance and whether providers offered language access services consistent with all four CLAS standards on language access services. We also analyzed the percentage of providers that completed each individual factor of the four-factor assessment and offered language access services consistent with each of the four standards.

We considered a provider to have conducted the four-factor assessment if the provider indicated at least one activity corresponding with each of the four factors. Table 1 lists each of the four factors and the corresponding survey question. See Appendix C for the categories of responses to each question.

Table 1: OCR Four Factors and Corresponding Survey Questions

Four Factors in OCR Guidance	Corresponding Question in Survey of Providers
Factor 1: The number or proportion of LEP persons eligible to be served or likely to be encountered in the recipient's service population	Which of the following sources of information does your organization use to determine the number or proportion of LEP persons from each language group represented in its geographic service area?
Factor 2: The frequency with which LEP persons come into contact with the recipient	Which of the following sources of information does your organization use to track how often it encounters LEP persons?
Factor 3: The importance, nature, and urgency of the program, activity, or service to people's lives	When determining whether to communicate to LEP persons in their preferred language, does your organization consider the importance and urgency of the activity, program, or service to people's lives?
Factor 4: The resources available to the recipient and costs for offering language access services	How does your organization assess whether it has resources available to provide language access services?

Source: OCR guidance and OIG survey of providers, 2010.

Similarly, we considered a provider to have offered language access services consistent with CLAS standards if the provider indicated activities meeting each of the four standards. For Standards 4, 6, and 7, we considered a provider to have offered language access services consistent with the standard if it indicated at least one activity corresponding with each of the survey questions about these standards. For Standard 5, providers needed to indicate at least two activities—one associated with verbal notification of rights and another associated with written notification. Table 2 lists the four CLAS standards on language access services and the corresponding survey question(s). See Appendix C for the categories of responses to each question.

Table 2: CLAS Standards and Corresponding Survey Questions

CLAS Standards on Language Access Services	Corresponding Questions in Survey of Providers
Standard 4: Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	During what percentage of your organization's business hours are language access services offered?
Standard 5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	Does your organization inform LEP persons of their right to receive language access services in their preferred language in any of the following ways?
Standard 6: Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).	Which of the following training topics does your organization require for staff, contractors, and volunteers?
Standard 7: Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	Which of the following written materials are translated into the languages of commonly encountered groups?
	Which of the following types of signs are posted in the languages of commonly encountered groups?

Source: CLAS standards and OIG survey of providers, 2010.

The survey had two questions related to CLAS Standard 7 to distinguish between patient-related materials and signs. Ten percent of providers responded "Not applicable" to the survey question related to posting signs. Upon review of the provider types, we concluded that this was a reasonable response for specific providers, such as home health agencies, and counted these providers as having offered language access services consistent with CLAS Standard 7 if they indicated only activities related to translating written materials.

We used the results of the response category frequencies for the CLAS standards to determine whether one standard was completed more or less frequently than any other standard. We used the Bonferroni method of multiple comparisons to determine whether any noted differences were statistically significant. A difference was statistically significant if the confidence interval of the difference did not contain zero using an alpha of 0.01.

Where possible, we calculated frequencies and ranges on the key questions related to costs, savings, nonfinancial obstacles, and benefits. We also reviewed providers' comments about how they calculated cost data to determine the extent to which the reported costs were comparable.

Unless noted, we projected survey statistics to all 16,853 Medicare providers located in the 313 counties with a high percentage of LEP persons. See Appendix D for a list of 95-percent confidence intervals for all statistical projections.

Data Limitations

This report relies on self-reported data. We did not verify providers' responses.

Because populations may shift, the 2000 decennial Census data may not exactly reflect the counties with the highest percentage of LEP persons in 2009, when the sample was selected. However, they were the most recent data available for all counties in the same year.

Standards

This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

Sixty-nine percent of providers conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer

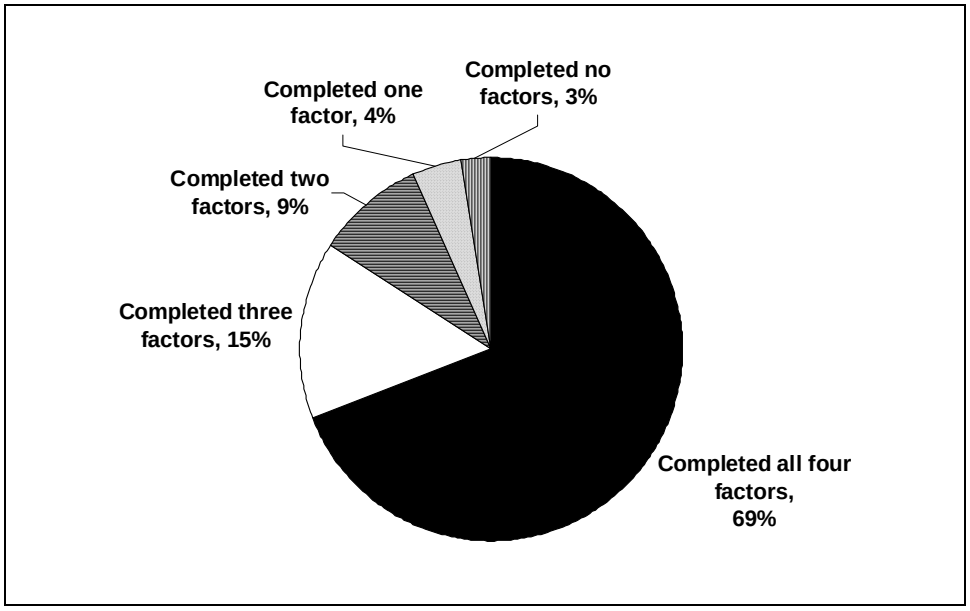
Sixty-nine percent of Medicare providers in counties with a high percentage of LEP persons considered all four factors of the recommended assessment. As noted previously, OCR guidance is not mandatory. Rather, it is guidance that providers may use to ensure meaningful access for LEP persons to critical services while not imposing an undue burden on small providers.

Providers that conducted the recommended four-factor assessment were more likely to be familiar with the OCR guidance.[44] Specifically, 85 percent of providers that conducted the assessment reported being familiar with the guidance. In contrast, only 40 percent of providers that did not conduct the assessment reported being familiar with the guidance.

Even though 31 percent of providers did not consider all four factors, almost all providers considered some of these factors. Eighty-four percent of providers considered at least three of the four factors and 97 percent considered at least one of the factors. Chart 1 illustrates the extent to which providers considered the four factors.

[44] The difference is statistically significant at the 95-percent confidence level.

Chart 1: Number of Factors Completed, by Percentage of Providers



Source: OIG analysis of provider survey responses, 2010.

When the factors are reviewed individually, the factor completed most frequently was Factor 4, assessing available resources. Table 3 lists the four factors and the percentage of providers that reported completing each factor.

Table 3: OCR Four Factors and Percentage of Providers Completing Each Factor

Four Factors in OCR Guidance	Percentage of Providers
Factor 1: The number or proportion of LEP persons eligible to be served or likely to be encountered in the recipient's service population	78%
Factor 2: The frequency with which LEP persons come in contact with the recipient	80%
Factor 3: The importance, nature, and urgency of the program, activity, or service to people's lives	92%
Factor 4: The resources available to the recipient and costs for offering language access services	94%

Source: OCR guidance and OIG analysis of provider survey responses, 2010.

Seventy-eight percent of providers reported determining the number or proportion of LEP persons in their service areas

Corresponding to the first factor in OCR guidance, 78 percent of providers reported determining the number or proportion of LEP persons represented in their geographic service areas. The greater the number or proportion of LEP persons, the greater the likelihood that language access services are needed.

Providers reported determining the number or proportion of LEP persons represented in their service areas using a variety of information sources, as listed in Table 4.

Table 4: Sources Providers Reported Using To Determine Number of LEP Persons

Sources*	Percentage of Providers
Patient utilization data	61%
Census data	45%
Community assessments conducted by their organizations	31%
Medicare data	30%
County or State health status reports	24%
Community assessments conducted by community organizations	15%
School enrollment data	7%
*Choices are not mutually exclusive.	

Source: OIG analysis of provider survey responses, 2010.

OCR guidance states that providers should first rely on their data from prior experiences with LEP encounters to determine the number of LEP persons in their geographic service areas. It also recommends that providers refine this assessment using other data sources. Seventy-one percent of providers that reported determining the number of LEP persons used multiple data sources. Providers relied primarily on patient utilization data, supplemented with other sources, to determine the number of LEP persons in their service areas. Only 17 percent of providers reported using patient utilization data as their only source.

Although 78 percent of providers reported determining the number of LEP persons in their service areas, only 46 percent reported that they monitor changes in the LEP population. Even though OCR guidance does not recommend that providers monitor demographic changes, it does note that a recipient's LEP plan may require annual reevaluation

of changes in demographics. Assessing data for shifts in the LEP population can help ensure that providers remain up-to-date on language needs in their service areas. Only 34 percent of providers reported monitoring changes in the LEP population annually. An additional 10 percent reported monitoring changes every 5 years and 2 percent reported monitoring changes every 10 years.

Eighty percent of providers reported determining the frequency of contact with LEP persons

Corresponding to the second factor in OCR guidance, 80 percent of providers reported determining the frequency with which they encountered LEP persons. The more frequent the contact with a particular language group, the more likely that language access services in that language are needed.

Providers reported collecting data on encounters with LEP persons primarily from two sources. Sixty-four percent of providers reported using data from patient databases and 62 percent reported using data from patient medical records. Forty-nine percent used both sources.

Ninety-two percent of providers reported considering the situation when determining what language access services to provide or reported offering services in all situations

Ninety-two percent of providers reported activities that correspond to the third factor in OCR guidance for determining the importance of language access services. This factor recommends that providers determine whether denial or delay of services or information because of a lack of language access services could have serious implications for LEP persons. To that end, 15 percent of providers reported assessing the importance and urgency of their programs, activities, and services. An additional 77 percent reported offering language access services in all types of situations regardless of importance and urgency, in which case determining the importance and urgency is no longer necessary.

Ninety-four percent of providers reported assessing the available resources

Almost all providers reported assessing available financial, material, and staff resources when determining what language access services to offer; such an assessment corresponds to the fourth factor in OCR guidance. Providers may use information about available resources to help them balance costs and benefits when deciding what language access services to offer. See Table E-1 in Appendix E for a list of the available resources that providers reported assessing.

Only 33 percent of providers offered services consistent with all four CLAS standards on language access services

Ninety-eight percent of providers in counties with a high percentage of LEP persons reported offering some language access services, but only 33 percent offered services consistent with all four of OMH's CLAS standards on language access services. As noted previously, CLAS standards are not mandatory. Rather, they are a resource that providers can use when developing their language access services.

Providers that offered language access services consistent with all four CLAS standards were more likely to be familiar with these standards.[45] Specifically, 82 percent of providers that offered language access services consistent with all four standards reported being familiar with the standards. In contrast, only 55 percent of providers that offered language access services that were not consistent with all four CLAS standards reported being familiar with the standards.

When the standards are reviewed individually, providers were most likely to offer language access services consistent with the standard about assuring the competence of language assistance provided by staff as opposed to the standards stating that services must be available during all business hours, that patients must be informed of their rights both verbally and in writing, and that written materials and signage should be translated into appropriate languages.[46] See Table 5 for each of the four CLAS standards on language access services and the percentage of providers that reported offering services consistent with each standard.

[45] The difference is statistically significant at the 95-percent confidence level.

[46] The difference is statistically different from other standards at the 95-percent confidence level in a multiple comparison test using a Bonferroni threshold of 0.01.

Table 5: CLAS Standards and Percentage of Providers Offering Services Consistent With Each Standard

CLAS Standards on Language Access Services	Percentage of Providers
Standard 4: Provide language assistance services at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	64%
Standard 5: Provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	52%
Standard 6: Assure the competence of language assistance provided. Family and friends should not be used to provide interpretation services (except on request by the patient).	86%
Standard 7: Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups in the service area.	71%

Source: CLAS standards and OIG analysis of provider survey responses, 2010.

Sixty-four percent of providers reported offering language access services during all business hours

Consistent with CLAS Standard 4, 64 percent of providers reported offering some type of language access services during all hours of operation. Further, 15 percent of providers offered language access services during more than half but less than all of their business hours.

Fifty-two percent of providers reported informing LEP persons both verbally and in writing of their right to receive language access services

Consistent with CLAS Standard 5, 52 percent of providers reported informing LEP persons verbally and in writing of their right to receive language access services. However, 23 percent of providers reported notifying LEP persons only verbally at check-in. Fifteen percent of providers reported notifying LEP persons only in writing of their right to receive language access services. Providers informed LEP persons in writing either through translated handouts or signs.

Eighty-six percent of providers reported requiring training for staff, contractors, and volunteers on language access services

Consistent with CLAS Standard 6, 86 percent of providers reported requiring training for staff, contractors, and volunteers on language access services. See Table E-2 in Appendix E for a list of the training topics that providers reported requiring for staff, contractors, and volunteers.

This standard also recommends that family and friends not be used as interpreters except when requested by the patient. Further, this standard states that minor children should never be used as interpreters or be allowed to interpret for their parents when they are the patients. Seventy percent of providers required training for staff, contractors, and volunteers on the use of family and friends as interpreters. In particular, 28 percent of providers required training on the use of minor children as interpreters.[47]

Although most providers reported requiring training for staff, contractors, and volunteers on language access services, only 39 percent reported formally testing them on their skills and competencies in providing language access services. CLAS Standard 6 mentions formal testing as a way to assure the competence of language assistance provided by staff. See Table E-3 in Appendix E for a list of the topics providers reported covering on formal tests.

Seventy-one percent of providers reported translating materials and posting signs in the languages of commonly encountered groups

Consistent with CLAS Standard 7, 71 percent of providers reported translating written materials and posting signs in the languages of commonly encountered groups.

Materials. Eighty-nine percent of providers reported translating at least one type of patient-related written material into the languages of commonly encountered groups. Further, 88 percent of providers reported translating at least one critical document as outlined by OCR guidance and CLAS standards as documents that are particularly important to translate. These documents include, but are not limited to, patients' rights information; medication directions; and screening, diagnosis, and treatment explanations. However, only 8 percent of providers translated all critical documents. See Table E-4 in

[47] Choices are not mutually exclusive.

Appendix E for a complete list of materials that providers reported translating.

Signs. Seventy-nine percent of providers either reported posting translated signs or reported that posting signs was not applicable to their organizations. Signs should provide notices of patient rights, the conflict and grievance process, and directions to facility services. Specifically, 68 percent of providers reported posting signs in the languages of commonly encountered groups. An additional 10 percent of providers reported that posting signs was not applicable to their organizations.[48] See Table E-5 in Appendix E for a list of signs that providers reported posting in commonly encountered languages.

Seventy-three percent of providers reported benefits to providing language access services and half reported obstacles

Seventy-three percent of providers reported benefits to providing language access services. The four most frequently reported benefits were (1) improved communication, (2) improved adherence to treatment regimen, (3) improved diagnosis and treatment, and (4) fewer complaints. See Table 6 for a list of benefits that providers reported.

[48] Percentages do not add to 79 percent because of rounding.

Table 6: Benefits Reported by Providers

Benefits*	Percentage of Providers
Improved communication	66%
Improved adherence to treatment regimen	58%
Improved diagnosis and treatment	51%
Fewer complaints	51%
Fewer adverse events and medical errors	45%
Fewer emergency visits	26%
Reduced length of patient visits	22%
Improved billing and collections	20%
Fewer facility readmissions	17%
Reduced length of facility stays	12%
Financial savings	2%
*Choices are not mutually exclusive.	

Source: OIG analysis of provider survey responses, 2010.

Very few providers reported financial savings from providing language access services. In fact, only 2 percent of providers reported that they saved money by providing language access services. Fifty-three percent of providers reported that they did not know whether they saved any money. One provider explained that savings because of a reduction in unnecessary tests, visits, and emergency room usage are difficult to measure while direct costs, such as those for interpreters, are measurable.

Fifty-four percent of providers reported obstacles to providing language access services

Fifty-four percent of providers reported obstacles to providing language access services, including such things as (1) a lack of training resources for staff, (2) costs of providing language access services, and (3) the broad range of languages spoken in the providers' communities. See Table 7 for a list of obstacles reported.

Table 7: Obstacles Reported by Providers

Obstacles*	Percentage of Providers
Lack of training resources for staff	32%
Cost of providing language access services	27%
Broad range of languages spoken in community	26%
Liability concerns	21%
Lack of staffing	18%
Staff discomfort in providing language access services	14%
Lack of means for staff to identify LEP persons	6%
*Choices are not mutually exclusive.	

Source: OIG analysis of provider survey responses, 2010.

Twenty-seven percent of providers reported cost as an obstacle. Providers may perceive costs to be an obstacle because they may not see savings that would offset their investment in providing language access services. Most providers bear the full cost of providing language access services. Only 3 percent reported receiving direct reimbursement for providing these services. Providers reported that these reimbursements were received from Medicaid and State or local governments.

Forty-five percent of providers reported that it would be useful to have additional assistance in overcoming obstacles and implementing language access services. In responding to the survey, these providers wrote in specific requests for assistance. These requests were, in general, for additional information, training, and financial assistance for providing language access services.

Specifically, information requests included such things as already-translated documents or the names of organizations that provide cost-effective translation and interpretation. Providers were interested particularly in resources within their communities. Another suggestion providers made was that models of language service provision be made available.

Few providers reported data on the costs of providing language access services and the data provided were not comparable

Because of the overall lack of reporting and the inability to compare data, we were unable to make any determinations about cost data related to language access services.

Of the 119 providers that responded to the survey, only 49 providers responded to the request for cost data. These providers reported data for at least one of the following requests: (1) annual expenditures on language access services, (2) expenditures by type of language access service, (3) expenditures by LEP person, or (4) expenditures on staff training for language assistance. Only three of these providers reported all requested cost data.

The cost data reported by the 49 providers ranged widely. For example, FY 2008 expenditures by one provider on interpreter services totaled $50. On the other hand, another provider indicated its total FY 2008 costs for interpreter services were $779,494. Data for cost per LEP person for interpreter services mirrored this wide range with one provider reporting spending $0.33 per LEP person and another provider reporting $1,500 per LEP person.

Providers' comments about how they calculated the data indicated that the wide range of costs might be the result of different approaches to calculating costs rather than a reflection of varying levels of service. For example, some providers reported capturing cost data at the organizational level rather than at the facility level and were unable to break out the data by facility. In addition, some providers indicated that they were unable to exclude salary costs (e.g., for bilingual employees) from cost data on language access services.

RECOMMENDATIONS

Sixty-nine percent of Medicare providers in counties with a high percentage of LEP persons conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer. However, only 33 percent of providers offered services consistent with all four CLAS standards on language access services.

OMH created the CLAS standards to guide providers to become more responsive to the cultural and linguistic needs of diverse populations. Providing language access services is crucial to ensuring access to high-quality health care for LEP persons. Clear communication between LEP persons and providers can lead to better health outcomes for LEP persons.

The MIPPA requires OIG to make recommendations on improving compliance with and enforcement of CLAS standards. However, in keeping with our assessment of voluntary compliance, we make recommendations to increase the percentage of providers that voluntarily offer services consistent with all four CLAS standards on language access services.

Providers that offered language access services consistent with the CLAS standards were more likely to be familiar with them. This indicates that educating providers on the standards may lead to an increase in the percentage of providers offering language access services consistent with CLAS standards.

To improve Medicare providers' awareness and implementation of CLAS standards, we recommend that:

OCR should inform providers about OMH's CLAS standards

OCR should assist providers that receive Federal financial assistance in offering high-quality language access services by informing them of OMH's CLAS standards. OCR could also inform providers about associated OMH resources, such as the *Health Care Languages Services Implementation Guide*. This could be done during civil rights reviews of new Medicare providers, technical assistance interactions, and complaint investigations involving LEP persons. During the civil rights review process, OCR, unlike OMH, has direct contact with almost all new Medicare providers that receive Federal financial assistance, such as hospitals, nursing homes, and home health agencies. Therefore, OCR has unique opportunities for education. OCR staff indicated that a collaborative relationship with OMH already exists, and we encourage

the two offices to continue sharing resource information to assist providers with serving LEP persons.

OMH should increase outreach to providers to familiarize them with CLAS standards

OMH should increase provider awareness of the CLAS standards by proactively educating them about this resource. OMH should be more proactive in its outreach because providers that are seeking out OMH's online resources are likely already aware of the need to be culturally and linguistically accessible. To be more proactive, OMH could lead an effort to increase awareness among providers about CLAS standards. OMH could collaborate with other HHS operating divisions that focus on health care, including CMS, as well as work with provider associations to disseminate the CLAS standards to providers.

The collaborative effort to inform providers about CLAS standards could focus on educating providers on the specific Language Access Services standards that providers were less likely to have implemented. To that end, the effort could stress that the CLAS standards encourage providers to (1) offer language access services during all hours of operation; (2) inform LEP persons both verbally and in writing of their right to receive language access services; (3) translate and post signs, particularly directions to facility services; and (4) translate critical materials.

In addition, we make the following recommendation to help Medicare providers offer affordable and accurate language access services:

OMH should offer model translated written materials and signs to providers

One suggestion offered by providers was that information about how to obtain already-translated materials be made available. To that end, OMH should provide model standard language for some frequently used written materials and signs in the languages of commonly encountered groups. OMH could take the lead in collaborating with other HHS operating divisions to develop model language for these materials. In particular, OMH could focus on providing translated language for critical documents. For example, OMH could provide language explaining patients' rights to language access services. After development, OMH could make the model language available online through its Center.

A number of benefits could be realized if OMH assisted providers with model translated written materials and signs. OMH could reduce the financial burden on providers, which in turn could help increase the

percentage of providers that offer translated materials. In addition, OMH would be ensuring the accuracy of critical patient-related documents offered to LEP persons.

AGENCIES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OCR and OMH concurred with our recommendations. OMH stated that it will take the lead in developing specific marketing strategies to inform providers of the CLAS standards. CMS indicated that it did not have any substantive comments. However, it did provide technical comments that we incorporated as appropriate.

For the full text of the agencies' comments, see Appendix F.

APPENDIX ~ A

Section 187 of the Medicare Improvements for Patients and Providers Act of 2008

SEC. 187. OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE.

(a) REPORT.—Not later than two years after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

(2) a description of the costs associated with or savings related to the provision of language services. Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

APPENDIX ~ B

Culturally and Linguistically Appropriate Services in Health Care Standards[49]

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

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

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

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

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

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

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

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[49] Office of Minority Health, *National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS)*, March 2001. Accessed at http://minorityhealth.hhs.gov on February 12, 2010.

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

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

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

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

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

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

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

APPENDIX ~ C

Categories of Responses to Key Survey Questions

Office for Civil Rights (OCR) Factor 1 Question: Which of the following sources of information does your organization use to determine the number or proportion of Limited English Proficient (LEP) persons from each language group represented in its geographic service area?

a) Census data
b) Community assessment conducted by a community organization
c) Community assessment conducted by your organization
d) County or State health status reports
e) Medicare data
f) Patient utilization data
g) School enrollment profiles
h) Other (please specify)

OCR Factor 2 Question: Which of the following sources of information does your organization use to track how often it encounters LEP persons?

a) Patient database
b) Patient medical records
c) Other (please specify)

OCR Factor 3 Question: When determining whether to communicate with LEP persons in their preferred language, does your organization consider the importance and urgency of the activity, program, or service to people's lives?

a) We provide language access services in all situations.
b) We consider the importance and urgency of the situation when determining what language access services to provide.

OCR Factor 4 Question: How does your organization assess whether it has resources available to provide language access services?

a) Assess availability of bilingual staff
b) Assess available technology
c) Determine whether outside funding is available
d) Examine operating funds to determine whether money is available
e) Review available community resources
f) Other (please specify)

Culturally and Linguistically Appropriate Services in Health Care (CLAS) Standard 4 Question: During what percentage of your organization's business hours are language access services offered?

a) All (100%)
b) More than 50% but less than 100%
c) Less than or equal to 50%
d) Organization does not offer language access services

CLAS Standard 5 Question: Does your organization inform LEP persons of their right to receive language access services in their preferred language in any of the following ways?

a) Given copies of language access rights materials in their preferred language
b) Referred to posted and translated signs about language access services
c) Told verbally during check-in process
d) Other (please specify)

CLAS Standard 6 Question: Which of the following training topics does your organization require for staff, contractors, and volunteers?

a) Cultural competence
b) Demographic data of communities served
c) How to collect data on primary language from LEP persons
d) How to respond to people who do not speak English
e) Information related to written policies and procedures regarding language access services
f) Language skills
g) Use of "I Speak" cards or other communication aids
h) Use of family members or friends as interpreters
i) Use of minor children as interpreters
j) Other (please specify)

CLAS Standard 7 Question 1: Which of the following written materials are translated into the languages of commonly encountered groups?

a) Advance directives
b) Applications to receive services
c) Community resources
d) Complaint forms
e) Discharge instructions
f) Explanations of screening, diagnosis, or treatment options
g) Facility menus
h) Financial assistance forms
i) Illness-related education
j) Informed consent documents
k) Intake forms
l) "I Speak" cards or other communication aids
m) Medication management and prescription directions
n) Notice of language access services
o) Patients' rights information
p) Wellness-related education
q) Other (please specify)

CLAS Standard 7 Question 2: Which of the following types of signs are posted in the languages of commonly encountered groups?

a) Available services
b) Business hours
c) Conflict and grievance procedures
d) Directions to facility services (such as admissions, pediatrics, emergency room, etc.)
e) Explanation of right to language access
f) Patients' rights information
g) Other (please specify)

APPENDIX ~ D

Estimates and Confidence Intervals

Table D-1: Estimates of Survey Responses

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that conducted the four-factor assessment recommended by Office for Civil Rights (OCR) guidance when determining whether to offer language access services	119	68.9	60.5%–77.3%
Percentage of providers that conducted the assessment recommended by OCR guidance that reported being familiar with it	82	85.4	77.6%–93.1%
Percentage of providers that did not conduct the four-factor assessment recommended by OCR guidance but reported being familiar with it	35	40.0	23.5%–56.5%
Percentage of providers that did not complete all four OCR factors	119	31.1	22.7%–39.5%
Percentage of providers that completed at least three of the four OCR factors	119	84.0	77.4%–90.7%
Percentage of providers that completed at least one of the four OCR factors	119	97.5	92.8%–99.5%*
Percentage of providers that completed three OCR factors	119	15.1	8.6%–21.7%
Percentage of providers that completed two OCR factors	119	9.2	4.0%–14.5%
Percentage of providers that completed one OCR factor	119	4.2	0.5%–7.9%
Percentage of providers that completed no OCR factors	119	2.5	0.5%–7.2%*
Percentage of providers that reported determining the number or proportion of Limited English Proficient (LEP) persons they were eligible to serve or likely to encounter in their geographic service areas (OCR Factor 1)	119	78.2	70.6%–85.7%
Percentage of providers that reported determining the frequency of contact with LEP persons (OCR Factor 2)	119	79.8	72.5%–87.1%
Percentage of providers that reported considering the situation when determining what language access services to provide or reported offering services in all situations (OCR Factor 3)	119	91.6	86.5%–96.7%
Percentage of providers that reported assessing available resources for offering language access services (OCR Factor 4)	119	94.1	89.8%–98.4%
*Confidence interval calculated with an exact method based on the binomial distribution.			

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that reported using patient utilization data to determine the number of LEP persons represented in their geographic service areas	118	61.0	52.1%–69.9%
Percentage of providers that reported using Census data to determine the number of LEP persons represented in their geographic service areas	118	44.9	35.8%–54.0%
Percentage of providers that reported using community assessments conducted by their organizations to determine the number of LEP persons represented in their geographic service areas	118	30.5	22.1%–38.9%
Percentage of providers that reported using Medicare data to determine the number of LEP persons represented in their geographic service areas	118	29.7	21.3%–38.0%
Percentage of providers that reported using county or State health status reports to determine the number of LEP persons represented in their geographic service areas	118	23.7	15.9%–31.5%
Percentage of providers that reported using community assessments conducted by community organizations to determine the number of LEP persons represented in their geographic service areas	118	15.3	8.7%–21.8%
Percentage of providers that reported using school enrollment data to determine the number of LEP persons represented in their geographic service areas	118	6.8	2.2%–11.4%
Percentage of providers that reported using multiple sources to determine the number of LEP persons represented in their geographic service areas	93	71.0	61.6%–80.4%
Percentage of providers that reported using patient utilization data as their only information source to determine the number of LEP persons represented in their geographic service areas	93	17.2	9.4%–25.0%
Percentage of providers that reported monitoring changes in the LEP population represented in their geographic service areas	114	45.6	36.3%–54.9%
Percentage of providers that reported annually monitoring changes in the LEP population represented in their geographic service areas	114	34.2	25.4%–43.1%

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that reported monitoring changes in the LEP population represented in their geographic service areas every 5 years	114	9.6	4.1%–15.2%
Percentage of providers that reported monitoring changes in the LEP population represented in their geographic service areas every 10 years	114	1.8	0.2%–6.2%*
Percentage of providers that reported using data collected from patient databases when determining the frequency of contact with LEP persons	118	63.6	54.7%–72.4%
Percentage of providers that reported using data from patient medical records when determining the frequency of contact with LEP persons	118	61.9	53.0%–70.8%
Percentage of providers that reported using data from both patient databases and patient medical records when determining the frequency of contact with LEP persons	118	49.2	40.0%–58.3%
Percentage of providers that reported assessing the importance and urgency of their programs, activities, and services	118	15.3	8.7%–21.8%
Percentage of providers that reported offering language access services in all types of situations regardless of importance and urgency	118	77.1	69.4%–84.8%
Percentage of providers that offered language access services consistent with all four Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards on language access services	119	32.8	24.2%–41.3%
Percentage of providers that offered some language access services	119	98.3	94.1%–99.8%*
Percentage of providers that offered language access services consistent with the CLAS standards that reported being familiar with them	39	82.1	69.8%–94.3%
Percentage of providers that offered language access services that were not consistent with CLAS standards that reported being familiar with them	78	55.1	43.9%–66.3%
Percentage of providers that reported offering language access services during all business hours (CLAS Standard 4)	119	63.9	55.1%–72.6%
*Confidence interval calculated with an exact method based on the binomial distribution.			

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that reported informing LEP persons verbally and in writing of their right to receive language access services (CLAS Standard 5)	119	52.1	43.0%–61.2%
Percentage of providers that reported requiring training for staff, contractors, and volunteers on language access services (CLAS Standard 6)	119	85.7	79.3%–92.1%
Percentage of providers that reported translating materials and posting signs in the languages of commonly encountered groups (CLAS Standard 7)	119	71.4	63.2%–79.7%
Percentage of providers that reported offering language access services during more than half of their business hours	116	14.7	8.1%–21.2%
Percentage of providers that reported notifying LEP persons only verbally at check-in of their right to receive language access services	104	23.1	14.8%–31.3%
Percentage of providers that reported notifying LEP persons only in writing of their right to receive language access services	104	15.4	8.3%–22.4%
Percentage of providers that reported requiring training for staff, contractors, and volunteers on the use of family members or friends as interpreters	119	69.7	61.4%–78.1%
Percentage of providers that reported requiring training for staff, contractors, and volunteers on the use of minor children as interpreters	119	27.7	19.6%–35.9%
Percentage of providers that reported formally testing the skills and competencies of staff, contractors, and volunteers in providing language access services	119	38.7	29.8%–47.5%
Percentage of providers that reported translating at least one type of patient-related written materials into the languages of commonly encountered groups	119	89.1	83.4%–94.8%
Percentage of providers that reported translating at least one critical document into the languages of commonly encountered groups	119	88.2	82.4%–94.1%
Percentage of providers that reported translating all critical documents into the languages of commonly encountered groups	119	8.4	3.3%–13.5%

*Confidence interval calculated with an exact method based on the binomial distribution.

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that reported that they either posted translated signs or that posting signs was not applicable to their organization	117	78.6	71.1%–86.2%
Percentage of providers that reported posting signs in the languages of commonly encountered groups	117	68.4	59.8%–76.9%
Percentage of providers that reported that posting signs was not applicable to their organizations	117	10.3	4.7%–15.8%
Percentage of providers that reported benefits to providing language access services	119	73.1	65.0%–81.2%
Percentage of providers that reported improved communication as a benefit	119	65.5	56.9%–74.2%
Percentage of providers that reported improved adherence to treatment regimen as a benefit	119	58.0	49.0%–67.0%
Percentage of providers that reported improved diagnosis and treatment as a benefit	119	51.3	42.1%–60.4%
Percentage of providers that reported fewer complaints as a benefit	119	51.3	42.1%–60.4%
Percentage of providers that reported fewer adverse events and medical errors as a benefit	119	45.4	36.3%–54.5%
Percentage of providers that reported fewer emergency visits as a benefit	119	26.1	18.0%–34.1%
Percentage of providers that reported reduced length of patient visits as a benefit	119	21.8	14.3%–29.4%
Percentage of providers that reported improved billing and collections as a benefit	119	20.2	12.9%–27.5%
Percentage of providers that reported fewer facility readmissions as a benefit	119	16.8	10.0%–23.6%
Percentage of providers that reported reduced length of facility stays as a benefit	119	11.8	5.9%–17.6%

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that reported saving money by providing language access services	119	1.7	0.2%–5.9%*
Percentage of providers that reported that they did not know whether they saved money by providing language access services	119	52.9	43.8%–62.0%
Percentage of providers that reported obstacles to providing language access services	111	54.1	44.6%–63.5%
Percentage of providers that reported a lack of training resources for staff as an obstacle	111	32.4	23.6%–41.3%
Percentage of providers that reported the cost of providing language access services as an obstacle	111	27.0	18.6%–35.4%
Percentage of providers that reported the broad range of languages spoken in the community as an obstacle	111	26.1	17.8%–34.4%
Percentage of providers that reported liability concerns as an obstacle	111	20.7	13.1%–28.4%
Percentage of providers that reported being understaffed as an obstacle	111	18.0	10.8%–25.3%
Percentage of providers that reported staff discomfort in providing language access services as an obstacle	111	14.4	7.8%–21.1%
Percentage of providers that reported a lack of means for staff to identify LEP persons as an obstacle	111	6.3	1.7%–10.9%
Percentage of providers that reported receiving reimbursement for providing language access services	119	2.5	0.5%–7.2%*
Percentage of providers that reported that it would be useful to have additional assistance in implementing language access services	111	45.0	35.6%–54.4%
*Confidence interval calculated with an exact method based on the binomial distribution.			

Source: Office of Inspector General analysis of provider survey responses, 2010.

APPENDIX ~ E

Supplemental Analysis Tables

Table E-1: Available Resources That Providers Reported Assessing

Available Resources*	Sample Size	Percentage of Providers	95-Percent Confidence Interval
Bilingual staff	119	89.1%	83.4%–94.8%
Technology	119	63.0%	54.2%–71.8%
Community resources	119	63.0%	54.2%–71.8%
Operating funds to determine whether money is available	119	33.6%	25.0%–42.2%
Outside funding	119	22.7%	15.1%–30.3%
*Choices are not mutually exclusive.			

Source: Office of Inspector General (OIG) analysis of provider survey responses, 2010.

Table E-2: Training Topics for Staff, Contractors, and Volunteers

Training Topics*	Sample Size	Percentage of Providers	95-Percent Confidence Interval
Use of family members or friends as interpreters	119	69.7%	61.4%–78.1%
How to respond to people who do not speak English	119	68.9%	60.5%–77.3%
Written policies and procedures regarding language access services	119	59.7%	50.7%–68.6%
Cultural competence	119	58.0%	49.0%–67.0%
How to collect data on primary language from Limited English Proficient persons	119	37.8%	29.0%–46.7%
Language skills	119	36.1%	27.4%–44.9%
Use of "I-Speak" cards or other communication aids	119	28.6%	20.3%–36.8%
Demographic data of communities served	119	27.7%	19.6%–35.9%
Use of minor children as interpreters	119	27.7%	19.6%–35.9%
*Choices are not mutually exclusive.			

Source: OIG analysis of provider survey responses, 2010.

Table E-3: Testing Topics Providers Reported Covering

Testing Topics*	Sample Size	Percentage of Providers	95-Percent Confidence Interval
Confidentiality requirements	119	33.6%	25.0%–42.2%
Medical terminology	119	33.6%	25.0%–42.2%
Policies and procedures	119	30.3%	21.9%–38.6%
Ability to interpret effectively	119	27.7%	19.6%–35.9%
Proficiency in English and non-English languages	119	26.9%	18.8%–35.0%
*Choices are not mutually exclusive.			

Source: OIG analysis of provider survey responses, 2010.

Table E-4: Materials That Providers Reported Translating

Material Type	Translated Material*	Sample Size	Percentage of Providers	95-Percent Confidence Interval
Critical	Patients' rights information	119	75.6%	67.8%–83.5%
	Advance directives	119	65.5%	56.9%–74.2%
	Informed consent documents	119	58.8%	49.9%–67.8%
	Complaint forms	119	52.9%	43.8%–62.0%
	Illness-related education	119	52.9%	43.8%–62.0%
	Notice of language access services	119	52.1%	43.0%–61.2%
	Medication management and prescription directions	119	50.4%	41.3%–59.5%
	Discharge instructions	119	47.9%	38.8%–57.0%
	Applications to receive services	119	43.7%	34.7%–52.7%
	Explanations of screening, diagnosis, or treatment options	119	42.0%	33.0%–51.0%
	Financial assistance forms	119	37.8%	29.0%–46.7%
	Intake forms	119	36.1%	27.4%–44.9%
Noncritical	Community resources	119	47.9%	38.8%–57.0%
	Wellness-related education	119	44.5%	35.5%–53.6%
	"I-Speak" cards or other communication aids	119	33.6%	25.0%–42.2%
	Facility menus	119	24.4%	16.5%–32.2%

*Choices are not mutually exclusive.

Source: OIG analysis of provider survey responses, 2010.

Table E-5: Signs That Providers Reported Posting in Commonly Encountered Languages

Types of Signs*	Sample Size	Percentage of Providers	95-Percent Confidence Interval
Patients' rights information	117	61.5%	52.6%–70.5%
Conflict and grievance procedures	117	44.4%	35.3%–53.6%
Available services	117	37.6%	28.7%–46.5%
Explanation of right to language access services	117	38.5%	29.5%–47.4%
Business hours	117	36.8%	27.9%–45.6%
Directions to facility services	117	21.4%	13.8%–28.9%
*Choices are not mutually exclusive.			

Source: OIG analysis of provider survey responses, 2010.

APPENDIX ~ F

Agencies' Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Director
Office for Civil Rights
Washington, DC 20201

DATE: May 27, 2010

TO: Daniel R. Levinson
Inspector General

FROM: Georgina C. Verdugo
Director

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Guidance and Standards on Language Access Services: Medicare Providers" (OEI-05-10-00050)

Thank you for the opportunity to review and respond to the OIG Draft Report: Guidance and Standards on Language Access Services: Medicare Providers (OEI-05-10-00050).

The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) appreciate OIG's efforts to determine the extent to which Medicare providers utilize the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* and Office of Minority Health's *Culturally and Linguistically Appropriate Services* (CLAS) standards. OCR also commends the OIG inspection team for both their thoroughness and professionalism during the review.

OCR concurs with the report's findings and recommendations and offers no comment.

/S/

Georgina C. Verdugo
Director

APPENDIX ~ F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

Office of Minority Health
Washington, D.C. 20201

DATE: May 26, 2010

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Garth N. Graham, M.D., M.P.H.
Deputy Assistant Secretary for Minority Health
Office of Minority Health
Office of the Secretary

SUBJECT: OIG Draft Reports: Guidance and Standards on Language Access Services: Medicare Providers, OEI-05-10-00050

Thank you for the opportunity to review and respond to the OIG draft report. We appreciate OIG's efforts to examine the extent Medicare Providers are fulfilling the requirements of (1) OCR's Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (OCR guidance) and (2) OMH's CLAS standards.

Based on our review of the report, our responses will only focus on those areas that apply to the CLAS Standards.

OIG Recommendation: Medicare Providers: OEI-05-10-00050

- **OMH should increase outreach to providers to familiarize them with CLAS standards.**

  OMH could collaborate with other HHS operating divisions that focus on health care, including CMS, as well as work with provider associations to disseminate the CLAS standards to providers.

- **OMH should offer model translated written materials and signs to providers**
  OMH could take the lead in collaborating with other HHS operating divisions to develop model language for these materials.

OMH concurs with OIG's recommendations. The OMH will take the lead in developing specific marketing strategies to inform providers of the CLAS standards. Additionally, OMH will facilitate the development of specific translated materials and signage for providers in collaboration with other HHS operating divisions.

U.S. Public Health Service

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: MAY 20 2010

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator and Chief Operating Officer

SUBJECT: Office of Inspector General (OIG) Draft Report: "Guidance and Standards on Language Access Services: Medicare Providers" (OEI-05-10-00050)

Thank you for the opportunity to review and comment on the OIG draft report entitled, "Guidance and Standards on Language Access Services: Medicare Providers" (OEI-05-10-00050). This is to notify you that the Centers for Medicare & Medicaid Services has reviewed the subject draft report, and we have no substantive comments. We are attaching technical comments for your consideration.

We appreciate the effort that went into this report and look forward to working with the OIG on this and other issues related to language access services.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Thomas F. Komaniecki, Deputy Regional Inspector General.

Nicole Hrycyk served as the team leader for this study and Meghan Kearns served as the project lead. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Melissa Baker, Benjamin Dieterich, Ericka Kilburn, Margo Rodriguez, and Mark Stiglitz; central office staff who contributed include Heather Barton and Kevin Farber.

Office of Inspector General

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