Enhancement of Services to People of Hispanic/Latino Heritage

Certified Public Manager Project

Elizabeth Duncan
Confidential Report

CPM Enhancement of Services to Hispanic/Latino Clients

The intent of this project is to enhance prevention, intervention and treatment services delivered to Hispanic/Latino consumers. The mission of the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is to ensure the provision of quality services to prevent or reduce the negative consequences of substance use and addiction. This Certified Public Manager candidate is employed by DAODAS as a treatment consultant. A primary responsibility is the delivery of technical assistance in the area of treatment to the service providers. The types of information in this report are frequently the subjects on which consultation is delivered. Information is regularly sent to the service providers to help them deliver better services.

As the number of Hispanic/Latino people living in South Carolina increases, it is important that services be culturally and linguistically appropriate. If the consumer receives services that are inconsistent with his/her own culture, the consumer will not engage in services and the chances for problem resolution are significantly reduced. The service providers tend to have their own practices, as well as policies and procedures, in working with Hispanic/Latino consumers. This creates an enormous duplication of effort in numerous areas related to service delivery. As a means to achieve enhanced services, this project has targeted certain key areas that are listed in the following:

- increased/continued awareness of the impact of Title VI of the Civil Rights Act of 1964
- translation of essential legal documents;
- testing and training of interpreters;
- cultural competence training.

At one point in time, there was a DAODAS workgroup that focused specifically on

serving the Hispanic/Hispanic consumer. There have been numerous changes in personnel and that workgroup is no longer operational. This candidate has been the key person to address issues regarding people with this heritage. Fortunately, there are other people who are willing to provide consultation and assistance as the need arises. The increased awareness has been perpetuated by becoming a regular agenda item in a monthly meeting of selected executive directors from across the state. The quarterly treatment directors meetings have addressed issues specific to working with Hispanic/Latino consumers many times. This has also been a subject of discussion at the meetings of the service providers executive directors. This candidate routinely asks providers what the current status of efforts in treating consumers who are Hispanic/Latino and what help is needed.

A factor that emphasizes the importance of services to Hispanic/Latino consumers is the rapid increase of this population in the United States in general and South Carolina in particular. The Census 2000 reported that 281.4 million people live in the United States and 35.3 million or about 13 percent are Hispanic/Latino. The Hispanic/Latino population in South Carolina has increased by 211.7 percent from 1990 to 2000. The Census 2000 reported that 95,076 Hispanic/Latino people live in South Carolina. This number has drawn much criticism and some experts state the actual maybe be four times higher. The Carolinas Associated General Contractors of America listed in the 2003 publication, under Spanish Resources, provided additional information about county growth that is listed in the following:

- Of the 379,616 residents in Greenville county, 14,283 are Hispanic/Latino.
- Richland County has 8,713 Hispanic/Latino residents.

- Beaufort county has 8,208 Hispanic/Latino people.
- Charleston county has 7,434 Hispanic/Latino residents.
- Spartanburg county has 7,081 Hispanic/Latino residents.
- In Anderson county, 1,832 of the 165,740 residents are Hispanic/Latino.
- Pickens county has 1,879 Hispanics.
- Jasper county had the greatest percentage change in its Hispanic/Latino population. It was 1,624 percent (from 69 people in 1990 to 1,190 people in 2000).

Every county in the state had an increase in the Hispanic/Latino population. Projections range and one projection is that South Carolina's Hispanic/Latino population will increase to 231,470 by 2005. The Census 2000 provided a breakdown of the South Carolina Hispanic/Latin heritage into four categories that are listed in the following:

- Mexican 52,871 or 56 percent
- Puerto Rican: 12,211 or 13 percent
- Cuban: 2,875 or 3.0 percent
- Other Hispanic: 27,119 or 28 percent.

It can be a matter of life and death for human service providers to have adequate resources, especially interpreting, for Spanish speaking consumers. In an April 21, 2002 article, the *The State* highlighted some of these the problems. At Palmetto Richland, requests for English-Spanish interpreting services have doubled in each of the last four years. In 2000, Lexington Medical Center admitted 2,192 Hispanic patients. Last year the number was 3,049. A large amount of information regarding the growth patterns in

South Carolina and in the United States is available in Appendix 1.

Addiction is a shame-based disease that is chronic, progressive and potentially fatal. This brain based disorder takes tremendous tolls emotionally, physically and spiritually. Alcohol is a factor in fifty percent of suicide attempts and completed suicides. People, especially those with Hispanic/Latino heritage, rarely seek treatment until there is a major crisis. The cultural framework is that problems are addressed within the family. There is a higher rate of Hepatitis C, with complications of cirrhosis, among Hispanic/Latino men. The people who are requesting treatment tend to have significantly more physical damage at an earlier age. Unless appropriate intervention and treatment services are delivered, the potential for emotional and physical damage increases. The provision of services is further complicated are language barriers.

Generally, it takes an adult three to five years to learn a new language. Many of the Hispanic/Latino people living in South Carolina have limited English proficiency (LEP). All of the contracts that DAODAS has with service providers include an agreement to maintain compliance the Title VI of the Civil Right Acts of 1964. This law has a significant impact in delivery of services to people with (LEP). Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d *et. seq*. states: "No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Regulations implementing Title VI, provide in part at 45 C.F.R. Section 80.3 (b): are listed below:

"(1) A recipient under any program to which this part applies may not, directly or through

contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit provided under the program.

(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program or the class of individuals to whom, or the situations in which such services, financial aid or other benefits, or facilities will be provided ... may not directly, or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, because of their race, color or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular, race, color or national origin."

The regional representative of the Office of Civil Rights has recommended that even if the consumer brings an interpreter that the agency should still have an interpreter present. There are a number of factors involved with this recommendation. One of which is that the consumer's interpreter may not interpret correctly, may leave out what the interpreter feels is inappropriate or may inappropriately interject his/her opinions into the process. The agency's interpreter would be present to monitor the interpretations. There have been numerous problems with allowing consumers to use their interpreters. One such problem occurred in another state, the consumer's interpreter confused the words lung and liver. The consumer had an invasive procedure and was not knowledgeable enough

even on the most basis elements to be able to give informed consent. In order to ensure compliance with Title VI, providers must take steps to ensure that people with LEP who are eligible for their programs or services have meaningful access to the health and social service benefits that they provide. The most important step in meeting this obligation is for providers to deliver the language assistance necessary to ensure such access, at no cost to the LEP person. In designing an effective language assistance program, the service provider develops procedures for obtaining and providing trained and competent interpreters in a timely manner, by taking some or all of the following steps:

- Hiring bilingual staff who are trained and competent in the skill of interpreting;
- Hiring staff interpreters who are trained and competent in the skill of interpreting;
- Contracting with an outside interpreter service for trained and competent interpreters;
- Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting;
- Arranging/contracting for the use of a telephone language interpreter service.

A vital part of a well-functioning compliance program includes having effective methods for notifying LEP persons regarding their right to language assistance and the availability of such assistance free of charge. These methods include the use of language identification cards which allow consumers to identify their language needs to staff. The identification of the need for interpreters must be recorded in the person's file. Signs in Spanish should be posted in waiting rooms, reception areas and other points of entry.

Title VI requires that qualified interpreters be used but offers little guidance as to what "qualified" means. Please see Appendix 2 for additional information on Title VI. In a state experiencing difficulties in service delivery to LEP consumers, this creates a troublesome dilemma. The South Carolina Department of Health and Environmental Control (DHEC), the South Carolina Department of Social Services (DSS) and to a lesser extent the South Carolina Department of Health and Human Services hired an Oregon based firm to assist in this process. The regional representative from the Office of Civil Rights also provided technical assistance. The company helped in the development of policies and procedures for working with consumers with LEP that can be used statewide. Additionally, a testing and a Code of Ethics training was developed and implemented. The exam tested participant in English to Spanish and Spanish to English. Participants can take a lower skill based test that would be useful to someone such as an administrative assistant as well as a more advanced level that would be needed in clinical encounters. When participants successfully complete the testing, they can then take the Code of Ethics training. The Office of Civil Rights heavily emphasizes the importance of ethic training for interpreters. Additionally, a film was made on how to effectively work with an interpreter. DHEC requires that anyone working with an interpreter view this video first.

The development and implementation of a program of this nature is costly and took place over years. This candidate was able to develop contacts with various leaders in the state. As a result, DHEC has allowed DAODAS funded programs to take the testing and the training at no cost. This candidate has been given copies of the draft policies and procedures and will receive a copy of the film. Please see Appendix 3 for a copy of the

draft policies and procedures. While there may be fees charged in the future, DAODAS remains the only agency allowed to participate in the testing/training. The draft policies and procedures have been sent by this candidate to all the service providers to help them in the revision of current policies.

DAODAS made a request to the Center for Substance Abuse Treatment (CSAT) for technical assistance. The primary requests center around the translation of legal documents and cultural competence training. Translation from English to Spanish can be very difficult because certain words or descriptions vary from one Spanish speaking country to another. Another complicated factor is that Spanish is a language that cannot be translated word for word. The information has be neutral, textbook Spanish that can be easily understood regardless of the country. CSAT translated documents incorporated the new Health Insurance Privacy and Portability Act requirements. Legal translations are much more costly. DAODAS was able to receive twelve legal documents and one brochure, that is related to three of the legal documents, translated to Spanish at no charge. The cultural competency training will be designed as a three-day training for trainers. There will be a curriculum that accompanies the training to better assist the providers in the training of new staff members. There tends to be frequent turnover in treatment staff. Training is too costly if the trained individual leaves the agency and the single resource for cultural competence is lost. The national level trainer recommended, by CSAT, is very interested in individualizing the training to meet the needs of the Hispanic/Latino population in South Carolina. He wants to meet with members of the Hispanic/Latino communities to help identify the barriers and strengths in service delivery. The trainer would also discuss similar issues and provide on-site technical

assistance with service providers from selected areas across the state. Key areas that the curriculum should addressed are listed as follows:

- basic overview of Title VI requirements;
- how to use an interpreter;
- guidelines for the determination of interpreter qualifications;
- a major focus on the culture of Hispanic/Latino clients and how to respect an individual's culture during counseling;
- how to work with individuals, couples and families;
- respect for an individual's spiritual beliefs and beliefs about counseling and medication;
- family secrets (e.g., binge drinking and domestic violence), cultural factors that increase problems within a family and barriers to "empowering" female clients;
- how the gender of a counselor impacts the manner in which clients react and disclose information;
- counseling children who are experiencing difficulties, especially in the schools, including how to help families when the parents have limited English proficiency and the children may or may not be fluent in English;
- effective ways to facilitate outreach activities;
- steps that can be taken to increase collaborative efforts with other agencies; and
- fear of the Bureau of Citizenship and Immigration Services (formerly the Immigration and Naturalization Service [INS]) and the resulting impact on

- clients' willingness to enter services.

Negotiations continue around the costs of the training. CSAT will be able to participate in cost sharing for the training.

Enhancement of services is expensive and it is easy to focus on other issues during the state budget crisis. However, there are a number of factors that can facilitate better utilization of resources. DAODAS has the distinct advantage of collaborative relationships with other health and human service providers. The information and opportunities made available through agencies, such as DHEC, have been enormously productive in terms of policy development and cost savings. Some of the service providers have identified needs in their community and developed services tailored to meet those needs. One of the service providers has an intensive in home service for Spanish speaking families. The family has a case manager who is available 24 hours per day, seven days per week. As one provider develops new programs, other agencies are more eager to follow suit. The identification of resources, such as CSAT, for translation and training have made the fiscal resources stretch further. This candidate was able to identify a resource that provides pamphlets and posters on prevention, intervention and treatment at no costs. The services providers were given information on how to access this resource. All these efforts help the service provider deliver better services and the consumer is able to receive the type of service needed in a cultural appropriate manner. Addiction does not just impact the addict; it affects the whole family including the children. The result is that consumers and their families receive the care they need and the recovery process begins.

Geographic area	Total population	Race								Hispanic or Latino(of any race)
		One race							Two or more races	
		Total	White	Black or African American	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Some other race		
South Carolina	4,012,012	3,972,062	2,695,560	1,185,216	13,718	36,014	1,628	39,926	39,950	95,076
COUNTY										
Abbeville County	26,167	25,981	17,881	7,926	27	59	7	81	186	217
Aiken County	142,552	140,875	101,745	36,442	566	905	36	1,181	1,677	3,025
Allendale County	11,211	11,154	3,068	7,960	10	14	7	95	57	181
Anderson County	165,740	164,430	135,177	27,491	362	703	27	670	1,310	1,832
Bamberg County	16,658	16,569	6,075	10,411	27	32	1	23	89	118
Barnwell County	23,478	23,308	12,956	9,990	81	91	8	182	170	327
Beaufort County	120,937	119,231	85,451	29,005	321	953	63	3,438	1,706	8,208
Berkeley County	142,651	140,233	96,997	37,985	748	2,671	114	1,718	2,418	3,935
Calhoun County	15,185	15,080	7,597	7,393	29	21	4	36	105	212
Charleston County	309,969	306,365	191,928	106,918	813	3,463	172	3,071	3,604	7,434
Cherokee County	52,537	52,097	40,409	10,801	103	163	11	610	440	1,092
Chester County	34,068	33,879	20,416	13,168	112	96	2	85	189	255
Chesterfield County	42,768	42,446	27,515	14,206	145	128	9	443	322	971
Clarendon County	32,502	32,333	14,602	17,273	78	84	10	286	169	560
Colleton County	38,264	37,952	21,245	16,140	242	97	15	213	312	551
Darlington County	67,394	67,041	38,402	28,104	127	142	6	260	353	658
Dillon County	30,722	30,506	15,481	13,932	679	103	8	303	216	539
Dorchester County	96,413	95,099	68,498	24,176	703	1,086	66	570	1,314	1,722
Edgefield County	24,595	24,426	13,962	10,209	81	59	8	107	169	503
Fairfield County	23,454	23,325	9,282	13,859	36	44	0	104	129	250
Florence County	125,761	124,909	73,760	49,474	282	881	21	491	852	1,383
Georgetown County	55,797	55,525	33,307	21,541	77	130	17	453	272	919
Greenville County	379,616	375,305	294,324	69,455	726	5,242	171	5,387	4,311	14,283

Geographic area	Total population	Race								Hispanic or Latino(of any race)
		One race							Two or more races	
		Total	White	Black or African American	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Some other race		
Greenwood County	66,271	65,782	43,455	21,036	116	470	24	681	489	1,902
Hampton County	21,386	21,293	9,173	11,906	43	36	2	133	93	547
Horry County	196,629	194,524	159,363	30,468	793	1,498	121	2,281	2,105	5,057
Jasper County	20,678	20,539	8,766	10,895	76	92	10	700	139	1,190
Kershaw County	52,647	52,205	37,701	13,840	154	164	18	328	442	886
Lancaster County	61,351	60,913	43,577	16,479	133	164	12	548	438	978
Laurens County	69,567	69,025	49,789	18,245	192	101	36	662	542	1,352
Lee County	20,119	20,020	7,048	12,787	27	39	1	118	99	264
Lexington County	216,014	213,891	181,844	27,274	725	2,259	83	1,706	2,123	4,146
McCormick County	9,958	9,901	4,459	5,365	7	29	3	38	57	86
Marion County	35,466	35,282	14,787	19,984	90	99	2	320	184	634
Marlboro County	28,818	28,545	12,820	14,618	968	70	1	68	273	205
Newberry County	36,108	35,784	23,115	11,958	102	106	33	470	324	1,533
Oconee County	66,215	65,670	59,025	5,550	145	235	13	702	545	1,562
Orangeburg County	91,582	90,945	34,045	55,736	423	396	15	330	637	875
Pickens County	110,757	109,813	99,978	7,559	179	1,312	13	772	944	1,879
Richland County	320,677	316,355	161,276	144,809	782	5,501	263	3,724	4,322	8,713
Saluda County	19,181	19,058	12,622	5,753	44	7	1	631	123	1,401
Spartanburg County	253,791	251,160	190,569	52,775	555	3,738	86	3,437	2,631	7,081
Sumter County	104,646	103,429	52,462	48,850	282	944	58	833	1,217	1,918
Union County	29,881	29,699	20,262	9,278	44	55	11	49	182	199
Williamsburg County	37,217	37,038	12,184	24,660	60	73	0	61	179	273
York County	164,614	163,122	127,162	31,532	1,403	1,459	39	1,527	1,492	3,220

Source: U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2.

	People QuickFacts	South Carolina	USA
	Population, 2001 estimate	4,063,011	284,796,887
	Population percent change, April 1, 2000-July 1, 2001	1.3%	1.2%
	Population, 2000	4,012,012	281,421,906
	Population, percent change, 1990 to 2000	15.1%	13.1%
	Persons under 5 years old, percent, 2000	6.6%	6.8%
	Persons under 18 years old, percent, 2000	25.2%	25.7%
	Persons 65 years old and over, percent, 2000	12.1%	12.4%
	Female persons, percent, 2000	51.4%	50.9%
	White persons, percent, 2000 (a)	67.2%	75.1%
	Black or African American persons, percent, 2000 (a)	29.5%	12.3%
	American Indian and Alaska Native persons, percent, 2000 (a)	0.3%	0.9%
	Asian persons, percent, 2000 (a)	0.9%	3.6%
	Native Hawaiian and Other Pacific Islander, percent, 2000 (a)	Z	0.1%
	Persons reporting some other race, percent, 2000 (a)	1.0%	5.5%
	Persons reporting two or more races, percent, 2000	1.0%	2.4%
	Persons of Hispanic or Latino origin, percent, 2000 (b)	2.4%	12.5%
	White persons, not of Hispanic/Latino origin, percent, 2000	66.1%	69.1%
	Living in same house in 1995 and 2000, pct age 5+, 2000	55.9%	54.1%
	Foreign born persons, percent, 2000	2.9%	11.1%
	Language other than English spoken at home, pct age 5+, 2000	5.2%	17.9%
	High school graduates, percent of persons age 25+, 2000	76.3%	80.4%
	Bachelor's degree or higher, pct of persons age 25+, 2000	20.4%	24.4%
	Persons with a disability, age 5+, 2000	810,857	49,746,248
	Mean travel time to work, workers age 16+ (minutes), 2000	24.3	25.5
	Housing units, 2000	1,753,670	115,904,641
	Homeownership rate, 2000	72.2%	66.2%
	Housing units in multi-unit structures, percent, 2000	15.8%	26.4%
	Median value of owner-occupied housing units, 2000	$94,900	$119,600
	Households, 2000	1,533,854	105,480,101
	Persons per household, 2000	2.53	2.59
	Median household money income, 1999	$37,082	$41,994
	Per capita money income, 1999	$18,795	$21,587
	Persons below poverty, percent, 1999	14.1%	12.4%

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, 2000 Census of Population and Housing, 1990 Census of Population and Housing, Small Area Income and Poverty

Table 5. South Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
TOTAL POPULATION					
BOTH SEXES					
Total	4,107,183	4,062,125	4,023,725	4,012,010	4,012,012
White alone	2,787,151	2,764,620	2,746,793	2,738,803	2,738,803
Black or African American alone	1,228,173	1,209,537	1,193,376	1,190,106	1,190,108
American Indian and Alaska Native alone	15,069	14,813	14,506	14,391	14,391
Asian alone	42,795	40,374	37,632	37,180	37,180
Native Hawaiian and Other Pacific Islander alone	2,171	2,054	1,932	1,851	1,851
Two or more races	31,824	30,727	29,486	29,679	29,679
Race alone or in combination with one or more races:					
White	2,813,808	2,790,326	2,771,413	2,763,547	2,763,547
Black or African American	1,243,522	1,224,149	1,207,200	1,204,149	1,204,151
American Indian and Alaska Native	28,327	27,997	27,582	27,623	27,623
Asian	51,598	48,795	45,605	45,156	45,156
Native Hawaiian and Other Pacific Islander	4,165	3,983	3,774	3,852	3,852
MALE					
Total	1,995,285	1,973,957	1,954,154	1,948,928	1,948,929
White alone	1,375,276	1,364,353	1,355,180	1,351,238	1,351,238
Black or African American alone	575,311	566,756	558,407	557,359	557,360
American Indian and Alaska Native alone	7,710	7,570	7,422	7,359	7,359
Asian alone	20,284	19,169	17,739	17,566	17,566
Native Hawaiian and Other Pacific Islander alone	1,187	1,131	1,062	1,014	1,014
Two or more races	15,517	14,978	14,344	14,392	14,392
Race alone or in combination with one or more races:					
White	1,388,382	1,376,986	1,367,254	1,363,339	1,363,339
Black or African American	582,558	573,644	564,889	563,924	563,925
American Indian and Alaska Native	14,196	14,012	13,818	13,841	13,841
Asian	24,634	23,348	21,677	21,483	21,483
Native Hawaiian and Other Pacific Islander	2,166	2,078	1,971	2,007	2,007

Table 5. South Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
FEMALE					
Total	2,111,898	2,088,168	2,069,571	2,063,082	2,063,083
White alone	1,411,875	1,400,267	1,391,613	1,387,565	1,387,565
Black or African American alone	652,862	642,781	634,969	632,747	632,748
American Indian and Alaska Native alone	7,359	7,243	7,084	7,032	7,032
Asian alone	22,511	21,205	19,893	19,614	19,614
Native Hawaiian and Other Pacific Islander alone	984	923	870	837	837
Two or more races	16,307	15,749	15,142	15,287	15,287
Race alone or in combination with one or more races:					
White	1,425,426	1,413,340	1,404,159	1,400,208	1,400,208
Black or African American	660,964	650,505	642,311	640,225	640,226
American Indian and Alaska Native	14,131	13,985	13,764	13,782	13,782
Asian	26,964	25,447	23,928	23,673	23,673
Native Hawaiian and Other Pacific Islander	1,999	1,905	1,803	1,845	1,845
NOT HISPANIC OR LATINO ORIGIN					
BOTH SEXES					
Total	3,997,898	3,959,772	3,927,547	3,916,934	3,916,936
White alone	2,692,144	2,676,381	2,664,661	2,657,800	2,657,800
Black or African American alone	1,218,878	1,200,052	1,183,597	1,180,413	1,180,415
American Indian and Alaska Native alone	13,407	13,252	13,029	12,950	12,950
Asian alone	41,779	39,437	36,780	36,376	36,376
Native Hawaiian and Other Pacific Islander alone	1,538	1,469	1,391	1,331	1,331
Two or more races	30,152	29,181	28,089	28,064	28,064
Race alone or in combination with one or more races:					
White	2,717,491	2,700,872	2,688,180	2,681,351	2,681,351
Black or African American	1,233,384	1,213,872	1,196,677	1,193,600	1,193,602
American Indian and Alaska Native	26,060	25,850	25,560	25,516	25,516
Asian	50,068	47,412	44,381	43,810	43,810
Native Hawaiian and Other Pacific Islander	3,333	3,218	3,085	3,060	3,060

Table 5. South Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
MALE					
Total	1,931,630	1,913,771	1,896,615	1,892,191	1,892,192
White alone	1,319,093	1,311,553	1,305,045	1,301,900	1,301,900
Black or African American alone	570,601	561,962	553,449	552,453	552,454
American Indian and Alaska Native alone	6,690	6,598	6,484	6,444	6,444
Asian alone	19,722	18,652	17,263	17,115	17,115
Native Hawaiian and Other Pacific Islander alone	823	791	742	710	710
Two or more races	14,701	14,215	13,632	13,569	13,569
Race alone or in combination with one or more races:					
White	1,331,552	1,323,579	1,316,554	1,313,383	1,313,383
Black or African American	577,444	568,465	559,562	558,586	558,587
American Indian and Alaska Native	12,878	12,749	12,599	12,589	12,589
Asian	23,823	22,610	21,010	20,760	20,760
Native Hawaiian and Other Pacific Islander	1,720	1,664	1,585	1,571	1,571
FEMALE					
Total	2,066,268	2,046,001	2,030,932	2,024,743	2,024,744
White alone	1,373,051	1,364,828	1,359,616	1,355,900	1,355,900
Black or African American alone	648,277	638,090	630,148	627,960	627,961
American Indian and Alaska Native alone	6,717	6,654	6,545	6,506	6,506
Asian alone	22,057	20,785	19,517	19,261	19,261
Native Hawaiian and Other Pacific Islander alone	715	678	649	621	621
Two or more races	15,451	14,966	14,457	14,495	14,495
Race alone or in combination with one or more races:					
White	1,385,939	1,377,293	1,371,626	1,367,968	1,367,968
Black or African American	655,940	645,407	637,115	635,014	635,015
American Indian and Alaska Native	13,182	13,101	12,961	12,927	12,927
Asian	26,245	24,802	23,371	23,050	23,050
Native Hawaiian and Other Pacific Islander	1,613	1,554	1,500	1,489	1,489

Table 5. South Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
HISPANIC OR LATINO ORIGIN					
BOTH SEXES					
Total	109,285	102,353	96,178	95,076	95,076
White alone	95,007	88,239	82,132	81,003	81,003
Black or African American alone	9,295	9,485	9,779	9,693	9,693
American Indian and Alaska Native alone	1,662	1,561	1,477	1,441	1,441
Asian alone	1,016	937	852	804	804
Native Hawaiian and Other Pacific Islander alone	633	585	541	520	520
Two or more races	1,672	1,546	1,397	1,615	1,615
Race alone or in combination with one or more races:					
White	96,317	89,454	83,233	82,196	82,196
Black or African American	10,138	10,277	10,523	10,549	10,549
American Indian and Alaska Native	2,267	2,147	2,022	2,107	2,107
Asian	1,530	1,383	1,224	1,346	1,346
Native Hawaiian and Other Pacific Islander	832	765	689	792	792
MALE					
Total	63,655	60,186	57,539	56,737	56,737
White alone	56,183	52,800	50,135	49,338	49,338
Black or African American alone	4,710	4,794	4,958	4,906	4,906
American Indian and Alaska Native alone	1,020	972	938	915	915
Asian alone	562	517	476	451	451
Native Hawaiian and Other Pacific Islander alone	364	340	320	304	304
Two or more races	816	763	712	823	823
Race alone or in combination with one or more races:					
White	56,830	53,407	50,700	49,956	49,956
Black or African American	5,114	5,179	5,327	5,338	5,338
American Indian and Alaska Native	1,318	1,263	1,219	1,252	1,252
Asian	811	738	667	723	723
Native Hawaiian and Other Pacific Islander	446	414	386	436	436

Table 5. South Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
FEMALE					
Total	45,630	42,167	38,639	38,339	38,339
White alone	38,824	35,439	31,997	31,665	31,665
Black or African American alone	4,585	4,691	4,821	4,787	4,787
American Indian and Alaska Native alone	642	589	539	526	526
Asian alone	454	420	376	353	353
Native Hawaiian and Other Pacific Islander alone	269	245	221	216	216
Two or more races	856	783	685	792	792
Race alone or in combination with one or more races:					
White	39,487	36,047	32,533	32,240	32,240
Black or African American	5,024	5,098	5,196	5,211	5,211
American Indian and Alaska Native	949	884	803	855	855
Asian	719	645	557	623	623
Native Hawaiian and Other Pacific Islander	386	351	303	356	356

NOTE: 'In combination' means in combination with one or more other races. The sum of the five race groups adds to more than the total population because individuals may report more than one race. The April 1, 2000 Population Estimates Base reflects modifications to the Census 2000 population as documented in the Count Question Resolution program, updates from the Boundary and Annexation Survey, and geographic program revisions. Dash (-) represents zero or rounds to zero. Data may not sum to National Estimates, released separately, due to controlled rounding.

Suggested Citation:
Table ST-EST2002-ASRO-05-45 - State Characteristic Estimates
Source: Population Division, U.S. Census Bureau
Release Date: September 18, 2003

Table 5. Georgia Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
TOTAL POPULATION					
BOTH SEXES					
Total	8,560,310	8,405,677	8,234,373	8,186,486	8,186,453
White alone	5,782,168	5,678,906	5,560,959	5,535,194	5,535,176
Black or African American alone	2,462,419	2,426,399	2,388,032	2,370,711	2,370,696
American Indian and Alaska Native alone	25,991	25,179	24,286	24,008	24,008
Asian alone	201,226	190,700	180,476	178,403	178,403
Native Hawaiian and Other Pacific Islander alone	6,117	5,829	5,548	5,301	5,301
Two or more races	82,389	78,664	75,072	72,869	72,869
Race alone or in combination with one or more races:					
White	5,850,082	5,743,560	5,622,457	5,594,697	5,594,679
Black or African American	2,502,870	2,464,482	2,423,909	2,405,439	2,405,424
American Indian and Alaska Native	57,286	55,997	54,566	54,294	54,294
Asian	227,281	215,474	204,072	201,033	201,033
Native Hawaiian and Other Pacific Islander	11,439	10,981	10,545	10,200	10,200
MALE					
Total	4,217,976	4,139,417	4,051,685	4,027,129	4,027,113
White alone	2,896,072	2,843,612	2,782,618	2,768,953	2,768,944
Black or African American alone	1,165,566	1,146,794	1,127,257	1,118,667	1,118,660
American Indian and Alaska Native alone	14,194	13,728	13,219	13,058	13,058
Asian alone	98,193	93,384	88,655	87,684	87,684
Native Hawaiian and Other Pacific Islander alone	3,391	3,244	3,093	2,962	2,962
Two or more races	40,560	38,655	36,843	35,805	35,805
Race alone or in combination with one or more races:					
White	2,929,895	2,875,768	2,813,176	2,798,559	2,798,550
Black or African American	1,184,960	1,164,964	1,144,309	1,135,140	1,135,133
American Indian and Alaska Native	29,450	28,726	27,934	27,806	27,806
Asian	111,099	105,668	100,359	98,957	98,957
Native Hawaiian and Other Pacific Islander	6,031	5,798	5,567	5,401	5,401

Table 5. Georgia Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
FEMALE					
Total	4,342,334	4,266,260	4,182,688	4,159,357	4,159,340
White alone	2,886,096	2,835,294	2,778,341	2,766,241	2,766,232
Black or African American alone	1,296,853	1,279,605	1,260,775	1,252,044	1,252,036
American Indian and Alaska Native alone	11,797	11,451	11,067	10,950	10,950
Asian alone	103,033	97,316	91,821	90,719	90,719
Native Hawaiian and Other Pacific Islander alone	2,726	2,585	2,455	2,339	2,339
Two or more races	41,829	40,009	38,229	37,064	37,064
Race alone or in combination with one or more races:					
White	2,920,187	2,867,792	2,809,281	2,796,138	2,796,129
Black or African American	1,317,910	1,299,518	1,279,600	1,270,299	1,270,291
American Indian and Alaska Native	27,836	27,271	26,632	26,488	26,488
Asian	116,182	109,806	103,713	102,076	102,076
Native Hawaiian and Other Pacific Islander	5,408	5,183	4,978	4,799	4,799
NOT HISPANIC OR LATINO ORIGIN					
BOTH SEXES					
Total	8,043,780	7,927,846	7,792,238	7,751,259	7,751,226
White alone	5,313,876	5,247,711	5,164,224	5,144,815	5,144,797
Black or African American alone	2,432,780	2,397,067	2,358,775	2,341,860	2,341,845
American Indian and Alaska Native alone	19,179	18,777	18,258	18,090	18,090
Asian alone	197,836	187,562	177,576	175,572	175,572
Native Hawaiian and Other Pacific Islander alone	3,903	3,763	3,622	3,449	3,449
Two or more races	76,206	72,966	69,783	67,473	67,473
Race alone or in combination with one or more races:					
White	5,376,667	5,307,660	5,221,377	5,199,932	5,199,914
Black or African American	2,469,729	2,431,889	2,391,590	2,373,472	2,373,457
American Indian and Alaska Native	48,256	47,513	46,552	46,233	46,233
Asian	222,265	210,884	199,858	196,779	196,779
Native Hawaiian and Other Pacific Islander	8,721	8,443	8,177	7,803	7,803

Table 5. Georgia Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
MALE					
Total	3,918,096	3,859,080	3,789,291	3,768,845	3,768,829
White alone	2,621,870	2,588,140	2,544,440	2,534,602	2,534,593
Black or African American alone	1,150,409	1,131,803	1,112,335	1,103,971	1,103,964
American Indian and Alaska Native alone	9,960	9,724	9,430	9,343	9,343
Asian alone	96,367	91,674	87,057	86,127	86,127
Native Hawaiian and Other Pacific Islander alone	2,038	1,968	1,897	1,817	1,817
Two or more races	37,452	35,771	34,132	32,985	32,985
Race alone or in combination with one or more races:					
White	2,653,110	2,617,907	2,572,760	2,561,905	2,561,896
Black or African American	1,168,037	1,148,323	1,127,822	1,118,834	1,118,827
American Indian and Alaska Native	24,128	23,699	23,162	23,002	23,002
Asian	108,484	103,237	98,099	96,666	96,666
Native Hawaiian and Other Pacific Islander	4,410	4,267	4,133	3,965	3,965
FEMALE					
Total	4,125,684	4,068,766	4,002,947	3,982,414	3,982,397
White alone	2,692,006	2,659,571	2,619,784	2,610,213	2,610,204
Black or African American alone	1,282,371	1,265,264	1,246,440	1,237,889	1,237,881
American Indian and Alaska Native alone	9,219	9,053	8,828	8,747	8,747
Asian alone	101,469	95,888	90,519	89,445	89,445
Native Hawaiian and Other Pacific Islander alone	1,865	1,795	1,725	1,632	1,632
Two or more races	38,754	37,195	35,651	34,488	34,488
Race alone or in combination with one or more races:					
White	2,723,557	2,689,753	2,648,617	2,638,027	2,638,018
Black or African American	1,301,692	1,283,566	1,263,768	1,254,638	1,254,630
American Indian and Alaska Native	24,128	23,814	23,390	23,231	23,231
Asian	113,781	107,647	101,759	100,113	100,113
Native Hawaiian and Other Pacific Islander	4,311	4,176	4,044	3,838	3,838

Table 5. Georgia Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
HISPANIC OR LATINO ORIGIN					
BOTH SEXES					
Total	516,530	477,831	442,135	435,227	435,227
White alone	468,292	431,195	396,735	390,379	390,379
Black or African American alone	29,639	29,332	29,257	28,851	28,851
American Indian and Alaska Native alone	6,812	6,402	6,028	5,918	5,918
Asian alone	3,390	3,138	2,900	2,831	2,831
Native Hawaiian and Other Pacific Islander alone	2,214	2,066	1,926	1,852	1,852
Two or more races	6,183	5,698	5,289	5,396	5,396
Race alone or in combination with one or more races:					
White	473,415	435,900	401,080	394,765	394,765
Black or African American	33,141	32,593	32,319	31,967	31,967
American Indian and Alaska Native	9,030	8,484	8,014	8,061	8,061
Asian	5,016	4,590	4,214	4,254	4,254
Native Hawaiian and Other Pacific Islander	2,718	2,538	2,368	2,397	2,397
MALE					
Total	299,880	280,337	262,394	258,284	258,284
White alone	274,202	255,472	238,178	234,351	234,351
Black or African American alone	15,157	14,991	14,922	14,696	14,696
American Indian and Alaska Native alone	4,234	4,004	3,789	3,715	3,715
Asian alone	1,826	1,710	1,598	1,557	1,557
Native Hawaiian and Other Pacific Islander alone	1,353	1,276	1,196	1,145	1,145
Two or more races	3,108	2,884	2,711	2,820	2,820
Race alone or in combination with one or more races:					
White	276,785	257,861	240,416	236,654	236,654
Black or African American	16,923	16,641	16,487	16,306	16,306
American Indian and Alaska Native	5,322	5,027	4,772	4,804	4,804
Asian	2,615	2,431	2,260	2,291	2,291
Native Hawaiian and Other Pacific Islander	1,621	1,531	1,434	1,436	1,436

Table 5. Georgia Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
FEMALE					
Total	216,650	197,494	179,741	176,943	176,943
White alone	194,090	175,723	158,557	156,028	156,028
Black or African American alone	14,482	14,341	14,335	14,155	14,155
American Indian and Alaska Native alone	2,578	2,398	2,239	2,203	2,203
Asian alone	1,564	1,428	1,302	1,274	1,274
Native Hawaiian and Other Pacific Islander alone	861	790	730	707	707
Two or more races	3,075	2,814	2,578	2,576	2,576
Race alone or in combination with one or more races:					
White	196,630	178,039	160,664	158,111	158,111
Black or African American	16,218	15,952	15,832	15,661	15,661
American Indian and Alaska Native	3,708	3,457	3,242	3,257	3,257
Asian	2,401	2,159	1,954	1,963	1,963
Native Hawaiian and Other Pacific Islander	1,097	1,007	934	961	961

NOTE: 'In combination' means in combination with one or more other races. The sum of the five race groups adds to more than the total population because individuals may report more than one race. The April 1, 2000 Population Estimates Base reflects modifications to the Census 2000 population as documented in the Count Question Resolution program, updates from the Boundary and Annexation Survey, and geographic program revisions. Dash (-) represents zero or rounds to zero. Data may not sum to National Estimates, released separately, due to controlled rounding.

Suggested Citation:
Table ST-EST2002-ASRO-05-13 - State Characteristic Estimates
Source: Population Division, U.S. Census Bureau
Release Date: September 18, 2003

Table 5. North Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
TOTAL POPULATION					
BOTH SEXES					
Total	8,320,146	8,206,105	8,082,261	8,049,474	8,049,313
White alone	6,178,210	6,102,863	6,018,702	6,000,978	6,000,805
Black or African American alone	1,817,634	1,792,254	1,765,084	1,753,176	1,753,188
American Indian and Alaska Native alone	106,454	104,840	103,125	102,355	102,355
Asian alone	135,006	126,757	119,115	118,215	118,215
Native Hawaiian and Other Pacific Islander alone	5,485	5,258	5,037	4,785	4,785
Two or more races	77,357	74,133	71,198	69,965	69,965
Race alone or in combination with one or more races:					
White	6,243,031	6,164,807	6,077,989	6,059,191	6,059,018
Black or African American	1,855,278	1,827,794	1,798,706	1,786,621	1,786,633
American Indian and Alaska Native	137,639	135,757	133,815	133,062	133,062
Asian	157,015	147,682	139,055	137,156	137,156
Native Hawaiian and Other Pacific Islander	10,007	9,614	9,264	8,933	8,933
MALE					
Total	4,081,520	4,021,896	3,960,106	3,942,783	3,942,695
White alone	3,065,347	3,025,178	2,982,721	2,973,101	2,973,010
Black or African American alone	856,657	843,797	830,701	824,594	824,597
American Indian and Alaska Native alone	52,858	52,064	51,162	50,748	50,748
Asian alone	65,554	61,524	57,807	57,410	57,410
Native Hawaiian and Other Pacific Islander alone	3,004	2,875	2,755	2,625	2,625
Two or more races	38,100	36,458	34,960	34,305	34,305
Race alone or in combination with one or more races:					
White	3,097,544	3,055,900	3,012,094	3,001,905	3,001,814
Black or African American	874,947	861,012	846,938	840,670	840,673
American Indian and Alaska Native	67,811	66,903	65,891	65,499	65,499
Asian	76,587	71,999	67,768	66,894	66,894
Native Hawaiian and Other Pacific Islander	5,260	5,052	4,866	4,703	4,703

Table 5. North Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
FEMALE					
Total	4,238,626	4,184,209	4,122,155	4,106,691	4,106,618
White alone	3,112,863	3,077,685	3,035,981	3,027,877	3,027,795
Black or African American alone	960,977	948,457	934,383	928,582	928,591
American Indian and Alaska Native alone	53,596	52,776	51,963	51,607	51,607
Asian alone	69,452	65,233	61,308	60,805	60,805
Native Hawaiian and Other Pacific Islander alone	2,481	2,383	2,282	2,160	2,160
Two or more races	39,257	37,675	36,238	35,660	35,660
Race alone or in combination with one or more races:					
White	3,145,487	3,108,907	3,065,895	3,057,286	3,057,204
Black or African American	980,331	966,782	951,768	945,951	945,960
American Indian and Alaska Native	69,828	68,854	67,924	67,563	67,563
Asian	80,428	75,683	71,287	70,262	70,262
Native Hawaiian and Other Pacific Islander	4,747	4,562	4,398	4,230	4,230
NOT HISPANIC OR LATINO ORIGIN					
BOTH SEXES					
Total	7,875,683	7,792,681	7,697,953	7,670,509	7,670,350
White alone	5,774,440	5,729,412	5,673,905	5,661,114	5,660,943
Black or African American alone	1,793,697	1,768,338	1,741,026	1,729,387	1,729,399
American Indian and Alaska Native alone	99,730	98,353	96,849	96,162	96,162
Asian alone	132,349	124,183	116,610	115,766	115,766
Native Hawaiian and Other Pacific Islander alone	3,823	3,648	3,482	3,272	3,272
Two or more races	71,644	68,747	66,081	64,808	64,808
Race alone or in combination with one or more races:					
White	5,834,313	5,786,714	5,728,815	5,714,971	5,714,800
Black or African American	1,828,008	1,800,729	1,771,658	1,759,834	1,759,846
American Indian and Alaska Native	128,886	127,327	125,644	124,872	124,872
Asian	153,086	143,904	135,403	133,466	133,466
Native Hawaiian and Other Pacific Islander	7,873	7,561	7,287	6,908	6,908

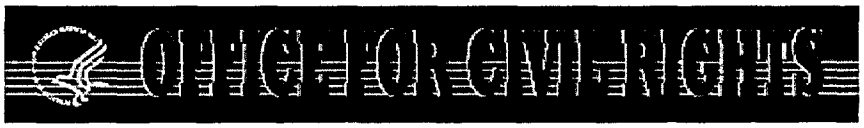
Table 5. North Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
MALE					
Total	3,822,409	3,778,077	3,730,322	3,716,158	3,716,073
White alone	2,828,655	2,803,488	2,774,910	2,768,239	2,768,151
Black or African American alone	843,782	830,880	817,653	811,709	811,712
American Indian and Alaska Native alone	48,746	48,072	47,278	46,920	46,920
Asian alone	64,084	60,096	56,414	56,049	56,049
Native Hawaiian and Other Pacific Islander alone	2,015	1,916	1,829	1,727	1,727
Two or more races	35,127	33,625	32,238	31,514	31,514
Race alone or in combination with one or more races:					
White	2,858,254	2,831,748	2,801,929	2,794,648	2,794,560
Black or African American	860,298	846,404	832,267	826,136	826,139
American Indian and Alaska Native	62,679	61,918	61,028	60,626	60,626
Asian	74,505	69,990	65,817	64,906	64,906
Native Hawaiian and Other Pacific Islander	4,030	3,861	3,716	3,537	3,537
FEMALE					
Total	4,053,274	4,014,604	3,967,631	3,954,351	3,954,277
White alone	2,945,785	2,925,924	2,898,995	2,892,875	2,892,792
Black or African American alone	949,915	937,458	923,373	917,678	917,687
American Indian and Alaska Native alone	50,984	50,281	49,571	49,242	49,242
Asian alone	68,265	64,087	60,196	59,717	59,717
Native Hawaiian and Other Pacific Islander alone	1,808	1,732	1,653	1,545	1,545
Two or more races	36,517	35,122	33,843	33,294	33,294
Race alone or in combination with one or more races:					
White	2,976,059	2,954,966	2,926,886	2,920,323	2,920,240
Black or African American	967,710	954,325	939,391	933,698	933,707
American Indian and Alaska Native	66,207	65,409	64,616	64,246	64,246
Asian	78,581	73,914	69,586	68,560	68,560
Native Hawaiian and Other Pacific Islander	3,843	3,700	3,571	3,371	3,371

Table 5. North Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
HISPANIC OR LATINO ORIGIN					
BOTH SEXES					
Total	444,463	413,424	384,308	378,965	378,963
White alone	403,770	373,451	344,797	339,864	339,862
Black or African American alone	23,937	23,916	24,058	23,789	23,789
American Indian and Alaska Native alone	6,724	6,487	6,276	6,193	6,193
Asian alone	2,657	2,574	2,505	2,449	2,449
Native Hawaiian and Other Pacific Islander alone	1,662	1,610	1,555	1,513	1,513
Two or more races	5,713	5,386	5,117	5,157	5,157
Race alone or in combination with one or more races:					
White	408,718	378,093	349,174	344,220	344,218
Black or African American	27,270	27,065	27,048	26,787	26,787
American Indian and Alaska Native	8,753	8,430	8,171	8,190	8,190
Asian	3,929	3,778	3,652	3,690	3,690
Native Hawaiian and Other Pacific Islander	2,134	2,053	1,977	2,025	2,025
MALE					
Total	259,111	243,819	229,784	226,625	226,622
White alone	236,692	221,690	207,811	204,862	204,859
Black or African American alone	12,875	12,917	13,048	12,885	12,885
American Indian and Alaska Native alone	4,112	3,992	3,884	3,828	3,828
Asian alone	1,470	1,428	1,393	1,361	1,361
Native Hawaiian and Other Pacific Islander alone	989	959	926	898	898
Two or more races	2,973	2,833	2,722	2,791	2,791
Race alone or in combination with one or more races:					
White	239,290	224,152	210,165	207,257	207,254
Black or African American	14,649	14,608	14,671	14,534	14,534
American Indian and Alaska Native	5,132	4,985	4,863	4,873	4,873
Asian	2,082	2,009	1,951	1,988	1,988
Native Hawaiian and Other Pacific Islander	1,230	1,191	1,150	1,166	1,166

Table 5. North Carolina Population Estimates by Sex, Race and Hispanic or Latino Origin: April 1, 2000 to July 1, 2002					
Sex, Race and Hispanic or Latino Origin	**July 1, 2002 Population**	**July 1, 2001 Population**	**July 1, 2000 Population**	**April 1, 2000 Population Estimates Base**	**Ccnsus 2000 Population**
FEMALE					
Total	185,352	169,605	154,524	152,340	152,341
White alone	167,078	151,761	136,986	135,002	135,003
Black or African American alone	11,062	10,999	11,010	10,904	10,904
American Indian and Alaska Native alone	2,612	2,495	2,392	2,365	2,365
Asian alone	1,187	1,146	1,112	1,088	1,088
Native Hawaiian and Other Pacific Islander alone	673	651	629	615	615
Two or more races	2,740	2,553	2,395	2,366	2,366
Race alone or in combination with one or more races:					
White	169,428	153,941	139,009	136,963	136,964
Black or African American	12,621	12,457	12,377	12,253	12,253
American Indian and Alaska Native	3,621	3,445	3,308	3,317	3,317
Asian	1,847	1,769	1,701	1,702	1,702
Native Hawaiian and Other Pacific Islander	904	862	827	859	859

NOTE: 'In combination' means in combination with one or more other races. The sum of the five race groups adds to more than the total population because individuals may report more than one race. The April 1, 2000 Population Estimates Base reflects modifications to the Census 2000 population as documented in the Count Question Resolution program, updates from the Boundary and Annexation Survey, and geographic program revisions. Dash (-) represents zero or rounds to zero. Data may not sum to National Estimates, released separately, due to controlled rounding.

Suggested Citation:
Table ST-EST2002-ASRO-05-37 - State Characteristic Estimates
Source: Population Division, U.S. Census Bureau
Release Date: September 18, 2003



HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS

FOR IMMEDIATE RELEASE
Wednesday, Aug. 30, 2000

Contact: Kathleen O=Brien (OCR)
(202) 619-0403

HHS Provides Written Guidance for Health and Human Services Providers To Ensure Language Assistance for Persons with Limited English Skills

The U.S. Department of Health and Human Services today issued written policy guidance to assist health and social services providers in ensuring that persons with limited English skills can effectively access critical health and social services.

The guidance, published in the *Federal Register* by the HHS Office for Civil Rights (OCR), lays out and explains more fully OCR's existing policies. It outlines the legal responsibilities of providers who receive Federal financial assistance from HHS - such as hospitals, HMOs and human service agencies - to assist people with limited English skills. It also provides a flexible road map to the range of options available to providers in meeting the language needs of the nation's increasingly diverse populations.

Publication of the guidance makes HHS the first federal agency to publish guidance since the issuance of Executive Order 13166 on serving persons with limited English skills, signed by President Clinton on August 11, 2000. The executive order requires each federal agency to have written policies on providing effective service to those with limited English proficiency who are served by federally-funded programs.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin by any entity that receives federal financial assistance. Under Title VI of the law, hospitals, HMOs, social service agencies and other entities that receive Federal financial assistance from HHS are required to take the steps necessary to ensure that individuals with limited English proficiency (LEP) can meaningfully access the programs and services. The requirements apply to state-administered as well as private and non-profit facilities and programs that benefit from HHS assistance. OCR is responsible for compliance with the law as it applies to HHS assisted programs.

In a letter to governors announcing publication of the written guidance, HHS Secretary Donna E. Shalala said, "This guidance enhances our ability to reach our national goal of eliminating racial and ethnic disparities in health, and will assist in increasing opportunities for persons with limited English proficiency to improve their socioeconomic status."

Some of the state-administered programs where access for persons with limited English proficiency may be especially important include the State Children=s Health Insurance Program (SCHIP), Medicaid and Temporary Assistance to Needy Families (TANF).

AEffective communication is the key to meaningful access, whether it is a hospital, a clinic or a benefits program," said OCR Director Thomas Perez. "Failure to communicate effectively can have serious consequences for millions of Americans."

The guidance emphasizes that providers have flexibility in designing effective programs. The types of language assistance a provider must have in place to ensure meaningful access depend on a variety of factors, including the size of the facility or covered entity, the size of the eligible LEP population it serves, the nature of the program or service, the objective of the program, the resources available to the facility or covered entity, and the frequency with which LEP persons come into contact with the program. Small practitioners and providers have considerable flexibility in determining how to fulfill their obligations to ensure meaningful access for persons with limited English proficiency.

"OCR has a history of working cooperatively with health and social services providers to help them comply with the law and serve their limited English populations effectively without causing undue burden," said Perez. "We have found widespread willingness to improve language assistance services, especially when providers learn that solutions can be tailored to fit individual situations, and services can be provided cost-effectively."

"With our requirements and flexible policies now in writing, we expect to make even greater progress in cooperation with health and social service providers in making services truly accessible to those with limited English skills. OCR will continue to be available to provide technical assistance to any covered entity seeking to ensure the operation of an effective language assistance program," Perez said.

Depending on the need and the circumstances of the individual facility, options for providing oral language assistance range from hiring bilingual staff or hiring on-staff interpreters to contracting for interpreter services as needed, engaging community volunteers, or contracting with a telephone interpreter service.

Examples of problem practices that have been found by OCR include: providing services to LEP persons which are more limited in scope or lower in quality than those provided to other persons; subjecting LEP persons to unreasonable delays; limiting participation in a program or activity on the basis of English proficiency; providing services to LEP persons that are not as effective as those provided to persons proficient in English; and failing to inform LEP persons of the right to receive free interpreter services or requiring them to provide their own interpreter.

As outlined in the guidance, satisfactory service to LEP clients should include:

- having polices and procedures in place for identifying and assessing the language needs of the individual provider and its client population;

- a range of oral language assistance options, appropriate to each facility's circumstances;

- notice to LEP persons of the right to free language assistance;

- staff training and program monitoring; and

- a plan for providing written materials in languages other than English where a significant number or percentage of the affected population needs services or information in a language other than English to communicate effectively.

"The purpose of putting these policies into writing is to help make the requirements of the law both clear and widely-known, among providers and potential LEP clients as well," Perez said. "We believe that by making these policies known, and making clear the flexibility we provide on a facility-by-facility basis, providers will be more likely to review and improve their language assistance services, and individuals with limited English skills will be better able to access the services they need."

The written guidance, "Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency," is available in the *Federal Register*, through OCR's 10 Regional Offices, or on the Internet at http://www.hhs.gov/ocr

###

OCR Home Page HHS Home Page

HHS Home | Topics | What's New | For Kids | FAQs
Disclaimers | Privacy Notice | FOIA | Site Info | Contact Us

OCR Mail
Date revised: August 29, 2000

Policy Guidance

Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency

A. ***BACKGROUND***

English is the predominant language of the United States. According to the 1990 Census, English is spoken by 95% of its residents. Of those U.S. residents who speak languages other than English at home, the 1990 Census reports that 57% above the age of four speak English "well to very well."

The United States is also, however, home to millions of national origin minority individuals who are "limited English proficient" (LEP). That is, they cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. Because of these language differences and their inability to speak or understand English, LEP persons are often excluded from programs, experience delays or denials of services, or receive care and services based on inaccurate or incomplete information.

In the course of its enforcement activities, OCR has found that persons who lack proficiency in English frequently are unable to obtain basic knowledge of how to access various benefits and services for which they are eligible, such as the State Children's Health Insurance Program (SCHIP), Medicare, Medicaid or Temporary Assistance to Needy Families (TANF) benefits, clinical research programs, or basic health care and social services. For example, many intake interviewers and other front line employees who interact with LEP individuals are neither bilingual nor trained in how to properly serve an LEP person. As a result, the LEP applicant all too often is either turned away, forced to wait for substantial periods of time, forced to find his/her own interpreter who often is not qualified to interpret, or forced to make repeated visits to the provider's office until an interpreter is available to assist in conducting the interview.

The lack of language assistance capability among provider agency employees has especially adverse consequences in the area of professional staff services, such as health services. Doctors, nurses, social workers, psychologists, and other professionals provide vitally important services whose very nature requires the establishment of a close relationship with the client or patient that is based on empathy, confidence and mutual trust. Such intimate personal relationships depend heavily on the free flow of communication between professional and client. This essential exchange of information is difficult when the two parties involved speak different languages; it may be impeded further by the presence of an unqualified third person who attempts to serve as an

interpreter.

Some health and social service providers have sought to bridge the language gap by encouraging language minority clients to provide their own interpreters as an alternative to the agency's use of qualified bilingual employees or interpreters. Persons of limited English proficiency must sometimes rely on their minor children to interpret for them during visits to a health or social service facility. Alternatively, these clients may be required to call upon neighbors or even strangers they encounter at the provider's office to act as interpreters or translators.

These practices have severe drawbacks and may violate Title VI of the Civil Rights Act of 1964. In each case, the impediments to effective communication and adequate service are formidable. The client's untrained "interpreter" is often unable to understand the concepts or official terminology he or she is being asked to interpret or translate. Even if the interpreter possesses the necessary language and comprehension skills, his or her mere presence may obstruct the flow of confidential information to the provider. This is because the client would naturally be reluctant to disclose or discuss intimate details of personal and family life in front of the client's child or a complete stranger who has no formal training or obligation to observe confidentiality.

When these types of circumstances are encountered, the level and quality of health and social services available to persons of limited English proficiency stand in stark conflict to Title VI's promise of equal access to federally assisted programs and activities.Services denied, delayed or provided under adverse circumstances have serious and sometimes life threatening consequences for an LEP person and generally will constitute discrimination on the basis of national origin, in violation of Title VI. Accommodation of these language differences through the provision of effective language assistance will promote compliance with Title VI. Moreover, by ensuring accurate client histories, better understanding of exit and discharge instructions, and better assurances of informed consent, providers will better protect themselves against tort liability, malpractice lawsuits, and charges of negligence.

Although OCR's enforcement authority derives from Title VI, the duty of health and human service providers to ensure that LEP persons can meaningfully access programs and services flows from a host of additional sources, including federal and state laws and regulations, managed care contracts, and health care accreditation organizations.[1] In addition, the duty to provide appropriate language assistance to LEP individuals is not limited to the health and human service context. Numerous federal laws require the provision of language assistance to LEP individuals seeking to access critical services and activities. For instance, the Voting Rights Act bans English-only elections in certain circumstances and outlines specific measures that must be taken to ensure that language minorities can participate in elections. *See* 42 U.S.C. Section 1973 b(f)(1). Similarly, the Food Stamp Act of 1977 requires states to provide written and oral language assistance to LEP persons under certain circumstances. 42 U.S.C. Section 2020(e)(1) and (2). These and other provisions reflect the sound judgment that providers of critical services and benefits bear the responsibility for ensuring that LEP individuals can meaningfully access their programs and services.

OCR issued internal guidance to its staff in January 1998 on a recipient's obligation to

provide language assistance to LEP persons. That guidance was intended to ensure consistency in OCR's investigation of LEP cases. This current guidance clarifies for recipient/covered entities and the public, the legal requirements under Title VI that OCR has been enforcing for the past 30 years.

This policy guidance is consistent with a Department of Justice (DOJ) directive noting that recipient/covered entities have an obligation pursuant to Title VI's prohibition against national origin discrimination to provide oral and written language assistance to LEP persons.(2) It is also consistent with a government-wide Title VI regulation issued by DOJ in 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs,"

28 C.F.R. Part 42, Subpart F, that addresses the circumstances in which recipient/covered entities must provide written language assistance to LEP persons.(3)

B. *LEGAL AUTHORITY*

1. *Introduction*

Over the last 30 years, OCR has conducted thousands of investigations and reviews involving language differences that impede the access of LEP persons to medical care and social services. Where the failure to accommodate language differences discriminates on the basis of national origin, OCR has required recipient/covered entities to provide appropriate language assistance to LEP persons. For instance, OCR has entered into voluntary compliance agreements and consent decrees that require recipients who operate health and social service programs to ensure that there are bilingual employees or language interpreters to meet the needs of LEP persons seeking services. OCR has also required these recipient/covered entities to provide written materials and post notices in languages other than English. *See Mendoza v. Lavine*, 412 F.Supp. 1105 (S.D.N.Y. 1976); and *Asociacion Mixta Progresista v. H.E.W.*, Civil Number C72-882 (N.D. Cal. 1976). The legal authority for OCR's enforcement actions is Title VI of the Civil Rights Act of 1964, the implementing regulations, and a consistent body of case law. The legal authority is described below.

2. *Statute and Regulation*

Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d *et. seq.* states: "No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Regulations implementing Title VI, provide in part at 45 C.F.R. Section 80.3 (b):

"(1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit provided

under the program;

(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program or the class of individuals to whom, or the situations in which such services, financial aid or other benefits, or facilities will be provided ... *may not directly, or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, because of their race, color or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular, race, color or national origin.*" (emphasis added).

3. ***Case Law***

Extensive case law affirms the obligation of recipients of federal financial assistance to ensure that LEP persons can meaningfully access federal-assisted programs.

The U.S. Supreme Court, in *Lau v. Nichols*, 414 U.S. 563 (1974), recognized that recipients of Federal financial assistance have an affirmative responsibility, pursuant to Title VI, to provide LEP persons with meaningful opportunity to participate in public programs. In *Lau v. Nichols*, the Supreme Court ruled that a public school system's failure to provide English language instruction to students of Chinese ancestry who do not speak English denied the students a meaningful opportunity to participate in a public educational program in violation of Title VI of the Civil Rights Act of 1964.

The *Lau* decision affirmed the U.S. Department of Health, Education and Welfare's Policy Memorandum issued on May 25, 1970, titled "Identification of Discrimination and the Denial of Services on the Basis of National Origin," 35 Fed. Reg. 11,595. The memorandum states in part: "Where the inability to speak and understand the English language excludes national origin minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students."

As early as 1926, the Supreme Court recognized that language rules were often discriminatory. In *Yu Cong Eng et.al. v. Trinidad, Collector of Internal Revenue*, 271 U.S. 500 (1926), the Supreme Court found that a Philippine Bookkeeping Act that prohibited the keeping of accounts in languages other than English, Spanish and Philippine dialects violated the Philippine Bill of Rights that Congress had patterned after the U.S. Constitution. The Court found that the Act deprived Chinese merchants, who were unable to read, write or understand the required languages, of liberty and property without due process.

In *Gutierrez v. Municipal Court of S.E. Judicial District*, 838 F.2d 1031,1039 (9th Cir. 1988), *vacated as moot*, 490 U.S. 1016 (1989), the court recognized that requiring the

use of English only is often used to mask national origin discrimination. Citing McArthur, *Worried About Something Else*, 60 Int'l J. Soc. Language, 87, 90-91 (1986), the court stated that because language and accents are identifying characteristics, rules that have a negative effect on bilingual persons, individuals with accents, or non-English speakers may be mere pretexts for intentional national origin discrimination.

Another case that noted the link between language and national origin discrimination is *Garcia v. Gloor*, 618 F.2d 264 (5th Cir. 1980) *cert. denied*, 449 U.S. 1113 (1981). The court found that on the facts before it a workplace English-only rule did not discriminate on the basis of national origin since the complaining employees were bilingual. However, the court stated that "to a person who speaks only one tongue or to a person who has difficulty using another language other than the one spoken in his home, language might well be an immutable characteristic like skin color, sex or place of birth." *Id.* At 269.

The Fifth Circuit addressed language as an impermissible barrier to participation in society in *U.S. v. Uvalde Consolidated Independent School District*, 625 F2d 547 (5th Cir. 1980). The court upheld an amendment to the Voting Rights Act which addressed concerns about language minorities, the protections they were to receive, and eliminated discrimination against them by prohibiting English-only elections.

Most recently, the Eleventh Circuit in *Sandoval v. Hagan*, 197 F. 3d 484 (11th Cir. 1999), *petition for cert. filed*, May 30, 2000, held that the State of Alabama's policy of administering a driver's license examination in English only was a facially neutral practice that had an adverse effect on the basis of national origin, in violation of Title VI. The court specifically noted the nexus between language policies and potential discrimination based on national origin. That is, in *Sandoval*, the vast majority of individuals who were adversely affected by Alabama's English-only driver's license examination policy were national origin minorities.

In the health and human service context, a recipient's failure to provide appropriate language assistance to LEP individuals parallels many of the fact situations discussed in the cases above and, as in those cases, may have an adverse effect on the basis of national origin, in violation of Title VI.

The Title VI regulations prohibit both intentional discrimination and policies and practices that appear neutral but have a discriminatory effect. Thus, a recipient/covered entity's policies or practices regarding the provision of benefits and services to LEP persons need not be intentional to be discriminatory, but may constitute a violation of Title VI if they have an adverse effect on the ability of national origin minorities to meaningfully access programs and services. Accordingly, it is useful for recipient/covered entities to examine their policies and practices to determine whether they adversely affect LEP persons. This policy guidance provides a legal framework to assist recipient/covered entities in conducting such assessments.

C. ***POLICY GUIDANCE***

1. ***Who is Covered***

All entities that receive Federal financial assistance from HHS, either directly or indirectly, through a grant, contract or subcontract, are covered by this policy guidance. Covered entities include (1) any state or local agency, private institution or organization, or any public or private individual that (2) operates, provides or engages in health, or social service programs and activities and that (3) receives federal financial assistance from HHS directly or through another recipient/covered entity. Examples of covered entities include but are not limited to hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health or social service research programs, state, county and local health agencies, state Medicaid agencies, state, county and local welfare agencies, programs for families, youth and children, Head Start programs, public and private contractors, subcontractors and vendors, physicians, and other providers who receive Federal financial assistance from HHS.

The term Federal financial assistance to which Title VI applies includes but is not limited to grants and loans of Federal funds, grants or donations of Federal property, details of Federal personnel, or any agreement, arrangement or other contract which has as one of its purposes the provision of assistance. (See, 45 C.F.R. Section 80.13(f); and Appendix A to the Title VI regulations, 45 C.F.R. Part 80, for additional discussion of what constitutes Federal financial assistance).

Title VI prohibits discrimination in any program or activity that receives Federal financial assistance. What constitutes a program or activity covered by Title VI was clarified by Congress in 1988, when the Civil Rights Restoration Act of 1987 (CRRA) was enacted. The CRRA provides that, in most cases, when a recipient/covered entity receives Federal financial assistance for a particular program or activity, all operations of the recipient/covered entity are covered by Title VI, not just the part of the program that uses the Federal assistance. Thus, all parts of the recipient's operations would be covered by Title VI, even if the Federal assistance is used only by one part.

2. ***Basic Requirements Under Title VI***

A recipient/covered entity whose policies, practices or procedures exclude, limit, or have the effect of excluding or limiting, the participation of any LEP person in a federally-assisted program on the basis of national origin may be engaged in discrimination in violation of Title VI. In order to ensure compliance with Title VI, recipient/covered entities must take steps to ensure that LEP persons who are eligible for their programs or services have meaningful access to the health and social service benefits that they provide. The most important step in meeting this obligation is for recipients of Federal financial assistance such as grants, contracts, and subcontracts to provide the language assistance necessary to ensure such access, at no cost to the LEP person.

The type of language assistance a recipient/covered entity provides to ensure meaningful access will depend on a variety of factors, including the size of the recipient/covered entity, the size of the eligible LEP population it serves, the nature of the program or service, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. There is no "one size fits all" solution for Title VI compliance with respect to LEP persons. OCR

will make its assessment of the language assistance needed to ensure meaningful access on a case by case basis, and a recipient/covered entity will have considerable flexibility in determining precisely how to fulfill this obligation. OCR will focus on the end result -- whether the recipient/covered entity has taken the necessary steps to ensure that LEP persons have meaningful access to its programs and services.

The key to providing meaningful access for LEP persons is to ensure that the recipient/covered entity and LEP person can communicate effectively. The steps taken by a covered entity must ensure that the LEP person is given adequate information, is able to understand the services and benefits available, and is able to receive those for which he or she is eligible. The covered entity must also ensure that the LEP person can effectively communicate the relevant circumstances of his or her situation to the service provider.

In enforcing Title VI and its application to LEP persons over the last 30 years, OCR has found that effective language assistance programs usually contain the four elements described in section three below. In reviewing complaints and conducting compliance reviews, OCR will consider a program to be in compliance when the recipient/covered entity effectively incorporates and implements these four elements. The failure to incorporate or implement one or more of these elements does not necessarily mean noncompliance with Title VI, and OCR will review the totality of the circumstances to determine whether LEP persons can meaningfully access the services and benefits of the recipient/covered entity.

3. ***Ensuring Meaningful Access to LEP Persons***

(a) ***Introduction - The Four Keys to Title VI Compliance in the LEP Context***

The key to providing meaningful access to benefits and services for LEP persons is to ensure that the language assistance provided results in accurate and effective communication between the provider and LEP applicant/client about the types of services and/or benefits available and about the applicant's or client's circumstances. Although HHS recipients have considerable flexibility in fulfilling this obligation, OCR has found that effective programs usually have the following four elements:

- **Assessment** - The recipient/covered entity conducts a thorough assessment of the language needs of the population to be served;

- **Development of Comprehensive Written Policy on Language Access** - The recipient /covered entity develops and implements a comprehensive written policy that will ensure meaningful communication;

- **Training of Staff** - The recipient/covered entity takes steps to ensure that staff understands the policy and is capable of carrying it out; and

- **Vigilant Monitoring** - The recipient/covered entity conducts regular oversight of the language assistance program to ensure that LEP persons

meaningfully access the program.

The failure to implement one or more of these measures does not necessarily mean noncompliance with Title VI, and OCR will review the totality of the circumstances in each case. If implementation of one or more of these options would be so financially burdensome as to defeat the legitimate objectives of a recipient/covered entity's program, or if there are equally effective alternatives for ensuring that LEP persons have meaningful access to programs and services, OCR will not find the recipient/covered entity in noncompliance.

(b) ***Assessment***

The first key to ensuring meaningful access is for the recipient/covered entity to assess the language needs of the affected population. A recipient/covered entity assesses language needs by:

- identifying the non-English languages that are likely to be encountered in its program and by estimating the number of LEP persons that are eligible for services and that are likely to be directly affected by its program. This can be done by reviewing census data, client utilization data from client files, and data from school systems and community agencies and organizations;
- identifying the language needs of each LEP patient/client and recording this information in the client's file;
- identifying the points of contact in the program or activity where language assistance is likely to be needed;
- identifying the resources that will be needed to provide effective language assistance;
- identifying the location and availability of these resources; and
- identifying the arrangements that must be made to access these resources in a timely fashion.

(c) ***Development of Comprehensive Written Policy on Language Access***

A recipient/covered entity can ensure effective communication by developing and implementing a comprehensive written language assistance program that includes policies and procedures for identifying and assessing the language needs of its LEP applicants/clients, and that provides for a range of oral language assistance options, notice to LEP persons in a language they can understand of the right to free language assistance, periodic training of staff, monitoring of the program, and translation of written materials in certain circumstances.(4)

(1) ***Oral Language Interpretation***-- In designing an effective language assistance program, a recipient/covered entity develops procedures for obtaining and providing trained and competent interpreters and other oral language assistance services, in a timely manner, by taking some or all of the following steps:

- Hiring bilingual staff who are trained and competent in the skill of interpreting;
- Hiring staff interpreters who are trained and competent in the skill of interpreting;

- Contracting with an outside interpreter service for trained and competent interpreters;
- Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting;
- Arranging/contracting for the use of a telephone language interpreter service.

See Section 3 (e)(2) for a discussion on "Competence of Interpreters."

The following provides guidance to recipient/covered entities in determining which language assistance options will be of sufficient quantity and quality to meet the needs of their LEP beneficiaries:

Bilingual Staff - Hiring bilingual staff for patient and client contact positions facilitates participation by LEP persons. However, where there are a variety of LEP language groups in a recipient's service area, this option may be insufficient to meet the needs of all LEP applicants and clients. Where this option is insufficient to meet the needs, the recipient/covered entity must provide additional and timely language assistance. Bilingual staff must be trained and must demonstrate competence as interpreters.

Staff Interpreters - Paid staff interpreters are especially appropriate where there is a frequent and/or regular need for interpreting services. These persons must be competent and readily available.

Contract Interpreters - The use of contract interpreters may be an option for recipient/covered entities that have an infrequent need for interpreting services, have less common LEP language groups in their service areas, or need to supplement their in-house capabilities on an as-needed basis. Such contract interpreters must be readily available and competent.

Community Volunteers - Use of community volunteers may provide recipient/covered entities with a cost-effective method for providing interpreter services. However, experience has shown that to use community volunteers effectively, recipient/covered entities must ensure that formal arrangements for interpreting services are made with community organizations so that these organizations are not subjected to *ad hoc* requests for assistance. In addition, recipient/covered entities must ensure that these volunteers are competent as interpreters and understand their obligation to maintain client confidentiality. Additional language assistance must be provided where competent volunteers are not readily available during all hours of service.

Telephone Interpreter Lines - A telephone interpreter service line may be a useful option as a supplemental system, or may be useful when a recipient/covered entity encounters a language that it cannot otherwise accommodate. Such a service often offers interpreting assistance in many different languages and usually can provide the service in quick response to

a request. However, recipient/covered entities should be aware that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service. It is important that a recipient/covered entity not offer this as the only language assistance option except where other language assistance options are unavailable (e.g., in a rural clinic visited by an LEP patient who speaks a language that is not usually encountered in the area).

(2) ***Translation of Written Materials*** -- An effective language assistance program ensures that written materials that are routinely provided in English to applicants, clients and the public are available in regularly encountered languages other than English. It is particularly important to ensure that vital documents, such as applications, consent forms, letters containing important information regarding participation in a program (such as a cover letter outlining conditions of participation in a Medicaid managed care program), notices pertaining to the reduction, denial or termination of services or benefits, of the right to appeal such actions or that require a response from beneficiaries, notices advising LEP persons of the availability of free language assistance, and other outreach materials be translated into the non-English language of each regularly encountered LEP group eligible to be served or likely to be directly affected by the recipient/covered entity's program. However, OCR recognizes that each federally-funded health and social service program has unique characteristics. Therefore, OCR will collaborate with respective HHS agencies in determining which documents and information are deemed to be vital.

As part of its overall language assistance program, a recipient must develop and implement a plan to provide written materials in languages other than English where a significant number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English to communicate effectively. 28 C.F.R. Section 42.405(d)(1). OCR will determine the extent of the recipient/covered entity's obligation to provide written translation of documents on a case by case basis, taking into account all relevant circumstances, including the nature of the recipient/covered entity's services or benefits, the size of the recipient/covered entity, the number and size of the LEP language groups in its service area, the nature and length of the document, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which translated documents are needed, and the cost of translation.

One way for a recipient/covered entity to know with greater certainty that it will be found in compliance with its obligation to provide written translations in languages other than English is for the recipient/covered entity to meet the guidelines outlined in paragraphs (A) and (B) below.

Paragraphs (A) and (B) outline the circumstances that provide a "safe harbor" for recipient/covered entities. A recipient/covered entity that provides written translations under these circumstances can be confident that it will be found in compliance with its obligation under Title VI regarding written translations.[5] However, the failure to provide written translations under these circumstances outlined in paragraphs (A) and (B) will not necessarily mean noncompliance with Title VI.

In such circumstances, OCR will review the totality of the circumstances to determine the precise nature of a recipient/covered entity's obligation to provide written materials in languages other than English. If written translation of a certain document or set of documents would be so financially burdensome as to defeat the legitimate objectives of its program, or if there is an alternative means of ensuring that LEP persons have meaningful access to the information provided in the document (such as timely, effective oral interpretation of vital documents), OCR will not find the translation of written materials necessary for compliance with Title VI.

OCR will consider a recipient/covered entity to be in compliance with its Title VI obligation to provide written materials in non-English languages if:

> (A) The recipient/covered entity provides translated written materials, including vital documents, for each eligible LEP language group that constitutes ten percent or 3,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected by the recipient/covered entity's program(6);
>
> (B) regarding LEP language groups that do not fall within paragraph (A) above, but constitute five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected, the recipient/covered entity ensures that, at a minimum, vital documents are translated into the appropriate non-English languages of such LEP persons. Translation of other documents, if needed, can be provided orally; and
>
> (C) Notwithstanding paragraphs (A) and (B) above, a recipient with fewer than 100 persons in a language group eligible to be served or likely to be directly affected by the recipient/covered entity's program, does not translate written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral translation of written materials.

The term "persons eligible to be served on likely to be directly affected" relates to the issue of what is the recipient/covered entity's service area for purposes of meeting its Title VI obligation. There is no "one size fits all" definition of what constitutes "persons eligible to be served or likely to be directly affected" and OCR will address this issue on a case by case basis.

Ordinarily, persons eligible to be served or likely to be directly affected by a recipient's program are those persons who are in the geographic area that has been approved by a Federal grant agency as the recipient/covered entity's service area, and who either are eligible for the recipient/covered entity's benefits or services, or otherwise might be directly affected by such an entity's conduct. For example, a parent who might seek services for a child would be seen as likely to be affected by a recipient/covered entity's policies and practices. Where no service area has been approved by a Federal grant agency, OCR will consider the relevant service area for determining persons eligible to

be served as that designated and/or approved by state or local authorities or designated by the recipient/covered entity itself, provided that these designations do not themselves discriminatorily exclude certain populations. OCR may also determine the service area to be the geographic areas from which the recipient draws, or can be expected to draw, clients/patients. The following are examples of how OCR would determine the relevant service areas when assessing who is eligible to be served or likely to be affected:

- A complaint filed with OCR alleges that a private hospital discriminates against Hispanic and Chinese LEP patients by failing to provide such persons with language assistance, including written translations of consent forms. The hospital identifies its service area as the geographic area identified in its marketing plan. OCR determines that a substantial number of the hospital's patients are drawn from the area identified in the marketing plan and that no area with concentrations of racial, ethnic or other minorities is discriminatorily excluded from the plan. OCR is likely to accept the area identified in the marketing plan as the relevant service area.

- A state enters into a contract with a managed care plan for the provision of health services to Medicaid beneficiaries. The Medicaid managed care contract provides that the plan will serve beneficiaries in three counties. The contract is reviewed and approved by HHS. In determining the persons eligible to be served or likely to be affected, the relevant service area would be that designated in the contract.

  As this guidance notes, Title VI provides that no person may be denied meaningful access to a recipient/covered entity's benefits and services, on the basis of national origin. To comply with the Title VI requirement, a recipient/covered entity must ensure that LEP persons have meaningful access to and can understand information contained in program-related written documents. Thus, for language groups that do not fall within paragraphs (A) and (B), above, a recipient can ensure such access by, at a minimum, providing notice, in writing, in the LEP person's primary language, of the right to receive free language assistance in a language other than English, including the right to competent oral translation of written materials, free of cost.

Recent technological advances have made it easier for recipient/covered entities to store translated documents readily. At the same time, OCR recognizes that recipient/covered entities in a number of areas, such as many large cities, regularly serve LEP persons from many different areas of the world who speak dozens and sometimes over 100 different languages. It would be unduly burdensome to demand that recipient/covered entities in these circumstances translate all written materials into dozens, if not more than 100 languages. As a result, OCR will determine the extent of the recipient/covered entity's obligation to provide written translations of documents on a case by case basis, looking at the totality of the circumstances.[7]

It is also important to ensure that the person translating the materials is well qualified. In addition, it is important to note that in some circumstances verbatim translation of materials may not accurately or appropriately convey the substance of what is contained in the written materials.

An effective way to address this potential problem is to reach out to community-based organizations to review translated materials to ensure that they are accurate and easily understood by LEP persons.

(3) ***Methods for Providing Notice to LEP Persons*** -- A vital part of a well-functioning compliance program includes having effective methods for notifying LEP persons regarding their right to language assistance and the availability of such assistance free of charge. These methods include but are not limited to:

- Use of language identification cards which allow LEP beneficiaries to identify their language needs to staff and for staff to identify the language needs of applicants and clients. To be effective, the cards (e.g., "I speak cards") must invite the LEP person to identify the language he/she speaks. This identification must be recorded in the LEP person's file;
- Posting and maintaining signs in regularly encountered languages other than English in waiting rooms, reception areas and other initial points of entry. In order to be effective, these signs must inform applicants and beneficiaries of their right to free language assistance services and invite them to identify themselves as persons needing such services;
- Translation of application forms and instructional, informational and other written materials into appropriate non-English languages by competent translators. For LEP persons whose language does not exist in written form, assistance from an interpreter to explain the contents of the document;
- Uniform procedures for timely and effective telephone communication between staff and LEP persons. This must include instructions for English-speaking employees to obtain assistance from interpreters or bilingual staff when receiving calls from or initiating calls to LEP persons; and
- Inclusion of statements about the services available and the right to free language assistance services, in appropriate non-English languages, in brochures, booklets, outreach and recruitment information and other materials that are routinely disseminated to the public.

(d) ***Training of Staff***

Another vital element in ensuring that its policies are followed is a recipient/covered entity's dissemination of its policy to all employees likely to have contact with LEP persons, and periodic training of these employees. Effective training ensures that employees are knowledgeable and aware of LEP policies and procedures, are trained to work effectively with in-person and telephone interpreters, and understand the dynamics of interpretation between clients, providers and interpreters. It is important that this training be part of the orientation for new employees and that all employees in client contact positions be properly trained. Given the high turnover rate among some employees, recipient/covered entities may find it useful to maintain a training registry that records the names and dates of employees' training. Over the years, OCR has observed that recipient/covered entities often develop effective language assistance policies and procedures but that employees are unaware of the policies, or do not know how to, or otherwise fail to, provide available assistance. Effective training is one means of ensuring that there is not a gap between a recipient/covered entity's written policies

and procedures, and the actual practices of employees who are in the front lines interacting with LEP persons.

(e) *Monitoring*

It is also crucial for a recipient/covered entity to monitor its language assistance program at least annually to assess the current LEP makeup of its service area, the current communication needs of LEP applicants and clients, whether existing assistance is meeting the needs of such persons, whether staff is knowledgeable about policies and procedures and how to implement them, and whether sources of and arrangements for assistance are still current and viable. One element of such an assessment is for a recipient/covered entity to seek feedback from clients and advocates. OCR has found that compliance with the Title VI language assistance obligation is most likely when a recipient/covered entity continuously monitors its program, makes modifications where necessary, and periodically trains employees in implementation of the policies and procedures.

4. *OCR's Assessment of Meaningful Access*

The failure to take all of the steps outlined in Section C. 3, above, will not necessarily mean that a recipient/covered entity has failed to provide meaningful access to LEP clients. As noted above, OCR will make assessments on a case by case basis and will consider several factors in assessing whether the steps taken by a recipient/covered entity provide meaningful access. Those factors include the size of the recipient/covered entity and of the eligible LEP population, the nature of the program or service, the objectives of the program, the total resources available, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. The following are examples of how meaningful access will be assessed by OCR:

- A physician, a sole practitioner, has about 50 LEP Hispanic patients. He has a staff of two nurses and a receptionist, derives a modest income from his practice, and receives Medicaid funds. He asserts that he cannot afford to hire bilingual staff, contract with a professional interpreter service, or translate written documents. To accommodate the language needs of his LEP patients, he has made arrangements with a Hispanic community organization for trained and competent volunteer interpreters, and with a telephone interpreter language line, to interpret during consultations and to orally translate written documents. There have been no client complaints of inordinate delays or other service related problems with respect to LEP clients. Given the physician's resources, the size of his staff, and the size of the LEP population, OCR would find the physician in compliance with Title VI.
- A county TANF program, with a large budget, serves 500,000 beneficiaries. Of the beneficiaries eligible for its services, 3,500 are LEP Chinese persons, 4,000 are LEP Hispanic persons, 2000 are LEP Vietnamese persons and about 400 are LEP Laotian persons. The county has no policy regarding language assistance to LEP persons, and LEP clients are told to bring their own interpreters, are provided with application and consent forms in English and if unaccompanied by their own interpreters, must solicit the help of other clients or must return at a later date with an interpreter. Given the size of the county program, its resources, the size of the

eligible LEP population, and the nature of the program, OCR would likely find the county in violation of Title VI and would likely require it to develop a comprehensive language assistance program that includes all of the options discussed in Section C. 3, above.

- A large national corporation receives TANF funds from a local welfare agency to provide computer training to TANF beneficiaries. Of the 2,000 clients that are trained by the corporation each month, approximately one-third are LEP Hispanic persons. The corporation has made no arrangements for language assistance and relies on bilingual Hispanic students in class to help LEP students understand the oral instructions and the written materials. Based on the size of the welfare agency and corporation, their budgets, the size of the LEP population, and the nature of the program, OCR would likely find both the welfare agency and the corporation in noncompliance with Title VI. The welfare agency would likely be found in noncompliance for failing to provide LEP clients meaningful access to its benefits and services through its contract with the corporation, and for failing to monitor the training program to ensure that it provided such access. OCR would likely also find the corporation in noncompliance for failing to provide meaningful access to LEP clients and would require it to provide them with both oral and written language assistance.

5. *Interpreters*

Two recurring issues in the area of interpreter services involve (a) the use of friends, family, or minor children as interpreters, and (b) the need to ensure that interpreters are competent, especially in the area of medical interpretation.

(a) ***Use of Friends, Family and Minor Children as Interpreters*** -- A recipient/covered entity may expose itself to liability under Title VI if it requires, suggests, or encourages an LEP person to use friends, minor children, or family members as interpreters, as this could compromise the effectiveness of the service. Use of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations. In a medical setting, this reluctance could have serious, even life threatening, consequences. In addition, family and friends usually are not competent to act as interpreters, since they are often insufficiently proficient in both languages, unskilled in interpretation, and unfamiliar with specialized terminology.

If after a recipient/covered entity informs an LEP person of the right to free interpreter services, the person declines such services and requests the use of a family member or friend, the recipient/covered entity may use the family member or friend, if the use of such a person would not compromise the effectiveness of services or violate the LEP person's confidentiality. Therecipient/covered entity should document the offer and declination in the LEP person's file. Even if an LEP person elects to use a family member or friend, the recipient/covered entity should suggest that a trained interpreter sit in on the encounter to ensure accurate interpretation.

(b) *Competence of Interpreters* -- In order to provide effective services to LEP persons, a recipient/covered entity must ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an

interpreter, though certification is helpful. On the other hand, competency requires more than self-identification as bilingual. The competency requirement contemplates demonstrated proficiency in both English and the other language, orientation and training that includes the skills and ethics of interpreting (e.g. issues of confidentiality), fundamental knowledge in both languages of any specialized terms, or concepts peculiar to the recipient/covered entity's program or activity, sensitivity to the LEP person's culture and a demonstrated ability to convey information in both languages, accurately. A recipient/covered entity must ensure that those persons it provides as interpreters are trained and demonstrate competency as interpreters.

6. *Examples of Frequently Encountered Scenarios*

Over the course of the past 30 years enforcing Title VI in the LEP context, OCR has observed a number of recurring problems. The following are examples of frequently encountered policies and practices that are likely to violate Title VI:

- A woman is brought to the emergency room of a hospital by her brother. The hospital has no language assistance services and requires her brother to interpret for her. She is too embarrassed to discuss her condition through her brother and leaves without treatment.

Alternatively, she is forced to use her brother as the interpreter, who is untrained in medical terminology and through whom she refuses to discuss sensitive information pertaining to her medical condition.

- A health clinic uses a Spanish-speaking security guard who has no training in interpreting skills and is unfamiliar with medical terminology, as an interpreter for its Hispanic LEP patients. He frequently relays inaccurate information that results in inaccurate instructions to patients.
- A local welfare office uses a Vietnamese janitor to interpret whenever Vietnamese applicants or beneficiaries seek services or benefits. The janitor has been in America for six months, does not speak English well and is not familiar with the terminology that is used. He often relays inaccurate information that results in the denial of benefits to clients.
- A state welfare agency does not advise a mother of her right to free language assistance and encourages her to use her eleven year old daughter to interpret for her. The daughter does not understand the terminology being used and relays inaccurate information to her mother whose benefits are jeopardized by the failure to obtain accurate information.
- A medical clinic uses a medical student as an interpreter based on her self-identification as bilingual. While in college, the student had spent a semester in Spain as an exchange student. The student speaks Spanish haltingly and must often ask patients to speak slowly and to repeat their statements. On several occasions, she has relayed inaccurate information that has resulted in misdiagnosis.
- A managed care plan calls the receptionist at an Ethiopian community organization whenever it or one of its providers needs the services of an interpreter for an Ethiopian patient. The plan instructs the receptionist to send anyone who is available as long as that person speaks English. Many of the interpreters sent to a provider either do not understand English well enough to interpret accurately or

are unfamiliar with medical terminology. As a result, clients often misunderstand their rights and benefits.

- A local welfare office forces a Mandarin-speaking client seeking to apply for SCHIP benefits on behalf of her three year old child to wait for a number of hours (or tells the client to come back another day) to receive assistance because it cannot communicate effectively with her, and has no effective plan for ensuring meaningful communication. This results in a delay of benefits.
- An HMO that enrolls Medicaid beneficiaries instructs a non-English speaking client to provide his or her own interpreter services during all office visits.
- A health plan requires non-English speaking patients to pay for interpreter services.

D. *PROMISING PRACTICES*

In meeting the needs of their LEP patients and clients, some recipient/covered entities have found unique ways of providing interpreter services and reaching out to the LEP community. As part of its technical assistance, OCR has frequently assisted, and will continue to assist, recipient/covered entities who are interested in learning about promising practices in the area of service to LEP populations. Examples of promising practices include the following:

Simultaneous Translation - One urban hospital is testing a state of the art medical interpretation system in which the provider and patient communicate using wireless remote headsets while a trained competent interpreter, located in a separate room, provides simultaneous interpreting services to the provider and patient. The interpreter can be miles away. This reduces delays in the delivery of language assistance, since the interpreter does not have to travel to the recipient/covered entity's facility. In addition, a provider that operates more than one facility can deliver interpreter services to all facilities using this central bank of interpreters, as long as each facility is equipped with the proper technology.

Language Banks - In several parts of the country, both urban and rural, community organizations and providers have created community language banks that train, hire and dispatch competent interpreters to participating organizations, reducing the need to have on-staff interpreters for low demand languages. These language banks are frequently nonprofit and charge reasonable rates.

This approach is particularly appropriate where there is a scarcity of language services, or where there is a large variety of language needs.

Language Support Office - A state social services agency has established an "Office for Language Interpreter Services and Translation." This office tests and certifies all in-house and contract interpreters, provides agency-wide support for translation of forms, client mailings, publications and other written materials into non-English languages, and monitors the policies of the agency and its vendors that affect LEP persons.

Multicultural Delivery Project - Another county agency has established a "Multicultural Delivery Project" that is designed to find interpreters to help immigrants

and other LEP persons to navigate the county health and social service systems. The project uses community outreach workers to work with LEP clients and can be used by employees in solving cultural and language issues. A multicultural advisory committee helps to keep the county in touch with community needs.

Pamphlets - A hospital has created pamphlets in several languages, entitled "While Awaiting the Arrival of an Interpreter." The pamphlets are intended to facilitate basic communication between inpatients/outpatients and staff. They are not intended to replace interpreters but may aid in increasing the comfort level of LEP persons as they wait for services.

Use of Technology - Some recipient/covered entities use their internet and/or intranet capabilities to store translated documents online. These documents can be retrieved as needed.

Telephone Information Lines - Recipient/covered entities have established telephone information lines in languages spoken by frequently encountered language groups to instruct callers, in the non-English languages, on how to leave a recorded message that will be answered by someone who speaks the caller's language.

Signage and Other Outreach - Other recipient/covered entities have provided information about services, benefits, eligibility requirements, and the availability of free language assistance, in appropriate languages by (a) posting signs and placards with this information in public places such as grocery stores, bus shelters and subway stations; (b) putting notices in newspapers, and on radio and television stations that serve LEP groups; (c) placing flyers and signs in the offices of community-based organizations that serve large populations of LEP persons; and (d) establishing information lines in appropriate languages.

E. *MODEL PLAN*

The following is an example of a model language assistance program that is potentially useful for all recipient/covered entities, but is particularly appropriate for entities such as hospitals

or social service agencies that serve a significant and diverse LEP population. This model plan incorporates a variety of options and methods for providing meaningful access to LEP beneficiaries:

- A formal written language assistance program;
- Identification and assessment of the languages that are likely to be encountered and estimating the number of LEP persons that are eligible for services and that are likely to be affected by its program through a review of census and client utilization data and data from school systems and community agencies and organizations;
- Posting of signs in lobbies and in other waiting areas, in several languages, informing applicants and clients of their right to free interpreter services and inviting them to identify themselves as persons needing language assistance;
- Use of "I speak" cards by intake workers and other patient contact personnel so

that patients can identify their primary languages;
- Requiring intake workers to note the language of the LEP person in his/her record so that all staff can identify the language assistance needs of the client;
- Employment of a sufficient number of staff, bilingual in appropriate languages, in patient and client contact positions such as intake workers, caseworkers, nurses, doctors. These persons must be trained and competent as interpreters;
- Contracts with interpreting services that can provide competent interpreters in a wide variety of languages, in a timely manner;
- Formal arrangements with community groups for competent and timely interpreter services by community volunteers;
- An arrangement with a telephone language interpreter line;
- Translation of application forms, instructional, informational and other key documents into appropriate non-English languages. Provision of oral interpreter assistance with documents, for those persons whose language does not exist in written form;

- Procedures for effective telephone communication between staff and LEP persons, including instructions for English- speaking employees to obtain assistance from bilingual staff or interpreters when initiating or receiving calls from LEP persons;
- Notice to and training of all staff, particularly patient and client contact staff, with respect to the recipient/covered entity's Title VI obligation to provide language assistance to LEP persons, and on the language assistance policies and the procedures to be followed in securing such assistance in a timely manner;
- Insertion of notices, in appropriate languages, about the right of LEP applicants and clients to free interpreters and other language assistance, in brochures, pamphlets, manuals, and other materials disseminated to the public and to staff;
- Notice to the public regarding the language assistance policies and procedures, and notice to and consultation with community organizations that represent LEP language groups, regarding problems and solutions, including standards and procedures for using their members as interpreters;
- Adoption of a procedure for the resolution of complaints regarding the provision of language assistance; and for notifying clients of their right to and how to file a complaint under Title VI with HHS.
- Appointment of a senior level employee to coordinate the language assistance program, and ensure that there is regular monitoring of the program.

F. *COMPLIANCE AND ENFORCEMENT*

The recommendations outlined above are not intended to be exhaustive. Recipient/covered entities have considerable flexibility in determining how to comply with their legal obligation in the LEP setting, and are not required to use all of the suggested methods and options listed. However, recipient/covered entities must establish and implement policies and procedures for providing language assistance sufficient to fulfill their Title VI responsibilities and provide LEP persons with meaningful access to services.

OCR will enforce Title VI as it applies to recipient/covered entities' responsibilities to LEP persons through the procedures provided for in the Title VI regulations. These

procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance, and technical assistance.

The Title VI regulations provide that OCR will investigate whenever it receives a complaint, report or other information that alleges or indicates possible noncompliance with Title VI. If the investigation results in a finding of compliance, OCR will inform the recipient/covered entity in writing of this determination, including the basis for the determination. If the investigation results in a finding of noncompliance, OCR must inform the recipient/covered entity of the noncompliance through a Letter of Findings that sets out the areas of noncompliance and the steps that must be taken to correct the noncompliance, and must attempt to secure voluntary compliance through informal means. If the matter cannot be resolved informally, OCR must secure compliance through (a) the termination of Federal assistance after the recipient/covered entity has been given an opportunity for an administrative hearing, (b) referral to DOJ for injunctive relief or other enforcement proceedings, or (c) any other means authorized by law.

As the Title VI regulations set forth above indicate, OCR has a legal obligation to seek voluntary compliance in resolving cases and cannot seek the termination of funds until it has engaged in voluntary compliance efforts and has determined that compliance cannot be secured voluntarily. OCR will engage in voluntary compliance efforts, and will provide technical assistance to recipients at all stages of its investigation. During these efforts to secure voluntary compliance, OCR will propose reasonable timetables for achieving compliance and will consult with and assist recipient/covered entities in exploring cost effective ways of coming into compliance, by sharing information on potential community resources, by increasing awareness of emerging technologies, and by sharing information on how other recipient/covered entities have addressed the language needs of diverse populations.

OCR will focus its compliance review efforts primarily on larger recipient/covered entities such as hospitals, managed care organizations, state agencies, and social service organizations, that have a significant number or percentage of LEP persons eligible to be served, or likely to be directly affected, by the recipient/covered entity's program. Generally, it has been the experience of OCR that in order to ensure compliance with Title VI, these recipient/covered entities will be expected to utilize a wider range of the language assistance options outlined in section C. 3, above.

The fact that OCR is focusing its investigative resources on larger recipient/covered entities with significant numbers or percentages of LEP persons likely to be served or directly affected does not mean that other recipient/covered entities are relieved of their obligation under Title VI, or will not be subject to review by OCR. In fact, OCR has a legal obligation under HHS regulations to promptly investigate all complaints alleging a violation of Title VI. All recipient/covered entities must take steps to overcome language differences that result in barriers and provide the language assistance needed to ensure that LEP persons have meaningful access to services and benefits. However, smaller recipient/covered entities -- such as sole practitioners, those with more limited resources, and recipient/covered entities who serve small numbers of LEP persons on an infrequent basis -- will have more flexibility in meeting their obligations to ensure meaningful access for LEP persons.

In determining a recipient/covered entity's compliance with Title VI, OCR's primary concern is to ensure that the recipient/covered entity's policies and procedures overcome barriers resulting from language differences that would deny LEP persons a meaningful opportunity to participate in and access programs, services and benefits. A recipient/covered entity's appropriate use of the methods and options discussed in this policy guidance will be viewed by OCR as evidence of a recipient/covered entity's willingness to comply voluntarily with its Title VI obligations.

G. *TECHNICAL ASSISTANCE*

Over the past 30 years, OCR has provided substantial technical assistance to recipient/covered entities, and will continue to be available to provide such assistance to any recipient/covered entity seeking to ensure that it operates an effective language assistance program. In addition, during its investigative process, OCR is available to provide technical assistance to enable recipient/covered entities to come into voluntary compliance.

H. *ATTACHMENTS*

Appendix A is a summary, in question and answer format, of a number of the critical elements of this guidance. The purpose of the summary is to assist recipient/covered entities further in understanding this guidance and their obligations under Title VI to ensure meaningful access to LEP persons. Appendix B is a list of numerous provisions, including but not limited to Federal and state laws and regulations, requiring the provision of language assistance to LEP persons in various circumstances. This list is not exhaustive, and is not limited to the health and human service context.

1. [1]A description of these requirements is included as Appendix B to this policy guidance.

2. [2]The DOJ directive has been issued contemporaneously with this policy guidance.

3. [3]The DOJ coordination regulations at 28 C.F.R. Section 42.405(d)(1) provide that "[w]here a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program (e.g., affected by relocation) needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

4. The Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 both provide similar prohibitions against discrimination on the basis of disability and require entities to provide language assistance such as sign language interpreters for hearing impaired individuals or alternative formats such as braille, large print or tape for vision impaired individuals. In developing a comprehensive language assistance program, recipient/covered entities should be mindful of their responsibilities under the

ADA and Section 504 to ensure access to programs for individuals with disabilities.

5. The "safe harbor" provisions in paragraphs (A) and (B) below are not intended to establish numerical thresholds for when a recipient must translate documents. The numbers and percentages included in these provisions are based on the balancing of a number of factors, including OCR's experience in enforcing Title VI in the context of health and human services programs, and OCR's discussions with other Department agencies about experiences of their grant recipient/covered entities with language access issues.

6. As noted above, vital documents include applications, consent forms, letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial or termination of services or benefits, that require a response from beneficiaries, and/or that advise of free language assistance. Large documents, such as enrollment handbooks, may not need to be translated in their entirety. However, vital information contained in large documents must be translated.

7. For instance, a Medicaid managed care program that regularly encounters, or potentially will encounter on a regular basis, LEP persons who speak dozens or perhaps over 100 different languages, would not be required to translate the lengthy program brochure into every regularly encountered language. Rather, the recipient/covered entity in these circumstances would likely be required to translate the written materials into the most frequently encountered languages. Regarding the remaining regularly encountered languages, the recipient/covered entity would be required to ensure that the LEP person receives written notification in the appropriate non-English language of the right to free oral translation of the written materials. In addition, the recipient/covered entity would frequently be required to provide written translations of vital documents that are short in length and pertain to important aspects of critical programs, such as a cover letter that outlines the terms and conditions of participation in a Medicaid managed care program, and/or contains time sensitive information about enrollment or continued participation.

OCR Home Page HHS Home Page

HHS Home | Topics | What's New | For Kids | FAQs
Disclaimers | Privacy Notice | FOIA | Site Info | Contact Us

OCR Mail
Date revised: September 1, 2000

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS

FOR IMMEDIATE RELEASE
Wednesday, Aug. 30, 2000

Contact: Kathleen O=Brien (OCR)
(202) 619-0403

HHS Provides Written Guidance for Health and Human Services Providers To Ensure Language Assistance for Persons with Limited English Skills

The U.S. Department of Health and Human Services today issued written policy guidance to assist health and social services providers in ensuring that persons with limited English skills can effectively access critical health and social services.

The guidance, published in the *Federal Register* by the HHS Office for Civil Rights (OCR), lays out and explains more fully OCR's existing policies. It outlines the legal responsibilities of providers who receive Federal financial assistance from HHS - such as hospitals, HMOs and human service agencies - to assist people with limited English skills. It also provides a flexible road map to the range of options available to providers in meeting the language needs of the nation's increasingly diverse populations.

Publication of the guidance makes HHS the first federal agency to publish guidance since the issuance of Executive Order 13166 on serving persons with limited English skills, signed by President Clinton on August 11, 2000. The executive order requires each federal agency to have written policies on providing effective service to those with limited English proficiency who are served by federally-funded programs.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin by any entity that receives federal financial assistance. Under Title VI of the law, hospitals, HMOs, social service agencies and other entities that receive Federal financial assistance from HHS are required to take the steps necessary to ensure that individuals with limited English proficiency (LEP) can meaningfully access the programs and services. The requirements apply to state-administered as well as private and non-profit facilities and programs that benefit from HHS assistance. OCR is

responsible for compliance with the law as it applies to HHS assisted programs.

In a letter to governors announcing publication of the written guidance, HHS Secretary Donna E. Shalala said, "This guidance enhances our ability to reach our national goal of eliminating racial and ethnic disparities in health, and will assist in increasing opportunities for persons with limited English proficiency to improve their socioeconomic status."

Some of the state-administered programs where access for persons with limited English proficiency may be especially important include the State Children=s Health Insurance Program (SCHIP), Medicaid and Temporary Assistance to Needy Families (TANF).

AEffective communication is the key to meaningful access, whether it is a hospital, a clinic or a benefits program," said OCR Director Thomas Perez. "Failure to communicate effectively can have serious consequences for millions of Americans."

The guidance emphasizes that providers have flexibility in designing effective programs. The types of language assistance a provider must have in place to ensure meaningful access depend on a variety of factors, including the size of the facility or covered entity, the size of the eligible LEP population it serves, the nature of the program or service, the objective of the program, the resources available to the facility or covered entity, and the frequency with which LEP persons come into contact with the program. Small practitioners and providers have considerable flexibility in determining how to fulfill their obligations to ensure meaningful access for persons with limited English proficiency.

"OCR has a history of working cooperatively with health and social services providers to help them comply with the law and serve their limited English populations effectively without causing undue burden," said Perez. "We have found widespread willingness to improve language assistance services, especially when providers learn that solutions can be tailored to fit individual situations, and services can be provided cost-effectively."

"With our requirements and flexible policies now in writing, we expect to make even greater progress in cooperation with health and social service providers in making services truly accessible to those with limited English skills. OCR will continue to be available to provide technical assistance to any covered entity seeking to ensure the operation of an effective language assistance program," Perez said.

Depending on the need and the circumstances of the individual facility, options for providing oral language assistance range from hiring bilingual staff or hiring on-staff interpreters to contracting for interpreter services as needed, engaging community volunteers, or contracting with a telephone interpreter service.

Examples of problem practices that have been found by OCR include: providing services to LEP persons which are more limited in scope or lower in quality than those provided to other persons; subjecting LEP persons to unreasonable delays; limiting participation in a program or activity on the basis of English proficiency; providing services to LEP persons that are not as effective as those provided to persons proficient in English; and failing to inform LEP persons of the right to receive free interpreter services or requiring

them to provide their own interpreter.

As outlined in the guidance, satisfactory service to LEP clients should include:

- having polices and procedures in place for identifying and assessing the language needs of the individual provider and its client population;
- a range of oral language assistance options, appropriate to each facility's circumstances;
- notice to LEP persons of the right to free language assistance;
- staff training and program monitoring; and
- a plan for providing written materials in languages other than English where a significant number or percentage of the affected population needs services or information in a language other than English to communicate effectively.

"The purpose of putting these policies into writing is to help make the requirements of the law both clear and widely-known, among providers and potential LEP clients as well," Perez said. "We believe that by making these policies known, and making clear the flexibility we provide on a facility-by-facility basis, providers will be more likely to review and improve their language assistance services, and individuals with limited English skills will be better able to access the services they need."

The written guidance, "Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency," is available in the *Federal Register*, through OCR's 10 Regional Offices, or on the Internet at http://www.hhs.gov/ocr

###

OCR Home Page HHS Home Page

HHS Home | Topics | What's New | For Kids | FAQs
Disclaimers | Privacy Notice | FOIA | Site Info | Contact Us

OCR Mail
Date revised: August 29, 2000

DHEC ADMINISTRATIVE POLICY MANUAL

Subject: Culturally and Linguistically Appropriate Services

Laws/Regulations – Department of Justice (DOJ) directive outlining obligations pursuant to Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d

EPA, Office of Civil Rights, Improving Access to Services for Person with Limited English Proficiency

Executive Order 13166

Americans with Disabilities Act of 1990

Regulations: Issued by DOJ 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs," 28 C.F.R., Section 42.414, Subpart F.

Title VI, provided in part at 45 C.F.R. Section 80.3 (a) and (b)(1)(ii), (iii),(iv),(vi) and (b)(2).

Secretary, U.S. Department of Health and Human Services Recommended Standards for Culturally and Linguistically Appropriate Health Care

Federal Register Vol. 65, No. 169, Aug. 30, 2000, page 52767, Section 2, 28 CFR Section 42.405(d)(1))

Definitions:

Cultural Competence: A culturally competent organization is one that: 1) truly seeks to understand the cultural and linguistic differences among staff and customer populations and recognizes that these differences can and do lead to barriers in delivery of services; 2) actively seeks to build their internal capacity to deliver services that are culturally and linguistically sensitive; and 3) understands the interplay between policy and practice and is committed to policies, procedures and programs that enhance services to diverse customers.

Limited English Proficient (LEP) or Sensory Impaired Customer: Any person who is sensory impaired and/or cannot speak, read, write or understand at a level that permits them to interact effectively with service providers.

Deaf, Hard-of- Hearing: Any person who cannot hear (deaf) or has other hearing problems.

Speech Disabled: Any person who may have a problem being understood due to speech impairment. The impairment may be a result of a stroke, throat surgery, or other conditions that make it difficult to understand a person.

Sensory Impaired: A term used to describe a hearing or visual impairment resulting in partial, profound, or complete loss of hearing or sight.

Interpretation: The oral restating in one language of what has been said in another language. Interpretation goes beyond words; it is explaining the meaning of one language, especially in speech and oral communication, into another language. In health and environmental services, interpretation involves conveying both the literal meaning and connotations of spoken and unspoken communication (e.g. body language, mannerisms) of the customer to the health and environmental provider and that the provider communicate effectively the program's activities, benefits and eligibility requirements to the customer.

Translation: The putting of words of one language into another language, particularly in written form. In health and environmental services, translation is used when converting written information from English-language medical and environmental forms, information brochures and other health and environmental materials into the customer's language.

Qualified Interpreter/Translator: A person who has demonstrated proficient knowledge and skills in English as well as in the language (verbal/writing and reading) of the customer. In addition, their skills should include cultural sensitivity and knowledge of the agency/program terminology and interpreter/translator's code of ethics.

TYY or TDD: A telecommunication device or a text telephone that assist the deaf or hard-of-hearing.

Policy Statement I:

DHEC will ensure federal guidelines, recommendations and laws governing culturally and linguistically appropriate services are implemented and monitored. Keeping the goal of effective communication and services in the forefront, we will adopt uniform and comprehensive standards that clarify provider and customer expectations and lead to a consistent and measurable level of services. *(See Attachment I)*

Rules:

1. Promote and support the behaviors, knowledge and skills necessary for staff to work effectively with customers and each other in a culturally diverse work environment.

2. Include in strategic goals, operational plans, policies, procedure statements and strategies to address culturally and linguistically appropriate services.

3. Require and arrange for on-going education and training for administrative, professional and support staff in culturally and linguistically competent service planning and delivery.

4. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in service areas, and become informed about the ethnic/cultural needs, resources, and assets of service areas/communities.

5. Bilingual preferences will be reflected within position descriptions when program customer populations warrant the need.

6. Cultural competent and linguistic appropriate questions and comments will be included in agency and program customer service satisfaction surveys.

Procedures:

1. Policies, procedures, guidelines and operational plans will be reviewed annually (in line with accountability report).

2. Refer to specific selections herein.

3. Customer service satisfaction surveys will be analyzed to evaluate cultural and linguistic appropriate services.

Responsibility:

Management and Office of Planning will ensure implementation, monitoring and evaluation.

Policy Statement II:

DHEC will assure access to health and environmental information and services for limited English proficient (LEP) customers. The purpose of this policy is to establish the rules and procedures for providing interpreting/translating services for customers with limited English proficiency. This policy is based on the belief that clear and accurate information is essential to quality health and environmental services which is consistent with civil rights, customer/patient rights, and informed consent provisions required under federal and state statues as well as by standards promulgated by the Joint Commission on the Accreditation of Health Care Organizations and Community Health Accreditation Program (CHAP).

Interpreters and Translators:

Rules

1. A qualified and trained bilingual employee (criteria for qualified and trained is set forth within this policy under section titled "Qualified and Trained and Compensation for Staff Interpreters/Translators") shall be used to facilitate bilingual communication. When no qualified and trained bilingual employee is available to provide requested or necessary interpreter or translator services, the agency must offer and secure, at no cost to the customer, a qualified interpreter or translator or Language Assistance Line service.

2. The agency will use staff, volunteer and contract interpreters and/or translators who are qualified and trained to provide interpreter or translator services and who agree to adhere to strict confidentiality and the interpreter/translator's code of ethics agreements *(Attachment*

II). All staff and contract interpreters must be proficient in both English and the other language and must have basic knowledge in both languages of specialized terms and concepts used frequently in the provision of the agency's services and procedures. All staff and contract interpreters or translators must have some orientation or training which includes the ethics and cultural aspects of interpreting/translating.

3. Staff will not use minors (under age 18) as interpreters.

4. Staff **shall not** require customers to use friends or family members as interpreters or translators. In fact, the agency discourages the use of friend and family of customers as interpreters. A friend or adult family member may be used as an interpreter or translator only if the LEP/sensory impaired customer initiates this request, after being advised that a free interpreter or translator (non-family friend) is available; AND if the customer is advised that use of such a person may compromise the effectiveness of the services or violate the confidentiality involved; AND if the customer agrees that an agency approved interpreter may also be required to be involved in the communications, in order, to assure that the agency is protected from possible liabilities. An approved agency interpreter service must be used to secure the waiver signature of the customer, before a friend or family member can serve as the interpreter. In the event a customer elects to use an adult friend or family member as their interpreter, the customer **must** sign a waiver (Attachment III) regarding the choice to not use an agency approved interpreter.

   Under any circumstances, the customer cannot waive DHEC's responsibility to provide effective services through effective communication.

   Part of the monitoring/accountability system will be to review the usage of this option to assure it is not used routinely.

5. Acceptable options for language assistance will be determined by assessment of customer population as defined in *attachment VI.*

Procedures:

Interpreters -When services are delivered to customers, whether by agency employees, through contractors, or through service providers, agency programs shall ensure the following:

1. That interpreter services are provided when requested by an LEP or sensory impaired identified customer;
   a. when an on site interpreter is not available agency contracted language assistance lines are to be used. Obtain information regarding the lines and usage from the district's designated person. Use of telephone interpretation should be limited to situations where there is not a bilingual staff person or contracted interpreter available to provide translation services.

2. That interpreter services are provided when requested by a contractor or service provider for an LEP or sensory impaired identified customer;

3. That interpreter services are provided when they are necessary to establish or maintain a customer's eligibility for agency programs and services.

4. That interpreter services are provided when they are necessary for the customer to access any services funded directly or indirectly by the agency.

5. That interpreter services are provided when they are necessary to provide access to public meetings sponsored by the agency or by those under contract to the agency.

6. That established agency methods and procedures are used to certify, screen, and/or evaluate the interpretation proficiency of bilingual employees and interpreters serving agency customers, employees, and providers.

7. That qualified bilingual employees and language services contractors are aware of the agency's Code of Professional Conduct *(Attachment II)*.

8. That each agency office which provides customer service be provided annually an updated list of names of qualified interpreters, including the language(s) in which they can interpret by the state office point of contact coordinator.

Translators (Written Communications) -In addition to spoken language interpretation, when agency services are delivered to identified LEP customers, whether by agency employees, through contractors, or through service providers, the agency shall:

1. Provide all major written communication to the customer in the appropriate primary language at no cost and without significant delay. "Major Communication" includes forms and letters such as the following: application forms, consent to treatment forms, notice of customers' rights and responsibilities, and hearing notices *(Refer Policy III – Procedures)*

2. Ensure that written materials that are routinely provided in English to applicants, customers and the public are available in frequently encountered languages other than English *(see Attachment IV)*.

3. When using forms or written communications with LEP and/or sensory impaired applicants/customers, reasonable efforts will be made to assist the applicants/customers in understanding the written communication. In some instances it may be necessary to supplement the written material. For example, for a person who is unable to read or who cannot read English, the form or other written material would need to be read or translated for the person. Letters, forms, or other printed materials to persons who have visual impairments may have to be typed in Braille, tape recorded or read to the person.

4. Coordinate translation, including the review and approval process of agency forms, and mailings.

5. Provide consultation, technical assistance, and administrative support to agency staff who develop, issue and produce forms and customer mailings.

Communication Assistance for the Deaf, Hard-of-Hearing, and Sensory Impaired Customers:

Rules:

1. All agency staff will be informed of services for communicating with deaf, hard-of-hearing and speech disabled customers.

2. Agency staff will inform customers of the Speech to Speech Relay Service and/or Relay South Carolina service (*Attachment V* – Services for communicating with deaf, hard-of-hearing and speech disabled customers)

3. When customer population demographics warrant (Attachment IV - Federal Guidelines for determining need by customer population) TTY or TDD devices will be obtained.

4. When using sign language interpreters must be certified/qualified and trained sign language interpreters (see certified/qualified in section below).

Procedures:

1. See attachment III- Services for communicating with deaf, hard-of-hearing and speech disabled persons.
2. Each unit that assessed a need for this service will keep a list of local resources of those persons that are available and approved sign language interpreters as defined in the criteria section.

Criteria and Compensation for Qualified Interpreters/Translators:

Rules:

1. Criteria for Qualified Interpreters/Translator including Sign Language:
    a. Must be 18 years of age.
    b. Demonstrates expressive and receptive skills and ethics of interpreting and translating.
    c. Evidence of testing levels of skills of both languages and command of the specialized terms and concepts relevant to encounters for which they will be providing interpreter and/or translator services.
    d. Demonstrates knowledge and understanding of Interpreter/Translator Code of Responsibility (Attachment II & IIa).
    e. Demonstrates knowledge of implications (legal and other) of inappropriate interpreter and/or translation services.
    f. Demonstrates knowledge and understanding of effective communication styles of LEP population for which they are providing interpreter or translation services.
    g. Interpreters for the deaf must show evidence of being approved by the S.C. Association of the Deaf or the National Registry of Interpreters for the Deaf.

2. Compensation for interpreter/translator services will be granted to the employee if:
    a. Program area/district has the need for the interpreter services.

b. Interpreter and/or translation duties are defined on the employee's position description.
c. Employee has proof of being a qualified and trained interpreter and/or translator as outlined in Criteria for Qualified Interpreters/Translator herein.

3. Compensation will be granted to existing employees based on Additional Duties and Responsibilities increase guidelines (Personnel Policy).

Contractual Interpreter/Translation Services:

All contractual relationships covering language interpretation and translation of written material are covered by the South Carolina Consolidated Procurement Code 11-36-10. Interpretation and translation service contracts are to be processed through the Bureau of Business Management in accordance with the agency procurement procedures.

Rules:

1. Contract interpreters and translators are to be used on an infrequent basis to supplement in-house capabilities.

2. Interpreters and translators must be qualified, trained, competent and readily available.

3. All contracts regardless of the source of funds or scope of work or services must include the non-discrimination term identified in Section 40 of the DHEC Procurement Procedures Manual. This term reads as follows:

> "No person shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination in relation to activities carried out under this contract on the grounds of race, age, health status, handicap, color, sex, religion or national origin. ***This includes the provision of language assistance services to individuals of limited English proficiency*** eligible for services provided by DHEC."

Procedure:

1. DHEC has a multi-term blanket purchase order for the use of the AT&T language line. The telephone number is 1-800-648-0156 extension 5831. Each program and district must set up and pay for their own account to gain access to the language line. There are 140 languages accessible on the language line for interpretation and translation services. All interpreters and translators are certified and accessible on a continuous basis. The current cost is $1.75 per minute.

   The Office of Minority Health has entered into a contract with the University of South Carolina, Center for Child and Family Studies to provide Spanish interpretation and translation services agency wide. To use the services provided under this contract, you should contact the DHEC HABLA Toll Free Line at 1-866-300-9327. Both translation and interpretation services are available via telephone during normal working hours and face to face within 24 hours. Agency and contract service providers may use the services of DHEC HABLA.

Policy Statement III:

Translation of written materials:
Ensure LEP persons have meaningful access to and can understand information contained in written documents, including forms, publications, and specific program documents; ensure the qualifications of any and all persons providing and/or approving translations of any and all documents and materials.

The following may be used as a guide to assist the agency to have greater assurance of compliance, but are not intended to establish numerical thresholds for when a document, brochure or other written materials must be translated:

Provide written materials including vital documents for each eligible LEP language group that constitutes 10 percent or 3,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected by the DHEC's programs and benefits.

Regarding LEP language groups that do not meet the 10 percent or 3,000 threshold, but constitute 5 percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected by DHEC's programs and benefits; ensure that, at a minimum, vital documents are translated into the appropriate non-English languages of such LEP persons.

If there are fewer than 100 persons in a language group eligible to be served or likely to be directly affected by DHEC's program and benefits, it is recommended that if this group is served frequent and regular, vital documents must be translated. The customer is to be provided a written notice in the primary language of the LEP group of the right to receive competent written and/or oral translation of documents and other materials at no cost to them. (Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency.)

Example: A county office has 150 Latinos who frequent the office on a regular basis. Assume 100 are LEP and need an interpreter. Even though the number may be well below the 1000 or 5% of the population, the frequency and the number combined could in, OCR's judgement, require that vital documents be interpreted or translated.

Rules:

1. We will provide notice at key points of contact to customers in their primary language informing them of their right to receive free interpretation and/or translation services.

2. We will translate and make available commonly used documents and materials for LEP customers.

Procedures:

1. Vital and essential documents, such as applications, consent forms, letters containing important information regarding participation in a program, notices pertaining to the reduction, denial or termination of services or benefits, of the right to appeal such actions or

that require a response from beneficiaries, notices advising LEP persons of the availability of free language assistance, and other outreach materials will be translated into the non-English language of each regularly encountered LEP group eligible to be served or likely to be directly affect by the agency's programs.

2. Notice of rights to services for LEP customers must be displayed or made available at key points of contact.
    a. Language identification posters which allow LEP persons to identify their language needs to staff and for staff to identify the language needs of the customer will be posted at all key entry points.
    b. Posters, brochures, booklets, outreach information and other materials that are routinely disseminated to the public will include statements about the right to free language assistance services.

3. Educational and outreach materials will be reviewed and translated in order of priority as determined by program areas based on standard criteria as set forth within the federal guidelines. (Federal Register Vol. 65, No. 169, Aug. 30, 2000, page 52767, Section 2, 28 CFR Section 42.405(d)(1))

4. Agency translation and interpretation procedures will be followed in each case to ensure consistency.

Policy Statement IV:

Training:

DHEC will provide all staff training regarding Cultural and Linguistic Policies and use of interpreters and translators annually.

DHEC will require testing and training for those staff who are hired and/or used as interpreters and/or translators.

Rules:

1. Staff orientation will include information regarding cultural and linguistic services.

2. Employees who are likely to have contact with LEP persons are to be provided during orientation and through in-services information regarding how to work effectively with in-person and telephone interpreters, understand the dynamics of interpretation between customers, providers and interpreters.

3. New employees will attend the DHEC approved Basic Cultural Competence training by the end of their first year of employment.

4. Agency approved testing and/or training will be conducted at least annually for those staff who provides interpreting and/or translating services.

5. Cultural and linguistic information/training/skills will be provided annually for all staff.

6. Staff training and testing records will be recorded and maintained by Quality Management.

Policy Statement V:

Assessment:
DHEC will ensure programs assess the community, their customers, and identify potential customers for which plans, services and products need to be targeted and tailored systematically.

Rules:

1. Service Area Assessments will include:
   a. assets and resources in community,
   b. demographic information about the community and customers, including number of LEP persons served.
   c. barriers to agency services,
   d. perceived and actual needs of the community and customers
   e. current resources for interpreters, translators of language assistance, including sign language.

2. Statewide assessments using available technology (such as GIS) and data (census, school district, agency tracking systems, etc) will be done centrally to determine county demographics.

Procedures:

1. Each Bureau/Office/Program/District will reflect in their operational plan methods for conducting assessments that enables the information to be available and reportable.

Policy Statement VI:

Monitoring
DHEC will annually; assess the LEP makeup of its customer population, monitor their communication needs, determine if staff has necessary knowledge about the policies and procedures outlined in this policy. DHEC will obtain feedback from LEP customers about LEP services being provided. DHEC will adjust its service delivery accordingly.

DHEC will also, ensure that staff are aware of the language needs of each LEP customer, determine processes in programs where language assistance is likely to be needed, and identifying resources needed, their location and how staff can access these resources in a timely manner.

Rules:

1. Offices under the Commissioner and each Bureau (Health Services, EQC, OCRM) will ensure customer-tracking systems include a mechanism for reporting number of LEP persons served and potential number for services. A current LEP makeup of service areas will be included in annual operational reports.

2. Information will include, but not limited to:

Primary language of customer, if not English
Indication of language assistance needed (Spanish, Sign, Korea, etc.)
Type of language assistance provided (Face to Face, telephone, etc.)

3. Program/service areas will report LEP numbers.

Procedure:

1. For year one (FY 2001-2002), a non-electronic mechanism will be used to obtain counts of LEP persons seeking or receiving services from DHEC.
2. All electronic databases and tracking systems will be designed or modified to ensure collection and reporting of accurate LEP information.
3. Intake forms will be reviewed and revised to reflect LEP information when the information can not be captured through electronic methods.

Assuring Cultural Competence in Health Care:

National Standards and Outcomes

ACTION: Final

Federal Register: December 22, 2000 (Volume 65, Number 247) [Page 80865-80879]

National Standards for Culturally and Linguistically Appropriate Services in Health Care

The complete report and text, along with supporting material, is available online at www.OMHRC.gov/CLAS.

Preamble

The following national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) responds to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

> **CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).**
>
> **CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).**
>
> **CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).**

The standards are also intended for use by:

Policymakers, to draft consistent and comprehensive laws, regulations, and contract language. This audience would include Federal, State and local legislators, administrative and oversight staff, and program managers accreditation and credentialing agencies, to assess and compare providers who say they offer culturally competent services and to assure quality for diverse populations. This audience would include: the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, professional organizations such as the American Medical Association and American Nurses Association, and quality review organizations such as peer review organizations; purchasers, including government and employer purchasers of health benefits, including labor unions; patients, must understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them; advocates, to promote quality health care for diverse populations and to assess and monitor care being delivered by providers and educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery, including educators from health care professions and training institutions, as well as educators from legal and social services professions.

The CLAS standards employ key concepts that are defined as follows:

CLAS standards:

The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Culturally and linguistically appropriate services: Health care services that are respectful of and responsive to cultural and linguistic needs.

Health care organizations: Any public or private institution involved in any aspect of delivering health care services.

Patients/consumers: Individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services.

Staff: Individuals employed directly by a health care organization, as well as those subcontracted or affiliated with the organization.

Standards:

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.

   This standard constitutes the fundamental requirement on which all activities specified in the other CLAS standards are based. Its intent is to ensure that all patients/consumers receiving health care service experience culturally and linguistically competent encounters with an organization's staff. The standard is relevant not only to staff, who ultimately are responsible for the kinds of interactions they have with patients, but also to their organizations, which must provide the managers, policies, and systems that support the realities of culturally competent encounters.

   Ways to operationalize this standard include implementing all other CLAS standards. For example, in accordance with Standard 3, ensure that staff and other personnel receive cross-cultural education and training, and that their skills in providing culturally competent care are assessed through testing, direct observation, and monitoring of patient/consumer satisfaction with individual staff/personnel encounters. Assessment of staff and other personnel could also be done in the context of regular staff performance reviews or other evaluations that could be included in the organizational self-assessment called for in Standard 9. Health care organizations should provide patients/consumers with information regarding existing laws and policies prohibiting disrespectful or discriminatory treatment or marketing/enrollment practices.

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.

   Diverse staff is defined in the standard as being representative of the diverse demographic population of the service area and includes the leadership of the organization as well as it's governing boards, clinicians, and administrative personnel. Building staff that adequately mirrors the diversity of the patient/ consumer population should be based on continual assessment of staff demographics (collected as part of organizational self-assessment in accordance with Standard 9) as well as demographic data from the community maintained in accordance with Standard 11. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

3. ***Health Care Organizations Should Ensure That Staff at All Levels and cross All Disciplines Receive Ongoing Education and Training in Culturally and Linguistically Appropriate Service Delivery.***

   Hiring a diverse staff does not automatically guarantee the provision of culturally competent care. Staff education and training are also crucial to ensuring CLAS delivery because all staff will interact with patients/consumers representing different countries of origin, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Health care organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME-or CEU- accredited education or other training in CLAS delivery, or arrange for such education and training to be made available to staff. This training should be based on sound educational (i.e., adult learning) principles, include pre- and post-training assessments, and conducted by appropriately qualified individuals.

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.***

Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. Title VI requires all entities receiving Federal financial assistance, including health care organizations, take steps to ensure that LEP persons have meaningful access to the health services that they provide. The key to providing meaningful access for LEP persons is to ensure effective communication between the entity and the LEP person. For complete details on compliance with these requirements, consult the HHS guidance on Title VI with respect to services for (LEP) individuals (65 FR 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Language services, as described below, must be made available to each individual with limited English proficiency who seeks services, regardless of the size of the individual's language group in that community. Such an individual cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or non-clinical staff at a health care organization. (Patients needing services in American Sign Language would also be covered by this standard, although other Federal laws and regulations apply and should be consulted separately.)

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.***

LEP individuals should be informed--in a language they can understand—that they have the right to free language services and that such services are readily available. At all points of contact, health care organizations should also distribute written notices with this information and post translated signage. Health care organizations should explicitly inquire about the preferred language of each patient/ consumer and record this information in all records. The preferred language of each patient/consumer is the language in which he or she feels most comfortable in a clinical or non-clinical encounter.

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).***

When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual--person for delivering language services'

they must assess and ensure the training and competency of individuals who deliver such services.

Bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter.

Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the patients/consumers.

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.***

It is important to translate materials that are essential to patients/consumers accessing and making educated decisions about health are. Examples of relevant patient-related materials include applications, consent forms, and medical or treatment instructions; however, health care organizations should consult OCR guidance on Title VI for more information on what the Office considers to be "vital" documents that are particularly important to ensure translation (65 FR 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/ lep].

Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of patients/consumers. Organizations should provide notice of the availability of oral translation of written materials to LEP individuals who cannot read or who speak non-written languages. Materials in alternative formats should be developed for these individuals as well as for people with sensory, developmental, and/or cognitive impairments.

The obligation to provide meaningful access is not limited to written translations. Oral communication often is a necessary part of the exchange of information, and written materials should never be used as substitutes for oral interpreters.

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.***

Successful implementation of the CLAS standards depends on an organization's ability to target attention and resources on the needs of culturally diverse populations. The purpose of strategic planning is to help the organization define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services. It also allows the agency to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission.

Accountability for CLAS activities must reside at the highest levels of leadership including the governing body of the organization. Without the strategic plan, the organization may be at a disadvantage to identify and prioritize patient/consumer service need priorities.

Consistent with Standards 9, 10, and 11, the results of data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

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.***

Ideally, these self-assessments should address all the activities called for in the 14 CLAS standards. Initial self-assessment, including an inventory of organizational policies, practices, and procedures, is a prerequisite to developing and implementing the strategic plan called for in Standard 8.

The purpose of ongoing organizational self- assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment should focus on the capacities, strengths, and weaknesses of the organization in meeting the CLAS standards.

Integrating cultural and linguistic competence-related measures into existing quality improvement activities will also help institutionalize a focus on CLAS within the organization. Linking CLAS- related measures with routine quality and outcome efforts may help build the evidence base regarding the impact of CLAS interventions on access, patient satisfaction, quality, and clinical outcomes.

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.***

The purposes of collecting information on race, ethnicity, and language are to:

- Adequately identify population groups within a service area;
- Ensure appropriate monitoring of patient/consumer needs, utilization, quality of care, and outcome patterns;
- Prioritize allocation of organizational resources;
- Improve service planning to enhance access and coordination of care; and
- Assure that health care services are provided equitably.

Language data also can help organizations develop language services that facilitate LEP patients/consumers receiving care in a timely manner. To improve the accuracy and reliability of language data, health care organizations should adapt procedures to document patient/consumer preferred spoken and written language. Written language refers to the patient/consumer preference for receiving health-related materials. Data collected on language should include dialects and American Sign Language.

For health encounters that involve or require the presence of a legal parent or guardian who does not speak English (e.g., when the patient/consumer is a minor or severely disabled), the management information system record and chart should document the language not only of the patient/consumer but also of the accompanying adult(s).

Health care organizations should collect data from patients/ consumers at the first point of contact using personnel who are trained to be culturally competent in the data collection process.

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.***

The purpose of this standard is to ensure that health care organizations obtain a variety of baseline data and update the data regularly to better understand their communities, and to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Both quantitative and qualitative methods should be used to determine cultural factors related to patient/consumer needs, attitudes, behaviors, health practices, and concerns about using health care services as well as the surrounding community's resources, assets, and needs related to CLAS. Methods could include epidemiological and ethnographic profiles as well as focus groups, interviews, and surveys conducted in the appropriate languages spoken by the patient/consumer population.

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.***

Patients/consumers and community representatives should be actively consulted and involved in a broad range of service design and delivery activities. In addition to providing input on the planning and implementation of CLAS activities, they should be solicited for input on broad organizational policies, evaluation mechanisms, marketing and communication strategies, staff training programs, and so forth. There are many formal and informal mechanisms available for this, including participation in governing boards, community advisory committees, ad hoc advisory groups, and community meetings as well as informal conversations, interviews, and focus groups.

Health care organizations should also collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served.

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.***

This standard requires health care organizations to anticipate and be responsive to the inevitable cross-cultural differences that arise between patients/consumers and the organization and its staff. Ideally, this responsiveness may be achieved by integrating

cultural sensitivity and staff diversity into existing complaint and grievance procedures as well as into policies, programs, offices or committees charged with responsibility for patient relations, and legal or ethical issues. When these existing structures are inadequate, new approaches may need to be developed.

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.***

Sharing information with the public about a health care organization's efforts to implement the CLAS standards can serve many purposes. It is a way for the organization to communicate to communities and patients/consumers about its efforts and accomplishments in meeting the CLAS standards

Code of Ethics
for
Interpreters/Translators

- **Proficiency**

I have met the minimum proficiency standards set by the agency in the languages for which I am being asked to interpret as demonstrated by passing the required examination and receiving satisfactory training evaluations.

- **Confidentiality**

I will treat all information learned during the interpretation as confidential, not divulging any information obtained through my assignments, including but not limited to information gained through interviews or access to documents and other written materials.

- **Accuracy: Conveying the Content and Spirit of What is Said**

I shall transmit the message in a thorough and faithful manner, giving consideration to linguistic variations in both languages and conveying the tone and spirit of the original message. A word-for-word interpretation may not convey the intended idea. I must determine the relevant concept and say it in language that is readily understandable and culturally appropriate to the listener. In addition, I will make every effort to assure that the client has understood questions, instructions and other information transmitted by the service provider

- **Completeness: Conveying Everything that is Said**

I shall interpret everything that is said by all people in the interaction, without omitting, adding, condensing or changing anything. If the content to be interpreted might be perceived because of cultural differences, as offensive, insensitive or otherwise harmful to the dignity and well-being of the customer, I will ***advise the professional of this before interpreting.***

- **Conveying Cultural Frameworks**

I shall explain cultural differences or practices to the provider(s) and clients when appropriate. I shall practice cultural competence and sensitivity.

- **Non-Judgmental Attitude about the Content to be Interpreted**

I understand an interpreter's function is to facilitate communication. Interpreters are not responsible for what is said by anyone for whom they are interpreting. Even if I disagree with what is said or think it is wrong, a lie or immoral, I will suspend judgment, make no comment, and interpret everything accurately.

- **Client Self-Determination**

I understand that as the interpreter the client may ask me for my opinion. If this happens, I will not influence the opinion of the clients by telling them or offering them advice as to what action to take during or after the assignment.

- **Attitude Toward Clients**

I shall strive to develop a relationship of trust and respect at all times with the client by adopting a caring, attentive, yet discreet and impartial attitude toward the client, toward his or her questions, concerns and needs.

I shall treat each client equally with dignity and respect regardless of race, color, gender, religion, nationality, age, gender, political persuasion or life-style choice. I will be sensitive and aware of dignity and respect within the context of the client's culture.

•Acceptance of Assignments
I understand that if my level of competency or personal sentiments make it difficult to abide by any of the above conditions, I shall decline or withdraw from the assignment.

I will disclose any real or perceived conflict of interest that could affect my objectivity. For example, an interpreter should refrain from providing services to family members or friends.

•Compensation
I shall not accept any fee or additional money, considerations or favors for my interpreter service from the client, patient or customer or his or her friends or relatives. I further understand that I shall not use the agency's time, facilities, equipment or supplies for private gain, nor will I use my position to secure privileges.

•Self-Evaluation
I shall represent my qualifications, certification(s), training and experience accurately and completely.

•Ethical Violations
I shall withdraw immediately from encounters that I perceive to be in violation of the Code of Ethics.

•Professionalism
I shall maintain professional behavior at all times while serving or working with clients and professionals.

I have read the above Code of Ethics and by my signature, I agree that I can interpret according to the standards set forth.

Signature Date

Address Phone

Source: This code is a modification of the Codes of Ethics from the Hospital Interpretation Program in Seattle, WA; Boston City Hospital in Boston, MA; and the American Medical Interpreters and Translators Association (AMITAS) 1999.

WAIVER OF INTERPRETER SERVICES

I understand that the South Carolina Department of Health and Environmental Control will provide a qualified adult interpreter to explain information, including medical and personal information, to me at no charge. I am voluntarily declining the offer. Instead, I have chosen to use an adult who will interpret information on my behalf. I understand that if I refuse to use the interpreter offered by DHEC, the information received by DHEC staff may not allow them to provide me the most effective and confidential services. Furthermore, DHEC may also elect to have an interpreter of their choosing present when they feel it necessary to assure effective services. In the future, if I decide to void this waiver, I may request the services of a DHEC qualified interpreter at any time and at no cost to me.

_____ _____

Customer (PRINT) DHEC Staff Signature

_____ _____

Customer Signature Date

Federal Guidelines
For
Determining Need of Required LEP Assistance

Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency

LEP language group that constitutes 10 percent or 3,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected by individual agency programs.

Regarding LEP language groups that do not meet the 10 percent or 3,000 threshold, but constitute 5 percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected, the agency ensures that, at a minimum, vital documents are translated into the appropriate non-English languages of such LEP persons.

Regarding translation of other materials not addressed herein:

Other materials and documents, if needed, can be provided orally; and not with standing paragraphs a and b above, if there are fewer than 100 persons in a language group eligible to be served or likely to be directly affected by an individual agency program, the agency does not translate written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral translation of written materials. (Federal Register Vol. 65, No. 169, Aug. 30, 2000, page 52767, Section 2, 28 CFR Section 42.405(d)(1))

Persons in language groups that do not fall within these guidelines should be notified of their right to receive oral translation of written materials.

Attachment V

Communication Assistance for Deaf, Hard-of-Hearing and Speech Disabled Customers

It has been brought to our attention that a service is provided through the SC Public Service Commission by SPRINT to assist everyone in South Carolina who has speech and hearing difficulties to communicate over the telephone. There is no charge to the consumer or agency. The service was established to better meet the needs of the deaf, hard-of-hearing and speech disabled citizens. The service will be another resource and mechanism to assist us in our efforts to better service our customers and comply with federal laws, such as, the ADA (American Disabilities Act).

- There are two services; one called **Speech to Speech Relay Service**, which is for those who may have a problem being understood due to a speech impairment. The speech impairment may be a result of a stroke, throat surgery, or other conditions that make it hard to understand someone.

- The other service is to assist with the deaf and hard of hearing people. It is the called **Relay South Carolina**. This assists those who are deaf and or have other hearing problems and need TTY (also known as TDD, Telecommunications Devices for the Deaf, or Text Telephone) to communicate.

Both of these services are available to anyone in the state for business or personal use. There is **no limit** to the number of times the service can be used or to the length of time for each call. The service can assist both English and Spanish speaking persons. There is no charge for using the relay service except when a long distance call is required to reach one of the parties. The long distance rate will be automatically discounted.

How does this service work?

Speech to Speech (STS) has trained operators who can assist in interpreting what the speech disabled person is saying and relay the information back to you. You or the customer will need to place a call to the toll free number (1-877-735-7277) and provide the number of the person to whom you need to talk. The service will then connect you to the person and you will resume talking to the other party like you do on a normal phone call. The relay operator will remain on the line to assure that all conversations are fully understood on both ends. Remember either the customer or the service provider can place the call.

Relay South Carolina (RSC) has trained operators who will interpret from your voice message into typed text messages and vice versa. If you need to reach a deaf or hard-of-hearing person who has a TTY you will place a call to a toll free number 1-800-735-2905 (giving message by voice) and provide the number of the person you need to talk to. When you call this number you will actually speak to the relay operator and they will type your voice message to the TYY user and provide you a voice response. The operator will connect you to the person and you will resume talking to the person you are calling like you do on a normal phone call. Please remember to speak to the TTY user directly, as the operator will type everything you say word for word. The TTY user can call you toll-free using the relay service and the number they need to use is 1-800-735-8583 (for TTY user).

Please feel free to call Relay SC Customer Service at 1-800-676-3777 or TTY for any assistance.

What if the customer does not have a special telecommunications equipment (e.g. TTY?

The great news is: there is a program that will provide deaf, hard-of-hearing and speech-disabled persons with special telecommunications equipment at no cost. You need to know this and make them aware of the program.

This program is call TEDP (Telecommunication Equipment Distribution Program). For information or to apply for this equipment you can call toll free (1-877-225-8337 Voice or 1-877-889-8337 TTY).

This is a service that can help us:

- provide better customer service;
- better meet the needs of our customers; and
- we need to **let everyone know** that this service is available.

OMH: 12/2000

Guidance for Determining Language Assistance Options

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language.

Bilingual Staff – Hiring bilingual staff for customer contact positions facilitates participation by LEP person. However, where there is a variety of LEP language groups in a service area, this option may be insufficient to meet the needs of all LEP applicants and clients. Where this option is insufficient to meet the needs, the recipient/covered entity must provide additional and timely language assistance. Bilingual staff must be trained and must demonstrate competence as interpreters.

Staff Interpreters - Paid staff interpreters are especially appropriate where there is a frequent and/or regular need for interpreting services. These persons must be competent and readily available.

Contract Interpreters - The use of contract interpreters may be an option for recipient/covered entities that have an infrequent need for interpreting services, have less common LEP language groups in their service areas, or need to supplement their in-house capabilities on an as needed basis. Such contract interpreters must be readily available and competent.

Community Volunteers - Use of community volunteers may provide recipient/covered entities with a cost-effective method for providing interpreter services. However, experience has shown that to use community volunteers effectively, recipient/covered entities must ensure that formal arrangements for interpreting services are made with community organizations so that these organizations are not subjected to ad hoc requests for assistance. In addition, recipient/covered entities must ensure that these volunteers are competent as interpreters and understand their obligation to maintain client confidentiality. Additional language assistance must be provided where competent volunteers are not readily available during all hours of service.

Telephone Interpreter Lines - **A** telephone interpreter service line may be a useful option as a supplemental system, or may be useful when a recipient/covered entity encounters a language that it cannot otherwise accommodate. Such a service often offers interpreting assistance in many different languages and usually can provide the service in quick response to a request. However, recipient/covered entities should be aware that such services might not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service. It is important that a recipient/covered entity not offer this as the only language assistance option except where other language assistance options are unavailable (e.g., in a rural clinic visited by an LEP patient who speaks a language that is not usually encountered in the area). **In that** this option has been adopted by the **SCDHEC,** it should be demonstrated that each staff person is **trained on how to effectively communicate with an LEP client through the Language** Line.