2. Eliminate unqualified interpretation

Section 1557 requires qualified interpreters and prohibits the use of:

1. A patient’s minor children (except in emergencies to prevent imminent patient harm)
2. Adult family and friends (unless the patient refuses an interpreter — provider may still utilize an interpreter if they determine the family member/friend cannot interpret adequately)
3. Bilingual staff, unless interpreting is part of “the individual’s current, assigned job responsibilities” and the staff member has demonstrated that he/she is:
   - Proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phonology; and
   - able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary language.

*Demonstrating these skills all require some form of interpreter training certification*

Staff Testing/Training

Test staff interpreters, as well as bilingual doctors and nurses who wish to interpret, for language proficiency and interpreter skills. Testing may include:

Language Proficiency Assessments
designed to measure the ability of individuals to communicate effectively in a specific language and follow the standards established by the Interagency Language Roundtable (ILR).

Assessments should cover:

- Grammar
  - Structural aspect of how the candidate speaks — error frequency and severity.
- Vocabulary
  - Ability to discuss various topics — lexical breadth and depth.
- Pronunciation
  - How well the candidate is understood by the native speaker.
- Fluency
  - How readily language comes to the candidate and how fluid the overall speech is.
- Cultural Appropriateness and Functional Expertise
  - Proper use of cultural references to frame opinions and statements and overall ability to communicate with native speakers on cultural topics.
- Strategies
  - Ability to control the conversation and keep it flowing in the right direction.

Interpreter Skills Assessments
to evaluate knowledge of medical vocabulary and ability to accurately communicate from one language to another in a clinical context, including:

1. Interpretations from English into the target language.
2. Interpretations from the target language into English.
3. Medical vocabulary in both languages.

Any staff member designated qualified to interpret should have that responsibility documented in writing. Best practice may be to add this designation added to the staff member’s job description.

Staff members who wish to provide care directly in non-English languages should be tested and certified to demonstrate that they are qualified bilingual providers.

3. Provide qualified interpreters to patients/family members/spouses/partners

Section 1557 mandates that providers “take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities.” It also bans discrimination based on association, meaning providers must supply interpreters as needed to their patient’s families, spouses, or partners as needed.

Hospitals may find it impractical to staff full-time interpreters for all languages, so many leading healthcare organizations “take reasonable steps to provide meaningful access” by partnering with leading healthcare organizations, CyraCom, which can supply interpreters via phone or video chat in hundreds of languages.

4. Confirm that remote interpretation options are fully functional

Section 1557 supports the use of qualified phone and video interpreters to help providers deliver timely language access to their LEP patients with the caveat that video interpretation must meet the quality standards set for ASL interpreting under Title IV of the Civil Rights Act.

5. Train staff to understand the importance and consequences of 1557

Section 1557 grants LEP individuals a specific cause of action against healthcare providers that fail to “take reasonable steps to provide meaningful access.” This is a departure from Title VI of the Civil Rights Act (the previous law on language access), which allowed fines and Medicare/Medicaid cuts to “take reasonable steps to provide meaningful access.” This builds on the precedent set by Title VI, which prohibits national origin discrimination and mandates language access in healthcare.

As of October 17, 2016, all covered organizations are required to achieve compliance with Section 1557. CyraCom has compiled the five-step guide to complying with the language access provisions of 1557: Learn more about the new law by downloading our Section 1557 Whitepaper.