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CHAPTER 11

Language Assistance

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DEPARTMENT DESCRIPTION

The primary focus of the Language Assistance Department (LAD) is to provide meaningful healthcare access to Limited English Proficient (LEP) patients by delivering language services that facilitate clear and accurate communication between healthcare providers and their patients, so they can make informed decisions. These services not only make communication among speakers of different languages possible; in the United States, they are also a federal mandate under the requirements of the Civil Rights Act of 1964, as ratified and amplified in Section 1557 of the Affordable Care Act of 2010.

Language Assistance departments typically deliver services for spoken languages and deaf patients needing sign language assistance or auxiliary aids to help them communicate. In certain healthcare institutions, LAD may also be responsible for supporting visually impaired patients and even providing housing communication aids, such as communication boards for patients whose native language is English but who are unable to communicate verbally for various reasons.

Most of the LAD's language services fall into two basic categories, interpretation and translation. Although many people use these terms interchangeably, they refer to two different aspects of this area of service. *Interpretation* is the rendering of communication verbally, whereas *translation* refers to the conversion of written text from one language into another.

In healthcare, the majority of the services the LAD provides involve interpretation, because most of the interactions between healthcare providers and their patients occur in person and are verbal in nature. In addition to these responsibilities, and depending on the organizational structure of the hospital, the LAD may also be accountable for testing the language skills of bilingual employees for

medical interpretation, maintaining records on these employees, consulting other hospital departments in matters related to languages, and other tasks.

The academic and language-skills requirements for medical interpreters in position descriptions vary greatly among institutions. Although federal law requires medical interpreters to be qualified, meaning that they must have demonstrated proficiency in English and at least one other spoken language, the law does not specify training or certification requirements. The most widely accepted minimum requirements for entry-level medical interpreters include a language-skills assessment and at least 40 hours of training in medical interpretation. Depending on the organization, interpreters could be required to have a college degree, one or more years of verifiable experience in the field, and even national certification as a medical interpreter.

KEY DEPARTMENT SERVICES

The most fundamental services the LAD provides are interpretation and translation, which should aim to provide LEP individuals with meaningful access to healthcare services. Interpretation must be offered for spoken and sign languages, whereas translation is required for the most common languages of the populations served by the facility.

Depending on the size and resources of the entity, interpretation can be delivered in one or more modalities. The three available methods of interpretation are in-person (sometimes referred to as on-site), video, and telephonic (exhibit 11.1). Although a large healthcare facility with ample resources should offer a mix of all three types, smaller operations may only need to use a combination of two, or even one. Other considerations for the provision of interpretation might be the location of the facility and availability of interpreters in the area.

Interpretation may occur during any phase of a patient visit, including registration, appointments, imaging, tests, treatments, surgery, counseling, patient

Exhibit 11.1: Interpretation: Methods of Delivery

- **In-person interpretation:** Interpretation provided live on site. Used for both spoken and signed languages.
- **Telephonic interpretation:** A type of remote interpretation where the three parties (patient, provider, and interpreter) participate in an interpreted conversation that takes place over phone lines.
- **Video remote interpretation:** Another type of remote interpretation where the participants connect to each other over the internet and are able to see and hear each other while an interpreter assists with language.

education, discharge instructions, and many other clinical and nonclinical interactions related to the patient's condition and treatment. The interpretation may extend beyond these examples, to include phone calls to and from the patients that may be generated for diverse reasons. Note that interpretation services should also cover LEP family members as long as they are involved in caring for the patient.

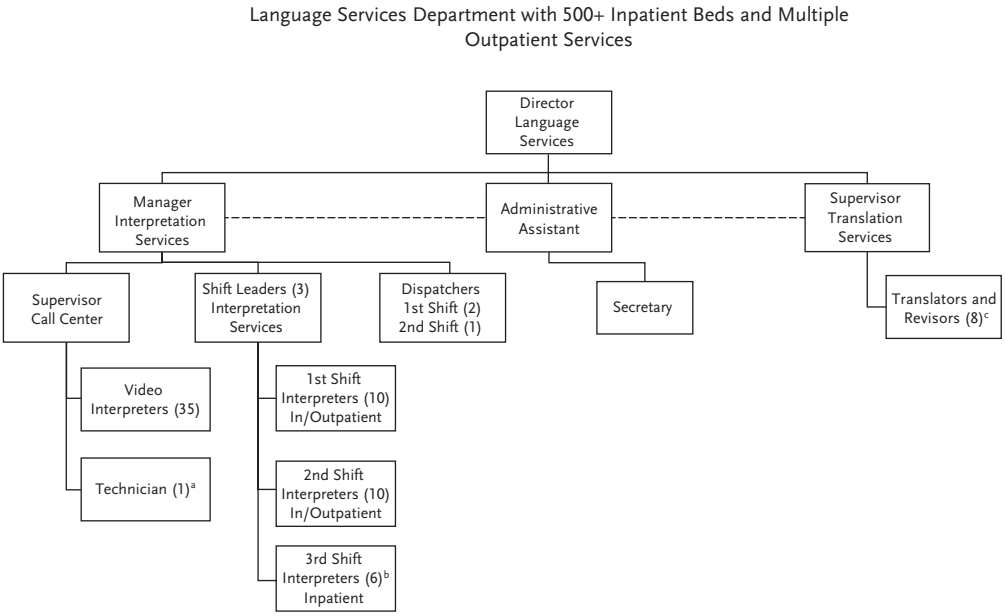
The translation side of language services should focus on the translation of vital written materials into the language of each frequently encountered LEP group eligible to be served or likely to be served. The classification of documents as vital or nonvital depends on the importance of the program, information, or service involved, along with the consequence to the LEP person if the information is not provided accurately or in a timely way. In both interpretation and translation, the services may be provided by contract personnel, provided that they comply with the requirements of the law. Smaller healthcare facilities may be able to provide language services without hiring employees, whereas larger hospitals may have a mix of offerings that will include hired and contract language professionals. Depending on the scope of responsibility placed on the LAD at each institution, the department may have other equally important services to provide, such as auxiliary aids for the deaf, communication devices or methods for the blind, and communication boards for patients with verbal communication challenges.

DEPARTMENT ORGANIZATIONAL STRUCTURES

The size and complexity of language service departments vary according to the patient population of the facility, its geographical location, and even the specialties and services provided. These operations may range from one on-site interpreter for only one language to a hundred or more interpreters working in several languages over different shifts throughout the day, plus translators, dispatchers, and support staff. In the former case, the interpreter may report directly to an administrator in charge of a larger department in the institution; in the latter case, the LAD may have a director, supervisor, and shift leaders over the interpreters.

The organizational structure of the LAD may also be organized around types of languages, volume of work, or shifts. It is not uncommon to see LAD personnel reporting to different areas or divisions, such as Clinical Support Services, Nursing, Clinical Operations, Social Work, and the like. However, the LAD should be under the supervision of a group that has a similar or common mission, one that understands that interpreters are an important part of the patient care team and that their mission is to assist patients in their journey through the healthcare system. Exhibit 11.2 shows a sample organizational chart for a large LAD that includes translation and interpretation sections along with an internal call center.

Exhibit 11.2: Sample Organizational Chart



Notes: (a) Technician provides support and repair for video remote interpretation tablets. (b) Third-shift interpreters are contacted via pagers; no dispatchers are needed on third shift. (c) Revisors are translators who revise translated documents for grammatical and technical issues before document translation is finalized.

KEY CUSTOMERS AND THEIR PERFORMANCE EXPECTATIONS

The customers of the LAD require interpretation, translation, or both. The vast majority are patients and healthcare providers in outpatient and inpatient areas. A smaller number come from other institutional departments that may need translation services to reach patient or employee audiences for various reasons. A few potential customers may be departments providing ancillary services. These departments, such as the Food and Nutrition Department, Police or Security Services, Human Resources, and Legal Services, may require assistance with translation or interpretation for their own purposes, not necessarily to interact with patients. In some cases, the LAD will also count family members of their patients among their customers. If any family members are involved in the patient's care and do not speak English, the healthcare organization must assist them in communicating with the care team, even if the patient speaks English.

In all these cases, the crucial expectations from the internal LAD customers are to receive quality language services in a timely manner. Other expectations

include professionalism, good customer service, prompt response to requests, and adherence to deadlines in the case of document translation.

Depending on the volume of the operation, providing timely interpretation every time can be challenging, especially if resources may be limited. Other important factors in providing timely interpretation are the inherent delays within the requesting units or areas, and coordinating the simultaneous meeting of patient, interpreter, and provider.

Communication is of paramount importance to manage the customer's expectations. Meeting with the appropriate service area or unit stakeholders to provide them with guidelines for language services, apprise them of departmental limitations, and learn about their language services needs is very important for strengthening relationships with internal customers and creating awareness of LAD's services and procedures.

KEY PROCESS FLOWS

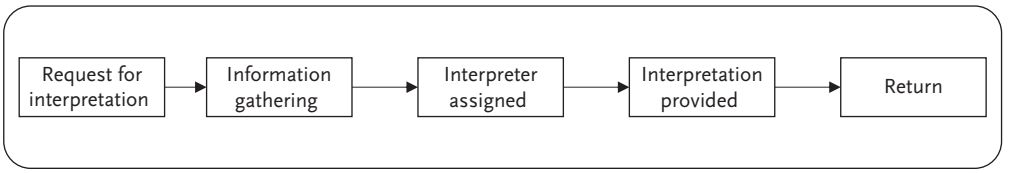
Although the process flows in the LAD are relatively simple, they can be handled in different manners. The main processes in the LAD are

- request and provision of interpretation services and
- request and provision of translation services.

A basic flow for the interpretation process is shown in exhibit 11.3.

This process can include many variations, depending on the resources available, the dispatch system selected for this purpose, and the complexity of the operation. The process can be manual, electronic, or a hybrid of both. Requests may be placed by phone, email, web page, or other electronic means. The key information needed for an interpretation request includes patient name, room number, medical record number, and requestor. The information needed to reach the requestor to provide the service may be gathered manually during the interaction with the requestor, or may be entered directly by them. The assignment of interpreters may also be handled manually, or automatically by a computer application with several

Exhibit 11.3: Basic Interpretation Flow



methods for assigning requests, such as rotation, preferred or assigned units, sectors, inpatient versus outpatient, and others. In a rotation method, interpreters would be rotated in order of availability as requests come in for all areas of the organization. Interpreters could be assigned to specific sectors or units of the institution, where they would work directly with the unit staff to provide service only to patients in their area of responsibility as appointments occur. Assignment also could be split between inpatient and outpatient areas, in which interpreters assigned to one of these sides would not cross into the other, and provide service only to the patients and staff within those areas.

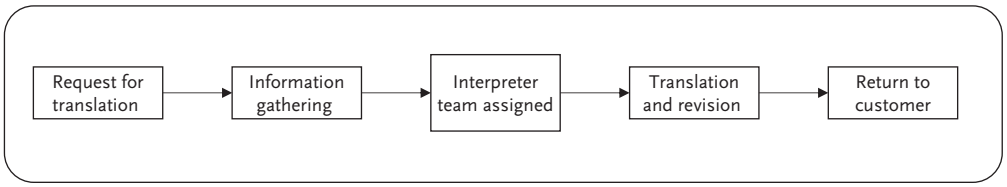
Besides in-person interpretation, the requests can also be handled via video or telephone. The interpretation itself can also be handled in one of the four basic types of interpreting, consecutive being the most widely used method in medical interpretation. Exhibit 11.4 provides an explanation of the four types. Once the interpretation is completed, the interpreter returns to an available status. As with the other parts of the process, the return can also be logged manually or electronically.

Translating documents follows a similar workflow as interpretation. The linear, uncomplicated process, as seen in exhibit 11.5, can be handled in other ways, depending on the specific needs of the organization.

Exhibit 11.4: Types of Interpretation

- **Simultaneous interpreting:** Also known as conference interpretation, involves the processes of instantaneously listening to, comprehending, interpreting, and rendering the speaker's statements into another language.
- **Consecutive interpreting:** Commonly used in meetings with few participants. The interpreter listens to a set number of utterances from the speaker and then gives their rendition in the target second language.
- **Whispered interpreting:** This method of interpreting, also known as *chuchotage*, is used in meetings with few participants. The interpreter, who is positioned right next to the listener, simply whispers to the listener precisely what the speaker is saying.
- **Sight translation:** The oral rendition of text written in one language into another language, usually done in the moment.

Exhibit 11.5: Basic Translation Flow



Documents for translation can be sent in their original form, via email, or uploaded to a specific website or cloud server, among other methods. Requestors can enter their information directly regarding the requirements for the translation. Once LAD knows the scope of the project, it assigns a translation/revision team to the project, depending on language, topic, availability, and other requirements, such as whether formatting is needed. Regardless of whether the translation can be handled in house or has to be outsourced, the length of the text should be known, to estimate cost and the amount of time the project will take.

Depending on the type of document, the translation could be handled manually by one translator, who would then pass it to another translator, who revises the original translation for accuracy and other factors, depending on the client's needs. The text also could be processed through different computer-assisted methods to obtain a machine-generated translation that would have to be revised or post-edited by a human translator or reviewer. Any formatting needed should be requested at the beginning of the project, so the new text is dropped in the desired format, then adjusted to the customer's requirements within the allotted time. Once the final translation is completed, the new document in the target language is sent back to the customer for their approval. If any corrections are needed, the document has to be sent back to the appropriate area for rework. One other process to consider is invoicing. The decision to set up an LAD as revenue generating depends on institutional preferences and accounting practices, and will drive the need for invoicing with the appropriate process flow.

KEY UNITS OF WORK AND VOLUME STATISTICS TO MONITOR

The data gathered while providing language services are very useful to the department and the institution. LAD data reveal the resources needed to provide language services and can be used to justify the need for more resources, track staff productivity, allocate resources, and determine if any issues may be developing in certain areas of the department.

LAD should keep track of the number of assignments, length of time per assignment, labor expenses, and number of full-time equivalent positions. The data should be gathered by type of service (in person, telephone, video, or translation) to look at growth, trends, and needs by type of service. The director should also monitor services by language and combine type of service and language to determine more specifically how the department uses needed resources. Comparing the data from one year to the next can reveal changes in numbers and trends that can explain or justify growth. To report trends to division leadership, a summary of the data, along with comparisons to previous years, can be presented monthly.

KEY METRICS TO MONITOR: PEOPLE, SERVICE, QUALITY/SAFETY, FINANCIAL

Monitoring these four areas keeps leadership informed of changes and allows the necessary modifications to more adequately control operations and stay within institutional parameters. People metrics provide valuable information regarding the need for recruitment, whether or not retention issues are present, and keeps track of staff recognition. Service metrics help monitor productivity and enable appropriate action should an issue surface. Quality metrics include response time and can show improvement in this area as operations are modified, and can also be used to monitor any safety issues. Financial metrics are related to expenses for personnel, contracted services, and department supplies. These data are helpful in adhering to budget. Personnel expenses are normally the largest LAD expense, but depending on the volume and management of the operation, contract services could be the largest. Exhibit 11.6 shows a sample scorecard used to track key monthly metrics the LAD can monitor. The specific metrics for target, stretch, threshold, and underperformance should be developed according to the metrics observed at each organization.

STAFFING MODELS

Adequately staffing a Language Services operation involves several factors, including hours of operation, patient volumes, languages needed, and the types of cases encountered in each practice.

Note that most of the work LAPs perform takes place during regular office hours, Monday through Friday during the daytime. An activity plot for most hospitals providing both outpatient and inpatient care would show a well-defined bell curve with a sharp increase in both areas in the demand for language services shortly after opening, and a sharp decrease at the end of the business day in the outpatient areas.

The need for interpreters shifts from outpatient clinics during the day to the Emergency Department and inpatient units at night. Some institutions may prefer to assign interpreters to specific units, whereas others may find rotating their interpreters among all services more efficient. A rotating operation keeps all interpreters exposed to many different specialties, making it easier for any interpreter to provide service in any area. Assigning interpreters to specific areas specializes them in a particular field, making them more difficult to replace, and even creating dependency on the interpreters by both staff and patients, who may prefer to work with the interpreter assigned to the unit. This dependency may create challenging situations when the assigned interpreter is on leave or otherwise unavailable.

Exhibit 11.6: Language Assistance Department Scorecard

Scorecard LANGUAGE ASSISTANCE DEPARTMENT								
	Metric	Under-performing	Threshold	Target	Stretch	Sept 2019	Oct 2019	Nov 2019
PEOPLE								
P1	**Recognition Letters:** # of recognition letters given (mail or other)	0		≥1				
P2	**Vacancies:** Total # of vacancies							
P3	**Year-to-Date Turnover:** % of staff who (voluntarily+involuntarily) left the institution since 9/1/19							
SERVICE								
S1	**Service Complaints:** # of service complaints received	>10	8–10	4–7	<4			
S2	**Dispatch Time:** Decrease the average time from receipt of request for in-person interpretation to time when interpreter is dispatched to assignment from 9.47 minutes to <9.25 minutes	≥9.47 min	9.46–9.25 min	9.24–9.03 min	<9.03 min			

(continued)

Exhibit 11.6: Language Assistance Department Scorecard *(continued)*

Scorecard LANGUAGE ASSISTANCE DEPARTMENT								
	Metric	**Under-performing**	**Threshold**	**Target**	**Stretch**	**Sept 2019**	**Oct 2019**	**Nov 2019**
S3	**Productivity:** # of KUoW metrics achieving productivity goals (refer to KUoW report)	<1		1				
Quality								
Q1	**Interpreter Interaction Time:** Average number of minutes of interpretation per interpreter and interaction	<10 min	10–13 min	14–16 min	>16 min			
Q2	**Audits and Regulatory Requirements:** % compliance with HR files	*Performance ranges under development*						
FINANCE								
F1	**Personnel Expense**	>Budget		≤Budget				
F2	**Other Operating Expense**	>Budget		≤Budget				
F3	**Total Operating Expense:** Personnel Expense + Other Operating Expense (Award Department Financial Goal)	>Budget		≤Budget				
F4	**Operating Income/Loss:** % Variance Actual to Budget							

Note: KUoW = key unit of work.

Another way of staffing is to follow a daily list of appointments and procedures. In this method, any delay in the appointment flow creates a delay in the interpretation flow, which increases as the day goes by, stacking up in different areas, and may prevent interpreters from servicing some of their patients, because they have to wait for already scheduled ones.

In institutions with a very diverse patient population, Language Assistance departments cannot have staff interpreters employed for every language needed. Such patient populations make it necessary to schedule appointments well ahead of time to request contract interpreters for other languages. In cases when there are walk-ins for languages not offered on staff and no live interpreter is available, the service can be provided over the phone, or via video, because these services are available on demand.

To demonstrate how to calculate the number of staff interpreters needed, exhibit 11.7 shows the assumptions and calculations used to determine the number of interpreter FTEs needed in a specific situation.

Exhibit 11.7: Language Assistance Staffing Model

Calculate the number of full-time equivalent positions needed to work an interpretation assignment.

1. Exclude Nonproductive Time
   - Exclude paid hours that are considered nonproductive such as paid time off, sick leave, jury duty, or Family Medical Leave
   - This is likely to be around 90% of total paid hours
   - Total = 4 hours per week per FTE is lost to nonproductive time
2. Exclude Time Spent on Non-Direct Patient Care Activities
   - 30 minutes per day for organizational tasks or 2.5 hours/week
   - 1 hour/month with committee work
   - 1 hour/month for continuing education
   - Total = 1 hour/week in non-direct patient care, leaving 88% of their productive hours for direct patient care
3. Direct Patient Care Demand: Interpretation Assignment
   A. Each intervention takes an average of 42 minutes (understanding some patients take more time and some take less time)

Example: Interpreter Model Assumptions:

- 87.5% nonproductive time per interpreter: 154 worked hours per month
- Deduct another 10% from productive hours to account for non-direct patient care time: 154 – 17 = 137
- Estimate that each intervention will take 42 minutes (0.7 hours)

(continued)

Exhibit 11.7: Language Assistance Staffing Model *(continued)*

A.	Total number of appointments needing interpretation per month	7,150
B.	Interpretation hours needed per month (0.7 × A)	5,005
C.	Available interpretation hours per interpreter per month	137
D.	Interpreter FTE needed (B / C)	36.53

As a general rule, an interpreter can see 6–10 patients per day.

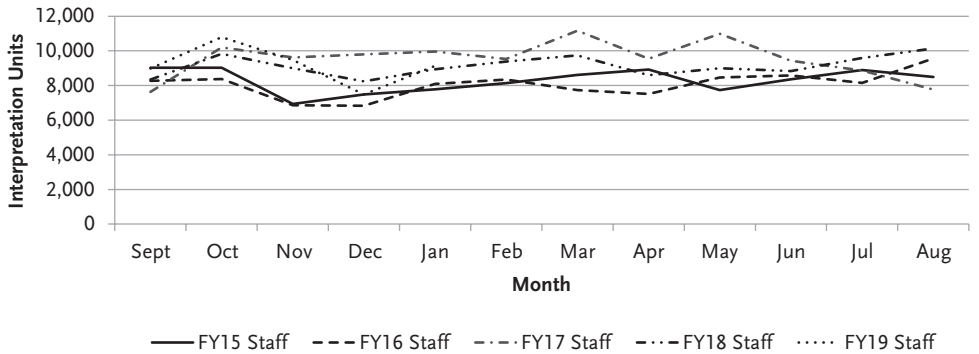
PRODUCTIVITY MODELS, INCLUDING WORK-TO-STAFF RATIOS AND INDUSTRY PERFORMANCE TARGETS

Measuring productivity and work-to-staff ratios in language services varies across institutions. Factors that affect productivity include type of institution, its volume and bed size, schedules and hours of operation, and methods of service delivery.

Delivery method (in person, telephone, video) makes a big difference in staff productivity. Some of the monthly metrics suggested to keep track of productivity include the number of assignments per employee and the total time they spend on those assignments. The data can yield productivity information, such as average minutes per call, hours spent interpreting per month, average number of hours interpreted per day, and average number of assignments per day.

These data, as well as the data collected from vendors of telephonic, video, and contract in-person interpretation, can be converted to interpretation units as a common unit of work. One suggestion is to convert the number of minutes interpreted in each modality to interpretation units equivalent to 15 minutes of interpretation per unit. This calculation can be modified to different numbers of minutes of interpretation per unit, depending on preference. Exhibit 11.8 shows a sample control chart with interpretation units per month tracked over a period of more than four years.

Exhibit 11.8: Total Staff Interpretation Units per Month



Benchmarks for language services are not readily available in the industry, so language services directors are advised to create relationships with directors at other institutions similar in size and working under similar circumstances, to compare performance standards.

In general, though, in-person interpreters can handle between 6 and 12 assignments per eight-hour shift. This workload may vary, depending on the nature of the interpretation work. An interpreter working at a community clinic taking care of more common medical appointments could face up to 30 assignments per day, whereas another at an oncology specialty hospital may only have an average of six assignments daily. An average of ten assignments per day per interpreter is a good starting point for in-person interpretation. Once productivity data is tracked for some time, and certain averages are known, work-to-staff ratios can be calculated for the specific situation, and benchmarks can be set for the operation, which can help determine work activity and decide the number of labor hours needed to cover the demand for language services.

STRATEGIES TO IMPROVE RECRUITMENT AND RETENTION

Depending on the level of experience required for each institution, different strategies can be applied to recruit good candidates for interpreter and translator positions. In certain situations there may be a need to recruit candidates as they graduate from a training institution. Creating relationships with local institutions that provide medical interpreter/translator training can prove useful to recruit graduates. Being able to do a presentation to students prior to graduation introduces the institution to potential candidates who might not have thought about certain organizations otherwise.

Other institutions may need to hire staff with experience in medical interpretation. Directors should build relationships with members and leaders of language assistance trade associations and volunteer to make educational presentations. Working with trade associations at the local, state, and national level can open a dialogue about the institution, the requirements for candidates, and what the institution can offer employees.

To promote retention, the director should provide staff with clear expectations of work, a complete understanding of their job functions, and a comprehensive orientation to the department and position. This approach should include an introduction to departmental staff, training on how work is expected to be conducted, and exposure to the work environment prior to new staff interpreting on their own. Having new interpreters shadow more experienced ones helps them learn the processes and understand the workplace culture.

Creating opportunities for advancement within the department is also good for employee retention. Having a tiered structure, where the interpreter or translator can advance in title and compensation, can help retain staff. Hiring for supervisory positions from within is also highly recommended, as this provides another opportunity for advancement.

Another factor that improves retention is providing professional development opportunities. Having a budget to assist with certification, conferences, and other development will help employees focus on doing their best in the department. Other important factors to strengthen retention are recognizing the valuable work of interpreters, asking for their input on improvement, and following up on their suggestions with regular staff updates.

KEY REGULATORY ISSUES

According to federal regulations, healthcare organizations receiving federal funds must provide LEP individuals with meaningful access to their services (US Department of Health and Human Services [HHS] 2016a). This regulation must be met by providing effective language assistance free of charge to the patient. The federal mandate is true for all healthcare providers receiving federal funds, regardless of their size, from large hospitals to individual practitioners. The regulations account for differences in size and available resources and allow for different methods of interpretation delivery. For example, an individual practitioner with only a few LEP patients may provide interpretation through a vendor of telephonic interpretation. This interpretation would only cost a few dollars per patient, and the service would be provided by calling an 800 number that would give the practitioner access to a wide range of languages on demand. On the other hand, large healthcare organizations are expected to provide a mix of interpretation services (i.e., face to face, contract video, and telephonic) to handle a much larger demand and diversity of language services.

Proper training of interpreters is also stipulated by law that requires interpreters to be qualified for medical interpretation and specifies what constitutes qualification. According to Section 1557 of the Affordable Care Act, a qualified medical interpreter for an individual with limited English proficiency is an interpreter who via a remote interpreting service or an on-site appearance

A. adheres to generally accepted interpreter ethics principles, including client confidentiality;
B. has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and
C. is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology (HHS 2016b).

Medical interpreter certification is not mandated by law whether they work in person, over the phone, or via video. The law prohibits minor children (under the age of 18) from interpreting, except for short-term emergency situations where an interpreter is not available (HHS 2016a). Using family or friends as interpreters is also prohibited, unless the patient specifically requests it (HHS 2016a). Should the patient request this, the hospital should determine if the person designated to interpret to/for the patient is capable of interpreting. The healthcare organization should still provide an interpreter to monitor the ad hoc interpreter, and the hospital-appointed interpreter should intervene if the designated interpreter does not provide adequate interpretation (accurate, impartial, and transparent). Other healthcare staff should refrain from interpreting, unless they are qualified to do so, because interpreting is an official job duty (HHS 2016b).

Regarding video interpretation, current regulations require certain standards. Video must be of high quality. The video interpretation must be done in real-time, full-motion video over a high-speed, wide-bandwidth video connection delivering high-quality images. The transmission of voices must be clear and audible, and users of the technology must be adequately trained to operate the equipment (HHS 2016c). Exhibit 11.9 provides a timeline showing the laws and regulations affecting language services for healthcare organizations.

Exhibit 11.9: Laws and Regulations Governing Language Services in Healthcare

- Title VI of the Civil Rights Act of 1964 prohibits discrimination of persons based on their race, color, or national origin by entities receiving federal funds.
- Since 1964, the Department of Justice has issued regulatory requirements that have been interpreted to prohibit denial of equal access to programs or services because of an individual's limited proficiency in English.
- On August 11, 2000, President Bill Clinton issued Executive Order 13166, "Improving Access to Services by Persons with Limited English Proficiency" (LEP).
- The same day, the Civil Rights Division of the US Department of Justice issued an initial Guidance document titled "Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency," in which it advised recipients of federal funding they were required to take reasonable steps to ensure meaningful access by LEP persons.
- On March 23, 2010, President Barack Obama signed the Affordable Care Act (ACA).
- On May 18, 2016, the US Department of Health and Human Services, Office for Civil Rights issued the implementing regulation for Section 1557 of the ACA, indicating covered entities must take reasonable steps to provide meaningful access, free of charge and in a timely manner.
- The Joint Commission has adopted several of the regulations related to language services included in the preceding documents and has converted them into standards for its customers to follow.

KEY TERMS FOR LANGUAGE ASSISTANCE

Interpretation: The facilitation of spoken or signed language communication between users of different languages.

Limited English Proficient: A term used in the United States for a person who is not fluent in the English language, often because it is not their native language.

Sight translation: The oral rendition of a written text.

Translation: The process of converting the written word from one language to another in a way that is culturally and linguistically appropriate so it can be understood by its intended audience.

REFERENCES

US Department of Health and Human Services. 2016a. "Nondiscrimination in Health Programs and Activities; Final Rule." 81 Fed. Reg. 31470. May 18 (45 CFR Part 92).

———. 2016b. "Nondiscrimination in Health Programs and Activities; Final Rule." 81 Fed. Reg. 31468. May 18 (45 CFR Part 92).

———. 2016c. "Nondiscrimination in Health Programs and Activities; Final Rule." 81 Fed. Reg. 31470–31471. May 18 (45 CFR Part 92).