



Summary of Forum Proceedings

Public Forum on

Language, Culture, and Health Care

September 19, 2007

November 2007

Hosted by the Governor's Interagency Council on Health Disparities

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The Public Forum on Language, Culture, and Health Care was organized and sponsored by the Governor's Interagency Council on Health Disparities. The Council would like to acknowledge and thank all of those who attended and shared their valuable stories, input, and suggestions:

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The members of the Council would also like to sincerely thank Stella Ji, Twi Staggs, and Tina Yates from N.W. Interpreters, Inc. for their interpretive services, professionalism, and contributions to the forum.

Council members in attendance at the forum:

Vickie Ybarra, Chair
Emma Medicine White Crow, Vice Chair
Martha Holliday
Winona Hollins Hauge

MaryAnne Lindeblad
Frankie Manning
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Introduction

The Governor's Interagency Council on Health Disparities (Council) held a public forum on September 19, 2007 in Tumwater, Washington to hear input about cultural and language barriers to health care. The Council wanted to hear whether people are able to obtain clear and accurate health information, either in writing or through interpreters, regardless of their cultural background or the language they speak. Spanish, Korean, and Vietnamese language interpreters were onsite during the forum.

The Council is responsible for developing recommendations to improve the availability of culturally and linguistically appropriate health literature and interpretive services. Information received at the public forum will be used to help develop those recommendations.

Public Forum Proceedings

Vickie Ybarra, Council Chair, welcomed participants and asked Council members in attendance, Council staff, and members of the public to introduce themselves. She explained the purpose of the public forum and informed participants that comments obtained would be used to guide the development of recommendations that would be shared with the Governor and Washington State Legislature.



Chair Ybarra asked participants if anyone had prepared comments that they wanted to share. While prepared written comments were received by Council staff in advance of the public forum (see appendix), no participants present at the forum had prepared comments. Therefore, Chair Ybarra moved forward with the discussion portion of the forum. Following, is a summary of the general themes that emerged during the discussion.

1. Recruitment and Retention of Interpreters

Participants discussed the lack of interpretive services, particularly for the Korean and Vietnamese communities. One participant mentioned that the Korean community is pleased that Korean language interpretive services are becoming more available. She shared that some patients had to reschedule medical appointments a number of times because Korean language interpreters were not available. A second participant added that there is a general lack of Vietnamese language interpreters, particularly female interpreters. She added that this was problematic for Vietnamese women who prefer to have an interpreter of the same sex, particularly pregnant women or women seeking gynecological treatment.

This conversation led to a follow-up discussion about strategies to recruit and retain more interpreters. Participants discussed that working conditions and benefits needed to be improved (e.g., higher pay, more stable pay, guaranteed hours). One suggestion was to provide interpreters with a wage rather than paying them per appointment, since appointments are often cancelled and income is subsequently lost. Participants indicated that there were probably enough qualified

interpreters available, but that the working conditions and benefits would need to be improved to attract and retain individuals into the profession.

One participant said that the interpretive services brokerage was a barrier for providers to obtain high quality interpretive services. She clarified that the process to obtain interpretive services through the brokerage was cumbersome. Another participant offered that national certification

“Because hours are not guaranteed, it is a very difficult position for people to get into if they don’t have another income to rely on.”

—Participant’s comment about the need for improved working conditions and pay for interpreters.

was a requirement for medical interpreters (both spoken and sign language interpreters). He added that the requirements for certification are expensive and time consuming, the process is onerous, and there is a lack of training programs – all of these factors serve as barriers to obtaining national certification to become a medical interpreter.

Another participant mentioned that having more availability of interpreters in the inpatient setting is important.

II. Quality in Interpreting

One participant shared that CHOICE Regional Health Network received a Robert Wood Johnson grant to develop recommendations for improving the quality of interpretive services. She shared that this work culminated in a report that was published in December 2007. The report looks at quality in two ways – the first being how to improve the quality of the interpretive services themselves and the second is how to improve the quality of the service delivery methods.

Another participant mentioned that Washington is one of the only states that require testing for medical interpreters. This participant added that while this is a good first step, the test needs to be improved.

III. Cultural Competency of Washington’s Healthcare System



One participant shared that many seniors are intimidated by their physicians and other health care providers and don’t offer any additional information about their condition than what is asked of them. She added that this is a social norm that needs to be addressed so that seniors can receive better initial care so they won’t have to return for follow-up care at a later date. One possible solution that was discussed is a model that Group Health is using to engage the patient in a conversation

and to check back with the patient that the information being recorded in the patient’s record is accurate. The participant added, however, that some patients will still feel that they are not competent enough to question the health care provider about the information being recorded.

Participants also discussed that time limits imposed on office visits serve as a barrier to high quality health care. As examples, one participant mentioned that patients with language barriers may need more time to discuss their medical histories and symptoms and would also require more time to fill out medical forms.

Other participants shared personal stories of poor quality healthcare they had received based on perceived discrimination and assumptions being made about their cultures. Participants discussed possible solutions, including the need for required cultural competency training for all providers. One participant mentioned that trainings using case-based scenarios are a good way to teach providers how to address cultural differences in their practices. Another solution is to have more providers who look like their patients, speak their language, and understand their culture. Two examples of systems changes that were brought up included programs to subsidize or alleviate student loans for students that come from communities of color and programs for students to work in underserved communities in exchange for tuition.

Participants generally agreed that the reason there are not more people of color and bilingual people going through health professions training is the cost of education. Early education in science and additional support for students of color to succeed in science is also needed. Another participant mentioned that role models in the community and in families also are needed to encourage students of color into the health professions.

“We’ve heard from our clients that they are more comfortable going to providers who look like them -- who come from the same culture, come from the same community.”

-Participant’s solution for improving the cultural competence of Washington’s healthcare system.

Another participant mentioned that more emphasis should be placed on teaching health literacy within families. She argued that this was one solution to improve communication between patients and providers. Additionally, she added that there are “speech communities,” and health care providers and health educators need to learn how to develop messages that resonate with the targeted communities.

IV. Culturally Competent Community Health Education Materials and Services

One participant shared information about the work of the Cross Cultural Collaborative of Pierce County, which represents communities of color, low-income communities, and the LGBTIQ community. The collaborative pays community-based organizations to provide services to the communities they serve. She emphasized the need to work directly with community representatives and organizations to develop health solutions and messages and to pay these individuals and groups for their service. The collaborative also works with the organizations to disseminate the materials and provide the services to the community and to obtain community feedback on what works and what needs to be altered to better suit particular populations.



Another participant shared information about the outreach and promotoras network in the Quincy and Moses Lake areas. The members of the network know who the leaders are in their communities and develop and provide information that the communities ask for. Due to their success, they've started to receive requests from county-level, state-level, and national-level organizations to help disseminate materials throughout their communities.

Participants discussed that state and local health departments need to connect with community groups and collaboratives, like those mentioned above. Rather than to translate English language materials, organizations need to figure out how to engage the communities themselves and work with the community members to build materials together. Participants also discussed ways to improve the quality of translated health education materials. One solution is to use back-translation. In addition, health educators and providers need to develop messages, whether in English or translations in other languages, at appropriate reading levels and limit the use of medical terminology whenever possible.

The group discussed other ways to improve the readability and comprehension of health education materials. Materials in English should be written at the sixth grade reading level, while Spanish-language materials should be written at the third grade level. Materials should have large font and pictures and contain as few words as possible. Materials should also be single-sided.

“As we create these materials...it’s important that we understand that just because we have these fancy terms, it doesn’t mean we have to use them... How does it help the patient?”

-Participant’s suggestion to improve the readability and quality of health education materials

It is also critical to bring culturally-relevant materials to the communities. For example, photo novellas and radio novellas that contain health information are well-received in many Spanish-speaking populations.



In terms of content of health education materials, another participant mentioned that health educators and providers need to consider the social determinants of health when creating health messages. She provided an example of a patient who could not follow her health care provider’s advice to eat more fruits and vegetables because she lived in a neighborhood where access to fresh food was limited.

One participant suggested that we need to create a bank or a clearinghouse of all these materials so everyone can have access to them. Participants discussed that there are some hospitals that aggregate materials, but their scope is limited. Other participants discussed that listserves are useful for identifying and sharing materials that have already been developed. The State Department of Health maintains the “Health Education Resource Exchange,” which serves as a repository for health education materials. Another participant mentioned that there might be a need for a certification process to ensure that high quality materials are made and disseminated.

Participants also discussed that health ministries and young people in the community are avenues for improving health. Another participant mentioned that we needed to be creative when finding sources for funding to create health education materials.

Summary

Key recommendations from the “Public Forum on Language, Culture, and Health Care” were to:

- Attract more interpreters into the profession with better working conditions, higher and more stable pay, and improved benefits.
- Work with community members and community-based organizations from the beginning to identify needed health education topics, develop appropriate health messages, and use relevant media and dissemination strategies.
- Improve the participation of people of color in the healthcare professions by addressing the cost of education.



Appendices

1. Written testimony from Sunnyside Community Hospital
2. Written testimony from Marc Brenman, Executive Director, Washington State Human Rights Commission

Sunnyside

COMMUNITY HOSPITAL

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September 19, 2007

To: The Governor's Inter-Agency Council on Health Disparities

To Whom It May Concern:

As you are all aware, communication is vital in the process of offering competent, quality healthcare. There is a risk of not only misunderstanding, but misdiagnosis, if provider and patient are not able to effectively communicate.

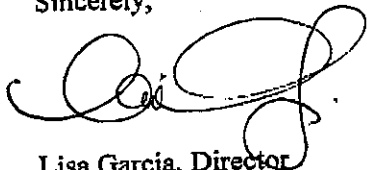
Sunnyside Community Hospital is located in the Yakima Valley of Eastern Washington. We are a rural community with a largely agricultural economic base. Because of this, we have a large percentage of our clientele arrive at our hospital and clinic doors not only in need of medical care, but Spanish translation services as well.

Sunnyside Community Hospital has been working to overcome these problems for several years, and we continue to review and upgrade our internal procedures to ensure that barriers of language and culture are overcome. We currently have nearly 40 employees who are certified Spanish interpreters, having either passed our own In-House Certification test, or are State LIST certified interpreters. For the most part, they have separate jobs within our facilities, such as RNs, receptionists, phlebotomists, LPNs, etc. They are distributed throughout the departments and our clinic in order to provide translation services to our patients and providers. If they are needed to interpret in other departments, we allow them to assist as they are able. We follow up with the various departments to insure that their translation needs are being met.

Our In-House certification process includes a 6-week course which involves not only learning grammar, vocabulary and sentence structure, but a Code of Conduct for Interpreters, which emphasizes confidentiality, impartiality, cultural awareness, mutual respect, and integrity.

For interpretation needs other than Spanish, we have contracted with Language Line Services for assistance in those circumstances. Our future goals include certifying more interpreters for those departments that still find themselves lacking in help at times.

Sincerely,



Lisa Garcia, Director
Human Resources
Sunnyside Community Hospital

**Public Testimony
Submitted for the Public Forum on Language, Culture, and Health Care
September 19, 2007**

Submitted by:
Marc Brenman
Executive Director
Washington State Human Rights Commission

Spokane LEP Presentation

May 2007

Introduction

Equal and effective access to government, non-profit, and business services and infrastructure are civil rights. People have these rights just because they are here—in this country, in this State. Today we are talking about people who are limited English proficient. Some are good people, and some are not. Just like the rest of us. Understanding their language is a first step toward lower barriers to their participation in society. Understanding language is not going to solve all our problems. There are many other steps that need to be followed. Cultural competence is one. Being on the same emotional wavelength is another.

How many of you have had or do have teenagers in your house? Chances are good, sometimes you wonder if you speak the same language.

Ethos

What business do I have talking with you about these issues? At least one person will tell you that I am just a plain old Anglo guy who doesn't even speak Spanish. And that's true. I also don't speak Russian, Somali, or Vietnamese. I also don't speak sign language and I'm barely computer literate. But I've been dragging this old white body around the civil rights business for about 34 years. And I've been working on limited English Proficiency issues for about that long. In one two year period while working for the Office for Civil Rights of the U.S. Department of Education (then HEW), I wrote eleven non-compliance letters against school districts, including the entire states of Hawaii and New Hampshire, and consulted on a similar case involving the 200 Native Corporations of Alaska. I wrote the LEP Guidance for the U.S. Department of Transportation, which employs more people than the state government of Washington. I've worked on three U.S. Supreme Court cases, and one Washington State Supreme Court case.

Statistics

Based on the 2000 census, over 26 million American citizens or residents speak Spanish

at home and almost 7 million individuals speak an Asian or Pacific Island language at home. If these individuals have a limited ability to read, write, speak, or understand English, they are limited English proficient, or "LEP."

In a 2001 Supplementary Survey by the U.S. Census Bureau, 33% of Spanish speakers and 22.4% of all Asian and Pacific Island language speakers aged 18-64 reported that they spoke English either "not well" or "not at all."

Between 1990 and 2000, the foreign-born population of the United States increased 44 % to 28.4 million people, according to the U.S. Census Bureau. This figure— 28.4 million— is 10 % of the nation's total population, the highest %age since 1930. People living in the United States speak over 300 different languages, and nearly 47 million people speak a language other than English at home, as reported by the U.S. Census Bureau (2003).

Barriers

What we sometimes forget is how much of a barrier language can pose for a person who does not speak English.

It can be a barrier to accessing important benefits or services, including assistance from the justice system.

It can be a barrier to understanding and exercising important rights;

It can be a barrier to complying with governmental or other responsibilities; and

It can be a barrier to understanding how to participate fully in our society.

Many people, particularly many of the elderly, may not have a realistic potential to learn English. We also know that a language cannot be learned overnight, even for those who are in English-as-a-second-language or other English language acquisition programs.

Health care providers are not typically trained in academic and continuing education settings to work with interpreters in providing services to people with limited English proficiency.

There are shortages in qualified personnel to provide medical translation and interpretation services especially in rural areas.

Inadequate resources have been allocated for the provision of translation and interpretation services at the state and local levels.

Segments of the immigrant and refugee population are unlikely to advocate for translation and interpretation services due to linguistic and cultural barriers, which include the perception of adverse political repercussions.

Persons with limited English proficiency are not likely to seek health care services unless the providers meet their linguistic needs. Delays in seeking health care often result in the need for costly services to treat advanced stages of diseases. This has serious ramifications for both the health care delivery system and the individual. Invasive diagnostic and treatment procedures, specialty care, lengthy hospitalization and longterm care are costly. Delayed access to health care may result in lost wages, decreased productivity and an increased risk for chronic illness, disability, undue suffering and possibly death. Studies have documented evaluation approaches and the cost benefits of providing interpretation services.

We must ensure that Federally-assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English.

Heightened requirements by recipients of federal financial assistance.

What that means.

Title VI of the Civil Rights Act of 1964

What it is

Prohibits race and national origin discrimination

By recipients of federal financial assistance

Lack of services

Guidance from federal agencies to recipients of federal financial assistance

www.lep.gov = excellent resource

HHS/OCR

ED/OCR

WLAD (Washington Law Against Discrimination, RCW 49.60)

The Hill-Burton Act

Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a “community service

obligation”, one of which is a general principle of non-discrimination in the delivery of services. HHS’s Office of Civil Rights has consistently interpreted this as an obligation to provide language assistance to those in need.

Medicaid

Medicaid, a Federal-state cooperative program of medical assistance, provides health insurance to adolescents, children and families who are poor, and people with disabilities and those who are indigent and elderly. Medicaid regulations require Medicaid providers and participating agencies, including long-term care facilities, to render culturally and linguistically appropriate services. The Health Care Financing Administration, the Federal agency that oversees Medicaid, requires that states communicate both orally and in writing “in a language understood by the beneficiary” and provide interpretation services at Medicaid hearings.

Medicare

Medicare is a Federal program that provides insurance to people 65 years of age or older, with certain disabilities who are under 65 years of age, and of any age with permanent kidney failure. Medicare addresses linguistic access in its reimbursement and outreach education policies. Medicare “providers are encouraged to make bilingual services available to patients wherever the services are necessary to adequately serve a multilingual population”. Medicare reimburses hospitals for the cost of the provision of bilingual services to patients.

Emergency Medical Treatment And Active Labor Act (EMTALA)

This Act requires hospitals with emergency departments that participate in the Medicare program to treat all patients (including women in labor) in an emergency without regard to their ability to pay. The EMTALA Act was passed to reduce the practice of “dumping” patients who lacked the financial ability to incur hospital costs. EMTALA stipulates a hospital’s responsibilities to the patient which include the diagnosis, treatment, informed consent, and notification of condition and intent to transfer to another facility. Hospitals that fail to provide language assistance to persons of limited English proficiency are potentially liable to federal authorities for civil penalties as well as relief to the extent deemed appropriate by a court.

State Children's Health Insurance Program (Healthy Families Program)

Health plans participating in the Healthy Families Program are required to comply with Title VI and other requirements for language assistance services using their existing capitated funds. No additional direct cost reimbursement or funding currently is available for language assistance services. However, the Managed Risk Medical Insurance Board (MRMIB) that administers the Healthy Families Program also could choose to provide an enhanced capitation rate for health plans and health providers serving Limited English Proficient health consumers.

Is this really happening?

As part of a settlement of a Title VI complaint in 1983 (amended in 1987) and subsequent state legislation, the state of Washington implemented a comprehensive language assistance program, the Language Interpreter Services and Translation (LIST) program. DSHS contracts with thirteen language assistance service organizations for interpretation services and with three language assistance service organizations for translation services. These language assistance service organizations provide services to several state government departments, including its Medical Assistance Administration (which administers Washington's Medicaid, State Children's Health Insurance Program and SSI programs), the Economic Services Administration (which administers Temporary Assistance for Needy Families and child support), the Health and Rehabilitative Services Administration (which administers mental health, alcohol, substance abuse, vocational rehabilitation and developmental disability programs and services for the deaf and hard of hearing), Juvenile Rehabilitation, the Children's Administration, Aging and Adult Services and the Management Services Administration.

Like many other states, Washington has been sued under Title VI, and as part of a consent decree issued more than 10 years ago to assure effective communication between patients and health providers, it established language support services and launched certification of interpreters (now available in seven languages). No civil suits have been filed since the programs began. Washington was also the first state to use the Medicaid match to help support the costs of interpretation services. Starting in 1992, the state established two contracting structures under Medicaid. For public hospitals and health departments, it enters into "interlocal agreements," reimbursing 50 percent of the cost of hiring interpreters, offset by its 50 percent federal administrative match (\$3 million in 2000), with no state money involved. For private physicians, clinics and outpatient services at hospitals, it pays interpreter agencies directly, to the tune of \$10 million a year in federal and state Medicaid dollars. The funds support services to the estimated 160,000 Medicaid recipients with limited English-speaking skills.

To ensure better quality control, accountability and efficiency in the private contracts, the state will soon move to a "brokerage system," using intermediaries between providers and interpreter agencies to improve scheduling and payment processes. The change is expected to save up to \$2.6 million in federal and state funds between January and June of next year. According to Tom Gray, section manager for transportation and interpreter services in the Medical Assistance Administration, the move won't supplant a provider's responsibility to assure language access. If the broker can't make an interpreter available, it's up to the provider to adhere to the spirit and letter of the law by finding someone else to do the job.

The state tests and certifies interpreters and translators in the following languages and dialects: Cambodian, Cantonese, Korean, Lao, Mandarin, Russian, Spanish and Vietnamese. The written part of the test includes sections on ethics, medical terminology, clinical and medical procedures, English language syntax and grammar, and syntax and grammar in the non-English language. The oral part of the test includes sections on sight

translation and consecutive interpretation. For other languages (over 80 other languages plus major dialects), there is a "qualification" process that includes a written test on ethics, medical terminology, clinical and medical procedures and translational writing in English; the oral part of the screening test includes sight translation, memory retention and back interpretation from the non-English language to English. For translators, the state tests qualifications through independent reviews.

Providers request language assistance services from the language assistance agencies. The language assistance agencies bill the state and are paid \$33.60-39.00/hour for interpreter services.

Voting Rights Act

Enforced by U.S. Dept. of Justice/Voting Rights Section

Translation of ballots.

Professional Standards

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions such as home health care and psychiatric facilities, and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health managed care organizations (MCOs), have adopted standards that require language access in health care.

JCAHO standards require health care organizations to “have a way of providing for effective communication for each patient served”. JCAHO standards expect that patient and family education take into account culture and language. The NCQA requires that MCO enrollees be provided with written materials that they can understand. This standard, however, only applies when 10% or more of the MCO membership is non-English speaking.

Liability

A person can die because of lack of language translation, for example, in a medical situation. Lawsuits can result.

Failure to provide interpretation and translation services may result in liability under tort principles in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also in some states the failure to convey treatment instructions accurately may raise a presumption of negligence on the part of the provider.

The ability to communicate well with patients has been shown to reduce the likelihood of malpractice claims. A study appearing in the Journal of the American Medical

Association indicates that the patients of physicians who are frequently sued had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate. The use of qualified medical interpretation and translation services enhances patient-provider communication, thereby decreasing the risk of malpractice.

Failure to communicate effectively also constitutes a threat to informed consent.

DOJ's Four Factor Analysis:

The number or proportion of LEP persons encountered in the Department's jurisdiction/precinct etc., including any seasonal, tourism, or other variations in the LEP population;

The frequency of contact with LEP individuals;

The nature and importance of the various types of encounters the Department has with LEP persons; and

The resources available to the Department and the costs associated with providing language services.

A Revised Cultural Formulation

Step 1: Ethnic identity. The first step is to ask about ethnic identity and determine whether it matters for the customer—whether it is an important part of the person's sense of self. As part of this inquiry, it is crucial to acknowledge and affirm a person's experience of ethnicity and the services they seek, need, or are having imposed on them.

Step 2: What is at stake? The second step is to evaluate what is at stake as customers and their loved ones face an episode of needing services. This evaluation may include close relationships, material resources, religious commitments, and even life itself.

Step 3: The service narrative. Reconstruct the customer's "service narrative" [38]. This involves a series of questions aimed at acquiring an understanding of the meaning of the services. Now here is something surprising-- the customer should recognize that the service provider does not fit a certain stereotype any more than they themselves do. Think of the stereotypes we carry around about police officers, for example.

Step 4: Psychosocial stresses. Step 4 is to consider the ongoing stresses and social supports that characterize people's lives. The service provider can also list interventions to improve any of the customer's difficulties.

Step 5: Influence of culture on clinical relationships. Step 5 is to examine culture in terms of its influence on customer relationships. One crucial tool in ethnography is the critical self-reflection that comes from the unsettling but enlightening experience of being between social worlds. We have to recognize and avoid bias, stereotyping, and fears.

This can be contrary to the view of the expert as authority and to the media's and critic's view that technical expertise is always the best answer. The statement "First do no harm by stereotyping" should appear on the walls of all service providers that cater to immigrant, refugee, and ethnic minority populations.

Step 6: The problems of a cultural competency approach. Finally, step 6 is to take into account the question of efficacy—namely, "Does this intervention actually work in particular cases?" There are also potential side-effects. Every intervention has potential unwanted effects, and this is also true of a culturalist approach. Perhaps the most serious side-effect of cultural competency is that attention to cultural difference can be interpreted by customers and families as intrusive, and might even contribute to a sense of being singled out and stigmatized. Another danger is that overemphasis on cultural difference can lead to the mistaken idea that if we can only identify the cultural root of the problem, it can be resolved. The situation is usually much more complicated. Simply providing special language services won't necessarily solve the problem.

Planning:

An effective LEP plan would likely include information about the ways in which language assistance will be provided. For instance, recipients may want to include information on at least the following:

Assign responsibility: Accountability: GMAP

Know your demographics

Who and how many speak what language and dialect?

What is their level of English proficiency?

Where do they live?

What is their preferred method of communication?

Types of language services available.

How staff can obtain those services.

How to respond to LEP callers.

How to respond to written communications from LEP persons.

How to respond to LEP individuals who have in-person contact with recipient staff.

How to ensure competency of interpreters and translation services.

Recipients should first examine their prior experiences with LEP individuals and determine the breadth and scope of language services that are needed. In conducting this analysis, it is important to:

Include language minority populations that are eligible beneficiaries of recipients' programs, activities, or services but may be underserved because of existing language barriers; and consult additional data, for example, from the census, school systems and community organizations, and data from state and local governments, community agencies, school systems, religious organizations, and legal aid entities.

Courts

Bad translations and interpretations can cause cases to be tossed out:

Spanish language interpreter the government provided for defendant during his naturalization interview was incompetent.

"In light of the fact that the indictment in this case is based upon statements made during the naturalization interview, this Court finds that the interpretation is so inaccurate as to render it unreliable as evidence of Defendant's actual statements."

<http://www.dallasnews.com/sharedcontent/APStories/stories/D8P0HQGTG3.html>

Interpreters

The widespread acknowledgement among federal agencies and language professionals at the conference of the critical shortage of interpreters and translators in the most commonly spoken languages, as well as the rarer ones.

More states need to put interpreter testing and certification programs in place, funding sources for language services need to be identified at all levels.

There aren't enough interpreter and translator training programs around the country. We need to certify in more languages.

There needs to be a national certification exam for medical interpreting.

Effectiveness

Equality

Barrier lowering

Rules on Schools

Lau v. Nichols, U.S. Supreme Court decision, 1974

Effectiveness; equivalent to education conducted in English to monolingual English speakers.

Usually higher % of LEP kids in schools than in adult population.

How long keep kids in programs?

Schoolyard v. academic language.

The particular difficulties of evaluating and serving students who are LEP with disabilities.

Impact of other laws—Sec. 504, IDEA

Bad to use family members

Spectrum of Types of Special Language Services Programs

From total immersion (sink or swim) to ESL to full bilingual/bicultural

Controversial

How long keep kids in programs?

The more jeopardy to the client/customer, the more the requirements.

Health Services Issues

Governor's Interagency Council on Health Disparities

“Consideration of Work Plan for Developing Recommendations Regarding Culturally and Linguistically Appropriate Materials and Services”

Law Enforcement

200 basic words and phrases

See also courts

When life and liberty are at jeopardy

Customer service

The problem of accents

The peculiar problem of higher education instruction

Accents can be a characteristic of national origin.

Must be understandable, if the job is one that entails communication.

Employment

General prohibition on barring use of non-English languages.

Safety exemptions

When people's lives depends on speaking one language

Essential function exemptions

E.g. radio announcer who needs to read English

Customer service

Bilingual staff

Interpreter services

Quality and certification issues

Medical, Legal

Embarrassments of bad translations.

Idioms

Bureaucratic language

Inventory of Resources

Staff language abilities

NPOs, Red Cross, other organizations

Public accommodations/ business establishments

Can't refuse to serve LEP people.

Bigger companies are pretty good at marketing to Hispanics

Training

Safety training. Should provide in appropriate languages.

“I Speak” cards

Non-verbal methods

Marketing

The Peculiar Problem of “English Only”

Voting Rights

Department of Justice

Problems of Literacy

(See also my FHWA Peer workshop presentation on literacy issues)

(From HHS LEP Guidance)

How does low health literacy, non-literacy, non-written languages, blindness and deafness among LEP populations affect the responsibilities of federal fund recipients?

Effective communication in any language requires an understanding of the literacy levels of the eligible populations. However, where a LEP individual has a limited understanding of health matters or cannot read, access to the program is complicated by factors not generally directly related to national origin or language and thus is not a Title VI issue. Under these circumstances, a recipient should provide remedial health information to the same extent that it would provide such information to English-speakers. Similarly, a recipient should assist LEP individuals who cannot read in understanding written materials as it would non-literate English-speakers. A non-written language precludes the translation of documents, but does not affect the responsibility of the recipient to communicate the vital information contained in the document or to provide notice of the availability of oral translation. Of course, other law may be implicated in this context. For instance, Section 504 of the Rehabilitation Act of 1973 requires that federal fund recipients provide sign language and oral interpreters for people who have hearing impairments and provide materials in alternative formats such as in large print, Braille or on tape for individuals with visual impairments; and the Americans with Disabilities Act imposes similar requirements on health and human service providers.

The problem of "**blindness to illiteracy**" is common, says the National Assessment of Adult Literacy, a survey conducted by the National Center for Education Statistics, which reports that an estimated 14 % of adults in the United States have "below-basic" levels of prose literacy, defined as the ability to use printed and written information to function in society. Twelve % of adults are also estimated to have below-basic "document literacy," meaning they can't read and understand drug or food labels.

Says researcher Dr. Erin Marcus, "There's also a growing body of research on health literacy, the ability to comprehend and use medical information." Patients with reading problems may avoid doctors' offices and clinics because they are intimidated by paperwork, but emergency rooms may be more user-friendly because there, someone asks questions and fills out the forms for you.

Problems of Mexican Indian languages, growing

Where the people speak neither English nor Spanish.

Heritage languages

"A culturally responsive school provides opportunities for students to learn in and/or about their heritage language. A school that meets this cultural standard:

1. Provides language immersion opportunities for students who wish to learn in their heritage language
2. Offers courses that acquaint all students with the heritage language of the local community.
3. Makes available reading materials and courses through which students can acquire literacy in the heritage language.
4. Provides opportunities for teachers and students to gain familiarity with the heritage language of the students they teach through summer immersion experiences under culturally appropriate setting."

[Proposed Standards For Culturally-Responsive Schools; Indian Education Plan For Washington State; Office Of Superintendent Of Public Instruction October, 2000]

Resources:

Lep.gov

Red Cross Language Bank

King and Kitsap Counties

The Puget Sound area continues to welcome large numbers of refugees and immigrants. As of 2003, Washington ranks 4th in the nation by number of newly arrived refugees; approximately 75,000 refugees reside in this state, with 60-65% living in King County alone. These new neighbors add to a population already exceptional in its diversity; in fact, one in four households in King County speak a language other than English in the home.

Language Line, commercial service

The American Medical Association publishes "The Cultural Competence Compendium," which contains information about language and cultural barriers. This book lists many organizations that specialize in providing interpretation services.

Shared with other NPOs, agencies, governmental agencies, including across state lines.

Spanish language TV + radio

A small media buy reaches 80% of Hispanic community.

Resource and cost issues, however, can often be reduced by technological advances, reasonable business practices, and the sharing of language assistance materials and services among and between recipients, advocacy groups, affected populations, and Federal agencies. For example, the following practices may reduce resource and cost issues where appropriate:

Training bilingual staff to act as interpreters and translators.

Information sharing through industry groups.

Telephonic and video conferencing interpretation services.

Translating vital documents posted on Web sites.

Pooling resources and standardizing documents to reduce translation needs.

Using qualified translators and interpreters to ensure that documents need not be "fixed" later and that inaccurate interpretations do not cause delay or other costs.

Centralizing interpreter and translator services to achieve economies of scale.

http://www.raconline.org/info_guides/culture/
 Cultural Competence and Limited English Proficiency
 Rural Assistance Center
 Health Emphasis

<http://library.med.utah.edu/24languages/>
Consumer Health Brochures in Multiple Languages

http://www.doleta.gov/reports/dpld_lep.cfm
Limited English Proficiency (LEP) and Hispanic Worker Initiative
US Dept of Labor

Specialized glossaries:
E.g. health, law enforcement, Workforce Investment Act
(<http://www.doleta.gov/usworkforce/LEP/glossary/>)

Special Tabulation of LEP Information from Census 2000

Washington
http://www.doleta.gov/reports/CensusData/LWIA_by_State.cfm?state=WA

Who, When, and How: The Current State of Race, Ethnicity, and Primary
Language Data Collection in Hospitals, Romana Hasnain-Wynia, Debra Pierce, and Mary
A. Pittman, The Commonwealth Fund, May 2004
http://www.cmwf.org/publications/publications_show.htm?doc_id=225959

Governor's Interagency Council on Health Disparities
Mailing Address: Post Office Box 47990, Olympia, WA 98504-7990
Physical Address: 101 Israel Road SE, Tumwater, WA 98501
Phone: 360/236-4110 Fax: 360/236-4088
Email: WSBOH@doh.wa.gov
www.sboh.wa.gov/hdcouncil

National Health Law Program Access Project
Language Services Action Kit: Interpreter Services in Health Care Settings
for People with Limited English Proficiency
<http://www.healthlaw.org/pubs/2003.lepactionkit.html>
Language Services Action Kit for advocates and others working to ensure that people
with limited English proficiency in their state get appropriate language assistance
services in medical settings.

Language Services Action Kit. PRICE: \$ 25.00
Action Kit Order Form <http://www.healthlaw.org/pubs/2003LEPform.pdf>
Or send an email with your mailing and billing information to
lepactionkit@accessproject.org

Pacific Interpreters
1020 SW Taylor, Ste 280
Portland, OR 97205
1-800-223-8899
503-223-8899

Email: information@pacinterp.com

Website: <http://www.pacinterp.com>

Offers fee-for-service telephone and videoconference interpreting, document translation services in more than 100 languages, and translators trained in clinical terminology. Telephone service available 24 hours a day, seven days a week.

DOJ Safe Harbor:

Safe Harbor. The following actions will be considered strong evidence of compliance with the recipient's written-translation obligations:

(a) The DOJ recipient provides written translations of vital documents for each eligible LEP language group that constitutes 5 % or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally; or

(b) If there are fewer than 50 persons in a language group that reaches the five % trigger in (a), the recipient does not translate vital written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost.

These safe harbor provisions apply to the translation of written documents only. They do not affect the requirement to provide meaningful access to LEP individuals through competent oral interpreters where oral language services are needed and are reasonable. For example, correctional facilities should, where appropriate, ensure that prison rules have been explained to LEP inmates, at orientation, for instance, prior to taking disciplinary action against them.

Health Issues

Several recent studies document how many non-English-speaking patients experience a reduced quality of life due to health-related issues. Studies also show that many of these populations lack trust in the health care system.

According to the Institute of Medicine, standardized data collection is critical to understanding and eliminating racial and ethnic disparities in health care. A critical barrier to eliminating disparities and improving the quality of patient care is the frequent lack of even the most basic data on race, ethnicity, and primary language of patients within health care organizations. The methods for collecting these data are disparate and, for the most part, incompatible across organizations and institutions in the health care sector.

Most hospitals (82 %) currently collect data on their patients' race and ethnicity, and 67 % collect information on patients' primary language. However, the data are not collected in a systematic or standard manner and are often not shared, even within different departments within the same hospital. Organizations that collect accurate data can use

this information to ensure they have sufficient language assistance services, develop appropriate patient education materials, and track quality indicators and health outcomes for specific groups to inform improvements in quality of care.

among hospitals that collect data on race/ethnicity, 70 % did not see any drawbacks to collecting the data. Drawbacks reported by the remaining 30 % included: discomfort on the part of the registrar or admitting clerk asking the patient for the information; problems associated with the accuracy of the data collected; a sense that patients might be insulted or offended, or resist answering questions about their race and ethnicity; patients often did not “fit” the categories that were given; a fear that data may not be kept confidential; and the possibility that collecting data on race and ethnicity might be used to profile patients and discriminate in the provision of care.

There are reactive reasons for collecting this information, such as measuring disparities in quality of care and utilization, but there are also proactive reasons for collecting this information, such as providing health care that is appropriate to a population. The distinction may be important to patients in terms of what matters and the message they want to hear. They may react more positively to a proactive desire rather than a reactive desire.

If we have a population where there are a lot of disparities, then that population is not available for the work force. This is not a population that functions well [This issue is] not just about physical health but about the health of society.

Hospitals, as one example of big societal infrastructure, collect data to understand the communities they serve; for grant applications; to match their workforce to the communities they serve; to provide certain donors with information about the patient mix; for targeting quality of care initiatives; for contractual compliance obligations, especially with government contracts (Medicare, Medicaid); and for the provision of interpreter services. Barriers to data collection include resource limitations, uncertainty about which racial/ethnic categorization system to use, negative perceptions of patients as to why data are collected, language and cultural barriers, lack of staff training, doubts as to the validity and reliability of the data, perceived legal barriers, and system or organizational barriers. Facilitators of data collection include developing educational programs and training for staff about the importance of collecting this information, the use of self-report by patients to improve the validity and reliability of the data, leadership support, and regulatory measures.

Data has been a key problem at getting at disparities. The data is fractionalized The way the data is fractionalized increases costs because you can't get resources to those communities that are at risk.

Health Care

As the number of people with limited English proficiency in the United States rises, the need for language services in health care settings also grows. Federal laws require health

care providers to offer language services, such as interpretation and translation, but many say they do not have the funds to do so. However, providers and others are often unaware that federal funds are available to help states pay for language services for patients covered by Medicaid and the State Children's Health Insurance Program (SCHIP).

Federal funding for interpreter and other language services can benefit everyone: health care providers, state governments, and patients with limited English skills in need of services. This offers an unusual opportunity for these stakeholders and others to come together to advocate for reimbursement for language services in their state Medicaid and SCHIP programs. The Action Kit includes materials that:

Explain the federal laws and policies that require health care providers to ensure access to services for people with limited English proficiency;

Explain how states pay for Medicaid and SCHIP services, and how they can get federal funding to help pay for language services, such as interpretation, for program enrollees; Describe models that some states have adopted to reimburse health care providers for language services; • Provide information and describe techniques you can use to demonstrate the need for language services in advocacy campaigns; List resources where you may find additional information about language services.

Small Health Practitioners

(From HHS LEP Guidance)

How does the guidance affect small practitioners and providers who are recipients of federal financial assistance?

A. Small practitioners and providers will have considerable flexibility in determining precisely how to fulfill their obligations to take reasonable steps to ensure meaningful access for persons with limited English proficiency. OCR will assess compliance on a case by case basis and will take into account the following factors:

- (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the recipient's program, activity or service;
- (2) the frequency with which LEP individuals come in contact with the program, activity or service;
- (3) the nature and importance of the program, activity, or service provided by the recipient; and
- (4) the resources available to the recipient and costs. There is no "one size fits all" solution for Title VI compliance with respect to LEP persons, and what constitutes "reasonable steps" for large providers may not be reasonable where small providers are concerned. Thus, smaller recipients with smaller budgets will not be expected to provide

the same level of language services as larger recipients with larger budgets. OCR will continue to be available to provide technical assistance to HHS recipients, including sole practitioners and other small recipients, seeking to operate an effective language assistance program and to comply with Title VI.

The special case of disaster preparation and evacuation.

Warning about health hazards:

Carbon monoxide

Effective communication.

Can't rely upon English-only printed materials.

Caution:

Internet translation services are not reliable.

Many people speak a language other than English, but do not read it. Some languages are oral rather than written, like Hmong.

Some documents may create or define legally enforceable rights or responsibilities on the part of individual beneficiaries (e.g., leases, rules of conduct, notices of benefit denials, etc.). Others, such as application or certification forms, solicit important information required to establish or maintain eligibility to participate in a Federally-assisted program or activity. And for some programs or activities, written documents may be the core benefit or service provided by the program or activity. Moreover, some programs or activities may be specifically focused on providing benefits or services to significant LEP populations. Finally, a recipient may elect to solicit vital information orally as a substitute for written documents.

Best Practices

Language Banks. In several parts of the country, both urban and rural, community organizations and providers have created language banks that dispatch competent interpreters, at reasonable rates, to participating organizations, reducing the need to have on-staff interpreters for low-demand languages. This approach is particularly appropriate where there is a scarcity of language services or where there is a large variety of language needs but limited demand for any particular language.

Language Support Offices. 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.

Some recipients have established working liaisons with local community colleges to educate the LEP community in transportation matters. One city formed a multilingual/multi-agency task force to address language barriers and the concerns of the affected communities.

The task force completed a survey of city staff with multilingual skills in order to identify employees willing to serve as interpreters and is preparing lists of community and cultural organizations.

Use of Technology. Some recipients use their Internet and/or intranet capabilities to store translated documents online, which can be retrieved as needed and easily shared with other offices. For example, a multilanguage gateway on a Web page could be developed for LEP persons and the public to access documents translated into other languages.

Telephone Information Lines and Hotlines. Recipients have subscribed to telephone-based interpretation services and established telephone information lines in common languages to instruct callers on how to leave a recorded message that will be answered by someone who speaks the caller's language.

Best Practices in Providing Language Services in Small Health Care Provider Settings:

Language access planning. Most providers interviewed for this project have designated a staff member to coordinate language service activities. Small health care providers are also developing written language plans, as suggested by the U.S. Department of Health and Human Services' Office for Civil Rights. These plans identify language needs and propose strategies for meeting those needs.

Determining language needs at first points of contact. Some small health care providers are taking steps to introduce language access at the first points of patient contact. For example, "I Speak . . ." posters and cards, which identify patients' language needs as soon as they walk through the door, are being used by front-desk staff.

Bilingual mid-level practitioners. A limited supply of bilingual physicians, along with heavy competition to hire those physicians, has motivated some provider sites to focus on recruiting and hiring bilingual mid-level staff, like certified nurse practitioners.

Dual role bilingual staff. Many of the small provider sites assessed are hiring bilingual office staff to perform multiple roles, including language assistance tasks. For example, individuals with conversational proficiency in a second language may provide limited services at the front desk (e.g., answering phones, scheduling appointments) while those with medical proficiency may interpret for patients during medical or clinical visits.

Dedicated staff interpreters. Particularly in communities with heavy demand for services in a particular language, small provider sites may hire full- or part-time, on-site interpreters.

Contract interpreters. Providers are also considering interpreters who are available to work on contract with small provider sites. Potential sources for hiring such interpreters include area hospitals, state or local agencies, refugee resettlement sites, community-based organizations, or commercial entities.

Community resources. Small health care providers can work with entities or individuals in their communities to improve the provision of language services. These may include local hospitals, managed care organizations, community-based organizations, community colleges, and former patients and their family members.

Interpreter competency. Small health care providers are increasingly taking steps to improve the competency of bilingual staff who serve as interpreters. On-the-job training is offered in some sites by bilingual, mid-level practitioners and office administrators, who are also used to assess language skills during the hiring process and to evaluate new staff in training. Community training resources, available through local hospitals and community colleges, are also being used to improve interpreter skills.

Innovative ways to use telephone language lines. Some small provider sites are developing ways to make telephone language lines (i.e., services that offers interpreters via telephone) accessible to both providers and patients. Some sites have placed speaker phones in examination rooms, while other providers carry cell phones with speakers that can be easily exchanged between provider and patient.

Minimizing use of family and friends. A growing number of small providers are seeking to minimize their reliance on using family or friends of patients as interpreters. Where family members are still being used, some providers will attempt to have a trained interpreter sit in during the medical encounter or follow up with the family within 24 hours to verify the patient's condition.

Language services throughout the patient encounter. Because LEP patients experience language barriers throughout the health care encounter, small health care providers are using interpreters to assist the individual throughout intake, clinical encounter, and follow-up.

Written translations. When evaluating the need for translated materials, small health care providers are making extensive use of existing materials. Sites are using translated materials offered by various organizations, Web-based materials from federal and state governments, and materials downloaded from health departments in other countries such as Taiwan and Hong Kong. Small provider sites are also working with bilingual staff, contract interpreters, local hospitals, and faith-based organizations to translate documents.

Patient satisfaction. Small providers are monitoring patient satisfaction as they continue to evaluate and expand their language services. This may be as simple as patient-charting notations or more formal patient surveys.

Funding opportunities. Small health care providers are seeking funding from a variety of sources, including federal, state and local governments; foundations; and nonprofit organizations.

Broader Recommendations:

Special language services are a legal, ethical, and economic development issue.

Washington is the most foreign trade dependent state in the nation. We need the diversity of workers who can speak the language of our overseas customers.

Developing and maintaining language ability can even be a national security matter.

Institutions should follow state and federal law.

When it comes to delivering services, it is better to not go it alone. Whether your goal is to increase access to services for specific populations, serve the uninsured, or target interventions in the community to improve care, it may be more effective if you collaborate with other organizations and stakeholders in the community. Collaboration can help you better align resources with needs, reduce competition, increase effectiveness, and make your results more sustainable. It requires that organizations work outside historical boundaries; dedicate people, skills, and energy to the effort; deal with a diversity of priorities and culture; and think of their organizational plans and operations as part of a system that needs to function seamlessly.

Institutions should standardize who provides information. Customers and clients are more likely to provide accurate information about patients' race, ethnicity, and language than a customer service representative based on observation.

Institutions should standardize when data are collected. Collection of data on customers' race, ethnicity, and language upon entry into the system will help ensure that appropriate fields are completed at the time a customer begins receiving services at the organization.

Institutions should standardize which racial and ethnic categories are used. If organizations are going to use categories, then the Office of Management and Budget (OMB) categories should be used, which would allow for use of standard racial and ethnic categories by all organizations. At the same time, organizations can use fine-grained categories of Hispanic or Asian groups, for example, that could then expand to broader U.S. Census categories as needed.

Institutions should standardize how data are stored. Race, ethnicity, and language

data should be stored in a standard format that is compatible across organizations and systems. Many of the newer data systems used by organizations have separate fields for race, ethnicity, and primary language. The data systems may allow for export and import and merging with customer level data files.

Institutions standardize their responses to customers and client concerns. Their concerns about the ways in which data on race, ethnicity, and language will be used should be addressed prior to collecting the information. There should be a uniform rationale offered to all customers and clients before asking them to identify their racial/ethnic background.

The National Hispanic Medical Association, with the Congressional Hispanic Caucus recommended the following for improving Hispanic health and access to health care.

Adopt a universal health care policy.

Develop a marketing strategy with community institutions to engage Hispanic leaders and populations in expanding health care services.

Increase Hispanic leadership at the U.S. Department of Health and Human Services, state and private organizations and advisory committees to encourage program development for Hispanic communities.

I don't mean to imply that looking at and listening to language or hiring Hispanics is the only way to approach social problems or customer service. But they are ways of lowering barriers to full participation in society, to protecting people, and to preserving their rights. We need to answer the question, "For whom are we developing initiatives and are these initiatives appropriate for these populations?"

For the French moral philosopher Emmanuel Levinas, in the face of a person's suffering, the first ethical task is acknowledgement. Face-to-face moral issues precede and take precedence over cultural ones. There is something more basic and more crucial than cultural competency in understanding the life of the client, and this is the moral meaning of suffering—what is at stake for the client; what the person, at a deep level, stands to gain or lose. We should not ask, for example, "What do Mexicans call this problem?" But asks, "What do you call this problem?" and thus a direct and immediate appeal is made to the person as an individual, not as a representative of a group.

This is what Franz Kafka said "a born doctor" has: "a hunger for people". And our main thrust is to focus on the client as an individual, not a stereotype; as a human being facing danger and uncertainty, not merely a case; as an opportunity for the service provider to engage in an essential moral task, not in cost-accounting or legalities.