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*Waimanalo Health Center
Waimanalo, HI*

Stephen P. Jiang, ACSW
Executive Director

August 12, 1999

**Irene Bueno
Domestic Policy Council
The White House
1600 Pennsylvania Avenue
Washington D.C. 20500**

Dear Ms. Bueno:

Due to a clerical error a pamphlet entitled Culturally Competent Health Service Delivery Under Managed Care for Asians and Pacific Islanders was left out of the enclosures sent to you on August 4, 1999 from Mr. Daniel Toleran..

I apologize for any inconvenience this may have caused you.

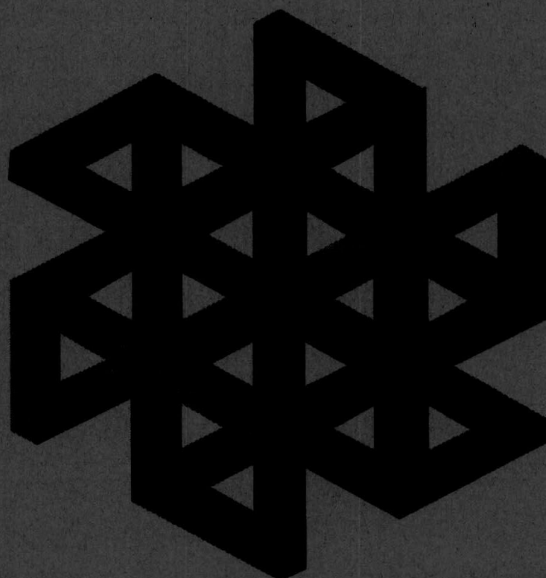
Sincerely,

**Siwaraya Rochanahusdin
Administrative Assistant**

Enclosures

A A P C H O

Culturally Competent Health Service Delivery Under Managed Care for Asians and Pacific Islanders



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September 1994

Acknowledgments

This report was prepared by Linus Huang under the direction of Laurin Mayeno, Aromie Noe and Ying-ying Meng.

This publication was supported by grant #CSH000009-11-0 from the Bureau of Primary Health Care through the National Association of Community Health Centers.

AAPCHO would like to recognize the following individuals for their contributions to the initial draft of this report: Freda Mitchem, NACHC; Liane Dong, AAPCHO; Stephen Jiang, AAPCHO and; Laurin Mayeno, Community Health Academy. AAPCHO would also like to thank Coco Yan Qiu for the cover design.

Suggested Citation:

Association of Asian Pacific Community Health Organizations. *Culturally Competent Health Service Delivery Under Managed Care for Asians and Pacific Islanders*. Oakland, California 1994.

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1. Introduction

Managed care has been implemented in many states and highlighted as a system to reduce health care costs for many Americans. However, the nature of its impact varies according to client population. For minority communities, such as Asian and Pacific Islander (API) and Hispanic populations with only limited English language proficiency (LEP) and a partial understanding of American culture and health care system, managed care has proven to be a mixed blessing. The purpose of this document is two-fold: (a) to discuss issues relating to the implementation of managed care and its impact on Asian and Pacific Islander (API) populations; and (b) to suggest methods for addressing and resolving these issues.

There are three broad ways in which managed care will adversely impact health care service delivery to Asians and Pacific Islanders. The first concerns the complexity of enrollment procedures. Frequently, when managed care is implemented, many APIs are assigned a primary care facility without their knowledge or consent. Although they are “officially notified” of their choice, through newspapers or mailed notices, no consideration is given for the barriers faced by these populations. These barriers include lack of familiarity with managed care systems and language and cultural differences. As a result, Asians and Pacific Islanders do not know how to access the managed care network or receive a rude shock when they discover they can no longer receive services at the health care facility with which they are accustomed.

Secondly, there is often a lack of staff in managed care facilities with the language and cultural competency skills to adequately serve API populations. Many Asians and Pacific Islanders usually receive primary care services from community health centers (CHCs), which often have staff members equipped to deal with their particular language and cultural needs. For various reasons, community health centers have not been included in managed care networks. When managed care is implemented, many APIs formerly receiving services at community health centers find that they were assigned to a new health care facility. These new facilities often do not have the skills or expertise to provide APIs with critically needed linguistically and culturally appropriate services. There are two major consequences of this situation. First, enduring the lack of linguistically and culturally appropriate service delivery is not an option for many APIs. Thus, they are forced to bypass their perhaps more conveniently-located managed care facilities and travel long distances and wait for hours to receive services from an often overburdened community health center. Second, Asians and Pacific Islanders on Medicaid can no longer apply benefits toward CHC services since they are outside the managed care network. In these instances, many of these patients will have to bear *extra costs* to continue to receive services at community health centers because managed care facilities simply cannot deliver services in a linguistically and culturally appropriate manner.

Finally, managed care’s major emphasis on cost efficiency often neglects the additional investments required to provide supplementary services for clients facing language and cultural barriers to health care access. In addition, community health

centers tend to serve predominantly at-risk populations, such as pregnant women and chronically-ill patients. AAPCHO's Uniform Database project revealed that in June 1991 to May 1992, Chinatown Health Clinic in New York had 20% pregnancy-related encounters, while only 3.3% of all national ambulatory encounters were pregnancy-related care based on data of the 1990 National Ambulatory Medical Care Survey. These have been issues preventing many community health centers which serve predominantly API communities from getting full compensation for their services in managed care networks. The commitment to provide culturally appropriate services to at-risk populations has sometimes conflicted with managed care's cost-efficiency orientation.

The focus of this document is on service delivery. Although this discussion is intended for policy makers as well as providers, the recommendations contained herein apply primarily to issues related to health care delivery. The packet contains the following sections: (a) the relevant legal foundations for providing linguistically and culturally appropriate health care services and major shortcomings identified; (b) general barriers to health care faced by Asians and Pacific Islanders; (c) cases studies to illustrate these barriers, and (d) *cultural competency*, an emerging concept in the health care industry that addresses issues of culturally appropriate service delivery. Finally, two models of culturally competent service delivery currently in implementation, and recommendations based on these models' general concepts.

2. The Legal Mandate

Title VI of the Civil Rights Act of 1964 says that “no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving Federal financial assistance.”¹ Title VI prohibits discrimination on the basis of race, color, or national origin. The United States Department of Health and Human Services (DHHS) has drawn up regulations concerning discrimination based on Title VI for any program or activity that receives any form of federal financial assistance.² Furthermore, in the landmark case *Lau vs. Nichols* (1974), the U.S. Supreme Court established that Title VI included within its scope prohibitions against discrimination on the basis of *language*.³ Even though language is not explicitly mentioned in Title VI, the Court determined that the San Francisco Unified School District was in violation of Title VI for its failure to provide language assistance to nearly two-thousand students of Chinese ancestry, ruling that the district had in effect discriminated against the students on the basis of *national origin*.

Despite the precedent set by *Lau vs. Nichols* establishing its unconstitutionality, language discrimination has by no means been eliminated. This is largely due to inadequate or inconsistent law enforcement. Stronger enforcement practices are needed, both in terms of more active surveillance by enforcement officials and in terms of modifying grievance procedures to make them more accessible to those who are unfamiliar with their rights and how assert them. Deficiencies in law enforcement, however, are also in part the result of insufficiently explicit legislation at both the national and state levels. At the national level, the constitutionality of language discrimination must be clearly established. At the state level, the specific procedures for enforcing federal law must be clearly and consistently prescribed.

¹ U.S. Department of Health and Human Services, Office for Civil Rights (1990). Your responsibilities as a health care or social service administrator under Title VI of the Civil Rights Act of 1964 (fact Sheet). Washington, DC: Government Printing Office.

² 45 C.F.R., Part 80.

³ 414 U.S. 563 (1974)

3. Barriers to Care

Asians and Pacific Islanders in the U.S. are confronted with two major types of barriers to health care. First, as do many Americans of all races, Asians and Pacific Islanders face socioeconomic barriers such as poverty. Based on data from the 1990 U.S. Census, the Asian/Pacific Islander Data Consortium (ACCIS) reports that 28.0 percent of all APIs under the age of 25 had incomes less than \$5,000—the highest rate of any racial group.⁴ 14.1 percent of all APIs fell below the poverty level, compared to 9.8 percent for Whites.⁵ Finally, the overall average per capita income for APIs was \$13,638, compared to \$14,420 for all Americans and \$15,687 for Whites.⁶

These statistics, however, are not entirely representative in that they aggregate all Asians and Pacific Islanders into one category. Although 1990 Census statistics are broken down by specific API ethnicity, this data is not yet available. Analysis of 1980 U.S. Census figures suggest that for certain API ethnic groups, the socioeconomic barriers are even more pronounced. Mayeno and Hirota report that in 1980, compared with the national poverty rate of 9.6 percent, 67.2 percent of Laotians, 65.5 percent of Hmongs, 46.9 percent of Cambodians (Khmer), 35.1 percent of Vietnamese, 27.5 percent of Samoans, and 13.1 percent of Koreans were in poverty.⁷

Furthermore, while the 1990 Census shows that the unemployment rate for API men and women on the whole were right around the national rates of 5.3 percent and 5.0 percent for men and women, respectively, the 1980 Census again suggests that the situation is different for Southeast Asians and Pacific Islanders. Compared to the national rate of 7 percent unemployment in 1980, Hmongs were unemployed at a rate of 20.0 percent; Laotians, 15.3 percent; Cambodians, 10.6 percent; Samoans, 9.7 percent; Vietnamese, 8.2 percent; and Tongans, 7.6 percent.⁸

Second, Asians and Pacific Islanders also face ethnic-specific barriers apart from socioeconomic obstacles to health care. Language barriers are one major obstacle. ACCIS reports that, of the 7,068,454 total APIs enumerated by the 1990 Census, 3,300,625 spoke an API language. Of these, 16.6 percent of those between the ages of 5 and 17 years reported speaking English “not well” or “not at all”. The figures were 22.9 percent for those between the ages of 18 and 64 and 48.8 percent for those age 65 years or older.⁹ Of 1,718,359 API households, 30.3 percent of them are “linguistically isolated”—

⁴Asian/Pacific Islander Data Consortium, *Asian and Pacific Islander Americans: A Profile of Socioeconomic Characteristics-1990: Profile Series 3-United States of America*. San Francisco, CA: 1992.

⁵*Ibid.*

⁶*Ibid.*

⁷Laurin Mayeno & Sherry M. Hirota, “Access to Health Care,” in Nolan W. S. Zane, David T. Takeuchi, & Kathleen N. J. Young, eds., *Confronting Critical Health Issues of Asian and Pacific Islander Americans*. Thousand Oaks: Sage Publications, 1994, p. 349.

⁸*Ibid.*, p. 350.

⁹ACCIS, *Asian and Pacific Islander Americans: A Profile of Socioeconomic Characteristics-1990: Profile Series 3-United States of America*. San Francisco, CA: 1992.

that is, there is no one in these households age 14 years or older who reported speaking English "well" or "very well."¹⁰

Beyond language, Asians and Pacific Islanders face cultural barriers when confronting the U.S. health care system. For example, Southeast Asians may find it difficult to accept the appointment system, and "...the concept of waiting two or three weeks to see a physician [may seem] inappropriate."¹¹ For certain ethnic groups, the American medical institution co-exists with traditional forms of health care. For example, many Native Hawaiians still rely on traditional healers and practices.¹² Also, the American biomedical model, which isolates and compartmentalizes ailments, may conflict with the more holistic conceptions of ailments in many API cultures.¹³ The relative complexity of the American model is reflected in the emphasis on specialization and the extremely fragmented nature of secondary and tertiary care, which can further impede Asians and Pacific Islanders access to necessary services. These cross-cultural conflicts, among others, are perpetuated by an American medical training system which has historically placed little emphasis on cultural awareness.

Another barrier faced by Asians and Pacific Islanders concerns their immigration status. According to Mayeno and Hirota, there are three issues related to API immigration status and health care.¹⁴ First, oftentimes many Asians and Pacific Islanders do not know if they are eligible for health services. Second, many Asians and Pacific Islanders fear that they will be deported if they attempt to seek services at a health care facility. Finally, many fear they might be classified as potential "public charges" by the Immigration and Naturalization Services (INS) and that they might be denied permanent residence if they seek services. It should be emphasized that these issues apply not only to illegal immigrants but legal immigrants as well. These problems are exacerbated in some areas by xenophobic social climates. In California, for example, Proposition 187, the so-called "Save Our State" initiative which seeks to deny health and social services (except for emergency services) to undocumented immigrants, and only serves to drive immigrants with critical health needs further underground.

¹⁰*Ibid.*

¹¹Mayeno & Hirota, "Access to Health Care," p. 354-355.

¹²*Ibid*, p. 355.

¹³*Ibid*, p. 355.

¹⁴*Ibid*, p. 356.

4. Case Studies

In order to illustrate the cultural and linguistic barriers facing Asians and Pacific Islanders, AAPCHO interviewed several members of the Hmong community in Fresno City. All of these members have had several encounters with the local health care system, and the following are excerpts from these experiences. These individuals were not chosen at random; they are among the few in their community who have at least limited proficiency in the English language. As such, they are often called upon to translate for family and friends when dealing with social service and health care providers.

These interviews are *not* intended to serve as a critical analysis of the health care system in Fresno; such a task cannot be accomplished solely by interviewing a small sample of community members. However, by presenting these interviews, we hope to shed light upon perceived barriers to health care access, and suggest courses of action for both health care providers and patients to address these obstacles.

4.1 Fresno, California

Fresno County is located in the Central Valley region of California. Its county seat, the city of Fresno, is approximately 180 miles southeast of San Francisco. The 1990 U.S. Census placed the county's population at 667,490 persons. Of this total, there were 57,239 Asians and Pacific Islanders, or 8.6 percent of the population. Forty-four percent of these APIs lived below the poverty level; on average, their per capita income was only 62.8 percent of the average of all county residents and only 50.4 percent that of whites. According to the 1990 Census, among all American cities with an API population of 10,000 or greater, Fresno, CA, has the second highest API poverty rate (Spring 1993, Vol. 1, No. 1). Of the 48,881 Asians and Pacific Islanders age 5 years and over, 16,487 or 33.7 percent, spoke English "not well" or "not at all."

By far, the largest API ethnic group in Fresno County is the Hmong, a group which originates in northern Laos but which is ethnically distinct from other Laotian groups. The Hmong comprise 32.0 percent of the API population in Fresno County and 2.7 percent of the entire county population. Like other Southeast Asian Americans, the Hmong are relatively recent arrivals to the United States, and have little or no English-speaking capability. More so than other Asians and Pacific Islanders, the Hmong are found at or near the poverty level.¹⁵

The Hmong face many barriers to health care service in the United States. In addition to facing impoverished conditions, the Hmong face a wide range of cultural barriers to health care access. The followings are a few real life cases.

¹⁵63.6 percent of the Hmong population in the U.S. is living in poverty according to *U.S. Poverty Rates*, U.S. Census Bureau, 1989, as reported by the Asian Pacific Health Care Venture, *Diversity and Growth: Current Issues and Challenges for the Future*.

4.2 Bee Yang's Case

One night about two years ago, a relative of Mr. Yang's began to experience serious stomach problems. Though none of the relative's immediate family members were entirely fluent in English, they were able to call for an ambulance. The paramedics who arrived at the scene did not speak Hmong and could not communicate effectively with the patient nor with anyone in the household. Consequently, they could not assess the relative's illness, and were unable to provide treatment.

The paramedics rushed Mr. Yang's relative to the county hospital, but there again, there were no medical personnel proficient in Hmong language. Although it was 2:00 a.m., Mr. Yang was called to interpret for his relative. The hospital staff could not provide treatment until Mr. Yang arrived at the hospital, after which the attending physician informed Mr. Yang of the patient's condition and options. Mr. Yang in turn related what he had been told to his relative to the best of his ability. Neither Mr. Yang nor his relative have any familiarity with Western medicine.

The surgery was scheduled for 10:00 a.m. later that morning. Mr. Yang finished speaking with hospital officials at 6:00 a.m., but had to leave to attend classes at Fresno State University (CSU-Fresno), where he was a student. He was not able to return to the hospital until 5:00 p.m. that evening, several hours after the surgery had been completed. The hospital staff was unable to verbally communicate with the patient and, even though the patient was literate, the staff had no written materials in the Hmong language available as an alternative form of communication. The staff was unable to convey to the patient post-surgical instructions, and could not legally release him from the facility.

4.3 Ker's Case

When Ker's father, who has high blood pressure, suffered a stroke, Ker took him to a physician at one of the local hospitals and was prescribed a number of drugs for his condition. Unfortunately, the medication generated adverse side effects in Ker's father. Traditional Hmong health care has no notion of drugs or side effects, so Ker's father was naturally concerned with these new symptoms. During a subsequent visit, the attending physician was unable to explain to Ker's father what side effects were or why the drugs were producing them. Upset at his inability to comprehend the physician's explanation, Ker's father stopped taking the medication. The physician, in turn, became upset with Ker's father for refusing to take it. Eventually the physician asked them to find another doctor to attend to them.

Ker obliged, and took his father to see a Vietnamese physician who worked at a small family clinic. Ker's father was more satisfied with his treatment under the new physician because he was given more free will—he was allowed to do things in accordance with his beliefs and expectations about health care. However, Ker felt that in a sense his father was given too much free will—that the new physician was simply allowing his patient to do anything he wanted and was not administering sufficiently responsible care.

The Vietnamese physician, and other Southeast Asian physicians, primarily serve members of the Southeast Asian community in Fresno. Since there are relatively few of them and the Southeast Asian community is one that continues to expand, there is greater demand on their time than from physicians in the larger hospitals and clinics in the area. Anxious to meet the needs of the client community, these physicians tend to place greater emphasis on seeing as many patients as possible, often at the expense of seeing any one patient for as much time as either would prefer. Indeed, Ker felt that the Vietnamese physician pressured for short sessions with his clients. Ker faced the dilemma of choosing between the Vietnamese physician, who was culturally more accessible to his father but who tended to rush patients, and an American doctor who, while perhaps less culturally sensitive, allotted more time for each patient (30 to 40 minutes, according to Ker).

4.4 Jerry's Case

Jerry's brother-in-law was killed in an automobile accident that also injured his nephew. His nephew was rushed to an emergency room to receive stitches. Jerry and his sister (the boy's mother) accompanied his nephew to translate on a follow-up visit to the hospital the next day. The physician explained that the oxygen flow to and from the wound must not be obstructed. Not having comprehended this point, Jerry's sister requested that a special cream be applied to the wounds to facilitate the healing process. The physician refused. Jerry's sister repeated the request, and the physician became visibly upset, called them "welfare people," and insultingly suggested that they seek alternative treatment from members of their own (ethnic) community.

4.5 Summary

It should be emphasized that the people in these case studies, not to mention the entire Hmong or API community, do not uniformly fear or dislike the health care system in Fresno County. On the contrary, they stated that there are many good physicians in the system whom they rely on a daily basis. Nonetheless, the language barriers of Yang's relative and ethnocultural obstacles faced by Ker's father and Jerry's sister are indicative of recent-immigrants' experience accessing health care. Based on anti-discrimination guidelines in Title VI, the Department of Health and Human Services stipulates that patients have the right to receive health care in their primary language. Yet, as demonstrated in the above case studies, patients who could not communicate with their physicians in English or understand mainstream cultural norms face extraordinary barriers in accessing needed care.

These cases also suggest that ad-hoc interpretation by bilingual family members, even when it is most convenient, can lead to misunderstanding and hostility between patient and provider. These family members/interpreters often speak English as a second language, and are otherwise unqualified to work in a health services capacity, in which

they are expected to translate complex medical terms for providers. In addition, interpretation by family members is generally considered unsatisfactory for ethical and legal reasons. In such cases, health care providers cannot guarantee the accuracy of the interpretation, nor can they guarantee informed consent. Furthermore, interpretation by a family member violates patient confidentiality.

5. Cultural Competency

Culturally appropriate, or *culturally competent*, health care¹⁶ is vital to overcoming the barriers to access reviewed in the previous section. Managed care, while improving the efficiency of service delivery for many sectors of the American population, generally fails to address issues of cultural access. Therefore, culturally competent health care applies to all states that have currently implemented or plan to implement managed care. A key potential impediment to cultural competency under managed care is the apparent conflict between managed care's emphasis on reducing costs and the investment in resources necessary to make the health care system more accessible to those populations that face cultural barriers. Particularly in the case of language barriers to access, Title VI makes clear the obligation for managed care, or any federally-funded health care plan or program, to ensure that Asians and Pacific Islanders are able to receive services as efficiently and effectively as other patient groups.

Cultural competency entails a holistic approach to achieving culturally appropriate service delivery. Although cross-cultural conflicts become most apparent during actual provider/client interaction, barriers to access exist at many levels and locations. Examples of this include: inadequate levels of funding for community health centers; a medical training system with little emphasis on cultural awareness; or in immigration policies which directly or indirectly contribute to a climate of fear for Asians and Pacific Islanders. Ultimately, a comprehensive solution to the problem of access for Asians and Pacific Islanders must address these barriers.

This document, however, will focus on service delivery. It is important to note that the delivery of linguistic and cultural appropriate services isn't just the responsibility of individual providers, but that it needs to become an integral part of the delivery system. This section identifies key issues in making service delivery culturally appropriate to API clients. Although culture is a profoundly dynamic process, it is hoped that the following discussion will give providers and policy makers a useful way of planning and executing service delivery in a culturally appropriate manner.

Broadly speaking, there are four issues regarding cultural competency in service delivery. These are: (a) communication; (b) health-related beliefs and practices; (c) role definitions; and (d) "threshold" issues. The first three issues address service delivery issues. The fourth is policy-related, and addresses the circumstances in which cultural competency is deemed necessary.

¹⁶The term "cultural competence" as it appears in the health care literature is generally intended to emphasize that cultural sensitivity without knowledge of ability to act upon it is not sufficient to provide effective service delivery to APIs and others facing cultural barriers to access. No derogatory meaning is intended by its use.

5.1 Communication

As discussed earlier, language is clearly a vital aspect of communication between provider and client in health care service delivery. The issue is of such prominent concern that it has, to some extent, assumed a life of its own outside of the broader concern for cultural appropriateness in service delivery. In most circumstances, language access is ensured through the use of staff interpreters. There are issues regarding the use of interpreters. One concerns the interpreter's familiarity with medical procedures and terminology. Although interpreters generally do not have to be fully-qualified nurses or physicians, clearly they must have minimal medical and technical proficiency in order to be effective interpreters. Furthermore, interpreters must be able to translate concepts alien to either provider or client in understandable terms to the receiving party. Literal or mechanical interpretations often say little more than no interpretation at all. Another issue is the availability of interpreter services. Interpreters cannot be effective if the volume of clients who need their services is too great. Under such circumstances, providers should consider hiring additional interpreters. Also, interpreters need to be available around the clock, for instance, in the event of an off-hours emergency.

Language access involves more than just verbal communication. Providers should also be aware of the potential need for written modes of communication to supplement interpreters; translated signs, official forms, and informational brochures and pamphlets should be made available as well. The effectiveness of written communication depends, of course, on patients' literacy levels (in both English and in the served API languages).

Furthermore, communication involves more than just language, either verbal or written. It also includes non-verbal communication such as body gestures or even silence. For example, in many Asian cultures, it is considered inappropriate to make direct eye contact. Not only should providers be aware of the meaning of gestures either consciously or unconsciously exhibited by their clients, but they should be aware of how their own gestures might be interpreted.

5.2 Health-Related Beliefs and Practices

In the previous section, some examples of contrasts between medical beliefs in the U.S. and in API cultures were presented. The objective of the health care provider is to deliver services in a manner that is respectful of the beliefs, practices, and customs of his or her clients.

In some API cultures, for example, blood is considered sacred, and many Asians and Pacific Islanders are consequently hesitant to submit to blood tests.¹⁷ In this situation, the health care provider should be aware of and sensitive to the sources of clients' apprehension. The provider should explain why blood tests are necessary in Western health care and should reassure them that the body replenishes its blood supply. Another example involves dietary practices. Many Asians and Pacific Islanders do not

¹⁷Examples from this section are taken from AAPCHO, "The Language Access Project: Final Report."

drink milk because they are lactose intolerant. Thus, it is important for providers to encourage clients to consume alternative sources of calcium, preferably in the form of their ethnic food.

Providers should also take advantage of client community institutions and events to facilitate health education and outreach. For example, providers should consider conducting educational forums or screenings through schools, churches, and other organizations. Advertising health-related announcements and/or general information through community newspapers or newsletters is another potential avenue of outreach. Participation in street festivals and other events further facilitates exposure to the community. Again, however, providers should be respectful and aware of health-related practices when outreaching. For example, for Chinese and other Asian cultures, discussing ailments on the Lunar New Year is frowned upon, as many believe it leads to ill health throughout the coming year. Therefore, many community health centers serving Asian communities close for the Lunar New Year or else avoid mentioning illness, disease, or death.¹⁸

Summarily, the task of the provider is to achieve some compromise between the demands of their own profession and the health-related beliefs and practices of their clients. This requires considerable understanding of API cultures on the part of the provider and a willingness to treat patients respectfully.

5.3 Roles Definition

Another aspect of communication between provider and client involves the intersection of the dynamics of provider/client interaction with that of other relationships prominent in API cultures. For example, many API cultures emphasize deference to elders. Young providers should thus be aware of possible tensions engendered when meeting with older clients.

Providers should also be aware of family and community decision-making structures when treating a client. In API culture, for example, a father or mother-in-law is considered the authority figure. In these instances, providers should try to allow for the inclusion of the father or other family members in any important health-related decisions that need to be made concerning family members.

5.4 "Threshold" Issues

An issue that has assumed great importance in managed care is how to determine when additional steps need to be taken to ensure culturally competent service delivery. In practice, this concern has been operationalized as the question of determining "threshold." Threshold determinations are based on how many limited English speaking patients face language barriers in a particular health care service area before the provision

¹⁸AAPCHO, "The Language Access Project: Final Report," p. 26.

of additional resources (i.e., interpreters, signage, language specific orientation and referrals) is deemed necessary.

Although the issue is more complex, there are two types of responses to this question. First, this “threshold” can be determined in terms of *percentages*. That is, managed care programs become obligated to provide language resources only when the language group in question reaches or exceeds a certain percentage of the enrollees within a specific geographic area. Second, the “threshold” can be determined in terms of *absolute number of the target population*.

Determining need on the basis of percentage has its merits, but in terms of cultural competency in service delivery, it is seriously flawed. The percentage-based method provides no protection for communities below the percentage threshold. Further, it is inconsistent with Title VI, which guarantees the rights of *individuals* from non-discrimination by federally-funded service providers. More in the spirit of Title VI is to determine need based on *absolute numbers* of APIs potentially “at risk” in terms of receiving services in a culturally appropriate manner.

California’s Medi-Cal managed care system originally determined thresholds by percentages, but has recently made the move to determining need on the basis of absolute numbers. From a cultural competency perspective this is an important and laudable precedent that should be followed in other states implementing managed care.

Under certain circumstances, “thresholds”, whether determined by percentages or by absolute numbers, should not apply. If a provider receives a patient who do not speak English, all steps should be taken to make communication between provider and client as effective as possible.

The purpose of this section has been to raise issues related to cultural competency in service delivery in a practical if somewhat simplified manner. In the next section, two models of culturally competent service delivery currently being implemented are presented. Both models are geared toward specific problems; neither are comprehensive in the sense of addressing the entire spectrum of issues related to cultural competency. However, they do represent active solutions to existing problems and as such are useful for suggesting recommendations for cultural competency in other areas of the U.S. health care system.

6. Two Models of Culturally Competent Service Delivery

We present in this section two existing programs targeted at APIs which address issues of cultural competency in service delivery. AAPCHO's Language Access Project (LAP)¹⁹ which is officially named as Development of Models and Standards for Bilingual/Bicultural Services for Asians and Pacific Islander Americans Clients is a model for tailoring interpersonal communication resources to the needs of limited English proficient (LEP) clients in service delivery situations. The Southeast Asian Developmental Disability Prevention (SEADD) Project²⁰ focuses on case management as a method for assisting refugees unfamiliar with the American health care system to obtain the health services they need. The two models feature concepts which are complementary rather than competing; conceivably the main ideas from both programs could be implemented, even within the same health care plan or service region.

6.1 The Language Access Project (LAP)

The LAP is roughly based on models provided by the nine community health centers in the AAPCHO consortium.²¹ These community health centers are all located in areas with a high API concentrations and, correspondingly, their respective clienteles are predominantly Asian and Pacific Islander. Asians and Pacific Islanders residing in these communities typically have recently arrived in the U.S., are low-income, and have both limited proficiency in the English language and limited familiarity with American culture and institutions. Communities with at-risk APIs—in terms of receiving basic social services—have proliferated in recent years, especially with increases in Asian immigration to the United States. There is thus a growing, critical need for strategies for providing culturally appropriate health care in these demographic areas.²²

As its title suggests, the LAP's purpose is to develop models and standards for language and cultural access to health care services. LEP persons require assistance in overcoming barriers in interpersonal communication. However, different providers face clienteles with varying levels of English proficiency. Generally speaking, the more language resources a provider offers, the more it costs to deliver services. Most providers have neither the client demand nor the resources to justify developing language assistance resources. It is thus desirable to identify different levels of language assistance that

¹⁹AAPCHO, "The Language Access Project: Final Report", October, 1993.

²⁰Dorothy M. Yonemitsu & James O. Cleveland, *Culturally Competent Service Delivery: A Training Manual for Bilingual/Bicultural Casemanagers.*, (Southeast Asian Developmental Disabilities Project), October, 1992.

²¹Although LAP is presented as a cohesive "model" in this document, it is in actuality a summary of the commonalties shared by the nine AAPCHO centers. Each CHC developed its strategies for providing language assistance independently and according to the needs of its service community; none in a strict sense structured themselves based on any general model of organization.

²²The following summary of LAP is presented for illustrative purposes only and is not intended to be an endorsement of specific AAPCHO policies. At best, we hope that health care providers will take general principles from LAP and tailor them to the context of their service plans and areas as appropriate.

corresponds to the English language proficiency of the communities served. The LAP presents such a taxonomy of assistance strategies framed in terms of *staff roles*. The project identified five major types of staff roles including:

1. *Multilingual staff member*—This type of staff role is optimal in two ways. First, if a diversity of languages are spoken in the client community, employing multilingual staff members to meet this diversity reduces the need for the health care facility to invest in additional language assistance resources.²³ Second, multilingual staff members enable direct communication between provider and client and make the process of service delivery more reliable and efficient. In practice, the market for multilingual health care professionals is tight. There are relatively few such providers but there is tremendous demand for them.
2. *Staff interpreter*—For health care facilities with high demand for language assistance resources, the next best option available is to employ professional staff interpreters. These interpreters are full-time employees of the facility whose sole responsibility is to provide interpretation services; as such, they can devote their full attention to performing this function. Although they are not qualified health care providers, interpreters usually have a working knowledge with health care terminology and issues to effectively facilitate communication between provider and client.
3. *Staff member who interprets but who has other primary responsibilities as well*—This arrangement is suitable for a health care facility with less stringent language resource demands, or which needs interpreter services in a language used by a relatively small portion of its clientele. Contrasted to full-time staff interpreters, these interpreters can sometimes run into conflicts trying to juggle the responsibilities demanded by their primary job functions.
4. *Staff member who occasionally interprets*—This type of staff role continues along the same lines as the last one. It is appropriate for a health care facility with infrequent demand for interpretation services in any or all languages. However, the conflict between the occasional interpretation duties and his/her primary job functions is even more pronounced than in the previous case. Furthermore, although this is not inherent in our conception of this staff role type, in practice, staff members who expect to be called upon to interpret only occasionally may not have the requisite familiarity with health care terminology and issues, and/or techniques of mediating dialogue between provider and client that is necessary for culturally competent service delivery.

²³This is not to say that multilingual persons are automatically proficient in culturally competent communication. However, it is expected that it would cost significantly less to train a multilingual health care professional to provide culturally appropriate services than it would be, for example, to hire a third-party interpreter.

5. *Outside interpreters*—If a health care facility has only very rare need for interpreters, either in general or for a particular language, the use of outside interpreters is a potential course of action. One difficulty with this strategy is that outside interpreters are not always readily available; systematic sources of “interpreters-for-hire” are not in abundance. Where this strategy is feasible, however, the advantage is that the interpreters are usually well-trained in medical terminology and concepts and, of course, in interpretation skills. The drawback is that, given the temporary nature of their service to the provider, outside interpreters usually do not have the opportunity to build relationships with providers and clients.

The LAP explicitly recommends against interpretation by family members or friends, a point raised earlier in this document. In these cases, the patient's right to confidentiality is compromised. In addition, providers cannot guarantee the accuracy of interpretation. Telephone interpretation, a method sometimes used in health care and which is effective for routine interpretation or for emergency cases where there is little time for an interpreter to physically arrive at the scene, is also discouraged as a general strategy for ensuring language access. The LAP assessed that telephone interpreters are typically unfamiliar with medical terminology and concepts, and/or do not provide cross-cultural interpretation between provider and client. In addition, people communicating via telephone are unable to perceive one another's physical communication cues.

As alluded to in the previous section, language access to health care goes further than finding the optimal arrangement of staff interpreters. The LAP points out that health care organizations serving a large number of LEP clients should also be responsible for providing translated signs, posters, clinical forms and information, and health education materials.²⁴

There are trade-offs for each of the strategies described above. No one strategy is clearly better than another across all cases. A health care facility must consider both the demand for language assistance in its service community and its own financial resources while planning to ensure language access. Our suggestion is that providers aim to provide the maximum amount of assistance resources as dictated by the demand for resources in the client community. Obviously, aiming to provide less than the demand potentially compromises language access. On the other hand, aiming to provide more, conceptually, reduces the “returns” on the provider's investment since the additional resources would presumably be utilized infrequently; this concern is most relevant to providers strapped for funding in the first place.

A crucial issue not directly addressed in the LAP report is exactly how a provider determines that the demand for language assistance in the client community is “high,” “moderate,” or “low”—i.e., the “threshold” issue raised in section 5.4. However, in a related project, the California Cultural Competency Task Force recommends concrete criteria for determining the extent of client demand for language assistance in service

²⁴Providing translated reading materials is, however, at best a supplementary strategy for resolving problems of language access, because many at-risk communities are characterized by high levels of illiteracy.

delivery.²⁵ The Task Force's specific concern is to ensure that administrators of selected health plans²⁶ hire staff members with the relevant cultural and language expertise in a manner proportional to the size of a given ethnic or primary language group of enrollees under that plan. The number of full-time employees recommended is computed according to the following guidelines:

Number of enrollees in ethnic or primary language group	Number of full-time positions available during normal service hours
0-100	0 ^a
100-420	0.5 ^b
420-840	1.0
840-1680	2.0
1680+	2.0 + 1.0 per 840 additional enrollees ^c

^aFor these groups, the Task Force recommends that basic services be made accessible 24 hours a day via telephone interpretation services, free of additional charge.

^bFor these groups, the Task Force recommends that important written documents be translated into relevant languages.

^cFor groups with at least 1680 enrollees, the Task Force recommends 1.0 full-time positions per 840 enrollees be available for service delivery, 24 hours a day.

Although the Task Force's concerns are not precisely those of the LAP's, this table can serve as a guide for estimating degrees of client demand for language assistance resources. For example, if a provider has less than 100 total LEP clients, it might consider employing staff members who interpret but who have other primary duties, or staff members who are only occasionally called upon to interpret. Similarly, if a provider has more than 420 LEP clients, it should seriously consider employing full-time staff interpreters whose sole responsibility it is to interpret.

6.2 Case Management

The second model presented here is the *case management* model. Case management in health care already exists at various sites in the U.S. health care system, but here we focus specifically on the Southeast Asian Developmental Disabilities Project (SEADD) and their efforts to implement case management as a method for delivering culturally competent services.

The SEADD Project is being implemented in San Diego County, California, and as the name implies, is aimed at helping Southeast Asian refugees who have arrived in the U.S. within the last fifteen years with mental and physical health care needs. Otherwise, they would have difficulty receiving needed care due to their unfamiliarity with the health care system. It is specifically targeted at "Southeast Asian refugee families with children

²⁵The California Cultural Competency Task Force, *Recommendations for the Medi-Cal Managed Health Care Program*, Feb. 8, 1994, Section 4.0, pp. 19-21.

²⁶Most importantly, those which receive federal funding.

ages 0-5 who have health problems, genetic disorders, or are at-risk or are developmentally disabled.”²⁷

The basic premise of the SEADD Project is to increase client participation in service delivery through the use of case managers as intermediaries between clients and providers. This involves considerably more than providing interpretation services on the part of the case manager. The case manager is expected to help clients become more knowledgeable about the U.S. health care system and to assist in making and executing long-term health care plans. Thus the case manager's role is more explicitly holistic in scope, whereas the LAP focuses more on language access at the specific site of provider/client interaction. SEADD pictures the case manager facilitating culturally competent health care by accomplishing four major tasks:

1. *Establishing relationships with the family*—Whereas the LAP's efforts are directed at the community level (or, to be more precise, a community-based health care provider), case management is an effort to provide culturally competent service delivery at the level of the *family*. Establishing a relationship with a family, which has recently arrived at the U.S. and is mistrustful of institutions and authority, can be complicated. The relationship between case manager and family must be based upon trust; therefore, an aggressive or arrogant approach to a family skeptical of the intentions of the case manager will not work. On the other hand, should initial contacts with families produce negative reactions, it is not enough for the case manager to simply give up.
2. *Consideration of important family values*—The case manager, of course, is expected to interact with family members in a culturally appropriate manner. In particular, SEADD stresses that case managers should understand and respect the customs observed by families of different cultures. For example, in many cultures the father is the head of the family and main decision-maker; thus, case managers should include the father's input in any decisions that need to be made.
3. *Case manager as advocate*—As mentioned previously, the case manager is not simply an interpreter for family members. He or she is responsible not only for building a constructive relationship between him- or herself and the client, but between the provider and the client as well.
4. *Networking*—Finally, it is the case manager's responsibility to identify the particular needs of his or her client family and to match these needs with appropriate services in the U.S. health care system. In the specific case of SEADD, which is especially concerned with developmental disabilities, case managers are expected to survey and evaluate a variety of programs such as Regional Centers for the Developmentally Disabled, or the Association for Retarded Citizens Infant Program,²⁸ and possibly recommend them for their clients.

²⁷Yonemitsu & Cleveland, *Culturally Competent Service Delivery*, p. 7.

²⁸*Ibid*, p. 36.

It is important to note that the case manager's responsibilities include both *intake* and *ongoing* duties. Once the case manager has established a relationship with a client family, it is imperative that he or she check in regularly (both over the phone and at the family residence); make periodic assessments of need and progress; assist in completing forms for services and/or arranging meetings between clients and specific providers; refer clients to other sources of service, sharing or even relinquishing clients as appropriate; and so on. In this sense, the case manager's relationship to the client family is similar to that of a family attorney's.

7. Conclusion

The linguistic and cultural appropriateness in managed care deserve further attention since it relates to the ability of many Asians and Pacific Islanders in the U.S. to receive adequate health care. The sources of the problems reside at various levels throughout the health care system. This document has specifically focused on problems and potential solutions to culturally inadequate care at the level of service delivery and policy.

Toward this end, a practical definition of cultural competency has been offered. To help suggest possible avenues of health care reform, two models of culturally competent service delivery currently in implementation have been presented. Both the LAP and case management models address problems applicable to managed care as well as other service arrangements. The LAP focuses on matching staff interpreter resources to client community demand. Case management focuses on helping clients navigate through the complex and vast terrain of the U.S. health care system. Although the community health centers featured in the LAP and SEADD's case management projects have been implemented in specific areas, the issues they address exist across the country. The purpose of this analysis is to provide policy makers and providers with an assessment on the impact of managed care on Asians and Pacific Islanders. This document has also suggested methods of addressing and resolving issues related to linguistic and culturally competent service delivery so that they can be incorporated into a more equitable, comprehensive and accessible health care system.

July 13, 1999

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RE: Suggestions for revisions to Title VI LEP Guidance

Dear Mr. Perez:

Thank you for giving us the opportunity to make suggestions to strengthen and enhance the Office of Civil Rights' Guidance Memorandum on "Title VI Prohibition Against National Origin Discrimination—Persons with Limited-English Proficiency" for publication in the Federal Register. We are submitting this proposed revision of the guidance with our explanation of the changes contained in this letter. These suggestions come primarily from the organizations who met with you in San Francisco on May 13 as well as others who have worked on this issue in California as well as nationally. It also reflects some of the views of the National Council on Interpretation in Health Care who will be submitting a separate letter to you shortly. We feel these changes and the publication of the revised Guidance are necessary to ensure that limited-English proficient persons (LEP) have equal access to health and social service programs which receive federal funding from the Department of Health and Human Services. Publication of this Guidance in the Federal Register will greatly enhance enforcement of Title VI with respect to persons with limited-English proficiency. We have reviewed existing law, regulations, OCR policies and decisions to justify our suggestions. The changes we are suggesting include the following:

- 1) Changing some areas from discretionary to mandatory.** We feel that in order to ensure equal access for LEP's, certain steps **MUST** be taken in every situation regardless of the size or type of provider. This includes data collection and an assessment of the language needs of the recipient's service population and the recipient's bilingual staffing.

In addition, we strongly recommend that the Guidance be amended to include a provision for a language access impact analysis, in order to assure compliance with Title VI. 45 C.F.R. §15.3(b)(2) requires that recipients, in determining what types of services, financial aid, benefits, or facilities will be provided, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, or have the effect of defeating or substantially impairing accomplishment of the objectives of the programs. Subsection 3 contains similar language regarding decisions regarding site locations.

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The proposed language in the guidance requires recipients to conduct a civil rights impact study before making decisions that would have a major implication and/or substantially alter an individual's language access to health or social services. Such a civil rights study would be an effective and efficient means of assuring that federal funding recipients do not make changes that would result in criteria or methods of administration that have the effect of defeating or substantially impairing the individuals rights under Title VI.

Such a study would avoid, for example, federally funded recipients from privatizing its TANF employment services without analyzing whether the contractor could assure equal access to LEP individuals.

- 2) **Clarification that Title VI protection applies to all LEP's regardless of the size of the language group that individual belongs to.** We have found that some recipients do not believe that they must provide access to everyone even if only one person in their service area uses that language. While most OCR Regional offices have indicated that Title VI imposes a duty on recipients to furnish language-appropriate services to all LEP patients/clients, regardless of the size of the language group to which they belong, this should be clearly spelled out in the Guidance. One decision noted, that while the draft regulations tie formal policies on the use of linguistic services to a threshold of 100 or more persons, "a recipient who denies services to even one person due to his LEP status violates Title VI." *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, produced by the National Health Law Program, January 1998, hereinafter "NHeLP", at 28 citing *In re Department of Social Services*, OCR. No. 08917009 at 3, n.1 (Sept. 30, 1992).
- 3) **Use of thresholds for determining minimum steps recipients must take.** We propose that a numeric or proportional threshold be used for determining when certain, specific steps must be taken by recipients. While the original guidance gave recipients many options, we believe that when a language group in the recipient's service population is numerically or proportionately "significant," then use of the best approaches to providing access in that language is required and justified. In addition, a numeric or percentage threshold is useful for clarifying when written materials need to be available in other languages in accordance with the Department of Justice coordination regulations at 28 CFR § 42.405 (d) (1). We propose to use the threshold included in the August 1993 draft regulations defined as "100 persons or 5 percent of the population in the recipient's service area." This is consistent with the approach taken in the Voting Rights Act amendment: "any group which comprises either 100 persons or at least 5 percent of the population..." Public Law 102-344 (Aug. 26, 1992), 106 Stat. 921. The numeric threshold of 100 persons is also consistent with the Medicare preaward clearance reviews conducted by OCR. *Investigative Procedures Manual*, ch. 18, p. 11.
- 4) **Definition of equal access.** This had been included in the earlier August 1993 draft proposed regulations developed by OCR. We believe it would be helpful to include this articulation of what equal access means.

- 5) What recipients must do to ensure equal access.** These are the sections which we feel are most important to strengthen the guidance. Many areas are covered including strengthening the list of options recipients have in providing language access and prioritizing the best ways to provide equal access.

a) Use of language/ethnic matching staff

We believe that use of bilingual, professionally and culturally competent, and ethnic matched staff in patient/client contact positions is the ideal way to ensure equal access to health and social services. Our proposed amendments reflect this and adds a proposed definition of “cultural competency” which is from the Department of Health and Human Services, Healthy People 2010 Draft Objectives.

Baker, Hayes and Fortier (1998) conducted patient satisfaction interviews among 457 Spanish-speaking patients exiting from a public hospital emergency room department. Patient satisfaction was measured by the provider’s friendliness, respectfulness, concern, ability to make the patient comfortable, and time spent for the exam. Patients who communicated through an interpreter or who did not have an interpreter when they thought one was necessary were less satisfied with the patient-provider relationship compared to patients who communicated adequately with their provider without the use of an interpreter. This indicates that the quality of interpretation technique and availability at that particular ER at that point in time did not meet consumer satisfaction. It should be noted that the interpreters used by the hospital were not trained as interpreters. But the study also implies that patients were most satisfied with a direct “language-match” with their provider.

b) Use of Bilingual Staff as interpreters

With respect to the examples of using bilingual staff as interpreters, in the health area, it can NOT be assumed that a nurse, medical student, or other staff (clinical or not) who speaks two languages will be sufficiently familiar with medical terms and concepts in both languages. Bilingual individuals, unless they were trained as health professionals in another country, generally only have conversational skills in the target language, and medical terminology would need to be specifically acquired through a course of study. In addition, such a bilingual individual may not have had training in medical interpreting skills, and risk making the same mistakes as untrained family and friends.

This issue can also be a problem when assumptions are made about “bilingual” staff or health professionals that communicate directly with LEP patients. Almost universally, the level of true bilingual ability is never ascertained, and these individuals may have learned the language conversationally at home, in high school, or in college, but lack training in medical terminology and concepts. Kaiser Permanente of Southern California has instituted a competency testing program for staff who wish to operate in a bilingual or interpreter capacity, but many provider organizations rely heavily on bilingual (untested) staff lists for both direct patient care and interpreting, and increasing numbers of managed care organizations market their services to LEP communities by highlighting their list of bilingual health

professionals. The presence of these lists may not be indicative of true language access.

c) Using Family Members and Friends (Including Minors) For Translation or Interpretation

Recipients should be prohibited from requiring, suggesting or encouraging beneficiaries to use family members or friends as interpreters. In addition, all recipients should be required to adopt a policy of prohibiting the use of minors as interpreters regardless of the beneficiary's request.

The current guidance fails to convey adequately the harm of using family members and friends for interpretation. And there is no mention of the particular problems posed by using children to interpret. The potential harm is significant. Enclosed is more background on the documented harm to children who are forced to interpret. Our proposed language explicitly prohibits the use of minor children for interpretation. The Guidance also allows a beneficiary to use a family member or friend upon request. Many recipients will rely on this exception to avoid compliance with Title VI. This policy must be strengthened and clarified to ensure that recipients and their employees understand their obligations under Title VI.

Research, anecdotal information, OCR complaints and resolutions support the recommended language. OCR Title VI complaints strongly suggest that many LEP individuals are not being advised that a free interpreter is available. To the contrary, as the National Health Law Program's study of health care providers shows, "most providers...advise patients to bring friends or family members with them to translate" and some providers have "routinely instructed patients to bring their own interpreters to appointments." NHeLP at 9. OCR has determined that instructing beneficiaries to use family members or friends as interpreters violates Title VI; nevertheless this practice is rampant. See e.g., NHeLP at 107-80, OCR Decisions I-05, V-01.

The recommended language clearly states that asking, suggesting, encouraging or requiring beneficiaries to bring their own interpreter violates Title VI. OCR Decisions support this position. See NHeLP at 107-111, OCR Decisions I-01, I-05, V-01, V-05, IX-01.

Our recommended language places the information about the availability of the free interpreter at the very beginning. The current Guidance places this information at the end of the sentence, making it vulnerable to misinterpretation. Thus, it has not always been clear to recipients and their employees that they must notify LEP persons of the availability of free interpreters. See NHeLP at 109, OCR Decision V-05. The recommended language clarifies this requirement.

OCR Decisions also support requiring a record of the offer of free interpreter services and the LEP individual's response. See NHeLP at 110, OCR Decision V-07.

d) Certification of interpreters

At this time, only one state has certification for medical interpreters (WA) and one has certification for interpreters working in Workmen's Compensation (CA),and

these tests are generally not well-regarded by professional medical interpreters. These two programs have been very controversial for a number of reasons: minimal adaptation of a court interpreter test for use by medical/social service interpreters; bias/irrelevance for non-written language groups; low passage rates by interpreters from certain language groups; and the high cost of testing as a barrier for freelance community-based interpreters. (In Washington State, both Chinese and Russian candidates, as of Feb. '98, had a higher overall pass rate than Spanish-speaking candidates, and the Korean rate was about the same as that for Spanish speakers. What was troublesome about the Washington statistics was the tremendous disparity in pass rates (from 60% for Chinese speakers to 14% for Lao), the low number of candidates attempting certification in some languages, the high number of drop outs after failure in other languages, and the resulting low level of availability of certified interpreters in some languages. Passage of the exam in Washington state, however, is required for state reimbursement of services). At this time, both the Massachusetts Medical Interpreter Association (MMIA) and the California Health Interpreters Organization are working to develop certification programs, and interpreter advocates in Minnesota and New York are doing similar work. The competency areas outlined by the Guidance are generally consonant with the Medical Interpreter Standards of Practice developed by the MMIA and endorsed last year by NCIHC.

e) Translated Signage and Written Materials

The guidance should be more explicit about how clients are informed of their right to receive bilingual or interpreter services. Providers should provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge.

It is frequently a challenge for individuals with LEP to access interpreter/bilingual services, even when an institution organizes and offers the services. At one large hospital in California with a million dollar interpreter services program and over 30,000 encounters per year, a former interpreter services coordinator estimated that perhaps 30 percent of all patients who needed an interpreter did not get one, most likely because staff were too busy to make a request to the interpreter services office. The availability of services is no guarantee that they will actually be used when the need arises. And without information about them, many LEP individuals would not think or would be hesitant to ask a provider to supply an interpreter. Both the OCR and NHeLP documents recognize the need to inform clients of the availability of interpreter, bilingual, and translation services, and many of these documents go beyond requiring that providers inform clients only at the time of accessing services.

Facilities around the country have developed innovative ways to publicize the availability of bilingual/interpreter services. At the University of Massachusetts Medical Center in Worcester, the staff at the main informational kiosk direct incoming LEP patients to a sign on the wall that has tear-off cards in many different languages. The patient selects the appropriate card for their language and hands it to

the staff person, who then contacts interpreter services. At the Pacific Medical Center Clinics in Seattle, WA, all new patients are automatically assigned an interpreter in their native language who appears at each visit unless the first visit reveals that the interpreter is unnecessary. At the community level, the Heartland Alliance in Chicago, IL, has published bilingual wallet cards that inform the carrier and any provider who receives it that the holder of the card is LEP and entitled to interpreter services under state and Federal law. The cards are distributed to individuals through community-based organizations and the carriers are instructed to present the card when seeking health services. Some of the compliance agreements reviewed by NHeLP suggest additional steps for providers to take, including the following: providers should publicize the availability of no cost programs and services in non-English community newspapers and on non-English radio and television stations; providers need to issue written notices to clients in their primary language informing them of their right to receive interpreter services; providers should inform LEP individuals of the availability of no cost interpreter services; and recipients should conduct community outreach to give notice to community agencies and referral sources about the facility's new [interpreter] policies.

We appreciate this opportunity to examine the January 1998 Guidance and make suggestions for strengthening and enhancing its impact on ensuring access for Limited-English Proficient persons. We look forward to continuing to work with you on further development of the revised Guidance for publication in the Federal Register. Deeana Jang will continue to follow-up with you as the process moves forward. She can be reached at (415) 954-9957.

Sincerely,

Deeana Jang, Dong Suh and Ignatius Bau, Asian and Pacific Islander American Health Forum

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encls.

APPENDIX--Use of family members or friends including minors as interpreters

The harms of using family members or friends, and particularly minors, as interpreters are multifaceted. Research and anecdotal information reveal many problems that result from this practice. These include: (1) requiring children to take on additional burdens, "adult" decision-making and responsibilities; (2) causing friction and a role reversal within the family structure, which can even lead to child abuse situations; (3) violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services; and (4) because family members and friends, particularly if they are minors, almost always are not competent to interpret, using them as interpreters often leads to serious negative consequences.

Any interpreter services provided by a family member or friend poses the problem of breaching confidentiality or compromising effectiveness. But when a family member or friend is a minor, there are additional concerns, such as burdening the child and straining the relationship between the child and his or her parents. Existing research indicates that some older children who interpret for their parents may experience some linguistic benefits from doing so in addition to the drawbacks. See Tse, "Language Brokering in Minority Communities: The Case of Chinese- and Vietnamese-American Students," *The Bilingual Research Journal*, 20(3/4) at 485-498 (1996) (hereinafter "Tse"); McQuillan & Tse, "Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy," *Language and Education*, 9(3) at 195-215 (1995) (hereinafter, "McQuillan & Tse"). These benefits, however, are far outweighed by the potential negative effects of using young children to translate. These negative effects are significant, particularly in situations involving health care providers and government offices.

A recent Los Angeles Times article about children who translate for their parents illustrates the potential for harm: A 13-year-old boy described feeling tongue-tied on a recent visit to a health clinic with his mother when the doctor asked him to explain the medicine that the doctor was prescribing to the child's mother. Gold, "Small Voice for Her Immigrant Parents," *Los Angeles Times*, A1 (May 24, 1999) (hereinafter, "Gold, 'Small Voice'") (see Attached). The potential for harm is exacerbated when providers use children to translate in gynecological or reproductive health settings, as in this situation: A provider performing an ultrasound on a pregnant LEP patient instructed the patient's seven-year-old daughter to tell her mother that the baby was stillborn. Only when the daughter became upset and refused to interpret the message was a professional medical interpreter called. National Health Law Program, "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities," at 10 (January 1998) (hereinafter, "NHLP").

A recent study of 150 Vietnamese- and Mexican-American women who are or had been welfare recipients in California, found that more than half (53.3%) used their children to translate for them. Most use their children for communicating with schools, filling out forms and communicating with government agencies. More than half of the women who use their children as interpreters identified problems with this practice. The top four problems were: (1) the child translated incorrectly; (2) the child left out information; (3) the information was too technical for the child; and (4) the child was unable to properly translate due to limited English skills. Several of the Mexican-American women reported that their children

sometimes answered questions without first checking with them. One woman's story illustrates the problems with using friends and family members for translation:

I asked a friend of mine to translate letters from the county for me but my friend gave me wrong information. I think I am going to be cut off aid because I could not understand the notice.... My 12-year-old son translates for me a lot. He helps me fill out forms and translates when I go to the doctor. He does not like to do it. He gets upset and tells me that I should be able to do it because I am older. It is too difficult for him.

A Vietnamese-American woman uses her seven-year-old daughter to translate for her but reported that her daughter is too young to understand many things. See Equal Rights Advocates, ">From War on Poverty to War on Welfare: The Impact of Welfare Reform on the Lives of Immigrant Women," at 12-14 (April, 1999) (hereinafter, "ERA") (see Attached).

In addition, the National Health Law Program's recent report found that using children for translation frequently results in children being pulled out of school to assist their parents. NHeLP at 9.

Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information. See generally, Tse; McQuillan & Tse. Children who act as language brokers influence the content of the messages that they translate, which, in turn, affects the ultimate decisions of their parents. They often take on the primary decision-making role for the entire family. Id. An 11-year-old child who acts as a "language broker" for her family described worrying about her family's finances. Once she felt bad because the water bill was high and she thought it was her fault. Another time she dreamed that there was a huge bill and she did not know how to pay it. Gold, "Small Voice." This role reversal can have serious negative effects on the family unit. The strain of using children as interpreters can even lead to child abuse because "it disrupts the traditional family structure in terms of parents providing that authority figure. A lot of the children don't view their parents role models and there is a lack of respect. The parents are totally frustrated. They want to exert some kind of control and resort to corporal punishment." Id.

Part of the strain on children and their families stems from the fact that children are not competent to serve as interpreters in the situations discussed here (hospitals and other health care providers, social services agencies, etc.). As with other untrained interpreters, children who translate are prone to omissions, additions, substitutions, volunteered answers and other problematic practices. See NHeLP at 9; ERA at 12. Some simply guess when they do not understand a word or concept. Gold, "Small Voice." It comes as no surprise that many of the children who serve in this role feel embarrassed, frustrated, resentful and ill equipped to deal with the added responsibilities of translating. McQuillan & Tse at 205.

GUIDANCE MEMORANDUM
Title VI Prohibition Against National Origin
Discrimination--Persons with Limited-English Proficiency

I. BACKGROUND

This memorandum is intended to offer guidance to staff of the Office for Civil Rights (OCR) with respect to its enforcement of the responsibilities of recipients of Federal financial assistance from HHS to persons with Limited-English Proficiency (LEP), pursuant to Title VI of the Civil Rights Act of 1964, 2000d et seq. ("Title VI"). Such recipients include hospitals, managed care providers, clinics and other health care providers as well as social service agencies and other institutions or entities that receive assistance from HHS. This document will provide guidance to OCR investigators in assessing compliance, negotiating voluntary compliance, and providing technical assistance. Through OCR's investigative activities in this area, both recipients and LEP beneficiaries will be made more aware of their respective obligations with respect to the provision and receipt of services.

The guidance is intended to clarify standards consistent with case law, well established legal principles that have been developed under Title VI, and policies developed by HHS and OCR in ensuring Title VI compliance.

Section 601 of Title VI states that "no person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Regulations implementing Title VI which are published at 45 C.F.R. Part 80, specifically provide that a recipient may not discriminate and may not, directly or through contractual or other arrangements, use criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular, race, color or national origin.

The statute and regulations prohibit recipients from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of beneficiaries in their programs, benefits or activities on the basis of race, color or national origin. Accordingly, a recipient must ensure that its policies do not have the effect of excluding from, or limiting the participation of, such persons in its programs and activities, on the basis of national origin. HHS and OCR have consistently interpreted the prohibition of discrimination on the "basis of national origin" to require the provision of language accessible services to LEP persons. This interpretation is based on the U.S. Supreme Court's decision, in Lau v. Nichols, 414 U.S. 563 (1974), wherein it recognized that recipients of Federal financial assistance have an affirmative responsibility, pursuant to Title VI, to provide LEP persons with meaningful opportunity to participate in public programs.¹ In Lau v. Nichols, the Supreme Court ruled that a school system's failure to provide English language instruction to students of Chinese ancestry who do not speak English denied the students a meaningful opportunity to participate in a public educational program in violation of the Civil Rights Act of 1964.² Further, HHS itself has made it clear that "A recipient of Federal financial assistance that does not have the ability to communicate with person of limited English proficiency deprives such persons of an equal opportunity to participate in and benefit from the services provided by the recipient. Because persons of limited English are disproportionately represented in

¹ Other courts have generally also followed Lau in the content of social services programs, e.g., Sanchez v. Maher 560 F.2d 1105(2d Cir. 1977); Reyes v. Thomson No. C91-0303 (D. Wash. Mar. 12 1991; Asociacion Mixta Progesista V. United States Dep't of Health, Educ., & Welfare, Civ. No. C72-882 SAW (N.D. Cal. 1976). But See Kuri v. Edelman 491 F.2d 684 (7th Cir. 1974).

² The Lau decision affirmed the U.S. Department of Education's Policy Memorandum issued on May 25, 1970, titled "Identification of Discrimination and the Denial of Services on the Basis of National Origin", 35 Fed. Reg. 11,595. The memorandum states in part: "Where the inability to speak and understand the English language excludes national origin minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students."

certain national origin groups, the inability to communicate with persons of limited English proficiency has the effect of discriminating on the basis of national origin . . . no person may be subjected to discrimination on the basis of national origin. . . ."³ Therefore, a recipient must take reasonable steps to provide services and information in languages other than English in order to ensure that LEP persons are effectively informed and can effectively participate in and benefit from its programs.

English is the predominant language of the United States and according to the 1990 Census is spoken by 95% of its residents. Of those residents who speak languages other than English at home, the 1990 Census reports that 57% of U.S. residents above the age of four speak English "well to very well." The United States is also, however, home to millions of national origin minority individuals who are limited in their ability to speak, read, write and understand the English language. The language barriers experienced by these LEP persons can result in limiting their access to critical public health, hospital and other medical and social services to which they are legally entitled and can limit their ability to receive notice of or understand what services are available to them. Because of these language barriers, LEP persons are often excluded from programs or experience delays or denials of services from recipients of Federal assistance. Such exclusions, delays or denials may constitute discrimination on the basis of national origin, in violation of Title VI.

LEP persons can and often do encounter barriers to health and social services at nearly every level within such programs. The primary reason for this difficulty is the language barrier that often confronts LEP persons who attempt to obtain health care and social services. Many health and social service programs provide information about their services in English only. Many LEP persons presenting at hospitals or medical clinics are faced with receptionists, nurses and doctors who speak English only, and often interviews to determine eligibility for medical care or social services are conducted by intake workers who speak English only.

³ 45 Fed.Reg.82,972 (December 17, 1980) (Notice).

The language barrier faced by LEP persons in need of medical care and/or social services severely limits their ability to gain access to these services and to participate in these programs. In addition, the language barrier often results in the denial of medical care or social services, delays in the receipt of such care and services, or the provision of care and services based on inaccurate or incomplete information. Services denied, delayed or provided under such circumstances could have serious consequences for an LEP patient as well as for a provider of medical care. Some states recognize the seriousness of the problem and require providers to offer language assistance to patients in certain medical care settings.

Since the Lau decision, OCR has conducted a number of complaint investigations and compliance and pre-grant reviews involving language barriers that impede the access of LEP persons to federally-assisted health and medical care and social services. OCR has found that where language barriers exist, eligible LEP persons are often excluded from programs, denied medical services or suffer long delays in the receipt of health and social services.

This guidance sets out standards for OCR staff to consider in determining whether federally-assisted providers of medical care or social services are taking steps to overcome language barriers to health care and social services encountered by LEP persons. The guidance emphasizes that Title VI requires recipients to provide language accessible services to all LEP individuals regardless of the size of the language population to which they belong or how uncommon the language may be. Based on the application of certain factors, it calls for stricter standards for certain providers, but provides flexibility to other providers in choosing the language assistance methods they will employ. Thus, small providers which do not have a significant language populations in their service area may be able to meet their responsibilities by choosing fewer or different options than the options which should be employed by larger providers or those providers serving many language groups.

OCR's position as set forth in this document is fully consistent with a government-wide Title VI regulation issued by the Department of Justice (DOJ) in 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs," 28 C.F.R. Subpart F. The DOJ regulation addresses the circumstances in

which recipients must provide language assistance, in written form, to LEP persons.⁴ The DOJ regulation does not address the question of oral language assistance. OCR's experience in conducting complaint investigations and compliance and pre-grant reviews demonstrates that oral communication between recipients and program beneficiaries is an integral part of the exchange that must occur in order for assisted programs and activities to appropriately function. Thus, OCR's longstanding position has been that recipients must also provide oral language assistance in languages other than English. This statement affirms this position.

II. DISCUSSION

A. Who is Covered

All entities that receive Federal financial assistance, regardless of the amount of that assistance, from HHS, either directly or indirectly through a subgrant or subcontract, are covered by this guidance. Covered entities would thus include any state or local agency, private institution or organization, or any public or private individual that operates, provides or engages in health, medical or social service programs and activities that receive or benefit from HHS assistance. Coverage includes all areas of operation of the recipient and is not limited to those areas funded by HHS. For example, an insurance company or managed-care organization that receives Medicare or Medicaid reimbursement would be ultimately responsible for ensuring that member limited English proficient persons are receiving language accessible care through any provider office or agency it has a contract or subcontract with. The insurance company or managed-care organization may directly provide the

⁴ The DOJ coordination regulations at 28 C.F.R. Section 42.405 (d)(1) provide that "[w]here a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program (e.g. affected by relocation) needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

bilingual staff or interpreter, or it may require the contracted agency to provide such assistance.

B. Ensuring Equal Access to LEP Persons

All recipients have the responsibility for ensuring that their policies and procedures do not deny or have the effect of denying such LEP persons equal access to federally assisted health, medical and social service programs, benefits and services for which such persons qualify.

In fulfilling its obligation of providing equal access for limited English proficient persons, a recipient may not:

- Provide services to persons of limited English proficiency that are more limited in scope or that are lower in quality than those provided to other persons;
- Subject a beneficiary to unreasonable delays in the provision of services because the beneficiary is of limited English proficiency;
- Require a beneficiary to provide an interpreter or to pay for the services of an interpreter;
- Rely on persons other than those employed directly by the recipient or under contractual or volunteer arrangement with the recipient to serve as interpreters, except where a beneficiary expressly requests that an adult family member or friend be allowed to serve as an interpreter after being informed that a qualified interpreter will be provided at no cost;
- Limit participation in a program or activity on the basis of limited English proficiency;
- Provide services to persons of limited English proficiency that are not as effective as those provided to others.

The key to ensuring equal access to benefits and services for LEP persons, is to ensure the service provider and the LEP client can communicate effectively, i.e., the LEP client should be given information about, and be able to understand, the services that can be provided by the recipient to address his/her situation and must be able to communicate his/her situation to the recipient service provider. The LEP client should also be advised and

understand information about his/her rights and obligations regarding health and public benefits programs. Equal access requires the provision of culturally and linguistic competent services.

Recipients are more likely to develop effective communication methods if they approach their Title VI responsibility in a structured rather than on an ad hoc basis.³ Therefore, recipients must, at no cost to the recipient:

- (A) Have a procedure for identifying the language needs of patients/clients. This should include an ability to collect, report and review data on:
 - the racial and ethnic composition and primary languages of the recipient's service area;
 - the racial and ethnic composition and primary languages of the recipient's contact staff by type of position held; and
 - whether persons who are limited-English proficient receive language assistance.
- (B) Have a procedure for tracking the provision of bilingual/interpreter services to LEP persons at all points of access to the recipient's services, to ensure that LEP persons are not denied access to the same range of services as English-speaking persons. This should include: Collecting and reviewing data regarding the provision of bilingual/interpreter services for each recipient service provided to LEP persons. [Data collected by the recipient regarding the frequency of delivery of those services, and segregating the data by primary language].
- (C) Have ready access to, and provide services of linguistically proficient, culturally competent, bilingual staff or interpreters in a timely manner during hours of operation. Providers should identify and record the beneficiary's preferred language.
- (D) Develop written policies and procedures for addressing the language assistance needs of LEP persons that include an assessment of:
 - the points of contact in the program or activity where language assistance is likely to be needed

- the non-English languages that are most likely to be encountered
 - the resources that will be needed to fulfill this responsibility
 - and the location and/or availability of such resources. In identifying available resources, recipients should consult with national origin organizations and groups in their service areas.
- (E) Disseminate interpreter policies and procedures to staff and ensure staff and patient/client awareness of these policies and procedures, availability of language accessible services, and of the recipient's Title VI obligations to LEP persons. In addition, all staff should receive training on interpreter policies and procedures.
- (F) Collect and review data identifying the patient/client's primary language and language used at home.
- (G) In collaboration with community-based organizations serving immigrant communities, develop a notification and outreach plan for LEP beneficiaries regarding the availability of bilingual/interpreter services, and the patient or client's right to them.
- (H) Where there is an underutilization of a recipient's services among persons in particular ethnic or LEP communities who qualify for them, develop a plan for outreach to those communities to notify them of the availability of the recipient's services.
- (I) Conduct a civil rights impact study before making decisions that would have a major implication and/or substantially alter a LEP individual's access to Health and Social Services.
- "Major implications" are those consequences of proposed policy actions which, if implemented, will negatively or disproportionately affect persons with limited English proficiency, who are employees, program beneficiaries or applicants for employment or program benefits or services.
 - "Policy actions" means those actions including, but not limited to, reorganization; office consolidation, closure or relocation; changes in service delivery methods; and implementation of new programs or services.

- The study must identify and address major language access impacts of proposed policy actions, and set forth a plan to correct any impacts so identified.
- (J) Establish internal systems to identify and address the language access implications of proposed policy actions, as defined above, before those actions are approved and implemented.
- (K) Designate someone within the recipient's agency or organization to serve as Title VI Coordinator. The Coordinator is responsible for developing, maintaining, and implementing an LEP plan.

C. Methods for Providing Interpretative Services

1. Standards for Applicable Options.

As was mentioned earlier, OCR's position is that in order to ensure that recipients develop effective communication methods that will comply with Title VI there must be structure and uniformity. However, OCR also recognizes that it should allow for some flexibility for certain providers given different factors that may exist in their service areas. Thus, the guidance sets forth that recipients who serve a significant non-English speaking language group must provide language accessible services by employing specific methods, while other recipients are provided with more flexible options. For purposes of this guidance, significant number or proportion means either 100 or more persons or 5% of the population eligible, whichever is less.

Where there are significant numbers or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program who needs service or information in a language other than English in order effectively to be informed of or to participate in the program, a recipient must have competent, bilingual staff in contact positions and/or staff interpreters.

Where there is not a significant number or proportion of eligible persons who need assistance or information in a language other than English, recipients should use the best option available as discussed in 2. And 3. below to provide language access. Recipients are reminded that Title VI imposes a duty on health and benefit providers to furnish language-appropriate services to

all LEP patients or clients regardless of the size of the language group to which they belong. Further, they are reminded that the denial of services, delay in provision of services or any denial of equal access to just one LEP person is a Title VI violation.

A recipients use of such minimum thresholds will not necessarily guarantee compliance with Title VI.

2. Provision of culturally competent, language matched staff and/or interpreter services

Bilingual/Interpreter services

Based on experience, OCR's position is that the best method for removing language barriers and ensuring equal access to LEP individuals is the provision of services by language and ethnic matched service providers. As discussed above, certain recipients must provide language access by using this method, while other recipients have the flexibility of choosing the option that best meets their Title VI obligations. Methods of providing language accessible services, in order of preference, include:

- 1) Hiring bilingual staff in positions having patient/client contact
- 2) Hiring staff interpreters
- 3) Arranging for an outside service to interpret/translate:
 - a. Using trained volunteer staff interpreters
 - b. Arranging for the services of and providing training to community interpreters who can either be paid or provide their services on a volunteer basis.
 - c. Contracting for with an outside in-person interpreter service such as community based organizations serving immigrant communities
- 4) Using a commercial service or community based organization to provide telephone interpreter service

Factors that must be considered by a recipient in determining which option(s) will best meet its Title VI obligation and the needs of its LEP beneficiaries are its size, the size of the LEP population in its service area, the setting in which interpreter services are needed, the availability of staff members and/or

volunteers to provide interpreter services during its hours of operation and the proficiency of available staff members or volunteers available to provide the needed services.

The options available to recipients for providing interpreter services to LEP persons have differing weaknesses and strengths depending on the situation. Hiring bilingual staff for certain critical positions, e.g., for patient or client contact positions, would facilitate participation by LEP persons. However, where there are several LEP language groups in a recipient's service area this option may be impractical as the only interpreter option, and additional language assistance options may be required.

Use of staff or community volunteers may provide recipients with a cost-effective method for providing interpreter services. However, recipients should ensure that such a system is sufficiently organized so that interpreters are readily available during all hours of its operation. In addition, recipients should ensure that such volunteers are qualified, trained and capable of ensuring patient confidentiality.

The use of contract interpreters may be an option for recipients that are small, have a significant but small LEP population, have less common LEP language groups in their service areas, or need to supplement their in-house capabilities on an as needed basis. Such contract interpreters should be readily available, qualified and trained.

Paid staff interpreters are especially appropriate where there is a very large LEP presence in a few major language groups. As in other options, these persons should be qualified and available. In most instances these employees are salaried and are entitled to the same benefits received by other employees.

A commercially or community-based organization run telephone interpreter service may be a useful option as a supplemental system, or may be useful when a recipient encounters an uncommon language that it cannot otherwise accommodate. Such a service often offers interpreting services in many different languages and usually can provide the service in quick response to a request. However, recipients should be aware that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program

or service or may require special arrangements to use such persons. Thus, the use of telephone interpreting services should be limited to situations where there is no bilingual staff person or contracted interpreter available to provide translation services.

General Prohibition of Use of Friends or Family members

A recipient should not require, suggest or encourage a beneficiary to use friends or family members as interpreters. Use of such persons could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations, to family or friends. In a medical and social services settings, ineffective communication can lead to serious, even life threatening, consequences. In almost all situations covered by this Guidance, family members and friends are not competent to act as interpreters, since they may lack familiarity with specialized terminology and concepts. Minor children should never be used as interpreters. Moreover, use of children to interpret can result in serious problems for the entire family, such as children making adult decisions, placing additional stress and responsibilities on children, and causing tension and disruption of the family structure.

At the first point of contact, if a language match staff is not available, a recipient must advise an applicant or beneficiary in his or her primary language that they have a right to a free, trained interpreter and that one is available at no cost. A recipient must not in any way discourage an LEP individual from receiving the assistance of a free interpreter. A recipient must not ask, suggest, encourage or require an applicant or beneficiary to provide his or her own interpreter. This offer of a free interpreter and the LEP person's response must be documented. A trained and competent free interpreter must be made available without unavoidable delay.

An adult family member or adult friend may be used as an interpreter only if all of the following occur: (1) a recipient initially advises of the right to and availability of a free interpreter; (2) the recipient does not in any way discourage the LEP individual's use of a free interpreter provided by the recipient; (3) the LEP individual requests the use of a non-minor family member or non-minor friend as an interpreter; and (4) the

recipients should have their own bilingual staff or interpreter present to ensure that use of the family member or friend would not compromise the effectiveness of services or violate the beneficiary's confidentiality.

Cultural and Linguistic Competency

A recipient should ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, as there is no nationally accepted certification for medical or social service interpreters. However, the competency requirement does contemplate proficiency in both English and the other language; training which includes interpreting skills, the ethics of interpreting, and cultural competence; and fundamental knowledge in both languages of any specialized terms and concepts peculiar to the recipient's program or activity. In clinical settings in particular, persons utilized as interpreters should be trained (orientation is not sufficient, and 40 hours is the average length among trainings well-regarded by medical interpreters), and assessed for their knowledge and before they are allowed to interpret in a medical setting. The National Council of Interpretation in Health Care can recommend the most current standards of practice upon which training and competency assessment can be based for interpreting in health care settings.

With respect to using bilingual staff as interpreters in health care settings, it can NOT be assumed that a nurse, medical student, or other staff (clinical or not) who speaks two languages will be sufficiently familiar with medical terms and concepts in both languages. Bilingual individuals, unless they were trained as health professionals in another country, generally only have conversational skills in the target language, and medical terminology would need to be specifically acquired through a course of study. In addition, such a bilingual individual may not have had training in medical interpreting skills, and risk making the same kinds of mistakes as untrained family or friends.

This issue can also be a problem when assumptions are made about "bilingual" staff, health, or other professionals that communicate directly with LEP patients. Almost universally, the level of true bilingual ability is never ascertained, and these individuals may have learned the language conversationally at

home, in high school, or in college, but lack training in appropriate terminology and concepts. Many recipients rely heavily on bilingual (untested) staff lists for both direct client interaction and interpreting. The presence of these lists may not be indicative of true language access. Recipients may need to formally assess the bilingual proficiency and cultural competency of staff who wish to operate in a bilingual or interpreter capacity.

Cultural competency means: A set of knowledge, skills, and attitudes that allows individuals, organizations, and systems to work effectively with diverse racial, ethnic, religious, and social groups.⁵ Culturally appropriate refers to an unbiased attitude and organizational policy that values cultural diversity in the population served; reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation, or generations and acculturation status; an awareness that cultural differences may affect health and the effectiveness of health care delivery; and knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits. Linguistically competent refers to skills to communicate effectively in the native language or dialect of the targeted population, taking into account general educational level, literacy, and language preferences.⁶

D. Translated Signage and Written Materials

A recipient who serves a significant number or proportion of a particular language group must translate all written information including applications, forms, notices, information, educational and/or informational materials, and signage at key points of contact to clients in that language. Additionally, such recipient must provide in such language written information

⁵ *Healthy People 2010 Objectives: Draft for Public Comment*, U.S. Department of Health and Human Services, Office of Public Health and Science, September 15, 1998, Page 23-3.

⁶ *Id* at Page 4-18.

regarding the client's right to receive interpreter services free of charge, the recipient's Title VI obligations, and the process for filing a complaint of discrimination based on a recipient's failure to provide language accessible services.

Other recipients, must employ the different factors discussed in section 2. above to determine whether they also have the obligations to directly translate materials as discussed above. If after assessing these factors, it is unfeasible for a recipient to translate applications, forms, notices, information, educational and/or informational materials, and signage at key points of contact, the recipient must ensure that the information is interpreted, in full, by either bilingual staff, interpreters or other method as mentioned above. Such a recipient must inform the client in writing of the written information itself or through another written method of the availability of free interpretation of said written materials.

Competency of Written Translations

Recipients should translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas. The quality of written translations and competence in translating is as important as in oral interpretation. Agencies should have in place translation methodologies and review processes to ensure the accuracy and appropriateness of translations. Professionally accepted standards include translation by an individual with demonstrated proficiency in both languages, including knowledge of appropriate terminology and concepts; back translation; and review by target audience groups. These minimum standards would discourage the direct translation of complicated jargon and concepts that are essentially untranslatable or require further explanation.

Recipients also should have in place written criteria for selecting translation vendors, including: 1) a review of the methods and procedures that are used, from submission of English copy to printing of finished materials; 2) how translators are recruited and trained; and 3) how review of translated material is accomplished. They should also have in place knowledgeable people to work with the vendors. Similar criteria should be in

place for determining the quality of purchased translations. There should be written policies forbidding "wildcat" translation (e.g. the doctor's sister who took Spanish in college).

Recipients should also make appropriate accommodations (such as verbal translations, audio or video formats) for limited English speakers who may not read well in their first language and persons whose languages lack a written version.

III. Compliance and Enforcement

In determining a recipient's compliance with Title VI, OCR's concern will be whether the recipient's system allows LEP beneficiaries to overcome language barriers and thus have equal access to, and an equal opportunity to participate in, health care and social service programs and activities. A recipient's use of the appropriate methods as discussed in this guidance, will be viewed by OCR as evidence of a recipient's intent to comply with its Title VI obligations.

Finally, it is very important when assessing recipient compliance with Title VI that processes not be mistaken for fulfilling the intent of the law. The intent is to ensure equal access to services. However, in reviewing the policies and processes that an institution says are intended to comply with the law, equal access is not a given if those policies are not adhered to and the processes for securing language access are of inadequate quality. For example, if an institution is able to show policies and procedures for collecting information about a client's primary language, keeping a list of bilingual employees, calling a bilingual employee who can act as an interpreter, or accessing a telephone language service with which they have a contract, it may appear that this institution is in compliance. But if in fact the clients do not understand everything being communicated to them and have the opportunity to question or otherwise exchange information with the provider because an interpreter is never brought to the patient, or staff person doing the interpretation has never been tested for proficiency or adequately trained to interpret, then equal access is not occurring. The effect is the same as if the institution had no systems in place and staff just called the local ethnic restaurant for an ad hoc telephone interpretation.

The procedural provisions of the regulations implementing Title VI, found at 45 C.F.R. Sections 80.6 through 80.10, are applicable to all complaints or compliance reviews regarding a recipient's compliance with its Title VI responsibility to LEP beneficiaries.



Association of Asian Pacific Community Health Organizations

Member Centers:

*Asian Health Services
Oakland, CA*

*Asian Pacific Health
Care Venture
Los Angeles, CA*

*Chinatown Health Clinic
New York, NY*

*Family Health and Social
Service Center
Worcester, MA*

*Papa Ola Lokahi
Honolulu, HI*

*International Community
Health Services
Seattle, WA*

*Kalihi-Palama Health Clinic
Honolulu, HI*

*Kokua Kalihi Valley
Health Center
Honolulu, HI*

*North East Medical Services
San Francisco, CA*

*Operation Samahan Health Clinic
National City, CA*

*South Cove Community
Health Center
Boston, MA*

*Waianae Coast Comprehensive
Health Center
Waianae, HI*

*Waimanalo Health Center
Waimanalo, HI*

Stephen P. Jiang, ACSW
Executive Director

August 4, 1999

**Irene Bueno
Domestic Policy Council
The White House
1600 Pennsylvania Avenue
Washington, DC 20500**

**RE: Office of Civil Rights' Guidance Memorandum on "Title VI
Prohibition Against National Origin Discrimination—Persons with
Limited-English Proficiency"**

Dear Ms. Bueno:

Greetings from Oakland, California. If my name rings a familiar bell, we met while you were still in Senator Cranston's office and I was on the Board of Filipinos for Affirmative Action. I am glad for the opportunity to reconnect again, and want to offer my congratulations to your sustained commitment to social justice.

As a background, a number of health and human service organization representative met with Mr. Perez of OCR in San Francisco last May, and AAPCHO also met with him in Washington D.C.

As you are aware, a number of organizations including AAPCHO offered suggestions to strengthen and enhance the Office of Civil Rights' Guidance Memorandum on "Title VI Prohibition Against National Origin Discrimination—Persons with Limited-English Proficiency" for publication in the Federal Register. On behalf of the group, Deanna Jang of the Asian Pacific Islander Health Forum submitted a proposed revision for the guidance along with our reasoning for these changes (the letter is enclosed for your reference).

AAPCHO is an association representing community health organizations dedicated to improving health status of Asian Americans and Pacific Islanders (AAPIs) in the United States and its territories, especially those who are medically underserved. AAPCHO advocates for policies and programs that will improve the provision of healthcare services that are community driven, financially affordable, linguistically accessible and culturally appropriate.

AAPCHO is providing you with resource materials, which may inform your office of AAPCHO's involvement in the area of access, especially in health care for the underserved, additional information can be access on the web at www.aapcho.org.

We look forward to hearing of any developments regarding the suggestions we made to strengthen and enhance the Office of Civil Rights Guidance Memorandum. If we can provide you with additional information, please do not hesitate to give me a call at (510) 272-9536 or via email, dtoleran@aapcho.org

Thank you for your time and consideration.

Sincerely,



Daniel E. Toleran

Associate Director for Policy and Planning

cc: Jeffrey B, Caballero, M.P.H., Interim Executive Director, AAPCHO
Jory Watland, Member of the Board of Directors, AAPCHO
Deanna Jang, Asian Pacific Islander American Health Forum

Enclosures: a) State Medicaid Managed Care: Requirements for Linguistically Appropriate Health Care (AAPCHO, 1996)
b) Developments of Models and Standards for Bilingual/Bicultural Health Care Services for Asian and Pacific Islander Americans (AAPCHO, 1996)
c) Letter to Mr. Thomas Perez, OCR Director

July 13, 1999

Mr. Thomas E. Perez
Director, Office for Civil Rights
Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, SW
Suite 515F, Humphrey Bldg.
Washington, DC 20201

RE: Suggestions for revisions to Title VI LEP Guidance

Dear Mr. Perez:

Thank you for giving us the opportunity to make suggestions to strengthen and enhance the Office of Civil Rights' Guidance Memorandum on "Title VI Prohibition Against National Origin Discrimination—Persons with Limited-English Proficiency" for publication in the Federal Register. We are submitting this proposed revision of the guidance with our explanation of the changes contained in this letter. These suggestions come primarily from the organizations who met with you in San Francisco on May 13 as well as others who have worked on this issue in California as well as nationally. It also reflects some of the views of the National Council on Interpretation in Health Care who will be submitting a separate letter to you shortly. We feel these changes and the publication of the revised Guidance are necessary to ensure that limited-English proficient persons (LEP) have equal access to health and social service programs which receive federal funding from the Department of Health and Human Services. Publication of this Guidance in the Federal Register will greatly enhance enforcement of Title VI with respect to persons with limited-English proficiency. We have reviewed existing law, regulations, OCR policies and decisions to justify our suggestions. The changes we are suggesting include the following:

- 1) **Changing some areas from discretionary to mandatory.** We feel that in order to ensure equal access for LEP's, certain steps **MUST** be taken in every situation regardless of the size or type of provider. This includes data collection and an assessment of the language needs of the recipient's service population and the recipient's bilingual staffing.

In addition, we strongly recommend that the Guidance be amended to include a provision for a language access impact analysis, in order to assure compliance with Title VI. 45 C.F.R. §15.3(b)(2) requires that recipients, in determining what types of services, financial aid, benefits, or facilities will be provided, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, or have the effect of defeating or substantially

impairing accomplishment of the objectives of the programs. Subsection 3 contains similar language regarding decisions regarding site locations.

The proposed language in the guidance requires recipients to conduct a civil rights impact study before making decisions that would have a major implication and/or substantially alter an individual's language access to health or social services. Such a civil rights study would be an effective and efficient means of assuring that federal funding recipients do not make changes that would result in criteria or methods of administration that have the effect of defeating or substantially impairing the individuals rights under Title VI.

Such a study would avoid, for example, federally funded recipients from privatizing its TANF employment services without analyzing whether the contractor could assure equal access to LEP individuals.

- 2) **Clarification that Title VI protection applies to all LEP's regardless of the size of the language group that individual belongs to.** We have found that some recipients do not believe that they must provide access to everyone even if only one person in their service area uses that language. While most OCR Regional offices have indicated that Title VI imposes a duty on recipients to furnish language-appropriate services to all LEP patients/clients, regardless of the size of the language group to which they belong, this should be clearly spelled out in the Guidance. One decision noted, that while the draft regulations tie formal policies on the use of linguistic services to a threshold of 100 or more persons, "a recipient who denies services to even one person due to his LEP status violates Title VI." *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, produced by the National Health Law Program, January 1998, hereinafter "NHeLP", at 28 citing *In re* Department of Social Services, OCR. No. 08917009 at 3, n.1 (Sept. 30, 1992).
- 3) **Use of thresholds for determining minimum steps recipients must take.** We propose that a numeric or proportional threshold be used for determining when certain, specific steps must be taken by recipients. While the original guidance gave recipients many options, we believe that when a language group in the recipient's service population is numerically or proportionately "significant," then use of the best approaches to providing access in that language is required and justified. In addition, a numeric or percentage threshold is useful for clarifying when written materials need to be available in other languages in accordance with the Department of Justice coordination regulations at 28 CFR § 42.405 (d) (1). We propose to use the threshold included in the August 1993 draft regulations defined as "100 persons or 5 percent of the population in the recipient's service area." This is consistent with the approach taken in the Voting Rights Act amendment: "any group which comprises either 100 persons or at least 5 percent of the population..." Public Law 102-344 (Aug. 26, 1992), 106 Stat. 921. The numeric threshold of 100 persons is also consistent with the Medicare preaward clearance reviews conducted by OCR. *Investigative Procedures Manual*, ch. 18, p. 11.

- 4) **Definition of equal access.** This had been included in the earlier August 1993 draft proposed regulations developed by OCR. We believe it would be helpful to include this articulation of what equal access means.
- 5) **What recipients must do to ensure equal access.** These are the sections which we feel are most important to strengthen the guidance. Many areas are covered including strengthening the list of options recipients have in providing language access and prioritizing the best ways to provide equal access.

a) Use of language/ethnic matching staff

We believe that use of bilingual, professionally and culturally competent, and ethnic matched staff in patient/client contact positions is the ideal way to ensure equal access to health and social services. Our proposed amendments reflect this and adds a proposed definition of “cultural competency” which is from the Department of Health and Human Services, Healthy People 2010 Draft Objectives.

Baker, Hayes and Fortier (1998) conducted patient satisfaction interviews among 457 Spanish-speaking patients exiting from a public hospital emergency room department. Patient satisfaction was measured by the provider’s friendliness, respectfulness, concern, ability to make the patient comfortable, and time spent for the exam. Patients who communicated through an interpreter or who did not have an interpreter when they thought one was necessary were less satisfied with the patient-provider relationship compared to patients who communicated adequately with their provider without the use of an interpreter. This indicates that the quality of interpretation technique and availability at that particular ER at that point in time did not meet consumer satisfaction. It should be noted that the interpreters used by the hospital were not trained as interpreters. But the study also implies that patients were most satisfied with a direct “language-match” with their provider.

b) Use of Bilingual Staff as interpreters

With respect to the examples of using bilingual staff as interpreters, in the health area, it can NOT be assumed that a nurse, medical student, or other staff (clinical or not) who speaks two languages will be sufficiently familiar with medical terms and concepts in both languages. Bilingual individuals, unless they were trained as health professionals in another country, generally only have conversational skills in the target language, and medical terminology would need to be specifically acquired through a course of study. In addition, such a bilingual individual may not have had training in medical interpreting skills, and risk making the same mistakes as untrained family and friends.

This issue can also be a problem when assumptions are made about "bilingual" staff or health professionals that communicate directly with LEP patients. Almost universally, the level of true bilingual ability is never ascertained, and these individuals may have learned the language conversationally at home, in high school, or in college, but lack training in medical terminology and concepts. Kaiser Permanente of Southern California has instituted a competency testing program for staff who wish to operate in a bilingual or

interpreter capacity, but many provider organizations rely heavily on bilingual (untested) staff lists for both direct patient care and interpreting, and increasing numbers of managed care organizations market their services to LEP communities by highlighting their list of bilingual health professionals. The presence of these lists may not be indicative of true language access.

c) Using Family Members and Friends (Including Minors) For Translation or Interpretation

Recipients should be prohibited from requiring, suggesting or encouraging beneficiaries to use family members or friends as interpreters. In addition, all recipients should be required to adopt a policy of prohibiting the use of minors as interpreters regardless of the beneficiary's request.

The current guidance fails to convey adequately the harm of using family members and friends for interpretation. And there is no mention of the particular problems posed by using children to interpret. The potential harm is significant. Enclosed is more background on the documented harm to children who are forced to interpret. Our proposed language explicitly prohibits the use of minor children for interpretation. The Guidance also allows a beneficiary to use a family member or friend upon request. Many recipients will rely on this exception to avoid compliance with Title VI. This policy must be strengthened and clarified to ensure that recipients and their employees understand their obligations under Title VI.

Research, anecdotal information, OCR complaints and resolutions support the recommended language. OCR Title VI complaints strongly suggest that many LEP individuals are not being advised that a free interpreter is available. To the contrary, as the National Health Law Program's study of health care providers shows, "most providers...advise patients to bring friends or family members with them to translate" and some providers have "routinely instructed patients to bring their own interpreters to appointments." NHeLP at 9. OCR has determined that instructing beneficiaries to use family members or friends as interpreters violates Title VI; nevertheless this practice is rampant. See e.g., NHeLP at 107-80, OCR Decisions I-05, V-01.

The recommended language clearly states that asking, suggesting, encouraging or requiring beneficiaries to bring their own interpreter violates Title VI. OCR Decisions support this position. See NHeLP at 107-111, OCR Decisions I-01, I-05, V-01, V-05, IX-01.

Our recommended language places the information about the availability of the free interpreter at the very beginning. The current Guidance places this information at the end of the sentence, making it vulnerable to misinterpretation. Thus, it has not always been clear to recipients and their employees that they must notify LEP persons of the availability of free interpreters. See NHeLP at 109, OCR Decision V-05. The recommended language clarifies this requirement.

OCR Decisions also support requiring a record of the offer of free interpreter services and the LEP individual's response. See NHeLP at 110, OCR Decision V-07.

d) Certification of interpreters

At this time, only one state has certification for medical interpreters (WA) and one has certification for interpreters working in Workmen's Compensation (CA), and these tests are generally not well-regarded by professional medical interpreters. These two programs have been very controversial for a number of reasons: minimal adaptation of a court interpreter test for use by medical/social service interpreters; bias/irrelevance for non-written language groups; low passage rates by interpreters from certain language groups; and the high cost of testing as a barrier for freelance community-based interpreters. (In Washington State, both Chinese and Russian candidates, as of Feb. '98, had a higher overall pass rate than Spanish-speaking candidates, and the Korean rate was about the same as that for Spanish speakers. What was troublesome about the Washington statistics was the tremendous disparity in pass rates (from 60% for Chinese speakers to 14% for Lao), the low number of candidates attempting certification in some languages, the high number of drop outs after failure in other languages, and the resulting low level of availability of certified interpreters in some languages. Passage of the exam in Washington state, however, is required for state reimbursement of services). At this time, both the Massachusetts Medical Interpreter Association (MMIA) and the California Health Interpreters Organization are working to develop certification programs, and interpreter advocates in Minnesota and New York are doing similar work. The competency areas outlined by the Guidance are generally consonant with the Medical Interpreter Standards of Practice developed by the MMIA and endorsed last year by NCIHC.

e) Translated Signage and Written Materials

The guidance should be more explicit about how clients are informed of their right to receive bilingual or interpreter services. Providers should provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge.

It is frequently a challenge for individuals with LEP to access interpreter/bilingual services, even when an institution organizes and offers the services. At one large hospital in California with a million dollar interpreter services program and over 30,000 encounters per year, a former interpreter services coordinator estimated that perhaps 30 percent of all patients who needed an interpreter did not get one, most likely because staff were too busy to make a request to the interpreter services office. The availability of services is no guarantee that they will actually be used when the need arises. And without information about them, many LEP individuals would not think or would be hesitant to ask a provider to supply an interpreter. Both the OCR and NHeLP documents recognize the need to inform clients of the availability of interpreter, bilingual, and translation services, and many of these documents go beyond requiring that providers inform clients only at the time of accessing services.

Facilities around the country have developed innovative ways to publicize the availability of bilingual/interpreter services. At the University of Massachusetts Medical Center in Worcester, the staff at the main informational kiosk direct incoming LEP patients to a sign on the wall that has tear-off cards in many different languages. The patient selects the appropriate card for their language and hands it to the staff person, who then contacts interpreter services. At the Pacific Medical Center Clinics in Seattle, WA, all new patients are automatically assigned an interpreter in their native language who appears at each visit unless the first visit reveals that the interpreter is unnecessary. At the community level, the Heartland Alliance in Chicago, IL, has published bilingual wallet cards that inform the carrier and any provider who receives it that the holder of the card is LEP and entitled to interpreter services under state and Federal law. The cards are distributed to individuals through community-based organizations and the carriers are instructed to present the card when seeking health services. Some of the compliance agreements reviewed by NHeLP suggest additional steps for providers to take, including the following: providers should publicize the availability of no cost programs and services in non-English community newspapers and on non-English radio and television stations; providers need to issue written notices to clients in their primary language informing them of their right to receive interpreter services; providers should inform LEP individuals of the availability of no cost interpreter services; and recipients should conduct community outreach to give notice to community agencies and referral sources about the facility's new [interpreter] policies.

We appreciate this opportunity to examine the January 1998 Guidance and make suggestions for strengthening and enhancing its impact on ensuring access for Limited-English Proficient persons. We look forward to continuing to work with you on further development of the revised Guidance for publication in the Federal Register. Deeana Jang will continue to follow-up with you as the process moves forward. She can be reached at (415) 954-9957.

Sincerely,

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APPENDIX--Use of family members or friends including minors as interpreters

The harms of using family members or friends, and particularly minors, as interpreters are multifaceted. Research and anecdotal information reveal many problems that result from this practice. These include: (1) requiring children to take on additional burdens, “adult” decision-making and responsibilities; (2) causing friction and a role reversal within the family structure, which can even lead to child abuse situations; (3) violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services; and (4) because family members and friends, particularly if they are minors, almost always are not competent to interpret, using them as interpreters often leads to serious negative consequences.

Any interpreter services provided by a family member or friend poses the problem of breaching confidentiality or compromising effectiveness. But when a family member or friend is a minor, there are additional concerns, such as burdening the child and straining the relationship between the child and his or her parents. Existing research indicates that some older children who interpret for their parents may experience some linguistic benefits from doing so in addition to the drawbacks. See Tse, “Language Brokering in Minority Communities: The Case of Chinese- and Vietnamese-American Students,” *The Bilingual Research Journal*, 20(3/4) at 485-498 (1996) (hereinafter “Tse”); McQuillan & Tse, “Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy,” *Language and Education*, 9(3) at 195-215 (1995) (hereinafter, “McQuillan & Tse”). These benefits, however, are far outweighed by the potential negative effects of using young children to translate. These negative effects are significant, particularly in situations involving health care providers and government offices.

A recent Los Angeles Times article about children who translate for their parents illustrates the potential for harm: A 13-year-old boy described feeling tongue-tied on a recent visit to a health clinic with his mother when the doctor asked him to explain the medicine that the doctor was prescribing to the child’s mother. Gold, “Small Voice for Her Immigrant Parents,” *Los Angeles Times*, A1 (May 24, 1999) (hereinafter, “Gold, ‘Small Voice’”) (see Attached). The potential for harm is exacerbated when providers use children to translate in gynecological or reproductive health settings, as in this situation: A provider performing an ultrasound on a pregnant LEP patient instructed the patient’s seven-year-old daughter to tell her mother that the baby was stillborn. Only when the daughter became upset and refused to interpret the message was a professional medical interpreter called. National Health Law Program, “Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,” at 10 (January 1998) (hereinafter, “NHLP”).

A recent study of 150 Vietnamese- and Mexican-American women who are or had been welfare recipients in California, found that more than half (53.3%) used their children to translate for them. Most use their children for communicating with schools, filling out forms and communicating with government agencies. More than half of the women who

use their children as interpreters identified problems with this practice. The top four problems were: (1) the child translated incorrectly; (2) the child left out information; (3) the information was too technical for the child; and (4) the child was unable to properly translate due to limited English skills. Several of the Mexican-American women reported that their children sometimes answered questions without first checking with them. One woman's story illustrates the problems with using friends and family members for translation:

I asked a friend of mine to translate letters from the county for me but my friend gave me wrong information. I think I am going to be cut off aid because I could not understand the notice.... My 12-year-old son translates for me a lot. He helps me fill out forms and translates when I go to the doctor. He does not like to do it. He gets upset and tells me that I should be able to do it because I am older. It is too difficult for him.

A Vietnamese-American woman uses her seven-year-old daughter to translate for her but reported that her daughter is too young to understand many things. See Equal Rights Advocates, "From War on Poverty to War on Welfare: The Impact of Welfare Reform on the Lives of Immigrant Women," at 12-14 (April, 1999) (hereinafter, "ERA") (see Attached).

In addition, the National Health Law Program's recent report found that using children for translation frequently results in children being pulled out of school to assist their parents. NHeLP at 9.

Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information. See generally, Tse; McQuillan & Tse. Children who act as language brokers influence the content of the messages that they translate, which, in turn, affects the ultimate decisions of their parents. They often take on the primary decision-making role for the entire family. *Id.* An 11-year-old child who acts as a "language broker" for her family described worrying about her family's finances. Once she felt bad because the water bill was high and she thought it was her fault. Another time she dreamed that there was a huge bill and she did not know how to pay it. Gold, "Small Voice." This role reversal can have serious negative effects on the family unit. The strain of using children as interpreters can even lead to child abuse because "it disrupts the traditional family structure in terms of parents providing that authority figure. A lot of the children don't view their parents role models and there is a lack of respect. The parents are totally frustrated. They want to exert some kind of control and resort to corporal punishment." *Id.*

Part of the strain on children and their families stems from the fact that children are not competent to serve as interpreters in the situations discussed here (hospitals and other health care providers, social services agencies, etc.). As with other untrained interpreters, children who translate are prone to omissions, additions, substitutions, volunteered answers and other problematic practices. See NHeLP at 9; ERA at 12. Some simply

guess when they do not understand a word or concept. Gold, "Small Voice." It comes as no surprise that many of the children who serve in this role feel embarrassed, frustrated, resentful and ill equipped to deal with the added responsibilities of translating. McQuillan & Tse at 205.