



PROVIDING LANGUAGE INTERPRETATION SERVICES IN HEALTH CARE SETTINGS: EXAMPLES FROM THE FIELD

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National Health Law Program

FIELD REPORT

May 2002

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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ACKNOWLEDGMENTS

This report could not have been written without the generous assistance of The Commonwealth Fund. The authors specifically would like to thank Karen Scott Collins, M.D., and Dora Hughes, M.D., of The Commonwealth Fund for their assistance and comments on earlier drafts of this report.

In addition, the authors thank all the individuals who completed the survey. Special thanks go out to the individuals who provided in-depth information about the 14 programs highlighted in this report: Gillian Dutton, Northwest Justice Project, and Bonita Jacques, Washington Interpreter Services and Translation program; Abigail Turner and Blong Yang of the Mid-Minnesota Legal Assistance; Loretta Saint-Louis of the Cambridge Health Alliance, Alice Chen, M.D., of The California Endowment, and Tony Winsour of the Massachusetts Law Reform Institute regarding the Massachusetts Hospital-Based Interpreter Services program; Jillian Middlebrooks of the Hennepin County (MN) Office of Multi-Cultural Services; Kelvin Quan of the Alameda Alliance for Health; Jennifer Cho of L.A. Care Health Plan; Javier Gonzalez and Francesca Gany, M.D., of New York University's Center for Immigrant Health, Remote Simultaneous Medical Interpretation project; Shiva Bidar-Sielaff of the University of Wisconsin Hospital and Clinics; Priscilla Mendenhall of the Northern Virginia Area Health Education Center; Cornelia E. Brown, M.D., of the Multicultural Association of Medical Interpreters; Cindy Roat and Thomas D. Lonner regarding the Cross Cultural Health Care Program; and Richard Keller, M.D., of HealthReach.

The authors also wish to thank Vivian Huang, of the California Primary Care Association, Kathy Poulos-Minott of the National LEP Task Force, and Elizabeth Jacobs, M.D., of the Collaborative Research Unit, Cook County Hospital, for their contributions to this report.

EXECUTIVE SUMMARY

The United States continues to be a magnet for immigrants from around the world. Data from the most recent Current Population Survey show that more than 28 million Americans are foreign-born, up from 9.6 million in 1970, and that over 44 million Americans speak a language other than English at home. In all, over 300 different languages are spoken in this country. While many immigrants have traditionally settled in major urban areas, a substantial number now also live in suburban and rural areas throughout the country.

Many recent immigrants have limited proficiency in English, which presents challenges for health care provision around the nation. Numerous studies have found that inadequate language services can negatively affect access to and quality of health care and may lead to serious health consequences. Not surprisingly, the recent influx of immigrants has brought with it a growing demand for appropriate and effective language services. A number of factors hinder such services, however, including an increase in the number of languages spoken, costs associated with providing such services, lack of knowledge on the part of health care providers of legal requirements for providing language services, and lax enforcement of federal and state laws, which has allowed many health care providers to neglect the issue.

The issue of access to language services has increasingly garnered national attention. Reiterating longstanding provisions of Title VI of the Civil Rights Act of 1964, President Clinton issued Executive Order 13166 in August 2000, “Improving Access to Services for Persons with Limited English Proficiency.” This executive order recommits the federal government to improving the accessibility of government-funded services to individuals with limited English proficiency (LEP). It requires each federal agency to develop and implement guidance to ensure meaningful access for these individuals without unduly burdening the fundamental nature of each department or program.¹ Subsequently, the Department of Health and Human Services (HHS) Office for Civil Rights issued its own guidance.²

While general recognition exists that ensuring access to language services improves the quality of health care provided to individuals with LEP, recipients of federal funds,

¹ EO 13166 also requires federal agencies to develop policies for ensuring access within the federal agencies themselves.

² Pursuant to a Department of Justice memorandum on October 26, 2001, HHS has republished its guidance and requested public comment. It will then evaluate whether to revise its guidance. See <http://www.hhs.gov/ocr/lep/preamble.html>.

such as state and local Medicaid agencies, hospitals, and managed care organizations, expressed concern about EO 13166 and HHS guidance, citing that they would be responsible for providing interpreters yet not receive reimbursement. A recent report from the Office of Management and Budget, however, estimates that language services would only add an extra 0.5 percent to the cost of the average health care visit.³ Moreover, the Centers for Medicare and Medicaid Services (CMS) have informed states that federal reimbursement for language services is available for Medicaid and State Children's Health Insurance Program (SCHIP) enrollees.⁴

These facts notwithstanding, health care providers have raised legitimate concerns about providing language services for patients with LEP. To address some of these concerns, the National Health Law Program, with funding from The Commonwealth Fund, undertook an assessment of programs under way to improve access to interpreter services in health care settings. It examined several different methods of providing oral interpretation, including using bilingual providers/staff, hiring staff interpreters, contracting with qualified interpreters, and creating interpreter pools. Because of time and cost limitations, this report does not address translation of written materials, interpretation in government offices, or other promising practices regarding, for example, cultural competency or ensuring language concordance between providers and patients.

The National Health Law Program developed a short survey instrument and distributed it to interested organizations nationwide during the fall of 2001 and winter of 2002. From the completed surveys, 14 programs and projects were selected for more in-depth assessment. Programs were selected to reflect a range of interpreter services in different health care settings, funding sources, and costs of implementation. Programs profiled in this report include those sponsored by state and local governments, managed care organizations, hospitals, community-based organizations, and educators. Examples include:

- **Statewide Medicaid/SCHIP reimbursement.** The agencies that administer Medicaid in Hawaii, Maine, Minnesota, Utah, and Washington obtain federal matching payments for language interpretation services provided to Medicaid and SCHIP enrollees. The report profiles programs in Minnesota and Washington.

³ This figure is based on the total number and average cost of emergency room visits, inpatient hospital visits, outpatient physician visits, and dental visits. Office of Management and Budget, *Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency*, Mar. 14, 2002; available at <http://www.whitehouse.gov/omb/infomag/regpol.html>.

⁴ Health Care Financing Administration, *Dear State Medicaid Director* letter (Aug. 31, 2000); available at <http://www.hcfa.gov/medicaid/letters/smd83100.htm>.

- **State and local government initiatives.** The Commonwealth of Massachusetts has implemented an emergency room interpreter law that requires general hospitals and acute psychiatric hospitals to offer no-cost interpreters to persons using their emergency rooms and inpatient psychiatric facilities. In Minnesota, the Hennepin County Office of Multi-Cultural Services is engaged in a number of activities to provide interpreters to clients, including at appointments with health care providers.
- **Managed care organizations.** In addition to paying for trained medical interpreters, the Alameda Alliance for Health in Alameda, California, has instituted a stipend policy to encourage physicians and physician extenders (such as physician assistants and registered nurses) to use professional medical interpreters. The L.A. Care Health Plan has developed a Health Care Interpreter Pilot Program, which offers training and certification to L.A. Care Health Plan providers and staff.
- **Hospitals.** The New York City Health and Hospitals Corporation and the Center for Immigrant Health of the New York University School of Medicine is operating a remote simultaneous medical interpreting program in conjunction with the city’s Gouverneur Hospital. Maine Medical Center in Portland has worked with the HHS Office for Civil Rights to develop a tailored plan for providing language access that reflects the suggestions made by the Office for Civil Rights in its LEP guidance. And eight health care facilities in Dane County, Wisconsin, are operating a collaborative enterprise to develop standardized interpreter policies and assess individuals’ abilities to provide competent interpretation services for the collaborating facilities.
- **Community-based organizations.** Community-based organizations are working with hospitals and health care providers to make qualified interpreters available to them. The language banks of the New York Multicultural Association of Medical Interpreters and the Northern Virginia Area Health Education Center are described.
- **Educational models.** Entities are focusing on making educational modules and courses available in order to increase the number of competent interpreters. This report highlights the “Bridging the Gap” curriculum developed by the Cross Cultural Health Care Program in Seattle, which is being used nationwide, and three programs that are benefiting local communities: a home-study certification program operated out of the HealthReach Community Care Clinic in Waukegan,

Illinois, and for-credit courses in medical interpreting being offered by colleges in Massachusetts and South Carolina.

With this report, the National Health Law Program has attempted to identify and describe promising programs and practices that can be adapted or replicated elsewhere. Recognizing that improving access to language interpretation services will involve increased spending, the report also identifies some of the current funding sources for such services.

Recommendations

The findings presented here demonstrate the need for a range of approaches tailored to the needs of specific communities and patient populations, and they show that such approaches are meeting with success. Some programs identify ways to develop reliable funding sources to pay for interpreters. Others document ways to increase the quantity of interpreters and the quality of the service they provide. In most instances, these efforts represent partnerships between government, providers, and communities, and they hold great potential to be replicated elsewhere.

With effective dissemination of these and other models, and technical assistance to implement them, health care organizations and providers could overcome many of the challenges of providing language interpretation services for their patients. More needs to be done, however, to improve funding for, development of, and access to these services; raise awareness of their necessity; and advance further research:

1. More states could develop mechanisms to obtain federal reimbursement for interpretation provided to Medicaid and SCHIP enrollees.
2. CMS could enhance mechanisms for reimbursing interpreters who are provided to Medicare beneficiaries.
3. States could review their provider manuals, guidelines, and contracts with managed care organizations to ensure that effective language services and cultural competency requirements and rates are included. States could require each managed care organization to develop a plan to ensure linguistic access and monitor and enforce implementation. States could evaluate whether language services are appropriately included in capitation rates for managed care.

4. Health care organizations and providers could investigate the availability of potential interpreter services in their communities, explore ways to use these services and develop others cost-effectively, and develop tailored, written plans for how they will provide language services.
5. Health care organizations and providers could record the primary language of patients in their health records and in providers' information management systems.
6. CMS could ensure the collection of primary language data of all Medicare, Medicaid, and SCHIP enrollees. For enrollees who are under age 18 or mentally incapacitated and under the care of a caregiver, states could also collect the primary language of the caregiver. The states and CMS could make this information available to health care providers so they could better plan for and provide language services to these enrollees who have LEP.
7. The Office for Civil Rights, in conjunction with CMS, could undertake a national education campaign to inform providers of: a) federal and state laws and guidelines governing access to language services; b) the need for trained medical interpreters and the problems of using family members, friends, minors, and untrained bilingual staff; c) funding sources for providing linguistic access; and d) promising practices for providing language services.
8. The Administration and Congress could increase funding for the Office for Civil Rights to ensure sufficient resources to assist recipients of federal funds in developing language access plans, monitor implementation of those plans, and investigate complaints of language barriers.
9. Future research could: a) compare the benefits of different types of interpretation in health care (such as in-person vs. telephonic, simultaneous vs. consecutive); b) compare the costs associated with various methods of providing language services; c) explore the ways in which health care providers can most effectively and efficiently provide language services; d) identify ways to increase the pool of trained medical interpreters; e) continue to compare health service consumption and health status of populations that experience language barriers with those that do not; f) explore whether payment rates could be modified or weighted based on patients' needs for linguistic services; and g) explore the benefits and costs of providing language services.

PROVIDING LANGUAGE INTERPRETATION SERVICES IN HEALTH CARE SETTINGS: EXAMPLES FROM THE FIELD

INTRODUCTION

The Need for Services

The United States continues to be a magnet for immigrants from around the world. Data from the most recent Current Population Survey show that more than 28 million Americans are foreign-born, up from 9.6 million in 1970—an increase of 191 percent. More than 44 million Americans, furthermore, speak a language other than English at home.⁵ In all, over 300 different languages are spoken in this country.⁶ The census reveals that four jurisdictions—California, the District of Columbia, Hawaii, and New Mexico—are now “majority minority” states. In five states—California, Hawaii, New Mexico, New York, and Texas—more than 10 percent of residents have limited English proficiency (LEP). The Southern California Association of Governments reports that, in Los Angeles County alone, 31 percent of residents are immigrants and more than 80 languages are spoken.⁷ Immigration is no longer confined to traditional urban areas, however. In North Carolina, for example, the Hispanic population increased by 164 percent between 1980 and 1997, and the Census now reports over 300,000 Hispanic residents in the state.⁸

It is critical for residents with limited English proficiency to be able to communicate with their health care providers. The literature is, by now, redundant with studies showing how language barriers can negatively affect access to and quality of health care and lead to serious health consequences. For example:

- Non-English-speaking patients are less likely to use primary and preventive care services and more likely to use emergency rooms.⁹

⁵ U.S. Census Bureau, *Profile of the Foreign-Born Population in the United States: 2000* (December 2001); available at www.census.gov/population/www/socdemo/foreign/cps2000.html. Grantmakers Concerned with Immigrants and Refugees offers a comprehensive website including an interactive map displaying statistics on immigrants and refugees in all 50 states; see <http://www.gcir.org>.

⁶ U.S. Census Bureau, *Profile of Selected Social Characteristics: 2000* (Table QT-02); available at <http://factfinder.census.gov>.

⁷ Southern California Association of Governments, *The State of the Region 2001*.

⁸ U.S. Census Bureau *Profile of General Demographic Characteristics: North Carolina: 2000* (Table DP-1); available at <http://factfinder.census.gov>; James H. Johnson, Jr. et al., “A Profile of Hispanic Newcomers to North Carolina,” *Popular Government* 65 (Fall 1999).

⁹ For example: J. Bernstein et al., “The Use of Trained Medical Interpreters Affects Emergency Department Services, Reduces Charges and Improves Follow-Up,” Boston Medical Center, 2001; I. S. Watt, D. Howel, and L. Lo, “The Health Care Experience and Health Behaviour of the Chinese: A Survey Based in Hull,” *Journal of Public Health Medicine* 15 (June 1993): 129–36; and S. A. Fox and J. A. Stein, “The Effect of Physician–Patient Communication on Mammography Utilization by Different Ethnic Groups,” *Medical Care* 29 (Nov. 1991): 1065–82.

- Non-English-speaking women who did not visit their practitioners for cervical screening gave as reasons the unavailability and inadequacy of translated materials (one brochure described the Pap smear screening as the “fat” test).¹⁰
- Patients with limited English proficiency in a pediatric emergency department use more medical resources (time and tests) than other patients.¹¹
- Asthmatic patients who do not speak the same language as their physician are less likely to keep scheduled office appointments and take prescribed medications and are more likely to use the emergency room.¹²

Recent Federal Initiatives Encourage Services

Although federal civil rights laws, particularly Title VI of the Civil Rights Act of 1964 (Title VI), have long been interpreted to prohibit discrimination against individuals with limited English proficiency,¹³ the federal government has responded to the recent growth of LEP populations through several initiatives. Taken together, these initiatives encourage public and private entities to better understand their populations with limited English proficiency, assess the costs associated with providing competent language services, and develop and implement plans for improving access to such services. For example:

- Executive Order 13166, issued in August 2000, requires each federal agency to issue guidance for improving access to programs and activities funded by the agency for individuals with limited English proficiency. The Department of Justice has followed the executive order with additional guidance, and federal agencies are now publishing and republishing their LEP guidance documents.¹⁴

¹⁰ J. Naish, J. Brown, and B. Denton, “Intercultural Consultations: Investigation of Factors that Deter Non-English-Speaking Women from Attending Their General Practitioners for Cervical Screening,” *British Medical Journal* 309 (Oct. 29, 1994): 1126–28.

¹¹ L. C. Hampers et al., “Language Barriers and Resource Utilization in a Pediatric Emergency Department,” *Pediatrics* 103 (June 1999, Part 1): 1253–56.

¹² A. Manson, “Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma,” *Medical Care* 26 (Dec. 1988): 1119–28.

¹³ For example: 42 U.S.C. § 2000d et seq. (Title VI of the Civil Rights Act of 1964); 45 C.F.R. § 80 et seq., which outlines HHS regulations implementing Title VI and prohibiting activities that have a disparate impact on the basis of race, color, or national origin; *Alexander v. Sandoval*, 532 U.S. 275, n.6 (2001), which assumes, but questions, the authority of HHS to promulgate disparate impact regulations; *Lau v. Nichols*, 414 U.S. 563 (1974), which requires federally funded school districts to take reasonable steps to provide students of Chinese origin with limited English proficiency with meaningful opportunities to participate in educational programs.

¹⁴ 65 Fed. Reg. 50123 (Aug. 16, 2000) (Department of Justice, Enforcement of Title VI of the Civil Rights Act of 1964, National Origin Discrimination Against Persons with Limited English Proficiency); Department of Justice, Memorandum for Heads of Departments and Agencies’ General Counsels and Civil Rights Directors Re: Executive Order 13166 (Oct. 26, 2001); available at <http://www.usdoj.gov/crt/cor/lep/Oct26Memorandum.htm>.

- The HHS Office for Civil Rights issued its LEP guidance in August 2000 and, following Department of Justice instruction, reissued the guidance and requested public comment on February 1, 2002.¹⁵ The guidance recognizes the need for flexibility in the provision of language services but calls on recipients of federal funds, such as hospitals, managed care organizations, and contractors, to: 1) assess the language needs of their patient populations; 2) develop written policies on how these populations can obtain competent language services, including both oral interpretation and written translation services; 3) avoid using minor children, family, and friends to interpret; 4) have methods for notifying persons of their right to language services; 5) monitor the policies; and 6) train staff for effective implementation of these policies.
- Also in August 2000, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) issued a letter to all state Medicaid directors regarding interpreter and translation services. The letter informs the states of their responsibilities under Title VI, includes a copy of HHS's LEP guidance, and emphasizes that federal matching funds are available for state expenditures related to providing and administering oral interpretation and written translation services for SCHIP and Medicaid beneficiaries.¹⁶
- In December 2000, the HHS Office of Minority Health issued 14 national standards on culturally and linguistically appropriate services in health care, four of which address language barriers to care.¹⁷

Recipients of federal funds, such as state Medicaid agencies, hospitals, and managed care organizations, are becoming increasingly familiar with federal legal requirements. State and local policy makers are recognizing the provision of language interpretation services in health care facilities as a community imperative, and hospitals and other health care providers generally accept the provision of these services as a business necessity. But a number of factors hinder such services, however, including an increase in the number of languages spoken, costs associated with providing such services, lack of knowledge of legal requirements on the part of many health care providers, and lax enforcement of federal and state laws, which has allowed health care providers to neglect

¹⁵ 65 Fed. Reg. 52762 (Aug. 30, 2000) (Office for Civil Rights: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency); available at <http://www.hhs.gov/ocr/lep/preamble.html>.

¹⁶ Health Care Financing Administration, *Dear State Medicaid Director* letter (Aug. 31, 2000); available at <http://www.hcfa.gov/medicaid/letters/smd83100.htm>.

¹⁷ 65 Fed. Reg. 80865 (Dec. 22, 2000) (Department of Health and Human Services: National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care); available at <http://www.omhrc.gov/clas>.

the issue. A recent report from the Office of Management and Budget, however, estimates that language translation services would only add an extra 0.5 percent to the cost of the average health care visit.¹⁸

METHODOLOGY AND SUMMARY OF FINDINGS

Project Methodology

The National Health Law Program (NHeLP), with funding from The Commonwealth Fund, undertook an assessment of current programs that are under way to improve access to interpreter services in health care settings. It examined several different methods of providing oral interpretation, including using bilingual providers/staff, hiring staff interpreters, contracting with qualified interpreters, and creating interpreter pools. Due to time and cost limitations, this report does not address translation of written materials, interpretation in government offices, or other promising practices regarding, for example, cultural competency or ensuring language concordance between providers and patients.

NHeLP developed a short survey instrument to obtain information about programs under way to increase access to competent language interpretation services in the community. The surveys were distributed electronically and by mail to interested organizations nationwide during the fall of 2001 and winter of 2002. The survey was distributed to individuals subscribing to NHeLP's listservs (health, immigration, language, and other interested advocates), as well as to members of the National Council of Interpretation in Health Care's Policy and Research Committee, the National Limited English Proficiency Task Force, and the listserv of the National Immigration Law Center. Information about the survey was also distributed to the Medicaid Coalition (convened by Families USA and composed of national organizations advocating on Medicaid issues), the Child Health Coalition (convened by the American Academy of Pediatrics and composed of national organizations advocating on child health issues), and the Children's Defense Fund's Child Health Information Project. The survey was posted on the National Health Law Program's website and interested persons were invited to complete it. The survey was not intended to elicit a complete listing of all available programs offering interpreters. Rather, the aim was to obtain an understanding of the range of models currently operating. The appendix, "Models for Language Services to Individuals with Limited English Proficiency," summarizes the activities that were identified.

¹⁸ This figure is based on the total number and average cost of emergency room visits, inpatient hospital visits, outpatient physician visits, and dental visits. Office of Management and Budget, *Report to Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency* (March 14, 2002); available at <http://www.whitehouse.gov/omb/inforeg/regpol.html>.

From the completed surveys, 14 programs were selected for more in-depth assessment. Programs were selected to reflect a range of interpreter services in different health care settings, funding sources, and costs of implementation. Programs profiled in this report include those sponsored by state and local governments, managed care organizations, hospitals, community-based organizations, and educators. Project staff conducted key interviews and research to learn more about these programs. The remainder of this report describes these promising examples from the field.

Summary of Findings

The provision of language interpretation services in health care settings is receiving increasing attention. The main concerns about these services include cost, the ability of health care providers to offer high quality, effective interpretation, and the lack of accurate data to measure need. This report finds that there are a growing number of promising programs and activities under way that address these concerns.

The activities described in this report clearly indicate that “one size does not fit all” when it comes to providing language interpretation services. They demonstrate the need for a range of approaches tailored to the needs of specific communities and patient populations, and show that such approaches are meeting with success. Some programs identify ways to develop reliable funding sources to pay for interpreters. Others document ways to increase the quantity of interpreters and the quality of service they provide. In most instances, these efforts represent partnerships between government, providers, and communities, and they hold great potential to be replicated elsewhere.

FUNDING OPPORTUNITIES

Federal law—as well as some state laws—requires recipients of government funds to provide appropriate language interpretation services in health care. Most of these laws, however, do not include an explicit funding mechanism (beyond the receipt of government funds themselves). Moreover, the exact costs of providing interpretation services are difficult to quantify and vary widely, depending on many factors, including how the services are organized and delivered, whether providers are bilingual, and the number of different languages spoken in the area served.¹⁹ Numerous sources of funding and support are available to cover costs associated with providing interpretation services in health care settings for individuals with limited English proficiency. The services described below are funded wholly, or in part, by the federal government, states, foundations, or nonprofit organizations.

¹⁹ The Office of Management and Budget, charged by Congress with conducting a cost-benefit analysis of EO 13166, released a report on March 14, 2002 (see note 18). See 66 Fed. Reg. 58824 (Nov. 30, 2001).

Federal Government

- *HHS Centers for Medicare and Medicaid Services: Medicaid and SCHIP.* Federal matching funds are available for state expenditures on language services for recipients of Medicaid and SCHIP, including services provided by staff and contract interpreters or telephone services. States can obtain a 50 percent administrative match or, if they adopt language assistance as a covered service under their state plan, receive a higher match based on the state's Federal Medical Assistance Percentage.²⁰
- *HHS Office of Minority Health.* Funding is provided for language services through the Bilingual/Bicultural Service Demonstration Grant Program. It awards funds to community-based organizations to provide language assistance to individuals with limited English proficiency seeking health care.²¹
- *HHS Health Resources Services Administration (HRSA).* While not directly funding language assistance services, HRSA identifies and promotes the replication of innovative community-based models under its Models That Work campaign. The campaign highlights programs that have demonstrated efficient and successful ways to assist individuals with limited English proficiency in accessing health care.²²
- *HHS HRSA Bureau of Primary Health Care.* Under a reauthorization bill currently being debated in Congress, community health centers would receive specific funding for interpreters.

State and Local Government

- *State departments of health and departments of social services.* Many states provide funds for language services through these departments, often focused on individuals seeking assistance at state offices. The South Carolina Department of Social Services, however, provides language assistance anywhere its clients need it, including medical settings.
- *County health departments.* Some county health departments, such as Fayette County, Kentucky, provide funding for language services. Assistance may be limited to those who access benefits at the county office.

²⁰ Health Care Financing Administration, *Dear State Medicaid Director* letter (Aug. 31, 2000); available at <http://www.hcfa.gov/medicaid/letters/smd83100.htm>.

²¹ See 42 U.S.C. § 300u-6 (b)(7), (e)(1).

²² See <http://bphc.hrsa.gov/mtw>.

- *Refugee offices.* Some state refugee offices provide funds to refugee organizations for language assistance to refugees.

Foundations

A number of foundations provide funds for language services. For example:

- The Fund for Immigrants and Refugees awarded grants to organizations serving the Chicago area to develop interpreter training programs and other activities designed to dismantle language and cultural barriers for individuals with limited English proficiency.
- The California Endowment has made cultural competence and linguistic access a major funding initiative, funding research, education, organizational development and standards of interpreter services, language access policy and advocacy, and interpreter training and consumer education.
- The Robert Wood Johnson Foundation recently initiated *Hablamos Juntos* (We Speak Together) which will provide grants to health care provider organizations to develop and test systems of medical interpretation, signage, and print materials across multiple delivery points within the health care system.

Nonprofit Organizations

Some nonprofit organizations provide language interpretation services, but problems may arise from over-reliance on free services from public and private agencies whose interpreters may not be trained in either the ethics of interpreting or medical interpretation.

Examples of Rates Charged for Interpretation Services

Program	Rate
Hawaii Medicaid (Fee-for-Service)	\$25–\$45/hour
Maine Medicaid (Fee-for-Service)	\$30/hour during normal business hours, \$40/hour during non-business hours
Minnesota Medicaid (Fee-for-Service)	\$12.50/15-minute interval
Utah Medicaid (Fee-for-Service)	\$35/hour for face-to-face, 1 hour minimum, \$22/hour for telephonic
Washington Medicaid (Fee-for-Service)	\$33.60–\$39/hour
Alameda Alliance for Health (Oakland, California)	\$90–\$100/hour, 2 hour minimum Stipends to providers: • \$30 if face-to-face interpretation used • \$20 if telephonic interpretation used
Multicultural Association of Medical Interpreters (Oneida, NY)	\$45–\$60/hour (with discounted contract rates)

EXAMPLES FROM THE FIELD

The following sections of this report describe the 14 highlighted programs, which fall into these categories:

- Statewide Medicaid/SCHIP reimbursement
- State and local government initiatives
- Managed care organizations
- Hospitals
- Community-based organizations
- Educational models

Please see the appendix for a complete listing of all the programs identified from the survey.

Statewide Medicaid/SCHIP Reimbursement

The federal government has recently clarified that federal Medicaid and SCHIP funds are available for state expenditures related to the provision of language services.²³ Currently, however, only five states—Hawaii, Maine, Minnesota, Utah, and Washington—have established mechanisms to obtain federal matching funds to provide language services to enrollees.²⁴ Each state currently receives reimbursement for language services as an administrative expense (equal to 50 percent of the costs). If a state chose to adopt language assistance as a covered service under their state plan, the state would receive a higher match based on its Federal Medical Assistance Percentage.

The states use two different payment models. Hawaii, Washington, and Utah contract with language interpretation agencies, to which the states pay directly for services. Maine and Minnesota require providers to pay interpreters and then receive reimbursement from the state. One example of each model is described below.

WASHINGTON: DIRECT PAYMENTS TO LANGUAGE SERVICE AGENCIES

Background

The Washington State Department of Social and Health Services (DSHS) created the Language Interpreter Services and Translation (LIST) program in 1991 to provide “high quality language support services to programs that serve [LEP] clients, in a professional and

²³ Health Care Financing Administration, *Dear State Medicaid Director* letter (Aug. 31, 2000); available at <http://www.hcfa.gov/medicaid/letters/smd83100.htm>.

²⁴ The provision of language services to managed care enrollees is primarily addressed through contracts between these states and managed care entities.

cost-effective manner, to promote equal access.”²⁵ As part of a consent decree in a lawsuit, DSHS agreed not only to provide and pay for interpreters for clients, but also to ensure the quality of interpreter services. DSHS administrative policy now requires all offices within the department to provide interpretation and translation services.²⁶ DSHS established LIST to ensure quality through the development and administration of a series of standardized tests that are required for interpreters working in medical or social service settings, for translators working for the state, and for bilingual workers who provide DSHS services in a language other than English. In addition, it coordinates the translation of documents within DSHS, contracts with and monitors translation reviewers, and monitors department-wide interpretation contracts.

Promising Practice

LIST provides certification testing for interpreters in the seven most prevalent foreign languages in Washington—Spanish, Vietnamese, Cambodian, Lao, Chinese (both Mandarin and Cantonese), Russian, and Korean. The state has created five types of certification tests, depending on the skills required.²⁷ Interpreters for all other languages must be “qualified” rather than “certified” (because of limited resources available for full certification in all languages).²⁸ The state has given tests for 88 languages plus major dialects and offers statewide testing at five sites with four days of testing per month per site. Additional tests are available upon request. The state also offers emergency/provisional certification for those having passed the written test but awaiting oral testing and in other limited situations.

In 1998, LIST began contracting with “language agencies” through a competitive procurement process.²⁹ The state currently contracts with 13 language agencies to provide

²⁵ Bonita Jacques, Chief, Washington State Office of Administrative Resources, “Language Services in State Government,” Presentation to The California Endowment, October 11, 2000.

²⁶ Washington Administrative Policy No. 7.21.

²⁷ Medical interpreters must take both a written and oral test, passing the written test first. The written test has five sections, all in multiple choice format: the professional code of ethics; medical terminology (symptoms, diseases, treatments, etc.), with the stem term in English and multiple choice options in the non-English language; clinical/medical procedures, with both questions and answers in English only; English language syntax and grammar; and non-English language syntax and grammar. The oral test has two parts: sight translation and consecutive interpretation. The oral test is audio-recorded, then scored by independent graders. See <http://www.wa.gov/dshs/list/ITsvcs.html>.

²⁸ The screening test is non-language-specific and consists of a written and oral test. The written test is entirely in English, with four sections: professional code of ethics; medical terminology; clinical/medical procedures; and translational writing test in the English language. The oral screening test has three parts, which are audio-recorded for scoring purposes: sight translation; memory retention; and back interpretation exercise from the target language into English. *Ibid.*

²⁹ This move was due in part to a need to standardize rates and assist in monitoring. Previously, the state had contracts with 1,200 interpreters and paid rates between \$13 and \$65 per hour with different arrangements for travel time, minimum billing allowances, parking, and meal reimbursement.

interpreters for over 26,000 encounters per month.³⁰ Interpreters are paid for a minimum of one hour; mileage is paid if an interpreter has to travel more than 30 miles.

Rather than require clients to schedule interpreters, a provider calls an approved language agency to arrange for an interpreter.³¹ The state requires providers to schedule interpreters to avoid interpreters independently soliciting work and/or acting as advocates rather than interpreters. Once services are provided, the language agency then bills the state for the services rendered. For interpretation services provided in a health care setting, the claim form requires the name of the referring physician as well as the diagnosis or nature of illness or injury. The state directly pays the language agency, and for Medicaid and SCHIP enrollees, obtains federal reimbursement. For 2001, payments to medical interpreters ranged from \$33.60 to \$39.00 per hour.³²

As noted by LIST, the benefits of this statewide program include fixed interpreter rates for the contract period (two years) and practical, cost-effective language testing and evaluation for prospective interpreters. Further, whereas DSHS had been the subject of 16 civil rights complaints filed with the HHS Office for Civil Rights and a class action lawsuit prior to 1991, it has had no legal action taken against it since the inception of LIST.

Issues to Consider

One of the primary concerns of Washington's program is the difficulty of the certification process, which has impeded the availability of interpreters. For example, since 1995, only 36 percent of those taking the medical certification test have passed, as have 38 percent of those who took the medical interpreter screening test. And in the midst of a difficult budget year, Governor Locke has proposed eliminating all state funds, and thus the federal match, for interpreters for Medicaid and SCHIP beneficiaries. Funding for interpreter services was reinstated into the budget when it went through the state legislature. While budget levels have been cut, the program remains intact.

³⁰ LIST coordinates interpretation services for all DSHS programs, including the Medical Assistance Administration (Medicaid, SCHIP, and SSI); the Economic Services Administration (TANF and child support); the Health and Rehabilitative Services Administration (including divisions of mental health, alcohol, and substance abuse, vocational rehabilitation, developmental disability, and services for the deaf and hard of hearing); Juvenile Rehabilitation; the Children's Administration; the Aging and Adult Services Administration; and the Management Services Administration. Bonita Jacques, "Language Services in State Government."

³¹ When an LEP client needs urgent care that cannot be rescheduled, and no other resources for an interpreter exist, a provider may use the more costly AT&T Language Line.

³² The rate includes all administrative costs as well.

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MINNESOTA: REIMBURSEMENT TO PROVIDERS

Background

According to Minnesota's Department of Human Services (DHS), approximately 87,000 low-income people living in Minnesota have limited English proficiency. Under its Limited English Proficiency Initiative, Ensuring Access to Human Services for All Minnesotans, implemented in 2001, DHS will spend just under \$4.3 million over two years for language services.³³ These include toll-free telephone services; translations of applications and forms; training and technical assistance for state and county staff; and updating data systems to track clients' language needs, identify barriers, and measure outcomes. The state expects to receive approximately \$1.9 million in federal reimbursements, primarily from language services provided to Medicaid and SCHIP enrollees.³⁴

DHS operates a toll-free multilingual telephone line for non-English-speaking residents to provide them with access to all of the services the department provides.³⁵ Assistance is available in eight languages: Arabic, Cambodian (Khmer), Hmong, Lao, Russian, Somali, Spanish, and Vietnamese. DHS worked with community organizations and businesses to provide the telephone service through the Department's Limited English Proficiency Project.³⁶

Promising Practice

In 2001, Minnesota established a mechanism to receive federal matching funds for language interpreter services for Medicaid and SCHIP enrollees, and in September, DHS

³³ As part of this initiative, each county human service agency must develop its own plan to meet the needs of applicants and clients with limited English proficiency.

³⁴ Minnesota Department of Human Services, *Limited English Proficiency Initiative: Ensuring Access to Human Services for All Minnesotans*, February 6, 2001; available at <http://www.dhs.state.mn.us>.

³⁵ In addition, each county human service agency must develop its own LEP plan to meet the needs of LEP applicants and clients.

³⁶ Minnesota Department of Human Services, *Infocenter: Multilingual Human Services Referral Lines*; available at <http://www.dhs.state.mn.us>.

announced the availability of these funds for fee-for-service recipients and managed care enrollees.³⁷ Under Minnesota's provisions, providers must both arrange and pay for interpretation services and then submit for reimbursement. All providers except inpatient hospitals must submit their bills to DHS for oral interpreter services that are provided to fee-for-service program recipients.³⁸ The state established a new billing code paying either \$12.50 or the usual and customary charge per 15-minute interval, whichever is less. Providers may only bill for interpreter services offered in conjunction with an otherwise covered service. For example, a physician may bill for the entire time a patient spends with the physician, nurse, or tests but not for appointment scheduling or interpreting printed materials. For managed care enrollees, providers must bill the prepaid health plan.

Issues to Consider

The Minnesota program has some obvious benefits: fewer claims to process, since one claim covers both the provider's fee for health care services and reimbursement for interpreter services; reduced administrative burdens by not having to issue provider numbers to interpreters; and less involvement in testing, screening, and licensing of interpreters. Yet the very distance that this program places between the state and medical interpreters may negatively affect the quality of the services provided since the state has no oversight authority. Providers, who have cited concerns about state reimbursement policies, may be reluctant to pay out of pocket for interpreter services and then await reimbursement. The speed, accuracy, and state response to providers' reimbursement requests may also affect provider willingness to use interpreters.

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³⁷ DHS Customer Services Division, *Language Interpreter Services Provider Update*, Update # 90; available at <http://www.dhs.state.mn.us> (September 14, 2001).

³⁸ The inpatient hospital DRG payment includes language interpreter services; hospitals cannot bill for these services separately during an inpatient stay.

State and Local Government Initiatives

In recent years, state legislatures, county governments, and administrative agencies have begun to recognize the growing need for language services and have adopted measures that require or encourage health care providers to ensure access to these services. Some state laws detail specific requirements for all or some health care services while others let the health care provider determine how to ensure linguistic access. The following section describes one state statute and one county program.

MASSACHUSETTS: INTERPRETATION IN HOSPITAL EMERGENCY SERVICES

Background

The hospital emergency room setting demands accurate and timely transfer of information. As noted by Massachusetts Department of Public Health Commissioner Dr. Howard Koh, “In a hospital emergency room, clear and fast communications can mean the difference between life and death.”³⁹

Language barriers in the emergency room can interrupt the flow of information and cause critical information not to be provided. Compared with providers and patients who are able to communicate freely, emergency room patients who experience language barriers are more likely to take longer to treat and to undergo expensive testing.⁴⁰ The need for emergency room interpreter services is further emphasized by the fact that non-English-speaking patients have been found more likely to use emergency rooms for their care.⁴¹

Promising Practice

The Commonwealth of Massachusetts has been a leader in the development and provision of language services in clinical health settings. Since 1989, most hospitals have submitted plans for providing interpreter services as part of the state’s Determination of Need process, which requires that providers reassess health care needs in the community and respond accordingly whenever a provider seeks to add or expand services or when ownership is transferred. Through this process, over 50 of the state’s 80 hospitals have addressed the provision of interpreter services, training for staff, and tracking of services.

³⁹ Commonwealth of Massachusetts, Executive Office of Health and Human Services, *New Interpreter Services Law for Hospital E-R’s Takes Effect July 1* (June 26, 2001).

⁴⁰ L. C. Hampers et al., June 1999.

⁴¹ For example: I. S. Watt, D. Howel, and L. Lo, “The Health Care Experience and Health Behaviour of the Chinese: A Survey Based in Hull,” *Journal of Public Health Medicine* 15 (June 1993): 129–36; and S. A. Fox and J. A. Stein, “The Effect of Physician–Patient Communication on Mammography Utilization by Different Ethnic Groups,” *Medical Care* 29 (Nov. 1991): 1065–82.

In April 2000, the legislature took additional steps to address the need for competent emergency room interpreter services when it passed Chapter 66 of the *Acts of 2000*, “An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services.”⁴² This law mandates that “every acute care hospital . . . shall provide competent interpreter services in connection with all emergency room services provided to every non-English-speaker who is a patient or who seeks appropriate emergency care or treatment.”⁴³ The law also applies to hospitals providing acute psychiatric services. The state attorney general is authorized to enforce the law, and individuals who are denied emergency services because of the lack of interpreters are also given legal standing to enforce their rights. The law did not become effective until July 1, 2001, to give smaller hospitals additional time to comply.

Following passage of the law, the Department of Public Health (DPH) initiated a wide range of activities. Regulations were issued to provide hospitals with detailed guidance on how to comply with the law.⁴⁴ For example, while the statute is silent on the point, the regulations clarify that individuals receiving language services cannot be charged for them. The regulations also explain that language services can be provided through bilingual staff, staff interpreters, or contract interpreters. Regardless of the method of delivery, hospitals must provide assurances that interpreters have received appropriate training. The regulations discourage contracts with telephone interpreter services and the use of family members as interpreters, and they prohibit using minor children to interpret.

The regulations also place ongoing responsibilities on hospitals. Hospitals must designate a coordinator of interpreter services, conduct an annual needs assessment, and ensure that interpreter services are competent. Hospitals must determine the primary language (as well as self-identified race and ethnicity) of all emergency room patients and record this information in the hospital’s management information system, as well as any patient records used by hospital staff. The hospital must make available written translations of important materials, including discharge instructions, consent forms, and advance directives.

The regulations also discuss notification of individuals. Individuals are to be informed of their right to interpreter services in the emergency room, orally or in writing

⁴² Massachusetts Gen. L. Ch. 111 § 25J(b) (emergency services), Ch. 123 § 23A(b) (acute psychiatric services). Rhode Island just passed legislation requiring hospitals to provide qualified interpreters as a condition of licensing. Rhode Island Gen. Laws § 23-17-54 (effective Jan. 1, 2002).

⁴³ “Competent interpreter services” are defined as interpreter services performed by a person who is fluent in English and in the language of a non-English-speaker, who is trained and proficient in the skill and ethics of interpreting, and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving emergency care.

⁴⁴ 105 Code Massachusetts Regs. § 130.1101 *et seq.*

in their primary language. Translated copies of the law itself are to be available in certain languages. Signs describing the law are to be posted in the emergency department. DPH has developed multilingual versions of the signs and made them available to hospitals.⁴⁵

DPH followed promulgation of the regulations with a best practices manual and extensive website postings. The *Best Practice Recommendations for Hospital-Based Interpreter Services* manual was developed by DPH in consultation with a number of organizations and entities active in promoting the provision of language services, including Boston Medical Center, Division of Medical Assistance, Cambridge Health Alliance, Health Care for All, the Latino Health Institute, the Massachusetts Hospital Association, the Massachusetts Law Reform Institute, the Massachusetts Medical Interpreters Association, and the University of Massachusetts Medical School. The best practice recommendations also draw upon the policy guidance issued by the HHS Office for Civil Rights.⁴⁶ The recommendations are extensive and practical. For example, hospitals are provided a list of the items and policies that, if addressed, will result in a comprehensive patient-oriented needs assessment and a written compliance plan. There are suggested procedures for identifying and assessing the language needs of patients. While Massachusetts does not have an official certification process, the recommendations discuss ways to ensure that interpreters are properly trained and provide competent services to patients.

DPH also constructed a website that provides extensive resources to hospitals. It includes the statute, regulations, best practices manual, a code of medical interpreter ethics, and extensive links to other web-based resources. Dates and locations for medical interpreter training are posted on the site, as is contact information for community language banks and telephonic interpreter services.⁴⁷

Issues to Consider

In the months since its passage and effective date, the Massachusetts emergency room interpreter law has received a great deal of attention. While much has been done, there are questions about the extent of hospitals' progress in implementing the law. Questions also remain about whether there are enough competent interpreters to do the work that the law requires. Recent reports indicate that some Boston-area facilities are experiencing "language overload" as an increasing number of their patients speak uncommon languages for which there are few or no interpreters. Some of these hospitals are beginning to work

⁴⁵ See <http://www.state.ma.us:80/dph/omh/interp/interpreter.htm>.

⁴⁶ Commonwealth of Massachusetts Department of Public Health Office of Minority Health, *Best Practice Recommendations for Hospital-Based Interpreter Services* (undated).

⁴⁷ See <http://www.state.ma.us/80/dph/omh/interp/interpreter.htm>.

together to develop a system that will allow them to exchange information about available interpreters and develop interpreter pools for unusual languages.⁴⁸

Finally, there are concerns about how hospitals will pay for the services required by the law. The federal disproportionate share hospital adjustment already provides hospitals serving a disproportionate number of Medicaid and uninsured persons with rate add-ons to compensate them somewhat for these patients. However, it is not clear whether this adjustment is adequate to cover the costs associated with the interpreter law. The law does require the state Medicaid program to reimburse hospitals for the cost of interpreter services for enrollees of the MassHealth Medicaid managed care program, however,⁴⁹ and the fiscal year 2002 budget includes an appropriation for these costs. The state's budget crisis makes Medicaid funding uncertain, though, and many non-English-speakers who use emergency rooms are not covered by Medicaid.

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HENNEPIN COUNTY, MINNESOTA: OFFICE OF MULTI-CULTURAL SERVICES

Background

Hennepin County is the largest of Minnesota's 87 counties. It is estimated that more than 100,000 individuals in the county, or more than 10 percent of its population, have limited English proficiency. Hennepin County has 33 departments that deliver over 1,000 programs to the citizens of Hennepin County and surrounding jurisdictions. From 1995 to 1999, patient visits to Hennepin County Medical Center requiring interpreter services increased approximately 111 percent.

Promising Practice

In 2000, the county established the Office of Multi-Cultural Services to facilitate the delivery of services to its diverse refugee and other new American populations in an

⁴⁸ Cindy Rodriguez, "Hospitals Eye Language Remedy," *Boston Globe*, Mar. 14, 2002.

⁴⁹ Massachusetts Gen. L. Ch. 118G §§ 7, 11.

efficient, effective, and culturally sensitive manner. The office seeks to coordinate existing services across departments to share bilingual and interpretive resources and partner with the community to provide outreach and education; enhance access to culturally and linguistically appropriate services; improve its staff members' cultural competency; and expand bilingual and bicultural employment opportunities.

The office's 44 staff speak 28 languages and act as a bridge between county departmental staff, its LEP clientele, and the community. Community outreach liaisons assist with such matters as forms completion, connection to resources, social services, health and child care issues, and home visits. Liaisons can accompany clients to medical appointments and have helped many understand the complexities of health care and managed care. Over 9,500 refugees and immigrants have received services since 2000.

The office also maintains a language bank of 10 interpreters. Partnering with the Hennepin County Department of Economic Assistance, interpreters provide on-site assistance in Arabic, Amharic, Italian, Oromiffa, Russian, Somali, and Spanish. The interpreters also respond to requests submitted by callers to a Minnesota language assistance line.

With the assistance of VISTA/AmeriCorps members, the office helps educate individuals with limited English proficiency about access to health care and other county services, among other issues. Partnerships with the Hennepin County Medical Center, the Community Health Department, and Hennepin County libraries help raise awareness of the services available to individuals with limited English proficiency in the county among potential clients and other community organizations that also serve them.

The office currently has a budget of \$1.8 million per year, some of which comes from grants but most of which is derived from the county budget via property tax assessments. This model has been replicated on a smaller scale by the city of Minneapolis.

In addition to the activities of the Office of Multi-Cultural Services, Hennepin County developed a Limited English Proficiency Plan to meet the legal obligation of language access requirements in compliance with Title VI of the Civil Rights Act of 1964. The plan "serves as a model to show Hennepin County's commitment to provide meaningful access to all individuals accessing any of Hennepin County health and human services."⁵⁰ At all times, non-English-speaking clients are offered the right to free interpreter services. The plan outlines linguistic access issues (e.g., LEP populations to be

⁵⁰ See <http://www.co.hennepin.mn.us/chpci/oms/lep.html>.

served, means of providing interpretive services, maintenance of bilingual directories, rules governing interpreters, physical privacy, and documentation), training (e.g., training of staff in accordance with HHS guidance, training of interpreters and bilingual staff, and continuing education), and monitoring (e.g., identification of an LEP manager in charge of implementation, prioritization for translation, and addressing resource needs). The county has an LEP manager to secure the resources necessary for ensuring that the language needs of the LEP person are met. In addition, the county is developing countywide standards for anyone providing interpreter services in any Hennepin County department. The LEP plan outlines a protocol for accessing interpreters, in order of preference: using bilingual staff (approximately 3 percent of Hennepin County’s workforce); staff interpreters; volunteers, students, and interns who have been through the language testing process; and contract interpreters. If language translation services cannot be provided by these means, the county agency must contact the LEP manager to determine how best to meet the client’s needs. If clients are offered free interpreter services and choose to utilize their own interpreter (such as a friend or family member), they must sign a waiver indicating that they are giving up their right to free interpreter services.

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Managed Care Organizations

Managed care organizations that enroll Medicaid, SCHIP, or Medicare patients or otherwise receive federal financial assistance must also comply with federal law and regulations requiring that patients have access to language services.⁵¹ According to the most recent CMS data, over 55 percent of all Medicaid beneficiaries are now enrolled in some type of managed care arrangement.⁵² With such a large number of Medicaid

⁵¹ The term “managed care organization” encompasses various types of health care delivery structures including, but not limited to health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service plans (POSs).

⁵² See Medicaid managed care enrollment table at <http://www.hcfa.gov/medicaid/omcpr00.pdf>.

beneficiaries enrolled in managed care plans, the steps taken by the managed care industry to address access to language services take on added importance.

Many of the states' Medicaid managed care regulations and contracts require accommodations for enrollees with limited English proficiency. The most common services are the provision of health plan materials in multiple languages and the availability of interpreter services for health plan enrollees. In addition, some Medicaid managed care contracts require health plans to deliver "culturally appropriate" or "culturally competent" services.⁵³ According to George Washington University's Center for Health Services Research and Policy, many Medicaid managed care contracts or requests for proposals require managed care organizations to provide materials in other languages (38 states), require services for persons whose primary language is not English (31 states), or include a cultural competence requirement (25 states).

The following section highlights two promising practices of California managed care organizations to ensure access to language interpretation services for individuals with limited English proficiency.

ALAMEDA ALLIANCE FOR HEALTH: INCENTIVES FOR PROVIDERS

Background

Alameda Alliance for Health (Alliance) is a nonprofit health plan that serves residents of Alameda County, California. Established in January 1996, the Alliance currently provides health services to more than 75,000 Alameda County residents. Since its inception, the Alliance has paid for the full cost of professional medical interpreters, both face-to-face and telephonic, and has made the arrangements to have interpreters available for members' physician appointments.

The Alliance has a Cultural and Linguistics Program, which oversees its policies regarding interpreters and translation of materials. The Alliance's aim to provide members with staff who speak their own language appears in member materials and on its website. If a language-concordant staff member is unavailable, the Alliance will provide an interpreter at no cost to its patients. The provider directory specifies the languages that providers and their staff speak, and patients can obtain additional information and assistance from Member Services.

⁵³ Cultural competency is commonly defined as "a set of interpersonal skills that allow [staff] to increase their understanding, appreciation, acceptance of, and respect for cultural differences and similarities within, among, and between groups, and sensitivity to how these differences influence relationships with [clients]." For other definitions, see <http://bhpr.hrsa.gov/diversity/cultcomp.htm>.

The Alliance’s policy states its preference that patients not use family or friends to interpret.⁵⁴ Patients may either call Member Services or submit a request to schedule an interpreter through the Alliance’s website, allowing three days’ advance notice. Currently, the Alliance contracts with Asian Health Services for interpreters, paying for a minimum of two hours or approximately \$90 to \$100 per encounter. Each year, the Alliance spends between \$10,000 and \$20,000 of its operating budget on interpreters.

Since approximately one-third of its 75,000 members have limited English proficiency, the actual use of medical interpreters does not match the probable need. One possibility for the low usage of interpreters is the lack of knowledge among providers that the Alliance pays for the service. An additional possibility is that many of the Alliance’s members have providers who speak their language. To analyze this possibility—a positive explanation for the low usage of interpreters—the Alliance is taking steps to identify the extent of language concordance between patients and providers. The Alliance currently obtains basic information on providers and their staff’s language abilities during the credentialing process. This information, however, is often insufficient to determine whether providers and their staff have sufficient language ability and whether bilingual staff are available when needed. For example, this information does not identify whether bilingual staff used as interpreters are full- or part-time employees.

Thus, the Alliance is conducting a survey to identify the languages spoken, and the extent of proficiency and availability, by providers and their staff. The survey will ask where and how an individual learned the language, recognizing the difference between having spoken a language other than English for many years versus having had a few years of high school or college instruction. Once the information is collected, those who meet a prescribed level of competency will be listed in the provider directory (a change in current practice of having providers simply self-identify as having personal or staff multilingual capability). The Alliance is also exploring the possibility of paying providers a stipend, recognizing bi- and multilingual ability as an additional medical skill.

Promising Practice

As of October 1, 2001, the Alliance instituted a new policy to pay physicians and physician extenders⁵⁵ a stipend for the use of a professional medical interpreter—\$30 for

⁵⁴ Alameda Alliance for Health, *Cultural and Linguistic Services*; available at http://www.alamedaalliance.com/cultural_services.html.

⁵⁵ “Physician extenders” include those who provide covered/billable physician services. For example, physician assistants or registered nurses often provide billable services. The policy specifically excludes payment for interpreters provided by hospitals in inpatient and pharmacy settings (the Alliance pays for the interpreters it provides to its members in inpatient settings).

each use of a qualified face-to-face interpreter and \$20 for each use of a telephonic interpreter. One impetus for the policy was the recognition that the use of a qualified interpreter requires additional skills from a provider, as well as additional time with the patient. Providers submit their claim for the stipend using a newly established billing code. They can receive this stipend when:

- A professional medical interpreter is used to facilitate communication between a provider and a patient and/or family member;
- The interpreter is used in the provider's office, clinic, during a home visit, or in the hospital;
- The interpreter is used in connection with a covered medical service, whether capitated or fee-for-service; and
- Interpreter services are arranged for and paid by the Alliance.

The Alliance has committed its own operating funds to cover the stipends and anticipates a cost of approximately \$15,000 per year.

Issues to Consider

The Alliance views the stipend as one method of increasing providers' use of interpreters. In the few months the stipend has been in effect, however, the Alliance has not seen a large number of claims. According to informal responses from providers, factors impeding the use of professional interpreters include: 1) lack of knowledge of the Alliance's policy to pay for interpreters (despite its repetition in manuals and bulletins); 2) ease of using family members/friends as interpreters; 3) ignorance of the qualitative differences professional interpreters provide; and 4) additional paperwork and billing. Nevertheless, given its commitment to language access, the Alliance intends to address these issues and does not foresee circumstances under which it would cease using the stipend.

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L.A. CARE HEALTH PLAN: HEALTH CARE INTERPRETER PILOT PROGRAM

Background

L.A. Care Health Plan (L.A. Care) is a public health maintenance organization that serves over 700,000 people living in Los Angeles County who are enrolled in Medi-Cal (California's Medicaid program), Healthy Families (California's State Children's Health Insurance Program), and CaliforniaKids (a program for low-income children not eligible for Medi-Cal or Healthy Families, funded by foundation grants and L.A. Care). L.A. Care is one of the state's largest health plans and is the nation's largest Medicaid health plan.

L.A. Care's enrollees include a significant number of individuals with limited English proficiency. Within its Healthy Families program, which has an enrollment of approximately 7,700 members, for example, 79 percent of members prefer a primary language other than English. These languages include: Spanish (71%); Cantonese (3%); Korean (1%); and Mandarin (1%).⁵⁶ Results from a member survey documented that 88 percent of the Spanish-speakers and 100 percent of the Cantonese-speakers said their households are monolingual.⁵⁷ The Medi-Cal program, which totals over 700,000 members, has seven threshold languages.⁵⁸ These include Spanish, Armenian, Cantonese, Vietnamese, Russian, Khmer, and English.

In January 2000, L.A. Care established a Culture and Linguistic Services Department. The Department created policies on interpreter services, translation of materials, cultural competency trainings, and proficiency of interpretation.⁵⁹ L.A. Care began applying these policies to all health care services within its network in fiscal year 2001.

The policies were developed to reflect the requirements of the Medi-Cal Managed Care Division Policy Letters, California's Managed Risk Medical Insurance Board contractual requirements, and Title VI of the Civil Rights Act of 1964 as outlined by HHS's Office for Civil Rights and the related presidential executive order issued in August 2000. L.A. Care is working to ensure that its members have access to culturally and linguistically appropriate services by providing culturally competent care; forming new linkages, as well as strengthening existing ones, with community service agencies; and

⁵⁶ L.A. Care Health Plan, Culture & Linguistics and Health Promotion & Education Departments, *Healthy Families Group Needs Assessment*, p.4 (June 2001).

⁵⁷ *Ibid.*, p.24.

⁵⁸ According to Medi-Cal regulations, a threshold language is one spoken by at least 3,000 eligible LEP beneficiaries residing in a county; 1,000 LEP beneficiaries residing in a single zip code who are eligible to be served or likely to be directly affected by the covered entity's services; or 1,500 LEP beneficiaries residing in two contiguous zip codes.

⁵⁹ Copies of the policies on translation; access to interpreter services at hospital, provider, and pharmacy sites; cultural awareness and sensitivity training; and proficiency of interpreters are available from L.A. Care Health Plan.

furthering education and outreach efforts into the diverse communities of Los Angeles County.

Promising Practice

L.A. Care sought to develop a health care interpretation pilot workshop to address the need for qualified medical interpreters. Prior to developing the curriculum and structure for this training, however, L.A. Care held a seminar for providers, “State and Federal Requirements on Culture and Linguistics and Its Impact on Health Care Delivery.”⁶⁰ It also conducted a survey to determine what was currently available and to identify the perceived needs and challenges of providers and staff in serving members with limited English proficiency.⁶¹

According to this survey, 51 percent of doctors said that their patients do not adhere to medical treatments because of cultural and language barriers.⁶² When asked whether they considered language and cultural issues important in the delivery of care to patients, 92 percent said that it was important or very important. Of the physicians surveyed:

- 82 percent would make use of translated material if made available to them;
- 58 percent would absolutely use interpreters if available to them, and another 17 percent most likely to use them;
- 50 percent would like training on how to use interpreters;
- 49 percent would be interested in having their staff trained as professional interpreters; and
- over 40 percent would want training in cultural competency or materials on the topic.⁶³

⁶⁰ Sessions held at the seminar included: “Integrating Cultural Responsiveness into Managed Care”; “Federal Civil Rights Law and Language Access”; “Cultural and Linguistic Standards: Medi-Cal Managed Care Contract Requirements”; and “Cultural and Linguistic Competency Requirements for the Healthy Families Program.”

⁶¹ The decision to conduct this survey arose from a number of factors. A 1999 survey of traditional safety net providers identified cultural competency as an area of need. L.A. Care’s 1999 Medi-Cal Managed Care Provider Satisfaction Survey also pointed to the need for greater education of providers on culture and language issues. Finally, California’s Healthy Families contract requires a needs assessment on health education and cultural and linguistic needs.

⁶² J. Cho and B. M. Solis, *Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on Their Diverse Member Population*, L.A. Care Health Plan, January 2001.

⁶³ Ibid.

Using the results of this survey as a guide, L.A. Care developed the Health Care Interpreter Pilot Program, a training program for L.A. Care providers and staff who provide interpretation services to patients as part of their job. Applicants are pre-screened to determine appropriateness for the training, primarily focusing on the individual's language ability. The complete course totals 48 hours and is divided into modules, which are offered quarterly, and participants receive a certificate after completing the training. The 41 initial participants included customer service staff, outreach liaisons, registered nurses, licensed vocational nurses, staff persons at safety net organizations,⁶⁴ and medical assistants. Thirty-one participants spoke Spanish; four, Vietnamese; one, Cambodian; one, Armenian; two, Kanjobal, a Mayan dialect; and two, Tagalog.

L.A. Care has estimated that the total cost of the four-part training will be \$15,000, which does not include staff time in outreach and administration. The health plan also anticipates offering additional training depending upon interest.

Issues to Consider

The training of existing staff in medical interpretation offers L.A. Care a remedy to the problem of using untrained staff, family members, and friends. Using multilingual staff to provide interpreter services when they have other job responsibilities, however, raises issues regarding skills and logistics. First, these staff must be properly trained in medical terminology, the role of the interpreter, and ethics. Second, tensions can arise when these staff spend time interpreting rather than fulfilling their primary job responsibilities. Co-workers may become unhappy with having to take up the slack when the staff member is called to interpret. Performance issues can become complicated when a supervisor is dissatisfied with the staff person's work as it relates to non-interpreting job responsibilities. Clinicians could become concerned that interpretation services might not be immediately available due to the multilingual staff member's other job responsibilities. Patients may want more time than the staff person can provide. In addition, multilingual staff members may be concerned about the sufficiency of interpreter training or may fear legal liability.⁶⁵ While L.A. Care's Health Care Interpreter Pilot Program addresses the issue of skills training, it does not address logistics.⁶⁶

⁶⁴ These staff included medical assistants and support services liaisons from a community clinic; a registered nurse from a county clinic; medical assistants from an IPA/medical group; and a staff interpreter from community clinic.

⁶⁵ Anecdotal information points to high turnover rates for these individuals.

⁶⁶ This concern may be somewhat abated if part of the individual's job description includes interpreting.

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Hospitals

Most hospitals in the United States receive some form of federal financial assistance and thus, according to Title VI, must ensure access to language interpretation services for their patients. Further, the critical nature of many patients' visits to the hospital through the emergency room accentuates the need for interpreters to ensure proper diagnosis and treatment. The three hospitals outlined below have found widely divergent methods of ensuring access to language translation services: technological innovations, comprehensive policies, and coordination of efforts with other local health care facilities.

GOUVERNEUR HOSPITAL: REMOTE SIMULTANEOUS MEDICAL INTERPRETATION

Background

New York University's Center for Immigrant Health (CIH) seeks to facilitate the delivery of linguistically, culturally, and epidemiologically sensitive health care services to new immigrant populations. CIH, founded in 1989, currently has programs that address the linguistic and cultural needs of persons with limited English proficiency and the educational needs of their health care providers and staff. As part of its language initiative programs, in 1995 CIH developed a medical interpreter project with the ultimate objective of creating a comprehensive medical interpreter network in New York City. CIH offers an introduction to medical interpreting course, a simultaneous medical interpretation training program, "train the trainer" modules, screening for bilingual aptitude, and development of medical terminology glossaries to reflect the different areas in medicine and behavioral health in which interpreters work.

Promising Practice

Gouverneur Hospital is a public facility located in a New York City neighborhood predominantly composed of Chinese and Hispanic immigrants. With approximately 50 percent of its patients having limited English proficiency, the hospital was experiencing a

high need for language translation services. In March 1999, CIH, with funding from the New York City Health and Hospitals Corporation, implemented a pilot project in remote simultaneous medical interpretation at Gouverneur Hospital to address this need.

The project uses trained medical interpreters who interpret for providers and patients through wireless headsets. Both patients and providers wear headsets during a given encounter, and their conversation is transmitted to a nearby receiver and then digitally over a fiber-optic line to a central switching station in the interpreter room. The interpreters, also wearing headsets, listen to what is said by one party and then transmit an interpretation to the other. The provider and patient only hear their own languages.

Currently, the program operates with 10 part-time interpreters who are available from 9:00 a.m. to 5:00 p.m., Monday through Friday. The interpreters are screened for bilingual aptitude and interpreting skill and undergo training in simultaneous interpretation.⁶⁷ The 60-hour training focuses on the acquisition of medical and colloquial terminology, understanding the medical encounter, and linguistic competency. Interpreters are trained to preserve linguistic register, tone, and tense through their interpretation. The interpreters continually undergo random quality monitoring by a language coach who uses a listening device built into the interpretation equipment. The languages currently available are Spanish, Mandarin, Cantonese, and Fuzhao (spoken in the Fuzhao region of China). Bengali interpreters will be added once the program expands to include Bellevue Hospital Center.

The pilot program initially operated in five examination rooms and provided interpretation for 150 to 200 encounters per month. The initial success of the program led physicians, patients, and administrators to obtain an expansion of the program to include all clinical areas at Gouverneur. In addition, Bellevue Hospital Center has embraced the technology and will implement simultaneous interpretation—using Gouverneur’s interpreters—in its emergency department and most ambulatory care areas. As part of the expansion, the program will offer cultural competency training to health care providers.

To identify the costs and benefits of the remote simultaneous medical interpretation project, The Commonwealth Fund and The California Endowment are supporting a cost-effectiveness time-motion study to compare the cost of using the service at full capacity to the cost of more common interpreter services as well as health care

⁶⁷ The initial group of interpreters is composed entirely of sight-impaired individuals trained in collaboration with the New York State Commission for the Blind and Visually Handicapped. The Commission paid for one-half of their salaries for the initial six months of their employment.

outcomes with different types of interpreter services. The more common services include remote consecutive medical interpreting (telephonic interpreting using a language line) and proximal consecutive medical interpreting (in-person interpreters).⁶⁸ The study will include direct medical and non-medical costs.

Issues to Consider

There is ongoing debate of the pros and cons of simultaneous versus consecutive interpretation. Simultaneous interpretation is generally believed to be more demanding than consecutive translation but adequate screening and training of interpreters could ensure that only qualified interpreters are used. The use of remote versus in-person interpretation may also affect provider-patient communication. For example, some patients may not feel comfortable disclosing sensitive information to a stranger on the other end of a headset, although patients at Gouverneur Hospital have not expressed any concerns about using the remote system. No study yet has compared in-person to telephonic interpretation with interpreters of equal skills.

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MAINE MEDICAL CENTER: INNOVATING THROUGH CIVIL RIGHTS COMPLIANCE

Background

In 1999, two foreign-born minority patients filed complaints with the HHS Office for Civil Rights against Maine Medical Center (MMC), charging MMC with violating Title VI of the Civil Rights Act of 1964. They alleged that the hospital was not providing adequate language access services to them. Following the filing of the complaints, MMC entered into negotiations with the Office for Civil Rights Region I office. The result was an extensive settlement agreement, executed on July 17, 2000.⁶⁹

⁶⁸ See “Issues to Consider” under “L.A. Care Health Plan” in this report.

⁶⁹ The settlement agreement is posted at <http://www.healthlaw.org/pubs/Alert000718.html>.

Promising Practice

The settlement covers a broad range of issues, such as providing qualified oral interpreter services, providing translated written materials, identifying the kinds of materials that should be translated, distributing information about translation services, and monitoring activities by the hospital. The settlement agreement is consistent with the policy guidance subsequently issued by the Office for Civil Rights in August 2000 and January 2002. It illustrates, in detail, how the recommendations of the guidance can be tailored and implemented to fit the needs of a particular community and hospital.

As part of the settlement, MMC agreed to create both a senior management staff position and a coordinator of interpreter services charged with coordinating and overseeing the activities specified by the settlement.

As part of the settlement, MMC agreed to provide a brochure, *What If I Don't Speak English?*, to patients at the first point of contact. This brochure will serve as a written notice to people with limited English proficiency of their right to language assistance from MMC. MMC also agreed to make notices and signs available in any language where there are 50 LEP persons in the service area speaking that language. When a patient first visits MMC, the hospital will assure that interpreters being used are competent and trained. It will discourage the use of minors as interpreters unless an emergent or urgent circumstance exists. MMC has listed a number of circumstances where it recognizes that interpreter services are needed and will be provided, including during the determination of medical history, discussion of patient's rights, execution of legal documents, explanation of financial obligations, treatment and discussion of treatment options and procedures, diagnostic testing, explanation of medications and/or follow-up treatment, and discharge instructions. Interpreters will also be provided for psychiatric evaluations, group or individual therapy counseling (such as grief counseling and crisis intervention, educational classes, and religious services).

The settlement agreement also addresses the training of hospital staff. MMC agreed to maintain lists of the staff that must attend training, along with the specific topics that will be included in the training. These include the importance of effective communication with LEP persons, procedures for identifying the LEP person's need for interpreter services and how to access them, telephone communication for LEP persons, use of family members and friends, role of the Coordinator of Interpreter Services, cultural sensitivity and diversity issues, and record-keeping procedures and reporting obligations. Finally, the agreement calls for record-keeping and data collection and requires a biannual review and

report under the supervision of an independent monitor to be selected by MMC with OCR approval.

Issues to Consider

While this settlement agreement contains extensive promises, questions remain about the extent to which the agreement will be implemented. The voluntary settlement agreement replaces an earlier agreement between OCR and MMC following similar allegations of failing to provide LEP patients with needed interpreter services in 1991. MMC will need to maintain a commitment to the new agreement, even through the inevitable turnover in personnel, which will result in the original parties to the agreement moving on. In addition, the Office for Civil Rights will need to monitor and enforce the agreement, something that may be tested by persistent understaffing and conflicting demands on OCR staff.

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DANE COUNTY, WISCONSIN: COLLABORATING TO PROVIDE INTERPRETER SERVICES

Background

Dane County, Wisconsin, has a population of approximately 450,000. The county includes Madison, Wisconsin, with a population of 300,000. Within the county, approximately 20,000 Hispanics reside, of which it is estimated that 15,000 have limited English proficiency. In addition to a large Hispanic population, there is also a significant Hmong population, currently 5,000 individuals.

Promising Practice

Prompted by a shortage of interpreters, concerns about the quality of interpreter service, and the need to save money, in 1997, eight hospitals and clinics in Dane County established the Health Care Providers' Interpreter Services Group.⁷⁰ The group is working

⁷⁰ These facilities are: Dane County Division of Public Health, University of Wisconsin Hospital and Clinics, Meriter Hospital, St. Mary's Hospital, Stoughton Hospital, Dean Medical Center, GHC, and University of Wisconsin Health-Physicians Plus.

to develop standardized interpreter policies and assess individuals' abilities to provide competent translation services for the collaborating facilities.

The group assesses Spanish-speakers' ability to interpret in health care settings through use of written and oral examinations. The written exam includes sections on vocabulary and interpreting patient instructions. The oral exam consists of role-plays and a discussion of an ethical situation, and is taped for evaluation. For other languages, the group has established a set of requirements that interpreters must meet, including an interview, commitment to the interpreters' code of ethics, and an acknowledgment of the group's policies and procedures. Ultimately, the group hopes to offer assessments in other languages.

The group has evaluated approximately 300 people since its inception, including individuals who had been interpreting prior to the initiation of the assessment. Only 40 to 50 individuals have passed the assessment, attesting to the group's high standards for interpreter skills. Those passing the assessment (for Spanish) or meeting the other requirements (for other languages) are included on a list made available to the facilities. The list currently includes approximately 140 individuals for all languages, including 32 Spanish-speaking interpreters.⁷¹ It is estimated that the administrative cost for the group totals \$3,000 to \$4,000 per year. Each facility assumes the actual cost of the interpreter services it uses.⁷²

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⁷¹ While 40 to 50 interpreters have been certified, 32 are currently on the active list of interpreters.

⁷² In addition to using interpreters from the approved list, the facilities may also have full-time interpreters paid for by their individual operating budgets. For example, the University of Wisconsin Hospital and Clinics has a staff of five in its Interpreter Services/Minority Community Relations Department: one director, three full-time interpreters, and one interpreter scheduler. For 2002, the overall budget for this department is approximately \$500,000, including salaries, benefits, administrative costs, and the hiring of freelance interpreters.

Community-Based Organizations

A variety of factors, including a lack of recognition among health care providers of federal and state requirements to provide language services and the lack of funding for interpreters have left much of the onus for providing qualified interpreters on community-based organizations (CBOs). CBOs serving individuals with limited English proficiency sometimes provide interpreters to accompany their clients to medical appointments as well as appointments at government agencies. Many CBOs have been creative in developing and finding funding for interpreter programs. Two programs are outlined below.

NORTHERN VIRGINIA AREA HEALTH EDUCATION CENTER: COMMUNITY-BASED INTERPRETER SERVICE

The Northern Virginia Area Health Education Center (AHEC) conducted several studies that identified the need for trained interpreters and cultural competency training for local health care providers. In response, AHEC created a full-service health care interpreting program. AHEC recruits, screens, trains, and tests interpreters, training them with the “Bridging the Gap” curriculum (see “Cross Cultural Health Care Program” under “Educational Models,” below). AHEC provides interpreter services to regional health care providers, including the public health department, mental health facilities, hospitals, and some social service providers. Approximately 50 to 60 interpreters who speak 20 languages are available. AHEC accepts requests from providers for interpreters, coordinates scheduling, bills providers, and pays the interpreters. AHEC has two full-time-equivalent staff members coordinating this program: a full-time training coordinator, a part-time scheduler, and a part-time program director.

AHEC also trains providers on how to communicate effectively through interpreters. The training lasts one hour, allowing many providers to coordinate the training with internal staff meetings. Both monolingual and bilingual providers have responded positively. The training has helped providers better understand the role of the interpreter and appreciate the high level of training and skills required for the profession. The program is funded by fees from providers, grants, and AHEC’s operating budget.

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MULTICULTURAL ASSOCIATION OF MEDICAL INTERPRETERS: COMMUNITY-BASED LANGUAGE SERVICE

The Multicultural Association of Medical Interpreters (MAMI), an independent nonprofit organization located in upstate New York, started as a professional association for interpreters. Recognizing the great need for trained interpreter services, MAMI established a language bank in 1998, which aims to ensure access to health care services for the approximately 18,000 refugees and immigrants in two upstate New York counties.⁷³ MAMI has responded to the need for language interpretation services by recruiting bilingual/bicultural individuals, most of whom are refugees and immigrants themselves, to become interpreters. MAMI trains the interpreters, offers professional interpretation and translation to approximately 40 health care and social service facilities and organizations, educates providers in cross-cultural medicine, and works to inform facilities about applicable language access laws and advocate for the provision of required services.

MAMI charges providers \$45 to \$60 per hour with discounts for contract rates based on advance payment and usage. Interpreters are first screened and then attend a training course, which consists of 60 hours of classwork and four hours of a supervised internship in a local health care facility. Individuals who complete the course and pass the oral and written exam receive a MAMI certificate in medical interpreting. The training currently costs \$200, and is subsidized by MAMI; for those facilities that wish to have their staff trained, it charges \$750. MAMI primarily provides interpreters for Bosnian, Russian, Vietnamese, and Spanish, but also serves additional languages including Arabic, Albanian, Farsi, French, Urdu, Punjabi, and Hindi.

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⁷³ In addition to MAMI, a local refugee resource center donates interpreting services free of charge to health care and social service providers but it is only able to provide interpreters in approximately one-third of the cases. Further, the refugee resource center is not required by the federal Office of Refugee Resettlement to provide services to refugees beyond their first eight months in the United States and does not have to assist refugees initially settled in another city or state.

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Educational Models

A variety of educational models exists to train individuals in medical interpretation. These programs help ensure that medical interpreters have the necessary language abilities and that they understand their role as interpreters, grasp ethical considerations, and are familiar with medical terminology. This report highlights three types of training programs: a nationwide model, a home-study model, and college-level coursework. Further information on training programs can be found in the *Directory of Health Care Interpreter Training Programs in the United States and Canada*, produced by the Cross Cultural Health Care Program.⁷⁴

CROSS CULTURAL HEALTH CARE PROGRAM: “BRIDGING THE GAP”

The Cross Cultural Health Care Program (CCHCP) was founded in 1992. While located in Seattle, CCHCP provides interpreter and cultural competency training and conducts research for a national audience. Its mission is to serve as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. CCHCP brings its training in linguistic and cultural competency to numerous health and social service settings around the country.⁷⁵ The trainings target three crucial groups within the health care system: staff that provide care, administrators who coordinate the delivery of care, and policy makers who regulate the form and manner of its delivery.

CCHCP developed “Bridging the Gap,” a 40-hour basic/intermediate training course for interpreters, perhaps the most widely recognized health interpreter training curriculum in the country. Many organizations that train interpreters utilize the “Bridging the Gap” curriculum through licensing agreements with CCHCP.

The course covers:

- basic interpreting skills (interpreter’s role, ethics, conduit and clarifier interpreting, intervening, and managing the flow of the session);
- information on health care (introduction to the health care system, how doctors think, anatomy, and basic medical procedures);

⁷⁴ See <http://www.xculture.org/training/overview/interpreter/survey.html>.

⁷⁵ CCHCP also trains interpreters and administers a centralized onsite interpretation services system for the PacMed health clinics in the Seattle area.

- culture in interpreting (self-awareness, basic characteristics of specific cultures, traditional health care in specific communities) and culture-brokering (helping providers understand patients’ culture and how it influences interactions and decision-making);
- communication skills for advocacy (listening skills, communication styles, and appropriate advocacy); and
- professional development.

Each participant receives a student handbook, materials about culture and traditional healing for 18 cultural communities, an interpreter’s guide to medications, and a medical glossary. The glossary has been translated into 10 languages (Spanish, Russian, Vietnamese, Amharic, Tigrignia, Cambodian, Lao, Somali, Korean, and Chinese). The course is heavily participatory, including practice sessions, role-plays, and small group discussions.

Since 1995, using the “Bridging the Gap” curriculum, CCHCP has trained nearly 2,000 interpreters in 18 states.⁷⁶ In addition, CCHCP has provided training for telephonic language line services interpreters.

CCHCP also offers a program to train trainers for the course. Those prepared through these workshops can then teach the course for licensed agencies. Under this arrangement, “Bridging the Gap” is now being offered regularly in more than 27 states.

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HEALTHREACH COMMUNITY CARE CLINIC: HOME-STUDY CERTIFICATION

Operating out of the HealthReach Community Care Clinic in Waukegan, Illinois, the Healthcare Access By Language Advocacy (HABLA) program offers medical interpretation training for local bilingual (English- and Spanish-speaking) residents. The program

⁷⁶ For a partial list of CCHCP clients, see <http://www.xculture.org/training/testimonials/index.html>.

primarily consists of self-paced home study with the goal of training individuals to provide competent interpreter services to private physician offices and HealthReach's outpatient clinics.

The program consists of 15 modules, including practice scenarios and in-clinic supervised practice and experience with patients. Faculty also provide individual, flexibly scheduled sessions with participants to review the modules and answer questions. Participants finish the course with an oral exam and practicum testing, which includes a mock patient encounter and observed interpretation with three to four clinic patients. Those completing the course are certified, and ongoing supervision and oversight occurs every six to 12 months.

While the program has been primarily targeted toward the large local Hispanic population, HABLA plans to expand to other immigrant groups. Currently, most of those participating are community members recruited through the Coalicion Latinos Unidos de Lake County, local communities of faith, social service agencies serving immigrants, and ads and/or articles in local Spanish-language newspapers.

To keep the cost of the training low, HABLA charges participants only \$5 per module. Since this fee does not cover actual costs, participants also agree to "pay-back" some of the training costs by receiving a reduced wage for initial interpretation services they provide to HealthReach clinic patients.⁷⁷ The combination of low cost and minimal classroom time makes the training more accessible to volunteers, employees of physician offices and clinics, and community members interested in developing new skills.

Most of the requests HABLA currently receives for interpreters come from patients, although some physician offices are also beginning to seek interpreters as well. A case manager schedules both the patient's off-site visit (i.e., for testing or to see a specialist) and the interpreter at the same time.

HABLA currently has five fully trained interpreters (three paid and two volunteer). An additional 28 individuals are in various stages of the training. HABLA is initially concentrating on increasing the number of paid, trained interpreters because those receiving payment for their services are easier to schedule. HABLA will work to keep the fee charged to local physicians as low as possible to increase the likelihood that physicians

⁷⁷ Initial funding, provided by the Illinois Fund for Immigrants and Refugees and the U.S. Department of Health and Human Services Office of Minority Health Bilingual/Bicultural Service Demonstration Project, has kept the costs low. If no additional funding is obtained after the initial funding expires, the costs may increase.

will use trained interpreters. One challenge HABLA has faced is convincing bilingual individuals that, with training, they have a useful and marketable skill.

The HABLA program currently operates on an annual budget of \$56,000. The clinic hopes the program will become self-sufficient, raising its operating costs from training fees, fees for translating written materials, and fees paid by providers for the interpreters' services.

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COLLEGE MEDICAL INTERPRETATION PROGRAMS

The Cambridge Health Alliance, a network of neighborhood health centers in Cambridge, Massachusetts, responded to its need for trained medical interpreters by establishing a collaboration with Neighbors for a Better Community, a neighborhood job development agency, and Cambridge College, a local college specializing in adult education, to develop a three-semester medical interpreter training program.⁷⁸ One goal of this program is to increase the pool of qualified candidates that Cambridge Health Alliance can hire.

The South Carolina Department of Social Services (DSS) also addresses its need for interpreters by collaborating with a local university. DSS contracts with the University of South Carolina College of Social Work (USC) to operate DSS's HABLA (Hispanic Bilingual Line and Assistance), a regional telephone line and in-person translation service. USC recruits Spanish-speaking, returning Peace Corps volunteers to enter its Master's of Social Work program and provides "Graduate Assistanceships," which offer scholarships for students to work part-time as interpreters and translators for DSS. After experiencing initial success, the program expanded to include the Department of Health and Environmental Control.

⁷⁸ About 51 percent of the Alliance's clients have limited English proficiency and speak 30 languages. The Alliance primarily addressed the language needs of its patients with staff interpreters for prevalent languages (63 percent of its interpreting is for Portuguese-speaking individuals), on-call interpreters, and usage of a language line for additional coverage.

DSS HABLA has two telephone lines for DSS use from 8:00 a.m. until 5:00 p.m., Monday through Friday, staffed by two graduate assistants who provide telephone interpretation upon request from caseworkers. The graduate students also travel (with a day's advance notice) to local offices to interpret for large groups/families or for complex situations. In their down time, the students work on translating DSS forms for the printing office and translating documents, letters, and notices for workers on an as-needed basis. For other languages, DSS uses a language line.

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CONCLUSIONS

This report highlights a number of promising practices that can be adapted or replicated to ensure access to qualified interpreters in health care settings. It is important to note that this report only focuses on language interpretation services; it does not address or identify promising practices regarding, for example, translation of written materials, cultural competency, or ensuring linguistic access through language concordance between providers and patients. While the programs highlighted in this report represent different approaches, the authors did not attempt to produce a comprehensive inventory of current language interpretation programs and activities. Thus, the findings presented here represent just one step in the process of identifying, analyzing, comparing, and evaluating the myriad models of providing language services and ensuring cultural competency in health care.

Yet, by examining the breadth and variety of existing programs, a number of issues are evident. First, concerns about cost are often cited as the primary barrier for providing language interpretation services. Current funding mechanisms, including in particular reimbursement through Medicaid and the State Children's Health Insurance Program, have, to date, only infrequently been used to reduce these concerns. Only five states currently have federal Medicaid/SCHIP reimbursement mechanisms. Additionally, data regarding patients' primary language is severely lacking, making it difficult for providers to identify who needs interpreter services. Currently, only one-third of states request primary language information on their SCHIP applications. Estimating the number of individuals who need interpreter services is impossible without comprehensive and reliable data.

Quality of interpreter services is also difficult to ascertain. The widespread use of informal and untrained interpreters has produced anecdotal evidence of poor quality, but little research has been conducted to compare quality between the use of trained, qualified interpreters with family members, friends, and other informal arrangements. Finally, there is little information about the cost, and potential cost savings, of interpretation. For instance, it is possible that interpreter services may cut overall health care costs by reducing unnecessary diagnostic testing and reliance on emergency departments, and that effective communication between providers and patients, enabled by interpreters, can help patients better understand and comply with recommended treatment regimens. The research certainly indicates that individuals who cannot communicate with their providers experience negative health consequences.

An examination of the various programs profiled in this report, however, clearly demonstrates that many solutions are available. Some programs illustrate the benefits of Medicaid/SCHIP and other funding mechanisms to pay for interpreters. Others have pioneered ways to increase both the quantity of interpreters and the quality of their services. With effective dissemination of these and other models, and technical assistance to implement them, health care organizations and providers could overcome many of the challenges of providing language interpretation services for their patients. More needs to be done, however, to improve funding for, development of, and access to these services; raise awareness of their necessity; and advance further research:

1. More states could develop mechanisms to obtain federal reimbursement for interpretation provided to Medicaid and SCHIP enrollees.
2. CMS could enhance mechanisms to reimburse for interpreters provided to Medicare beneficiaries.

3. States could review their provider manuals, guidelines, and contracts with managed care organizations and ensure that effective language services and cultural competency requirements and rates are included. States could require each managed care organization to develop a plan to ensure linguistic access and monitor and enforce implementation. States could evaluate whether language services are appropriately included in capitation rates for managed care.
4. Health care organizations and providers could investigate the availability of potential interpreter services in their communities, explore ways to use these services and develop others cost effectively, and develop tailored, written plans for how they will provide language services.
5. Health care organizations and providers could record the primary language of patients in their health records and providers' information management systems.
6. CMS could ensure the collection of primary language data of all Medicare, Medicaid, and SCHIP enrollees. For enrollees who are under age 18 or mentally incapacitated and under the care of a caregiver, states could also collect the primary language of the caregiver. The states and CMS could make this information available to health care providers so they could better plan for and provide language services to these enrollees who have limited English proficiency.
7. The HHS Office for Civil Rights, in conjunction with CMS, could undertake a national education campaign to inform providers of: a) federal and state laws and guidelines governing access to language services; b) the need for trained medical interpreters and the problems of using family members, friends, minors, and untrained bilingual staff; c) funding sources for providing linguistic access; and d) promising practices to effectively provide language services.
8. The Administration could increase funding for the HHS Office for Civil Rights to ensure sufficient resources to assist recipients of federal funds in developing language access plans, monitor implementation of those plans, and investigate complaints of language barriers.
9. Future research could: a) compare the benefits of different types of interpretation in health care (such as in-person vs. telephonic, simultaneous vs. consecutive); b) compare the costs associated with various methods of providing language services; c) explore the ways in which health care providers can most effectively and

efficiently provide language services;⁷⁹ d) identify ways to increase the pool of trained medical interpreters; e) continue to compare health service consumption and health status of populations that experience language barriers with those that do not; f) explore whether payment rates could be modified or weighted based on the patient's need for linguistic services;⁸⁰ and g) explore the benefits and costs of providing language services.

⁷⁹ Upcoming studies by the Cross Cultural Health Care Program and New York University's Center for Immigrant Health will begin examining this issue.

⁸⁰ For example, in Medicare, hospital payment rates have modifiers or weights such that a hospital receives a higher payment under certain circumstances.

**APPENDIX. MODELS FOR LANGUAGE SERVICES
TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY**

This chart summarizes the results of a survey conducted by the National Health Law Program in the fall of 2001 and winter of 2002. The survey was distributed by postal and electronic mail to interested organizations across the country and posted on the National Health Law Program’s website. Additional information was obtained by following up with survey respondents. Please note that this survey was not designed to produce a complete listing of all of the activities now under way to remove language barriers to health care. Rather, the results are intended to highlight different models currently operating and furnish information about promising practices.

Note: Programs denoted in italics are discussed in depth in the body of this report.

STATE/AGENCY/ PROGRAM	DESCRIPTION
FEDERAL PROGRAMS	
Health Resources Services Administration (HRSA) HIV/AIDS Bureau	Funds a variety of projects including the Bridges Project (New York City), which offers interpretation by paid, on-call bilingual peer advocates, and other projects that address cultural and/or linguistic sensitivity (Arizona, California, Massachusetts, New Mexico).
HRSA “Models That Work” Campaign	A public-private partnership that identifies programs with exemplary records of improving community health, shares information with other communities that face similar problems, and supports these organizations with winning strategies in helping communities that want to replicate these solutions. See http://bphc.hrsa.gov/mtw . Past winning strategies that addressed linguistic access issues have included providing medical interpretation services (including certification of interpreters); translation services; bilingual/bicultural AmeriCorps members to staff school health centers; and outreach and education.
Medicaid and the State Children’s Health Insurance Program (SCHIP)	Reimbursement available to states for language assistance including interpreters and translation (<i>Dear State Medicaid Director</i> letter, August 31, 2000).
Medicare	Reimbursement for inpatient interpretation services is included in hospitals’ overhead costs. No reimbursement is provided for outpatient interpreter services.
Office of Minority Health Bilingual/Bicultural Service Demonstration Grant Program	Recent focus on managed care (15 projects from September 30, 1997, through September 29, 2000). Activities included providing: interpreters; cultural competency training for health care providers and professionals; medical interpreter curriculum development, training, and practicum placements; and development of linguistically and culturally sensitive health education materials. See http://www.omhrc.gov/OMH/sidebar/aboutOMH.htm .

STATE/AGENCY/ PROGRAM	DESCRIPTION
United States Department of Agriculture (USDA)	USDA awarded grants to four counties totaling \$538,000 to implement programs to help Hispanics gain access to health care, build county coalitions among health care providers and Hispanic groups, and work with national experts in the field of health care access. One program sends health care and social service workers for a Spanish-language immersion program.
STATE MEDICAID/SCHIP FEE-FOR-SERVICE PROGRAMS	
Hawaii	<p>The state contracts with two language service organizations that help individuals with limited English proficiency who are Medicaid fee-for-service patients or children with disabilities in the SCHIP program. The state pays the language service agency a rate of \$25 to \$45/hour. Interpreters are allowed to charge for travel, waiting time, or parking. No payment is provided for interpreters on staff or bilingual providers. The state has guidelines on billing procedures and utilization, and language service organizations are expected to monitor quality and assess the qualifications of the interpreters they hire.</p> <p>QUEST, the state's Medicaid managed care program, includes funding in its capitated rates for enabling/translation services (based on volume and claims submission data).</p>
Maine	The state established a billing code for interpreters. Providers have flexibility in determining how to provide interpretation through local resources, national language interpreter services, or comparable services. Providers bill the state, although hospitals, private nonmedical institutions, nursing facilities, and intermediate care facilities for the mentally retarded do not bill separately. Interpreter costs are allowable and included as part of rate of reimbursement. The state reimburses for a minimum hourly charge and then for 15-minute increments, including travel to and from the location. (<i>Maine Medical Assistance Manual</i> , Chapter 101, 1.06-3.)
Minnesota	<p>The state reimburses fee-for-service providers who provide language interpreter services via phone or in person. The provider hires, contracts, or arranges the interpreter service and then bills the state using the billing code. Providers are paid the lesser of usual and customary charges or \$12.50/15-minute unit.</p> <p>Enrollees in managed care receive language interpreter services from their health plan, as required in managed care contracts.</p>
Utah	<p>The state contracts with five language service organizations (covering 27 languages) to provide in-person and telephone interpreter services to fee-for-service Medicaid, SCHIP, and medically indigent program patients. The health care provider must call the contracted organization to arrange for the service. Providers cannot bill Medicaid directly for using the interpretation services nor do they receive any rate enhancements for being a bilingual provider or having interpreters on staff. The contracted language service organizations are paid by the state an average of \$22/visit for phone interpretation and \$35/hour for in-person interpretation with a one-hour minimum.</p> <p>For enrollees in managed care, Utah requires health plans to provide language interpretation services for their patients as part of the contract agreements.</p>

STATE/AGENCY/ PROGRAM	DESCRIPTION
<i>Washington</i>	<p>The Department of Social and Health Services (DSHS) contracts with interpreter organizations to provide language interpretation/translation for all programs under DSHS (including Medicaid, SCHIP, federally qualified health centers, and aging services). Providers arrange for interpreters, who directly bill the state. See Admin. Policy No. 7.21.</p> <p>The state offers testing and certification, and specifies that interpreters speaking Spanish, Chinese, Vietnamese, Korean, Russian, Cambodian, and Laotian must be certified, and that interpreters who speak other languages must be qualified. Reimbursement ranges from \$33–\$39/hour depending on agency/region.</p>
STATE AND LOCAL LAWS/ORDINANCES⁸¹	
California: Dymally-Alatorre Bilingual Services Act, Gov. Code § 7290 et. seq.	State and local public agencies serving a substantial number of individuals with limited English proficiency must provide services and materials in the languages spoken by those persons.
California (San Francisco): City Administrative Code, Equal Access to Services	<p>Requires city departments to offer bilingual services and materials if a “substantial number” of the public utilizing city services has limited English proficiency. Focuses on bilingual staffing, translation of materials, public meetings, recorded telephonic messages. Telephonic messages must be in each language spoken by a “substantial number” of people with limited English proficiency or, where applicable, by a “concentrated number” of people with limited English proficiency.</p> <p>“Substantial number” of people with limited English proficiency is defined as 10,000 city residents or 5 percent of those who use the department’s services.</p> <p>“Concentrated number” of people with limited English proficiency is defined as 5 percent of the district where the covered department facility is located or 5 percent of those persons who use the services provided by the covered department facility.</p>
California (Oakland): City Ordinance, Equal Access to Services	<p>Requires city departments to offer bilingual services and materials if a “substantial number” of the public utilizing city services has limited English proficiency. Focuses on bilingual staffing, translation of materials, public meetings, and recorded telephonic messages.</p> <p>“Substantial number” is defined as at least 10,000 city residents with limited English proficiency that speak a shared language other than English.</p>
Florida: Fla. Stat. § 641.54	Statutory requirement: each health maintenance organization shall provide to subscribers, upon request, the policies and procedures for addressing the needs of non-English-speaking subscribers.
Idaho: IDAPA 16.03.09.090	Administrative code, rules governing the Medical Assistance Program, consent for sterilization: an interpreter must be provided if the recipient does not understand the language used on the consent form or the language used by the person obtaining the consent.

⁸¹ This section includes a limited selection of recent statutes, regulations, and ordinances. Additional information on state laws is available in *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, Appendix G* (January 1998, Kaiser Family Foundation). An update of this guide will be available in the fall of 2002.

STATE/AGENCY/ PROGRAM	DESCRIPTION
Maryland: Md. Code Ann. §§ 10-1102, 3	Statutory requirement: requires “oral language services” for LEP individuals who have contact with a state agency on a weekly or more frequent basis. Oral language services are defined to include staff interpreters, bilingual staff, telephone interpreter programs, and private interpreter programs. Also requires translation of “vital” documents when the LEP population is greater than 3 percent of the geographic area served by the state agency.
<i>Massachusetts: 105 C.M.R. 130.1100 et seq.</i>	Statutory requirement, interpreting in hospital emergency services and inpatient psychiatric facilities: requires the state to compensate hospitals for interpreting costs in ER and inpatient psychiatric facilities. See the Massachusetts Department of Public Health website, http://www.state.ma.us/dph/omh/interp/interpreter.htm , for information on hospital-based interpreter services, including best practices and resources and other materials.
Massachusetts: 105 C.M.R. 162.303	Administrative regulation, substance abuse outpatient counseling services: the client record must include the client’s primary language if other than English.
Minnesota: Minn. Stat. § 62Q.07	Statutory requirement: All organizations that issue or renew health plans must annually file an “action plan” that includes a detailed description of the policies and procedures for enrolling and serving high-risk and special needs populations. The plan must describe the barriers that are present and how the health plan will address those barriers to improve access to care for these populations, including those with limited English proficiency.
Montana: Mont. Code Ann. § 33-36-201	Statutory requirement: each managed care plan in the state must submit an access plan, including the health carrier’s efforts to address the needs of covered persons with limited English proficiency.
New Mexico: 13 N.M. Admin. Code 10.13.29	Administrative regulation: Each managed care plan must ensure that information and services are available in languages other than English, and that services are provided in a manner that takes into account cultural aspects of the enrollee population. Each managed care plan must submit a plan that addresses how it will identify the language needs of enrollees and measures it will take to ensure access for enrollees with limited English proficiency in both administrative and health care encounters with the plan and its providers. The plan must outline steps the organization will take to ensure availability of adequate interpretation services within its network and whether interpreting services are available to enrollees on a 24-hour basis for emergency care.
New York: N.Y.C.R.R. § 405.7	Statutory requirement, patients’ rights: Hospitals must afford to each patient the right to exercise patients’ rights regardless of the patient’s language or impairment of hearing or vision. Skilled interpreters must be provided to assist patients in using these rights. The hospital must manage a resource of skilled interpreters and provide translation/transcriptions of significant hospital forms, instructions, and information to provide effective visual, oral, and written communication with all persons receiving treatment in the hospital regardless of a patient’s language. Interpreter services and translation/transcriptions of significant hospital forms and instructions must be regularly available for non-English-speaking groups comprising more than 1 percent of the total hospital service area population, as calculated by demographic information available from the Census.

STATE/AGENCY/ PROGRAM	DESCRIPTION
Oregon: Or. Admin. r. 410-141-0760	<p>Administrative regulation: Primary care case managers (PCCMs) are expected to have a plan to access qualified interpreters who can interpret in the primary language of each “substantial population” of non-English-speaking members. The plan must address the provision of interpreter services by phone and in person. Interpreters must be capable of communicating in English and the primary language of the members and translate medical information effectively.</p> <p>PCCMs must provide education on the use of services, including urgent care and emergency services. The state Office of Medical Assistance Programs may provide PCCMs with appropriate written information on the use of services in the primary language of each “substantial population” of non-English-speaking members enrolled with the PCCM.</p> <p>“Substantial population” is defined as 35 non-English-speaking households enrolled with the PCCM that speak the same language.</p> <p>“Non-English-speaking household” is defined as a household that does not have an adult PCCM member who is capable of communicating in English.</p>
Rhode Island: R.I. Gen. Laws § 23-17-54	<p>Statutory requirement: Every hospital must, as a condition of initial or continued licensure, provide a qualified interpreter if an appropriate bilingual clinician is not available to translate (qualified interpreters must be over 16 years of age). Each hospital must post multilingual notices in conspicuous places setting forth the requirement. Regulations have not yet been promulgated.</p>
Texas: 25 Tex. Admin. Code § 30.27	<p>Administrative regulation: Requires managed care organizations (MCOs) to develop a written cultural competency plan describing how the MCO will effectively provide health care services to members from varying cultures, races, ethnic backgrounds, and religions to ensure that those characteristics do not pose barriers to gaining access to needed services. At a minimum, the MCO must make interpreter services available for members as necessary to ensure effective communication regarding treatment, medical history, or health education.</p>
Washington: Rev. Code Wash. (ARCW) § 74.04.025	<p>Statutory requirement: The Department and the Office of Administrative Hearings must ensure that bilingual services are provided to non-English-speaking applicants and recipients. The services must be provided to the extent necessary to assure that non-English-speaking persons are not denied, or unable to obtain or maintain, services or benefits because of their inability to speak English.</p> <p>Initial client contact materials must inform clients in their primary language of the availability of interpretation services for non-English-speaking persons. Basic informational pamphlets must be translated into all primary languages.</p> <p>To the extent that written communications directed to applicants or recipients are not in the primary language of the applicant or recipient, the Department and the Office of Administrative Hearings must include with the written communication a notice in all primary languages of applicants or recipients describing the significance of the communication and specifically how the applicants or recipients may receive assistance in understanding, and responding to if necessary, the written communication. The department must assure that sufficient resources are available to assist applicants and recipients in a timely fashion with understanding, responding to, and complying with the requirements of all such written communications.</p>

STATE/AGENCY/ PROGRAM	DESCRIPTION
LOCAL PROGRAMS	
Arizona	
Good Samaritan Regional Medical Center (Phoenix)	Eleven full-time, two part-time, and one on-call interpreters.
Maricopa Medical Center (Phoenix)	Twelve full-time and two part-time interpreters, plus 100 assistants who interpret on an as-needed basis.
Mayo Clinic Scottsdale (Scottsdale)	Two full-time Spanish interpreters; maintains a list of other languages that can be interpreted by its 3,500 staffers.
St. Joseph's Hospital and Medical Center (Phoenix)	Seven full-time interpreters, two of whom are on duty at any given time.
California	
<i>Alameda Alliance for Health</i> (Alameda County)	Provides a stipend to providers for the appropriate use of interpreters (\$20 for telephonic interpreters, \$30 for in-person interpreters) and pays for interpreter costs. Lists providers' languages in its directory.
Asian Health Services (Oakland)	Asian Health Services is a community health clinic that offers interpreters, both on-site and via telephone, from 8:00 a.m. until 10:00 p.m. daily. The primary languages spoken are Cambodian, Cantonese, Farsi, Korean, Mandarin, Spanish, and Vietnamese. Asian Health Services also trains interpreters and provides cultural competency training for providers.
California Primary Care Association	Issued <i>Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices</i> outlining promising practices in CPCA-member community clinics and health centers.
Health Access (San Francisco)	Videoconferencing Medical Interpretation Project is a pilot demonstration project at San Francisco General Hospital and Alameda County Medical Center. The project uses videoconferencing technology to provide patients with limited English proficiency and their providers with a real-time medical interpreter located off-site.
Healthy House	Healthy House currently provides a 40-hour health care interpreter training, offers Training of Trainers and mentoring for potential trainers, teaches providers how to work effectively with interpreters, and educates health care consumers about their language rights and the benefits of working with trained health care interpreters. Healthy House is working collaboratively with other organizations in California to develop language proficiency tests and an interpreter readiness assessment. In addition, Healthy House subcontracts language services with health care organizations through the Healthy House Language Bank.
Kaiser Permanente/City College of San Francisco	The Health Care Interpreter Training Program was developed as a partnership between the Health Science Department at the City College of San Francisco and the San Francisco Kaiser Permanente Medical Center. The program is designed to train bilingual and bicultural students to develop the awareness, knowledge, and skills necessary for effective language interpretation in health care settings through academic preparation, practical skills training, and service in community-based health care settings and educational organizations.

STATE/AGENCY/ PROGRAM	DESCRIPTION
<i>L.A. Care Health Plan</i> (Los Angeles)	Pilot interpreter training program that provides medical interpretation training free to any staff, including all affiliated health plans or providers.
La Maestra Family Clinic (San Diego)	Cultural liaison model that trains clinic support staff with similar cultural backgrounds as patient population to provide interpretation assistance both on- and off-site (specialist's offices, hospitals, etc.).
Pacific Asian Language Services for Health (PALS) (Los Angeles and Orange Counties)	PALS recruits, assesses, and trains medical interpreters. Offers interpreters to five hospitals and other health care providers on a fee-for-service basis (\$65 to \$75/hour with a one-hour minimum). PALS educates consumers through a consumer health education workshop in 14 languages with 14 community partners. PALS also educates providers about language access needs and cultural competency, how to use interpreters, and Title VI provisions. PALS seeks to identify existing interpreting policies of local hospitals and other organizations and health care providers for analysis and advocacy.
Connecticut	
La Clinica Hispana (New Haven)	Yale University Mental Health Center, Department of Mental Health: bilingual, bicultural clinic focusing on mental health issues for monolingual, uninsured persons with chronic mental illness; free services provided when resources permit.
District of Columbia	
La Clinica del Pueblo	Operates an interpreter program that provides interpreters to accompany patients to specialty appointments and hospital procedures. Referrals come from 10 primary care clinics (the clinics themselves have bilingual staff to interpret but are unable to offer interpreters when patients have off-site appointments). Funded through government and foundation grants and does not charge patients or providers. Screens and trains interpreters (in collaboration with Northern Virginia Area Health Education Center).
Florida	
Lutheran Social Services (Jacksonville)	Developed its own language interpreter service; providers and hospitals pay for interpreter services.
Hawaii	
Helping Hands Hawaii	Operates nonprofit multilingual access line, which contracts interpreters to government agencies (19 primary languages and 90 others).
Kalihī-Palama Health Center	Bilingual staff speak 14 languages; also utilizes Helping Hands Hawaii and contract interpreters when necessary.
Illinois	
Illinois Department of Human Services (IDHS) and Illinois Coalition for Immigrant and Refugee Rights (ICIRR)	In fiscal year 2000, IDHS and ICIRR distributed \$1 million to 26 community-based organizations to provide outreach and interpretation services.

STATE/AGENCY/ PROGRAM	DESCRIPTION
Fund for Immigrants and Refugees (Chicago)	Twenty-three foundations and the state contribute to a pooled fund, which recently provided 12 grants to social services and health care organizations to overcome language and cultural barriers and four grants to develop interpreter training and pool programs, in part for health access projects focused on increasing language assistance and cultural competence.
Healthcare Interpreter Services (Chicago)	Operated by Chicago Health Outreach (part of the Heartland Alliance). Started with seed money from the state refugee resettlement office, the program is now self-sufficient from its contracts with area hospitals and providers. Provides interpreter services in more than 30 languages and trains community-based and ethnic associations to provide interpreter services.
<i>HABLA program</i> (Lake County)	HealthReach Community Care Clinic offers a home study program to train medical interpreters. Primarily utilizes volunteer interpreters but pays two full-time interpreters. Provides interpreters to local doctors' offices; patients call for interpreters and doctors pay for services.
Kentucky	
Center for Women and Families (Louisville)	Language advocate program (based on Multilingual Access Model developed by Asian Women's Shelter in San Francisco). Hires bilingual staff, created part-time emergency language advocate position.
County Health Department (Fayette)	<p>The Health Department employs one full-time medical interpreter and two part-time contract interpreters. The full-time interpreter spends one day per week in a local clinic; contract interpreters spend a few hours per week in the clinic.</p> <p>Providers check the Health Department schedule to see when an interpreter is available and try to schedule limited English-speaking patients at that time.</p>
Maine	
<i>Maine Medical Center</i>	Language coordinator tracks and monitors linguistic access. The Center utilizes local resources, national language interpreter services (AT&T line), or other comparable services to provide interpretation. Written signage and "I speak" cards used for early identification of primary language.
Massachusetts	
<i>Cambridge Health Alliance</i> (Cambridge)	<p>Cambridge Health Alliance offers specialized clinical services in primary care and mental health with bilingual and bicultural staff. Utilizes staff interpreters, on-call interpreters (for higher volume times and evening/weekends), freelance interpreters (for lower volume languages), and telephone line as safety net.</p> <p>The Alliance developed a three-semester medical interpreter training program with Cambridge College and Neighbors for a Better Community (a job development agency).</p>
Children's Hospital (Boston)	The Interpreter Services Department arranges for interpreters in more than 35 languages. Spanish-speaking interpreters are available 24 hours a day: they are in the hospital weekdays between 8:30 a.m. and 6:00 p.m. and on call evenings and weekends. The interpreter on call helps locate interpreters in other languages for in-person or three-way phone conferencing.

STATE/AGENCY/ PROGRAM	DESCRIPTION
Harvard Pilgrim Health Center (Boston area)	<p>In selected sites, Harvard Pilgrim Health Center implemented a Spanish and Portuguese interpreter services program staffed by trained medical interpreters who are scheduled to attend physician visits with patients identified as needing an interpreter. Interpreters are also available to help patients 24 hours a day either by phone or in-person and with all contacts in the HMO, including appointment scheduling, laboratory, radiology, and pharmacy visits.</p> <p>Interpreters added to each clinic are relieved of other job responsibilities. They receive 50 hours of training, including instruction on medical vocabulary, the ethics of patient confidentiality, and working in a triadic interaction between patient, physician, and interpreter. All interpreters must pass an assessment exam at the end of training.</p>
Interpreters Services Collaborative (Boston)	Greater Boston area directors and coordinators of interpreter services at hospitals share information on delivery of services and lists of interpreters.
Maryland	
Foreign-born Information and Referral Network (FIRN) (Howard County)	Provides interpreters for Health Department staff and patients during weekly clinics. Interpreters assist in setting appointments, coordinating outreach, completing patient forms, and arranging access to postpartum and family planning services. Interpreters attend English-as-a-second-language classes to disseminate information about the availability of prenatal care.
Maryland Office for New Americans	The Office has provided grants to two organizations for training and coordinating interpreters with refugee resettlement money.
Montgomery County Volunteer Language Bank	The Language Bank is a group of volunteer interpreters/translators available to nonprofit or public agencies registered with the Volunteer Center to assist those agencies in services to area residents with limited English proficiency. It currently has approximately 75 volunteers speaking 20 languages.
Holy Cross Hospital (Silver Spring)	The hospital is establishing a central resource of bilingual staff that can interpret and language training programs for medical staff to teach medical terminology in other languages. It is exploring the possibility of rewarding bilingual employees who interpret with paid leave.
Minnesota	
Children's Hospital (St. Paul)	Mental Health Initiative: hospital pays for staff and contract interpreters primarily from operating expenses.
Department of Health Services (DHS)	DHS operates a toll-free language line to provide information about human services/materials. Uses the AT&T language line for communication between individuals with limited English proficiency and DHS staff. Offers training and technical assistance for state/county staff. Is updating data systems to track clients' language needs, identify barriers, and measure outcomes. Budget is approximately \$4.3 million over two years.

STATE/AGENCY/ PROGRAM	DESCRIPTION
<i>Office of Multi-Cultural Services</i> (Hennepin County)	The Office has 44 staff that speak 28 languages. Ten county community outreach liaisons assist clients with filling out applications and understanding managed care and accompany clients to medical appointments. Vista/AmeriCorps supported-staff help educate individuals with limited English proficiency in the community to access health care and county services. Ten interpreters staff a language bank, responding to calls from individuals seeking access to county services and provide interpretation for clients at intake interviews and other appointments with county staff. Annual budget is \$1.8 million annual budget, primarily from property tax assessments and some grants.
New York	
<i>Gouverneur Hospital</i> (New York City)	The New York University Center for Immigrant Health, with funding from the New York City Health and Hospitals Corporation, operates a remote simultaneous medical interpretation program. Examination rooms are equipped with headsets and connect to a “language bank” with interpreters trained in simultaneous translation. This pilot program was recently expanded throughout Gouverneur Hospital and to Bellevue Hospital Center. It also provides cultural competency training for providers, training for medical interpreters (both simultaneous and consecutive), and community outreach. Service encounters number 150 to 200/month. Simultaneous interpretation currently available during normal business hours. Bilingual staff, volunteers, and language line are used as back-up.
<i>Multicultural Association of Medical Interpreters</i> (Oneida)	Operates a fee-for-service, nonprofit language bank providing interpreters and an interpreter training course.
Roberto Clemente Center (New York City)	Operates under the assumption that culture is an essential component of mental health treatment and offers services through an all bilingual and bicultural staff.
University of Rochester	The University of Rochester Medical Center Department of Psychiatry offers a mentored curriculum in mental health interpreting with both a curriculum text and videotape components.
North Carolina	
Access Program (Greensboro)	Jewish Family Services’ operating budget has limited funding for interpreters at clients’ doctor’s visits.
Ohio	
Immigrant Health Care Access Coalition (Cleveland)	Educates hospitals about their obligations under Title VI and educates individuals with limited English proficiency about their rights. Produced a booklet describing health care rights and resources, including interpreter services at hospitals.
Language Task Force (Columbus)	Coalition of community-based organizations that offers cultural competency training for medical providers. Working to establish interpreter coordinators at local hospitals and policies and procedures for providing interpreters.
Universal Health Care Action Network (UHCAN) of Ohio (Columbus)	Coordinates and trained a pool of interpreters for county human services agency; launching a website from which subscribing providers can schedule interpreters.

STATE/AGENCY/ PROGRAM	DESCRIPTION
Oregon	
Centro Hispano of Southern Oregon	Offers a low-cost interpreting program for the local community.
Pennsylvania	
Critical Path AIDS Project (Philadelphia environs)	Provides no-cost interpretation/translation services to HIV/AIDS providers in the immediate surrounding counties. Also provides training and a resource library.
Rhode Island	
International Institute	Offers interpreters that speak 60 languages, including all the major European languages, five dialects of Chinese, and dozens of African languages. Includes a statewide system of more than 50 simultaneous and/or consecutive interpreters available 24 hours a day.
Rhode Island Hospital (Providence)	Eight full-time staff interpreters (speaking Portuguese, Spanish, Cambodian, Laotian, Russian, Creole, Armenian, and Arabic) available during normal business hours plus additional coverage hours for Spanish and Portuguese. Student volunteers from Brown University supplement the staff of interpreters. Also uses services of an outside agency to provide interpreters in other languages and AT&T language line as a back-up.
Social Economic Development Center for Southeast Asians (SEDC) (Providence)	SEDC's Language Bank offers interpreters in health care and other settings paid for by the provider. A 1.5 full-time-equivalent staff coordinates over 60 interpreters who are independent contractors. Interpretation is available in more than 40 different languages.
South Carolina	
<i>Department of Social Services (DSS)</i>	DSS operates HABLA (Hispanic Bilingual Line and Assistance), a regional phone line and in-person interpretation service. DSS contracts with the University of South Carolina's College of Social Work, which recruits Spanish-speaking returning Peace Corps volunteers to enter its Masters of Social Work program. Students receive scholarships to work part-time as interpreters and translators for DSS workers.
South Carolina Hispanic Outreach's Adelante Program (Columbia)	Offers Hispanic cultural competency and Latino health beliefs workshops for health care professionals. Trains bilingual staff and volunteers to become qualified interpreters. Provides community outreach through the local health department with community liaisons.
Tennessee	
Rural Medical Services (Cocke County)	Utilizes bilingual providers/staff to provide interpreters on- and off-site at specialist appointments, hospitals, and the Health Department. Outreach workers are funded partially by March of Dimes.
Vanderbilt Hospital (Nashville)	Tracks languages of providers and clients and matches patient's language to that of provider, where possible.
Texas	
Project Link (Austin)	Provides information and training to health care providers regarding interpreter services and provides referrals for additional assistance, including with translation.

STATE/AGENCY/ PROGRAM	DESCRIPTION
Virginia	
<i>Northern Virginia Area Health Education Center AHEC</i> (Annandale)	AHEC operates a full-service health care interpreting program. It recruits, screens, trains, tests, and coordinates scheduling of interpreters.
Roanoke Interpreter Services (Roanoke)	Offers interpreters who are reimbursed by customers, hospitals, and the state (for services provided to Roanoke City Health Department).
Washington	
PacMed Health Clinics (Seattle area)	Centralized on-site interpretation services system (administered by the Cross Cultural Health Care Program) with eight staff interpreters, three schedulers, over 40 contract interpreters, and six agencies that provide interpretation services in 52 languages for 33,000 patient encounters every year (150-200/day).
Wisconsin	
<i>Dane County Health Care Providers' Interpreter Services Group</i>	Eight health care facilities collaborate to provide interpreter services. Interpreter coordinators from each facility meet monthly, share a common list of interpreters, and jointly discuss issues.

RELATED PUBLICATIONS

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#523 *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (March 2002). Karen Scott Collins, Dora L. Hughes, Michelle M. Doty, Brett L. Ives, Jennifer N. Edwards, and Katie Tenney. This report, based on the Fund's 2001 Health Care Quality Survey, reveals that on a wide range of health care quality measures—including effective patient–physician communication, overcoming cultural and linguistic barriers, and access to health care and insurance coverage—minority Americans do not fare as well as whites.

#524 *Quality of Health Care for African Americans* (March 2002). Karen Scott Collins, Katie Tenney, and Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of African Americans.

#525 *Quality of Health Care for Asian Americans* (March 2002). Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Asian Americans.

#526 *Quality of Health Care for Hispanic Populations* (March 2002). Michelle M. Doty and Brett L. Ives. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Hispanics.

#532 *Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care* (March 13, 2002). Eric C. Schneider, Alan M. Zaslavsky, and Arnold M. Epstein, Harvard School of Public Health/Harvard Medical School. *Journal of the American Medical Association*, vol. 287, no. 10. In this article the authors report that among Medicare beneficiaries enrolled in managed care plans, African Americans are less likely than whites to receive follow-up care after a hospitalization for mental illness, eye exams if they are diabetic, beta-blocker medication after a heart attack, and breast cancer screening.

#492 *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (September 2001). Ruth T. Perot and Mara Youdelman. Using interviews conducted with administrators at federal health agencies, this report finds wide gaps between the goals of federal initiatives to eliminate racial and ethnic disparities in health care—such as Healthy People 2010—and the efforts of federal health agencies to collect and report data needed to help achieve these goals. The report provides the first comprehensive analysis of the policies and statutes governing the collection of health care data by race, ethnicity, and primary language.

Addressing Racial Disparities in Health Care Delivery: A Regional Response to the Problem (January 2001). Alan R. Fleischman and Emily B. Wood, New York Academy of Medicine. Copies are

available from the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029, Tel: 212-822-7222, E-mail: ewood@nyam.org.

Minority Health in America (2000). Carol J. Rowland Hogue, Martha A. Hargraves, and Karen Scott Collins (eds.). This book reviews findings from The Commonwealth Fund's 1994 *National Comparative Survey of Minority Health Care*, providing the documentation needed to assess the successes and failures of the current system with regard to minority health care and to chart productive directions for the future. Copies are available from the Johns Hopkins University Press, 2715 North Charles Street, Baltimore, MD 21218-4363, Tel: 410-516-6900, Fax: 410-516-6968, E-mail: www.press.jhu.edu.

Population Characteristics of Markets of Safety Net and Non-Safety Net Hospitals (September 1999). Darrell J. Gaskin and Jack Hadley. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 76, no. 3. This article reports that urban safety net hospitals disproportionately serve minority and low-income communities that otherwise face financial and cultural barriers to health care. Copies are available from the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029-5293.

Race, Gender, and Partnership in the Patient-Physician Relationship (August 11, 1999). Lisa Cooper-Patrick, Joseph J. Gallo, Junius J. Gonzales, Hong Thi Vu, Neil R. Powe, Christine Nelson, and Daniel E. Ford. *Journal of the American Medical Association*, vol. 282, no. 6. Copies are available from Genuine Article/Institute for Scientific Information, 3501 Market Street, Philadelphia, PA 19104, Phone: 1-800-336-4474 option 5, Fax: 215-386-4343, E-mail: ids@ininet.com.

#321 *U.S. Minority Health: A Chartbook* (May 1999). Karen Scott Collins, Allyson Hall, and Charlotte Neuhaus. This chartbook, which is intended to serve as a quick reference for currently available information on minority health, shows that minorities continue to lag behind whites on many important health indicators, including infant mortality rates, life expectancy, and health insurance coverage.

#300 *Community Health Centers in a Changing U.S. Health Care System* (May 1999). Karen Davis, Karen Scott Collins, and Allyson G. Hall. In this policy brief, the authors discuss how major changes in the health care system—the growth of managed care and an increasingly for-profit health care sector—affect the delivery of health services provided by community health centers. These centers have played a critical role in serving some of the most vulnerable populations for more than 30 years.

#311 *Medicaid Managed Care and Cultural Diversity in California* (March 1999). Molly Coye and Deborah Alvarez, the Lewin Group. The authors examine the effect of cultural competence contract provisions that were enacted in 1993 by Medi-Cal, California's Medicaid program. Analysis finds early promise in improving access to and understanding of health care services for low-income, non-English-speaking minority enrollees.

#314 *Employer-Sponsored Health Insurance: Implications for Minority Workers* (February 1999). Allyson Hall, Karen Scott Collins, and Sherry Glied. This report shows that disparities in minorities' health insurance coverage can be found across industries, occupations, and part- and full-time workers, and that no matter what the company size, minority workers are less likely to receive health insurance from their employer.