
OVERCOMING BARRIERS

To Providing Culturally Competent Healthcare

***Recommendations
for Strategic Healthcare Planning
for Charlotte-Mecklenburg's
Culturally Diverse
Community***

PREPARED BY THE

***Healthcare Task Force of the
Mayor's International Cabinet***



CHARLOTTE, NORTH CAROLINA

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INTRODUCTION

This report documents the challenges faced by Charlotte-Mecklenburg's growing immigrant population groups and by our healthcare organizations in accessing and providing quality healthcare. It has been compiled by the Healthcare Task Force, composed of healthcare professionals and both members and friends of our ethnic population groups under the aegis of the Mayor's International Cabinet. The objective of the position paper is to advocate for an interdisciplinary, systematic approach to deliver quality healthcare for Charlotte-Mecklenburg's culturally and linguistically diverse population groups.

The Mayor's International Cabinet wishes to thank the Healthcare Task Force Team responsible for the development and composition of this position paper. They are:

Conchita Bailey	<i>Mecklenburg County Health Department</i>
Sydney Barton	<i>Mecklenburg County Medical Society</i>
Monique Caselli	<i>Choice Translating & Interpreting</i>
Ngongo Elongo-Musafiri	<i>Zairean Community of Charlotte</i>
Janet Harlan	<i>Former Director of Inlingua</i>
Jesus A. Hernandez	<i>Nursing Instructor, RN, MSN, CS, FNP, Presbyterian Hospital School Of Nursing/Novant Health</i>
Denise Howard	<i>RN, MSN, FNP</i>
Carolina Jones	<i>Charlotte Chemical Dependency Center</i>
Marcia Lampert	<i>Director of Clinical Care Management, Carolinas Healthcare System</i>
Denisa Leach	<i>Former Chair of the International Services & Organizations Committee and Board of Directors, Mayor's International Cabinet</i>
Angelique Speight	<i>Metrolina AIDS Project/Caring for Families</i>



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In addition, critical contributions to the definition of community service issues and goals were made by the following members of the 1995-1996 International Services & Organizations Committee of the Mayor's International Cabinet (now the Community Services Committee):

Marian Beane, Henry J.Q. Donker, Nancy Elliott, Catherine Hansen, Janet Henderson, Sylvester Iheanacho, Kimm Jolly, Gloria Pace King, Pat Korry, Michelle Luhr, Wanda Montgomery, Glen Mowry, Jonas F. Mullins, Jr., Michael Nguyen, Wally Penilla, Ralph Peters, Margaret Pierce, Amy Pitts, Kathy Raynon, Jim Schoen, Eugene Shipman, Kay Smith, Elizabeth Thurbee, Elaine Turner, John Wallace and Bruce Wolven.

Other individuals whose contribution of time and effort assisted in the development of this project include:

Lorne Lassiter, 1998 Chair, *Community Services Committee of the Mayor's International Cabinet*

Cindy Stringham-Smith, Executive Director, *Mayor's International Cabinet*

Will Mattison, Intern, *Mayor's International Cabinet, Student, University of North Carolina at Charlotte*

EXECUTIVE SUMMARY

The Charlotte-Mecklenburg community can no longer be defined in terms of black and white. During the last ten to fifteen years, a tremendous growth of diverse population groups has graced our area with the many colors and cultures of other countries. The largest and fastest growing foreign population groups in our area are Hispanics and Southeast Asians, especially Vietnamese. In 1998, there were estimated to be approximately 40,000 Hispanics and 10,000 Vietnamese in Charlotte-Mecklenburg, with demographers predicting these numbers to increase dramatically into the next century. Attracted by our prosperous economy, quality of life, and an already strong concentration of foreign born residents, these and other foreign population groups will continue to move to the Charlotte area.

A large immigrant population presents our community with a number of benefits, as well as with a number of challenges. Certainly our nation has prospered from the multicultural diversity of its people. At the same time, our social service, medical and educational systems are being challenged to adequately meet the needs created by so many foreign born residents. In fact, hospitals are often the first line of response in meeting the healthcare needs of immigrants. Some of the challenges hospitals and healthcare providers face include: language barriers, differences in values and beliefs, and legal standards/requirements.

In order to assist healthcare organizations in determining how effectively they are meeting the needs of diverse client groups, this report includes a comprehensive **Self-Assessment** survey. The **Goals** section of this report identifies the areas that local healthcare providers need to address to deliver appropriate healthcare to all residents of Charlotte-Mecklenburg. The **Rationale** section explores each of the challenges cited above in greater depth and provides examples of difficult, and often dangerous situations caused by the failure of our healthcare system to meet these challenges.

Immigrants have the responsibility to learn English as their second language. However, learning a new language and adapting to a culture vastly different from one's own takes time. As new immigrants continue to arrive, our community will be confronted with even greater challenges in helping immigrants bridge the gaps of language and culture in order to provide cost-effective and safe, quality healthcare.



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The objective of this report is to advocate for an interdisciplinary systematic approach – a very deliberate, proactive, purposeful plan - to deliver quality healthcare to our growing linguistically and culturally diverse residents.

There is no desire on the part of the authors of this paper to find fault or to blame our community's healthcare institutions. In fact, there are varying degrees of awareness about the size and dramatic growth of our immigrant population groups. After all, the demographic shifts have happened rather quickly. In addition, it is recognized that our hospitals and other medical agencies are already taking some actions to help bridge language and cultural barriers. Some of these initiatives have included:

- development of databases of employees with foreign language skills;
- classes on cultural sensitivity and foreign languages;
- surveys of how and when departments are using interpreters and problems encountered;
- occasional use of skilled professional interpreters;
- creation of cultural diversity departments or committees.

Charlotte-Mecklenburg healthcare institutions have initiated many efforts in an attempt to effectively serve our diverse population groups, but many more opportunities still exist.

The objective of this report is to advocate for an interdisciplinary systematic approach – a very deliberate, proactive, purposeful plan - to deliver quality healthcare to our growing linguistically and culturally diverse residents. There is foundation support available for such efforts. For example, the Duke Endowment, in the spring of 1997, launched an initiative to assist hospitals and communities in addressing social and cultural issues which inhibit access to healthcare for Hispanic and Asian/Pacific Island immigrants. The objectives of this program have been to encourage hospitals to provide high quality, accessible care to these often overlooked segments of our population, and to encourage other community service providers to work with each other, and with local hospitals, to provide a coordinated continuum of quality care.

The ***Options*** section of this paper offers additional suggested actions which can help bridge the language gap and improve communications throughout the continuum of healthcare. This section includes ideas drawn from the experiences of hospitals in larger cities. They include the creation of a community interpreter program, the regular use of skilled medical interpreters, and the recruitment and hiring of minority and multilingual health professionals.¹ The ***Options*** section also offers suggestions in the development of cultural sensitivity and cross-cultural competence. Successful examples of options can be drawn from other cities which have dealt with similar challenges by creating professional client representative positions to serve as interpreters, and cultural liaisons between immigrant families and hospital staff.²

In the interest of patients' rights, we suggest actions to help

¹ Woloshin S., Bickell, N.A., Swartz, L.M., Gany, F & Welch, H.G. (1995) "Language Barriers in Medicine in the United States." *Journal of American Medical Association (JAMA)*, 273 (9), (724-728.L) p. 726

² Friedman, E.C. (1992) "America's Growing Diversity: Melting Pot or Rainbow?" *Healthcare Forum Journal* 1, 10-14 pgs. 12 & 14.

providers ensure the rights of clients with regard to access to healthcare, treatment and respect. The ***Evaluation: Measurements of Success*** section will help organizations gauge progress along the way. The ***Resources*** section includes a list of organizations, language services, training programs, and internet sites which can help in providing quality, culturally competent care. The ***Appendices*** section, containing references and a glossary of terms, is provided to help with further exploration. This section also contains an important memorandum from the Office for Civil Rights regarding patients and healthcare.

As the population of Charlotte-Mecklenburg continues to grow, it will become increasingly diverse. It is important to recognize that the differences in language and culture among our population cause barriers to accessing and providing quality healthcare for all. There are significant costs already embedded in the process of care that our healthcare institutions and providers should consider, and which would easily justify the cost and routine use of skilled interpreters. The adherence to existing laws and ethical codes in order to preserve the worth and dignity of all peoples needs to be considered as well.

We as a community have the responsibility to help our foreign-born residents bridge the language gap by providing skilled medical interpretation and cross-cultural competence in healthcare. This position paper is offered to assist and support our community's healthcare providers to begin to develop a very deliberate approach to meeting the healthcare needs of our growing body of immigrant residents, while providing cost-effective and safe medical care.

SELF-ASSESSMENT

Language is often the first barrier encountered when working with people from other countries. Although it is only one element of culture, it is an important one. It is necessary to create an environment where your clients and staff are able to communicate effectively.

This assessment is to be used as a guide for planning services needed to communicate with non-English speaking clients in your healthcare setting. This survey has not been tested for validity or reliability.

DIRECTIONS

Answer all questions. Circle the answers which accurately describe your healthcare setting. After you have completed the survey, tally the numbers which have been identified with each response. Refer to the scale on the last sheet of this assessment as a guide.

Circle the appropriate answer for each question.

1. There are written policies in place which address the needs of the non-English speaking populations.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

2. Policies, procedures, and guidelines are currently in place to evaluate the need for an interpreter.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

3. When a patient who does not speak English pre-schedules an appointment, we make special provisions ahead of time for an interpreter.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

4. Directions and information signs displayed incorporate the major languages spoken in our community.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

5. Children or minors are not used to interpret or translate medical client information.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

6. Informed consent including treatment, diagnostic, financial information, research and Patients' Rights documents are available in all major languages.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

7. Discharge instructions and information regarding medical appointments are written simply in the major languages spoken in our community.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

8. Staff training and education has been presented on cultural diversity issues such as the prevailing beliefs, customs, and values of the ethnic communities we serve.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

9. There are materials and resources in major languages and an agency glossary of technical and healthcare terms which can be used for interpreting and translations.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

10. Written policies and procedures are in place to protect the confidentiality of the non-English speaking client. Family members or non-agency personnel are not used to interpret without a client's permission.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

11. Information and community resources on interpreter services are up to date, on site, and accessible to employees.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

12. Client satisfaction surveys and grievance procedures are available in all major languages.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

13. Non-English speaking clients are informed on how to communicate their concerns to a representative in our organization.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

14. The reception areas in our healthcare setting include magazines and books which reflect the ethnic communities we currently serve.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

15. When a client enters our system for services, there is an admission database which includes an assessment of a client's cultural identity and healthcare practices.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

16. There is a process in place to assess the ability of non-English speaking clients to read and understand documents that are written in their native language.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

17. Family members and friends are rarely used as interpreters in our healthcare setting.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

18. Bilingual members of our staff have been given training on medical terminology and can serve as interpreters.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

19. Our organization is actively recruiting multilingual, multicultural healthcare professionals.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

20. There is a process in place to assess the competency of interpreters and translators.

5 4 3 2 1
Always Frequently Sometimes Infrequently Never

Total number of points: _____

This scale is to be used as a guide.

If your score was:

100-90: Your organization is basically doing an excellent job of meeting the needs of the non-English speaking population.

89-70: Your organization is meeting some of the basic needs of the non-English speaking population and may need to look at the specific issues that were scored at 3 or below. Would recommend collaborating with other healthcare providers to get ideas on how they may have already met these needs and utilize the resources included in this handbook for further information.

69 or below: Your organization needs to step back and look at developing a strategic plan for meeting the basic needs of the non-English speaking client when they enter your healthcare setting. This plan can include information on accessing interpreters, developing a resource file on local resources, providing education for staff on cultural diversity and healthcare issues, and translating key documents in the languages most frequently needed.

GOALS

In developing a purposeful and proactive strategic plan to deliver not only adequate, but also appropriate healthcare to all of the residents of Charlotte-Mecklenburg and the surrounding region, healthcare providers should consider adopting the following goals:

- Improve communications throughout the entire continuum of healthcare for the Charlotte region's linguistically and culturally diverse.
- Ensure quality, accessibility and cost-effective healthcare for all segments of the Charlotte region's diverse population, including the elimination of unnecessary diagnostic tests or treatments.
- Provide individualized, culturally competent healthcare in an ethical, professional, culturally sensitive manner.
- Safeguard the rights of healthcare clients in the

RATIONALE

Background

If you look around you, you will see the changes in black and white, brown, yellow and red. As perhaps the largest wave of immigration this century has seen hits the United States, International House of Metrolina, Inc. estimates that living in Charlotte-Mecklenburg today there are an estimated 100,000 foreign-born residents – a higher concentration (*one in eight*) than for the United States as a whole (*one in ten*³). According to 1997 figures, 9.6% of US residents were born elsewhere.⁴ These numbers are projected to increase dramatically throughout this decade and into the next century. What makes the current immigration wave unique is that 80% of the newcomers are non-European.⁵

Demographers predict that between the 1990 and 2000 census the Hispanic population in this country will increase by 53%, and the Southeast Asian population by 65%. The Census Bureau just released figures revealing that there are already more Hispanic than African-American children in America.⁶ By the year 2005, projections are that Hispanics will be the largest minority group in the United States.

Challenges

These population shifts have caused a dramatic impact on our economy, real estate development and education systems. This demographic information also demands attention because of the shifts in present and potential customers accessing the healthcare system. Immigrants need medical services and face a number of barriers in obtaining adequate healthcare. These barriers include a lack of insurance, primary care providers, awareness of and trust in the US healthcare system, involvement of the family in decision-making, and a tradition of folk medicine or a preference for self-treatment. There are numerous other hurdles in obtaining quality care: lack of transportation; limited hours of service at healthcare facilities; difficulty getting time off work; and long waiting periods at clinics. With all these difficulties, it should come as no surprise that minority groups have historically demonstrated poor health status and an under-utilization of healthcare services.⁷

³ U. S. Census Bureau, 1997 data

⁴ CNN interactive at CNN.com. April 9, 1998 US News Story Page

⁵ CNN interactive at CNN.com. April 9, 1998 US News Story Page

⁶ Meckler, L. (1998, July 15). Hispanic kids outnumber black kids. The Charlotte Observer, pp. A4.

⁷ Woloshin p. 727

It is important to understand that hospitals will often be the first line of response for meeting immigrants' medical needs. The challenges that healthcare providers will face include:

- *Language barriers that affect the ability of the healthcare provider and the linguistically diverse to communicate.*
- *Increased costs inherit in the current process of care of linguistically and culturally diverse customers.*
- *Very different value and belief orientations between the culturally diverse customer and western medical organizations regarding health and wellness, leading to conflicts in resolving health problems.*
- *Legal and professional standards of care mandated by governing bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), that may well be overlooked and not maintained.*

The following sections will explore each of these challenges in greater depth. Difficult, and at times dangerous, situations have occurred in our community and around the country when encountering these obstacles to quality healthcare. Given the size and dramatic growth of the area's foreign born, it is our responsibility as a "world class" community to promptly develop a deliberate and purposeful plan to help our increasingly diverse residents bridge the barriers of language and culture to obtaining first-rate healthcare.

A significant percentage of the residents of Charlotte-Mecklenburg (*estimated to be as high as 34,000⁹*), do not speak English or have very limited English proficiency. The vast majority of healthcare providers in the area do not speak any other language as fluently as they do English. Consequently, when the healthcare provider and the linguistically diverse meet, language will always be a major barrier in providing safe medical care. The importance of effective communication is never so crucial as in the areas of healthcare and emergency services. In the initial encounter, the ability of the healthcare provider to interview the client and obtain a complete history is vital to assist in deriving an accurate diagnostic statement. Consider the following scenario:

✦
Language Barriers

**“What the Scalpel is to
the Surgeon, Words are
to the Clinician...
the Conversation
Between
Doctor and Patient
Is the
Heart of the
Practice of Medicine.”⁸**

⁸ Woloshin p. 724

⁹ U.S. Census Bureau, 1995 data

A recently arrived Hispanic couple living in Monroe is on the way to a Charlotte emergency room with a screaming infant son whose belly is distended. Neither the husband nor wife speaks English, but a professional Spanish interpreter in Monroe has been contacted. The interpreter calls the hospital to tell hospital staff that the couple is on the way; she will be glad to interpret for free if the hospital personnel would call her when the couple arrives. Her help is refused. No one on duty in the emergency room speaks Spanish, and they are unable to interview the couple and discover that the baby has been unable to urinate. Instead the couple and their son are shunted off to an examination room and wait for a prolonged period of time. While the medical situation might not have been life threatening, it was quite serious and caused great emotional upheaval for the parents.¹⁰

Language barriers present formidable hurdles in accessing and receiving quality healthcare. While professional interpreters are common in business and diplomacy, and are required by law in federal courts, they are still rare in healthcare. Instead, the medical field relies on three sub-optimal methods to communicate.¹¹ One method may involve clinicians attempting to use their own limited language skills, frequently using hand gestures and speaking loudly, rather than more slowly and without jargon. This method compromises information transfer and distracts the provider's intellectual focus from clinical thinking. A second common method is to enlist the help of the patient's family members, friends, or ad-hoc bilingual strangers. Yet, observational studies have shown that such sources translate words or phrases incorrectly 23% to 52% of the time.¹² For someone called away from his regular job responsibilities, interpreting might represent an unwelcome, unpaid burden, and the individual may not feel totally committed to the task. Furthermore, medicine has a technical and scientific language which demands clarity and specificity in translating. Ad-hoc recruited volunteers may lack sufficiently acceptable language skills and may not have an understanding of the language of medicine. Such volunteers frequently commit stereotypical errors, omissions, additions, and substitutions that result in serious semantic distortions.¹³ Furthermore, soliciting the help of volunteer interpreters, especially family or friends, can also undermine patient confidentiality, which is a right guaranteed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A third method for communicating is enlisting the help of children in language translation. This can be upsetting for children, however, as they may

¹⁰ Anecdote relayed by Petra Tousing, Union County CATI interpreter, 1995

¹¹ Woloshin p. 724

¹² Woloshin p. 724

¹³ Woloshin p. 724

be exposed to very sensitive, often distressing information that not only disrupts the family's social order, but can also compromise care.

Consider the following scenario:

A 50-year-old female peasant from Mexico comes to a medical clinic, accompanied by her 35-year-old son. She has been treated at this clinic before, and her son usually interprets because he is fairly fluent in both languages. This time a professional interpreter has been called because the son must go to work.

“Before going in to the room, the physician expresses to me his concern about whether the health problems claimed by this woman are real or imagined. She has been in the clinic three times before, each time with different vague and diffuse complaints, none of which make medical sense. As we learn, the poor woman has a fistula in her rectum. In her previous visits, she could not bring herself to reveal her symptoms in the presence of, and therefore to, her son as he interprets for her. She tells me that she has been so embarrassed about her condition that she has invented other symptoms to justify her visits to the physician. She confesses that she has been eager to have a hospital staff interpreter from the first visit, but her hope had not materialized until now.”¹⁴

Language barriers can also impair communication from the physician to the patient, thereby impacting patient education as well as shared decision making. If patients misunderstand instructions, proposed care is undermined. Language barriers consequently result in poor compliance, inappropriate follow up, patient frustration and potentially life threatening situations.

“In another case, a 70 year old Cuban woman was being discharged from the hospital into the care of her daughter, also a non-English speaking resident of Cuba. The woman's granddaughter was doing the interpreting, as she had throughout the hospital stay with reasonable success. The young girl thought she did a good job of clearly explaining the discharge instructions, but her aunt, the person for whom she was interpreting, did not understand that the grandmother's medication was to be tapered off. Instead, after release from the hospital, the aunt cut back the dosage suddenly. This error was discovered only when the patient returned to the hospital very ill with other complications.”¹⁵

¹⁴ Haffner, L. (1992). Translation is not enough: Interpreting in a medical setting. *Western Journal of Medicine*, 157 (3), 255-259.

¹⁵ Haffner p. 258

When pressed for time, it is tempting to forge ahead and “make do,”

relying on dimly remembered high school Spanish and a family member's broken English. But a little Spanish or Vietnamese and broken English is inadequate for proper medical care. There are clear clinical impacts for inadequate interpretation. The potential for misdiagnosis, delays in treatment leading to acute situations, poor compliance – all result in poor quality of care. Moreover, patient frustration and dissatisfaction may well lead to avoidance of routine care and delay of needed care, causing the patient to enter the system at more advanced stages of disease. In order to avoid these costly mistakes, healthcare providers must create an environment where non-English speaking patients can communicate with properly trained personnel and receive the best possible healthcare available.

Costs

The cost of professional interpreters is frequently cited as the reason why trained medical interpreters are not routinely used in the process of care. Little thought has been given to the higher costs already embedded in the process of treating our immigrants with whom there are language and cultural barriers. Consider the following scenario:

Mr. Vasquez is a 35-year-old Mexican male who has been living in Charlotte for one year. Mr. Vasquez speaks very little English. He has been working odd jobs in construction for the past two weeks. One day while working, Mr. Vasquez vomits, grabs his chest and points. Standing beside Mr. Vasquez is Mr. Jones, another construction worker. Mr. Jones observes Mr. Vasquez vomiting and pointing to his chest, and drives his co-worker to the hospital emergency department. Mr. Jones and Mr. Vasquez are unable to communicate with one another due to a language barrier. Upon arrival at the emergency department, Mr. Jones explains what happened to the nurse triage, and Mr. Vasquez is immediately taken into an examination room to be assessed by a nurse and physician. Neither the nurse, nor the physician, speaks Spanish, and due to this inability to communicate, they are unable to obtain a history from Mr. Vasquez. The physician orders the following:

Procedure	Charges
Stat EKG	\$120.00
Stat CPK Isoenzymes	75.00
Electrolytes	45.00
CBC	35.00
Stat Portable Chest	<u>120.00</u>
Total Charges	\$395.00¹⁶

¹⁶ 1997 Observational Study charges (cost figures for 1998-1999 have remained stable)

The EKG, electrolytes, and CBC are normal. The chest x-ray indicates that Mr. Vasquez has a hiatal hernia. One and one half hours later a nurse who happens to speak Spanish comes on duty. The nurse talks with Mr. Vasquez and finds out that he has a history of a hiatal hernia and has been on medication. Mr. Vasquez is given a GI cocktail, at a cost of \$50.00 and discharged from the emergency department.¹⁷

In this very typical situation, the hospital ordered unnecessary tests to assist the physician in making an appropriate diagnosis. The extra lab work resulted in direct costs that were almost eight times higher than necessary. In addition, extra costs also were incurred for the lengthier engagement of the emergency department and the additional amount of time the physician and the nurse had to devote to Mr. Vasquez. Had an interpreter been employed at an approximate hourly cost of \$35, not only would treatment have been delivered appropriately and rapidly, but the hospital would have saved \$310 in lab work alone! Clearly the cost of excessive lab work more than justified the presence of a medically trained interpreter.

Resource time is of significant importance. A non-scientific observational time study conducted at one of our area hospitals revealed that language barriers cause healthcare providers to tie up resources two to four times longer in attempts to communicate.¹⁸ The purpose of the study was to compare the length of time necessary for a nurse to obtain a history from a non-English speaking client versus an English speaking client. This observation occurred during a one-week period. The amount of nursing time required for the non-English speaking client compared to the English-speaking client increased by 100% (from 20 minutes to 40 minutes). In questioning the nurses as to why the history took longer, their responses were that the increased amount of time was due to the language barrier. This increased time impacts actual nursing hours per client. The outcome of the study also reflects an increase in clients' waiting time, feelings of frustration on the part of nurses and clients, and overtime expenses for nurses to complete a clinic. Not only are there additional direct costs to the institution due to overtime, but there is also additional indirect costs due to increased client waiting time. Increased waiting time, along with the frustration of difficult communication, can result in client dissatisfaction. Dissatisfaction, as stated earlier, can affect clients' willingness to return for services on future occasions. It may also cause clients to delay care until the ailment is at an acute stage, which could require expensive emergency room treatment.

¹⁷ Anecdote relayed by Denise Howard, nursing instructor, Carolinas Healthcare Systems, 1997

¹⁸ Observational study conducted at CMHS, 1996

In summary, unnecessary costs, attributable to current methods of treating our non-English speaking residents, can be quantified as follows:

- *Extra lab tests to diagnose the problem;*
- *Extra time to obtain a history and treat the patient;*
- *Nursing overtime costs;*
- *Increased use of the Emergency Room rather than health clinics.*

Cultural Barriers

“The challenge to health care – change resistant as it tends to be – is not to try to paint the rainbow white but rather to celebrate the growing explosion of colors and cultures, and to find its appropriate place in the expanding spectrum of who we are.”¹⁹

It appears that the total costs of continuing current methods of treating our foreign born residents have not been adequately considered. It is also apparent that as well as monetary costs, the quality of healthcare is impacted.

Hispanics, Southeast Asians, Russians, Africans, and other non-English speaking new residents form the latest groups of refugees and immigrants dealing with the challenges of the Western medical care system. But, as many African-American, Native American, and earlier immigrant populations have known for decades, the barrier of language is not the only barrier to receiving high quality healthcare. Perhaps an even larger barrier is the cross-cultural barrier which exists between provider and patient. Language interpretation, preferably by a qualified medical interpreter, is only a first step in providing quality care. Confusion can occur even when verbal and written communication is accurate.

Providing effective medical care and treatment requires understanding not only what patients say, but also what they mean when they say it. Cultural values and beliefs influence an individual's behavior toward health and illness. “There is always a cultural negotiation that goes on in the physician's office about what he thinks is going on and what the patient is willing to accept.”²⁰ Doctors may be regarded with exaggerated awe, distrust, or a mixture of both.

For example, a healthcare provider may encounter a Russian patient who has dismissed the physician as a “ninny” because of her casual dress and friendly bedside manner. In another case, a nurse may encounter a Vietnamese patient who has cut his medication in half, convinced that American medicine is too strong for his smaller body size. In yet another hospital room, daughters of an elderly Nicaraguan woman may not follow the doctor's instructions to tell their mother of her serious condition and need for radical surgery, believing it will rob her of hope. A Haitian woman may refuse to allow a blood test,

¹⁹ Friedman, E. C. (1992) America's growing diversity: Melting pot or rainbow? *Healthcare Forum Journal* 1, 10-14, p. 14

²⁰ Goode, E.E. (1993, February 15). “The Cultures of Illness.” *US News and World Report*. p. 75.

because she is afraid that her blood, which holds part of her soul, could be used for sorcery. What is clear in all these cases is that a lack of cross-cultural competence can cause frustration and misunderstanding, directly impacting the quality of care immigrant patients will receive. Understanding a patient's culturally determined disease model can be crucial to providing adequate care.

“Consider that culture is central to:

- *How people organize their experiences*
- *How patients seek assistance*
- *What patients define as a problem*
- *What patients understand as the causes of illness*
- *How the patient views his or her symptoms*
- *How hopeful or pessimistic a patient is about recovery*
- *What attitudes a patient has towards sharing emotional problems or pain*
- *Expectations of treatment*
- *What is perceived to be the best method of treatment.*²¹

A group's learned and common values, beliefs, norms, practices, direct thinking, decisions, and patterns of behavior impact attitudes towards healthcare. In some cultures, the extended family makes decisions about whether the individual is sick, about how to seek care, and about choosing the appropriate treatment. In other cultures, folk healing practices are quite common and may be consulted first, utilizing Western medicine only when all else fails. The following situation provides an example of Mexican-American folk-healing and the potential conflict with traditional healthcare.

“... a non-Hispanic caseworker recommended the removal of a Mexican-American boy from his family because of potential physical danger. The assessment indicated that the child in question was ill and in need of medical care, but the mother had obvious emotional problems and appeared to be irrational; the mother had kept on saying, in broken English, that she could not allow any evil spirits to come near her child and had locked the child in his room, hung from the ceiling a pair of sharp scissors just above his head, and would not allow anyone, including the caseworker and the doctor, to enter the child's room.... The mother explained that she had used several home remedies to help her child's fever go away, but evil spirits had already taken possession of

²¹ Torres, S. (1993). “Cultural Sensitivity: A Must for Today's Primary Care Provider.” *Advanced for Nurse Practitioners* 1 (4), p. 17.

her child and the usual remedies no longer helped. The only thing left to do was to prevent new spirits from entering the child's body."²²

A Mexican-American worker familiar with folk-healing practices was asked to intervene. She acknowledged the validity of the woman's beliefs, and offered her another way to consider the situation.

*"She told the mother that although she had not seen anyone use this cure before she had heard her grandmother talk about it. To protect the patient and his or her entire surroundings, however, the grandmother usually nailed the scissors on the room's entrance door. The worker explained that, should the spirits attach themselves to anyone who wished to enter the room, the scissors on the entrance door would immediately prevent them from doing so and thus provide stronger protection to the patient. The Mexican-American worker went on to ask the mother if this made sense to her. She asked the mother if she thought this would be more beneficial since it would allow her child to be seen by the caseworker and the doctor. The mother agreed and emphasized that she wanted only what was best for her child. They changed the location of the scissors and welcomed the caseworker and the doctor to examine the child."*²³

While the above example is an extreme one, folk healing is a reality within our community. It needs to be considered a strength and a resource when serving individuals of certain cultures. View folk healing as an opportunity to build rapport and trust with the patient.

In other cultures, different belief systems may cause additional, unexpected behaviors. Time orientation may affect the behavior of patients and their willingness to consider preventative care or compliance with treatment. Some may rely on herbal medicine or religious prayer and traditional rituals of cleansing, causing conflicts with traditional medicine. However, appealing to a patient's roots may be the most effective means in treating those more comfortable and familiar with folk healing practices.

²² Krajewski-Jaime, E.R. (1991). "Folk-Healing Among Mexican-American Families as a Consideration in the Delivery of Child Welfare and Child Health Care Services." *Child Welfare* LXX (2) pgs. 158-159.

²³ Krajewski pgs. 158-159.

"Take the case of a Cambodian woman who came to Faust's clinic complaining of headaches, back pain and disturbed sleep. The woman, born in a rural province, had been raped repeatedly by Khmer Rouge soldiers, lost her husband and older brother to the Pol Pot regime and

witnessed her sister-in-law's brutal murder. Doctors tried treating her with antidepressants, sedatives and psychotherapy, but nothing seemed to help. Finally, the staff thought to bring in priests from a Buddhist temple to conduct a banskoi, a ceremony for the loss of the dead. The service, allowing the woman to mourn her loved ones in a traditional ritual, helped more than any Western prescription."²⁴

In summary, the "lack of cultural sensitivity, lack of cultural diversity in the workplace, and lack of cultural competence directly impacts the quality of care patients receive. The well-documented poor health status of African-Americans, Hispanics, and Asian Americans is a direct reflection of these issues. Not being culturally competent as a healthcare provider or institution results in miscommunication, inappropriate diagnoses and treatment plans, alienation and frustration on the part of the provider and patient, and poor utilization of resources, including use of the Emergency Department as a primary care facility. Resources are wasted, programs are not cost effective, patients are non-compliant, and care of chronic illnesses such as hypertension or diabetes suffers tremendously."²⁵ The development of cultural sensitivity and cross-cultural competence in healthcare creates the opportunity to deliver quality care and good patient outcomes to all of our community's residents.

Professional Standards and Legal Considerations

In a medical context, accurate communication is paramount to basic quality healthcare services, and misunderstandings can be dangerous, expensive, and potentially tragic. We have discussed the language, cultural and cost issues that come in to play in providing services to recent immigrants. However, there are also legal and professional standards of care mandated by governing bodies that must be carefully considered in providing healthcare services to our culturally and linguistically diverse population.

From a legal standpoint, there are various laws that dictate equal access to quality healthcare for all people. First, is Title VI of the Civil Rights Act of 1964 (see Appendix C), which states that "no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefit of, or be otherwise subject to discrimination" under any federally supported program. The Office for Civil Rights extended this protection to language, as a fundamental characteristic of national origin,²⁶ and the implementing regulation

²⁴ Goode, pg. 75.

²⁵ Walker, P.F. (1994). "Delivering Culturally Competant Care in a Multicultural Society: Challenges for Physicians." *The HCMS Bulletin* 66(4) p. 9.

²⁶ Woloshin, p. 725.

of the statute (45 C.F.R. 80) cites the example of failing to provide interpreter services as a clear violation of Title VI.²⁷ The Civil Rights Office requires that all Department of Health and Human Services' funded health programs provide patients who have limited ability in English access to services equal to those provided to English speakers. There is a risk of losing all federal funds, including Medicare and Medicaid payments, if health programs do not comply.

However, Title VI of the Civil Rights Act is not the only compelling legal argument. Additional mandates for interpreter services are cited in other laws, including the Disadvantaged Minority Health Improvement Act of 1990 (PL 101-527) and the Patient Self-Determination Act (PSDA) also passed by Congress in 1990. PSDA confers on the patient the right to have certain kinds of information and to agree to or refuse treatment upon admission to a healthcare institution or program, provided the institution or program is supported in some way by Medicare or Medicaid.²⁸ True informed consent, as opposed to a paper shuffling exercise, is at best a very difficult process across the huge chasm of language and culture without skilled medical interpretation.

In addition to laws, there are existing ethical codes and professional standards that require better quality healthcare services than are currently and consistently being provided in our community to the culturally and linguistically diverse. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) addresses meeting the needs of these individuals in its discussion of Patients Rights and Organizational Ethics. In this section of the Accreditation Manual for Hospitals, JCAHO seeks to improve client outcomes by assuring that the rights of all clients, regarding access, treatment, and respect, be protected, regardless of cultural values or the ability to speak English.²⁹ As we have discussed, access to healthcare is tenuous at best across the divide of language and culture. Treatment is compromised when cultural values and beliefs are misunderstood or ignored. Respect and patient confidentiality are undermined when patients are forced to use bilingual family or friends. The Joint Commission expects full compliance with these standards, and full hospital accreditation depends on it. Are we only paying lip service to these standards?

²⁷ Berg, C. (1994). "The Language Link: How to Remove the Communication Barrier." The HCMS Bulletin 66(4), p.17.

²⁸ Ulrich, L.P. (1994). "The Patient Self Determination Act and Cultural Diversity." Cambridge Quarterly of Health Care Ethics 3(3), p. 410.

²⁹ Joint Commission on Accreditation for Health Care Organizations. (1995). 1996 Comprehensive Accreditation Manual for Hospitals. Oakbrook Terrace, IL.

Conclusion

Our population in Charlotte-Mecklenburg has changed dramatically during the last ten to fifteen years. We are extremely diverse, with a concentration of foreign-born residents higher than that of the United States as a whole.³⁰ Demographers predict that our country and our region will get increasingly diverse as we progress into the next century. It is important that our new, foreign-born residents learn English. In the meantime, it is necessary to recognize that language and culture represent huge barriers to accessing and providing quality healthcare. There are significant costs already inherent in the process of care that our healthcare providers and institutions appear to not be taking into account, costs that would easily justify the fees and routine use of skilled medical interpreters. The adherence to existing laws and ethical codes in order to preserve the worth and dignity of all peoples need to be considered as well. We, as a community, have the responsibility to help our new residents bridge these barriers by providing skilled, qualified, medical interpretation. In Charlotte, providing skilled interpreters would be a significant first step in bridging these barriers.

³⁰ U.S. Census Bureau, 1997 data.

OPTIONS

Options are suggested actions that agencies individually may choose to meet the stated goals. Many have been implemented successfully by healthcare agencies across the country. The options are listed from initial minimal solutions to advanced optimal solutions.

A. Patient Rights

1. Provide culturally diverse patients with key documents, such as the Patient Bill of Rights, advanced directives, informed consent, research study consent, and agency mission statement and grievance procedure in patient's native language.
2. Display in public areas the Patient Bill of Rights, information and directional signs, and interpreter and translator services provided by agency all in the major foreign languages of the community (*in Charlotte, Spanish and Vietnamese represent the two largest ethnic groups*).
3. Inform culturally diverse patients of healthcare access and patient rights using multiple and public service announcements.
4. Incorporate language that supports equal access, nondiscrimination protection of client rights, cultural diversity, and transcultural healthcare into agency's mission and values statement.
5. Network with major healthcare agencies in the community to develop patient documents, teaching materials, and an automated health information line in major languages in the community (*Spanish and Vietnamese*).
6. Explore financial incentives from federal, state, and local governments as well as private foundations or endowments that support protection of client rights, equal access, non-discrimination, and cultural diversity.

B. Cultural Competency

1. Use current data to maintain an ongoing assessment of Charlotte-Mecklenburg's growing culturally diverse population for community and agency health planning, needs assessment, and staff development.
2. Recognize that individuals from different countries who speak the same language may have different cultural values.
3. Implement a staff orientation/development curriculum which addresses cultural diversity/sensitivity, communication and transcultural healthcare, and incorporates special needs for child health, obstetrical/gynecological/sexual health, mental health and chemical dependency, terminal care and nutrition. (*Examples include Texas Children's Hospital, and San Diego Medical Center at the University of California*).
4. Incorporate patient's healthcare needs, cultural values, preferences, perceptions and special communication needs into agency admission documents and/or health databases.
5. Actively recruit a multilingual and multicultural workforce, especially for high need areas such as emergency transport, emergency department, health clinic, admissions, and discharge planning, home health and outpatient services.
6. Develop a professional client representative position or identify agency departments and/or individuals that are accountable for assuring quality healthcare for Charlotte-Mecklenburg's culturally diverse population, including patient advocacy, interpreter and translator services, teaching, counseling and referrals, customer complaints and concerns, staff development and data analysis.

C. Communication

1. Encourage patient to bring, if possible, their own professionally trained medical interpreter. Never use children, family members or untrained agency staff or translators for sensitive, confidential patient health information in order to prevent misinterpretations or cultural misunderstandings. While no national standards describing a “professionally trained” medical interpreter currently exist, one working in this field should be skilled in certain areas, including being fluent in both of the given language pairs as well as the ability to facilitate understanding between two people who are speaking different languages. A professionally trained medical interpreter should also continue to improve their medical terminology and procedures as well as participate in the various medical interpreting seminars and programs available.
2. Assess patient’s ability to read or understand complex health information in his or her own language. Always speak in the first person in order to build the patient/provider relationship and to keep clear on who is talking. The interpreter should also verify that the patient understands what is told to him or her by pausing frequently to ask if they have any questions or comments for the provider.
3. Demonstrate sensitivity to the patient’s privacy and choice of who should act as interpreter. Encourage the idea of a “pre-session” between interpreter, provider, and patient where basic introductions are made and reassurances are secured regarding confidentiality before the appointment begins. Obtain written informed consent from the patient before divulging confidential information to an interpreter.
4. Assure accessibility to trained interpreters and translators by maintaining an updated community directory of professional interpreters, community agencies for communication services, and intra-agency resources. Verify competency of non-professional interpreters before using them as resources.
5. Provide written health instructions as well as maps or directions to agencies in major languages.
6. Provide translation of material and resources in major languages and an agency glossary of healthcare and technical terms that can be used for interpreting and translation.

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7. Access AT&T Language Line, for example, for simple interpretation where counseling is not required and other services are not available.
 8. Recognize that miscommunication may lead to delays, inefficiency, unnecessary diagnostic tests, misdiagnosis, increased length of stay, litigation, and increased costs.
 9. Update agency interpreters with latest information on medical interpreting and translation to maintain effectiveness.
 10. Offer interpreting and medical terminology programs to bilingual personnel to develop interpreting and translation skills.
 11. Develop contacts with professional interpreting skills and translation agencies to provide services when needed.
 12. Recruit and train college students to become competent interpreters in exchange for college tuition.
 13. Offer English as a Second Language class as a forum for health education.
 14. Increase the number of minority and multilingual health professionals as a means of improving access to healthcare and communications.

EVALUATION: MEASUREMENTS OF SUCCESS

The health care industry has many methods, tools, and techniques available in quality management for improvement to validate that desired outcomes are being achieved. Several of these processes may be utilized to gauge if options were effective and set goals were met. These may include:

1. Revise patient satisfaction questionnaire to inquire about satisfaction with protection of patient rights, provision of culturally competent care, communication, and appropriate use of interpreters.
2. Follow-up on any patient complaints related to communication, patient rights, or culturally competent care maintaining records on their incidence and trends.
3. Conduct random patient record audits of linguistically and culturally diverse clients for evidence of informed consent, individualized assessments, incorporation of cultural preferences in health care, client teaching, and resource utilization.
4. Interview, and review the records of, linguistically and culturally diverse clients using standards provided by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for patient rights to evaluate if these were met.
5. Conduct a utilization study in the Emergency Department comparing the turnaround time for care and cost of diagnostic tests ordered, for both linguistically and culturally diverse clients and native English speaking clients with the same diagnosis, to evaluate if there is significant differences in delays or increased costs.
6. Develop a tool to evaluate how interpreter and translation services are provided, including competence of the interpreter, availability of critical forms and materials, costs to institution or client, and delays in receiving care or being discharged due to communication problems.
7. Convene a quality improvement team to address the issues of providing culturally competent care and examine their report and recommendations.

RESOURCES

The following is a list of international resources currently available in the Charlotte-Mecklenburg region that may be of service to healthcare providers addressing the needs of the international population. The list is not exclusive. Listing of these services does not constitute any endorsement by The Health Care Task Force and/or the Mayor's International Cabinet and there is no warranty, express or implied. The Mayor's International Cabinet does not assume and hereby disclaims any liability to any party for any loss or damage caused by errors or omissions in this listing, whether such errors or omissions result from negligence, accident or any other cause.

Agencies/Organizations

Advocacy Council for Internationals

322 Hawthorne Lane, Charlotte, NC 28204

Contact: José Hernández Paris

Tel: (704) 333-8099

A council of community service providers who meet to address needs and advocate on behalf of the international community in the Charlotte area.

Catholic Social Services

Resettlement Office

1123 South Church St., Charlotte, NC 28203

Contact: Barbara Douglas

Tel: (704) 370-6930

Receives new refugees into the city as a sponsoring agency, assists former refugees in locating relatives, brings individual refugees to a level of self-sufficiency economically and socially.

Charlotte Chemical Dependency Center

Latino Treatment Services

100 Billingsley Road, Charlotte, NC 28211

Contact: Carolina Jones

Tel: (704) 376-7447

Pioneering in substance abuse services for Latinos, committed to delivering quality services appropriate for Latinos using bilingual and bicultural professionals.

International Health and Community Services

1900 Central Avenue, Charlotte, NC 28205

Contact: Tuyet Seethaler

Tel: (704) 333-4262

Provides individual client advocacy to immigrants and refugees as well as healthcare with holistic approach.

International House

322 Hawthorne Lane, Charlotte, NC 28204

Contact: Glenn Yoder

Tel: (704) 333-8099

Provides various services designed to help internationals as they adjust to life in the United States, including ESL classes, friendship groups, citizen classes etc. Offers education programs and resources to assist the community in providing for the growing numbers of internationals, including a directory of available translators and interpreters (updated annually), "Tip of the Iceberg" by Amorette Mayr, a cultural awareness handbook, cross-cultural training, presentations and consultations, diversity programs, conversation hours in various languages including Spanish.

Latin American Coalition

322 Hawthorne Lane, Charlotte, NC 28204

Contact: Violeta Moser

Tel: (704) 333-5447

Provides information and referral services to the Spanish-speaking community in areas of education, health, employment, immigration, etc. Assesses the needs of Hispanics in the community and acts as advocates for these needs.

The Mecklenburg County Health Department

Beatties Ford Road

Tel: (704) 336-6400

Contact: Dr. Steven Keener

Billingsley Road

Tel: (704) 336-4700

Family Planning & Prenatal Care

Tel: (704) 336-6500

Tel: (704) 336-6449 (direct line to Spanish speakers)

Tel: (704) 336-6420 (direct line to Spanish speakers)

Provides five part-time bilingual (Spanish) interpreters for Child Health, Maternity, WIC, Family Planning, and Prenatal Care, including home visits where necessary.

NOVA (New Options for Violent Action)

Latino Program

Contact: Patty Dorian

3623 Latrobe Drive, Suite 107, Charlotte, NC 28211

Tel: (704) 336-4344

Tel: (704) 336-7603 (for appointments)

Provides training classes in anger management.

Programa Esperanza

1123 S. Church St., Charlotte, NC 28203-4003

Contact: Teresa Villamarin

Tel: (704) 370-3235

Helps to link Hispanics to the community resources or services that they need, such as healthcare, employment, immigration services, school and legal representation.

Language Services

TRANSLATORS

About Translations

Tel: (704) 366-5781

ALS Translating and Interpreting

Tel: (704) 334-2699

AT&T Language Line

Tel: 1-(800) 528-5888

Provides on-line interpreting services over the phone.

Berlitz Translation Services

Tel: 1-(800) 423-6756

Carolina Interpreting and Consulting Services

Tel: (704) 532-7446

Carolina Multilingual Services

Tel: (803) 366-7365

Choice Translating & Interpreting, LLC

Tel: (704) 717-0043

<http://www.choicetranslating.com>

Translation Services International, Inc.

Tel: (704) 375-8530

<http://www.tsitranslation.com>

Language Schools

Audio-Forum

Tel: (800) 243-1234

Self-instructional programs in foreign languages and English as a Second Language; offers Spanish for Healthcare Workers program.

Berlitz Language Centers

5821 Fairview Road, Charlotte, NC 28210

Tel: (704) 554-8169

Provides foreign language training with native-fluent instructors as well as English as a Second Language programs – private or group.

Buck Language and Intercultural Services

Charlotte, NC 28244

Tel: (704) 542-9973

Provides language and cross-cultural training, US-German specialists.

ilingua School of Languages

2101 Rexford Rd. East, Suite 300, Charlotte, NC 28211

Tel: (704) 366-1499

Provides customized language and cultural awareness training to individuals and small groups. Special English as a Second Language programs tailored to the needs of the community.

Training

Central Piedmont Community College

Nursing – Continuing Ed. Courses

1201 Elizabeth Avenue, Charlotte, NC 28235

Tel: (704) 330-6508

Offering a Spanish for Healthcare Professionals class (ongoing).

Choice Translating & Interpreting, LLC

8701 Mallard Creek Road, Suite 116, Charlotte, NC 28262

Tel: (704) 717-0043

Fax: (704) 717-0046

<http://www.choicetranslating.com>

Offering translating and interpreting services in various languages for many industries including health care. Also offer medical interpreter training, cultural competency training, and language assessment testing.

University of North Carolina at Charlotte

School of Nursing

9201 University City Blvd., Charlotte, NC 28213

Tel: (704) 547-4687

Offering a Spanish for Healthcare Professionals class (ongoing).

Print Materials and Videos

Latino Health in the United States: A Growing Challenge

American Public Health Association

Tel: (202) 789-5600

Publication exploring the growing challenges to Latino health in the United States.

Tip of the Iceberg

The Charlotte Mecklenburg- Community Relations Committee

(R12/97)

Editor: Amorette Pearce Mayr

A resource handbook for service providers working with the international community in Charlotte-Mecklenburg.

Transcultural Healthcare Videos

Insight Media

2162 Broadway (POB 621), New York, NY 10024-0621

Video Selections

Transcultural Nursing Care: *A discussion of culturally congruent healthcare and universality, plus anthropologists' view.* 45 min.

Transcultural Nursing: Discovery and Dialogue. *A panel discussion with Dr. Madeleine Leninger, Dr. A. Kulwicksi, and K. Edmonds on the stresses and importance of culturally competent care in improving healthcare systems.*

22 min.

Transcultural Nursing: Basic Concepts of Transcultural Nursing. *The video describes from a nurses perspective experiences in dealing with different cultures, and the need for viewing issues from the patient's perspective.* 22min.

Cultural Diversity: Appreciating Differences. *Distinguishing between stereotypes and generalities, this video explores cultures, views, eye contact, distance and views of time.* 25min.

Web Sites

Center for Cross-Cultural Health

www1.umn.edu/ccch/index.html

Contains training and research relating to the role of culture in healthcare.

Culturally Competent Care for Diverse Populations

www.dgim.ucsf.edu/pods/html/divpeople.html

Presents a paper by Melissa Welch, MD, MPH; as well as a detailed reference list.

Diversity Database, University of Maryland

www.inform.umd.edu/EdRes/Topic/Diversity/

Lists resources relating to cultural diversity and multiculturalism.

Diversity Rx (Resources for Cross-Cultural Health Care)

www.diversityrx.org

Dedicated to promoting cultural competence in an effort to improve healthcare standards for ethnically diverse communities.

Diversity Training University International

www.diversityintl.com

Website offering courses to students interested in becoming “diversity trainers” teaching the topics of multiculturalism and diversity.

EthnoMed

<http://healthlinks.washington.edu/clinical/ethnomed/>

Website offering a guide to ethnic medicine

JAMARDA Resources

www.jamardaresources.com/

Provides training and education in ethnic, religious, and cultural diversity for health care workers.

Office of Minority Health Resource Center

www.omhrc.gov/welcome.htm#TOC

A division of the U.S. Department of Health and Human Services, website offers information on minorities and health care.

APPENDICES

APPENDIX A

REFERENCES AND OTHER READINGS

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APPENDIX B

GLOSSARY

Acculturation: The process of adapting to another culture. To acquire the majority group's culture.

Alien: Every person applying for entry to the United States. Anyone who is not a U.S. citizen.

Allopathic: Health beliefs and practices that are derived from current scientific models and involve the use of technology and other modalities of present-day healthcare, such as immunization, proper nutrition, and resuscitation.

Alternative health system: A system of healthcare a person may use that is not predicated within their traditional culture, but is not allopathic.

Assimilation: To become absorbed into another culture and to adapt its characteristics. To develop a new cultural identity.

Care: Factors that assist, enable, support, or facilitate a person's needs to maintain, improve or ease a health problem.

Culture: Nonphysical traits, such as values, beliefs, attitudes, and customs that are shared by a group of people and passed from one generation to the next. A meta-communication system.

Culture shock: Disorder that occurs in response to transition from one cultural setting to another. Former behavior patterns are ineffective in such a setting and basic cues for social behavior are absent.

Demography: The statistical study of populations, including statistical counts of people of various ages, sexes, and population densities for specific areas.

Disadvantaged background: Both educational and economic factors that act as barriers to an individual's participation in health professions program.

Discrimination: Denying people equal opportunity by acting on a prejudice.

Emerging majority: People of color-blacks, Asian/Pacific Islanders, American Indians, Eskimos, or Aleuts; and Hispanics-who are expected to constitute a majority of the American population by the year 2020.

Ethnicity: Cultural group's sense of identification associated with the group's common social and cultural heritage.

Ethnocentrism: Tendency of members of one cultural group to view the members of other cultural groups in terms of the standards of behavior, attitudes, and values of their own group. The belief that one's cultural, ethnic, professional, or social group is superior to that of others.

Ethnomedicine: Health beliefs and practices of indigenous cultural development which are not practiced in many of the tenants of modern medicine.

Faith: Strong beliefs in a religious or other spiritual philosophy.

Folklore: Body of preserved traditions, usually oral, consisting of beliefs, stories, and associated information of people.

Healing: Holistic or three-dimensional phenomenon that results in the restoration of balance or harmony, to the body, mind, and spirit; or between the person and the environment.

Health: A state of balance between the body, mind, and spirit.

Heritage consistency: Observance of the beliefs and practices of one's traditional cultural belief system.

Heritage inconsistency: Observance of the beliefs and practices of one's acculturated belief system.

Homeopathic: Health beliefs and practices derived from traditional cultural knowledge to maintain health, prevent changes in health status, and restore health.

Homeopathy: System of medicine based on the belief that a disease can be cured by minute doses of a substance that, if given to a healthy person in large doses, would produce the same symptoms that the person being treated is experiencing.

Illness: State of imbalance among the body, mind, and spirit; a sense of disharmony both within the person and with the environment.

Immigrant: Alien entering the United States for permanent (*or temporary*) residence.

Indigenous: People native to an area.

Medically underserved community: Urban or rural population group that lacked or lacks adequate health care services.

Melting pot: The social blending of cultures.

Metacommunication system: Large system of communication that includes both verbal language and nonverbal signs and symbols.

Modern: Present-day health and illness beliefs and practices of the providers with the American, or Western, health-care delivery system.

Multicultural nursing: Pluralistic approach to understanding relationships between two or more cultures in order to create a nursing practice framework for broadening nurses' understanding of health-related beliefs, practices, and issues that are part of the experiences of people from diverse cultural backgrounds.

Natural folk-medicine: Use of natural environment as well as herbs, plants, minerals, and animal substances to prevent and treat illness.

Nonimmigrant: People who are allowed to enter the country temporarily under certain conditions, such as crewmen, students, and temporary workers.

Pluralistic society: A society comprising people of numerous ethnocultural backgrounds.

Prejudice: Negative beliefs or preferences that are generalized about a group that may lead to “prejudgment.”

Racism: The belief that members of one race are superior to those of other races.

Rational folk medicine: Use of the natural environment and use of herbs, plants, minerals, and animal substances to prevent and treat illness.

Raza-Latina: A popular term used as a reference group name for people of Latin American descent.

Religion: Belief in a divine or superhuman power or powers to be obeyed and worshipped as the creator(s) and ruler(s) of the universe.

Resident alien: A lawfully admitted alien.

Restoration: Process used by a given person to return to health.

Sexism: Belief that members of one sex are superior to those of the other sex.

Social organization: Patterns of cultural behavior related to life events, such as birth, death, child rearing, and health and illness, that are followed within a given social group.

Socialization: Process of being raised within a culture and acquiring the characteristics of the given group.

Spirit: The non-corporeal and non-mental dimension of a person that is the source of meaning and unity. The source of the experience of spirituality and every religion.

Spiritual: Ideas, attitudes, concepts, beliefs, and behaviors that are the result of the person’s experience of the spirit.

Spirituality: The experience of meaning and unity.

Stereotype: Notion that all people from a given group are the same.

Superstition: Belief that performing an action, wearing a charm or amulet, or eating something will have an influence on life events. These beliefs are upheld by magic and faith.

Taboo: A culture-bound ban that excludes certain behaviors from common use.

Time: Duration, interval of time; also instances, or points in time.

Traditional: Ancient, ethnocultural-religious beliefs and practices that have been handed down through the generations.

Traditional epidemiology: Belief in agents-other than those of scientific nature, causing disease.

Undocumented alien: Person of foreign origin who has entered the country unlawfully by bypassing inspection or who has overstayed the original terms of admission.

Xenophobia: Morbid fear of strangers.

The above glossary is taken from Cultural Diversity in Health and Illness, 4th edition, (1996) by R.E. Spector, pages 357-363 “Selected Key Terms Related to Cultural Diversity in Health and Illness.”

APPENDIX C

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

Guidance Memorandum
January 29, 1998

- Introduction to Limited-English-Proficiency Guidance
- I. Background
- II. Discussion
 - A. Who is Covered
 - B. Ensuring Equal Access to LEP Persons
 - C. Interpreter Services
- III. Compliance and Enforcement

Introduction to Limited-English-Proficiency Guidance

The Office for Civil Rights (OCR) has issued the following guidance memorandum on national origin non-discrimination and Limited-English-Proficiency (LEP) to OCR staff to ensure consistent application of Title VI of the Civil Rights Act of 1964 to health and social services programs funded by HHS. The import of the memorandum is that it addresses language assistance that may be required for effective communication between health and social service providers and persons of Limited English Proficiency (LEP). Pursuant to Title VI, such assistance is appropriate where language barriers cause LEP persons to be excluded from or denied equal access to HHS-funded programs.

In reviewing the memorandum, you will note that it spells out factors that OCR staff will consider when working with HHS-funded programs to ensure that persons of Limited English Proficiency (LEP) are not discriminatorily denied equal access to or an equal opportunity to benefit from health and social services programs on the basis of national origin. The guidance also describes a variety of options that may be used in addressing the language assistance needs of LEP persons. In presenting these options, the guidance stipulates that health and social service providers are not required to use all of the suggested methods listed. However, providers should establish and implement policies and procedures for fulfilling their Title VI equal opportunity responsibilities to LEP persons. OCR developed this guidance based on tested practices identified in compliance reviews and negotiated settlements with recipients to provide language services.

Sincerely,

Dennis Hayashi
Director
Office for Civil Rights

I. Background

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

The guidance is intended to clarify standards consistent with case law and well established legal principles that have been developed under Title VI.

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

The statute and regulations prohibit recipients from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of beneficiaries in their programs, benefits or activities on the basis of race, color or national origin. Accordingly, a recipient must ensure that its policies do not have the effect of excluding from, or limiting the participation of, such persons in its programs and activities, on the basis of national origin. Such a recipient should take reasonable steps to provide services and information in appropriate languages other than English in order to ensure that LEP persons are effectively informed and can effectively participate in and benefit from its programs.

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

LEP persons can and often do encounter barriers to health and social services at nearly every level within such programs. The primary reason for this difficulty is the language barrier that often confronts LEP persons who attempt to obtain health care and social services. Many health and social service programs provide information about their

services in English only. Many LEP persons presenting at hospitals or medical clinics are faced with receptionists, nurses and doctors who speak English only, and often interviews to determine eligibility for medical care or social services are conducted by intake workers who speak English only.

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

This guidance sets out factors for OCR staff to consider in determining whether federally-assisted providers of medical care or social services are taking steps to overcome language barriers to health care and social services encountered by LEP persons. The guidance emphasizes flexibility to providers in choosing the language assistance options they will employ. Thus, small providers and/or providers who serve only one or two language groups may be able to meet their responsibilities by choosing fewer or different options than the options selected by larger providers or those providers serving many language groups.

The U.S. Supreme Court, in *Lau v. Nichols*, 414 U.S. 563 (1974), recognized that recipients of Federal financial assistance have an affirmative responsibility, pursuant to Title VI, to provide LEP persons with meaningful opportunity to participate in public programs. In *Lau v. Nichols*, the Supreme Court ruled that a school system's failure to provide English language instruction to students of Chinese ancestry who do not speak English denied the students a meaningful opportunity to participate in a public educational program in violation of the Civil Rights Act of 1964. ¹

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

national origin, OCR has required recipients to provide language assistance to LEP persons.

OCR's position as set forth in this document is fully consistent with a government-wide Title VI regulation issued by the Department of Justice (DOJ) in 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs," 28 C.F.R. Subpart F. The DOJ regulation addresses the circumstances in which recipients must provide language assistance, in written form, to LEP persons.² The DOJ regulation does not address the question of oral language assistance. OCR's experience in conducting complaint investigations and compliance and pre-grant reviews demonstrates that oral communication between recipients and program beneficiaries is an integral part of the exchange that must occur in order for assisted programs and activities to appropriately function. Thus, OCR's longstanding position has been that recipients may be required to provide oral language assistance in languages other than English. This statement affirms this position.

II. Discussion

A. Who is Covered

All entities that receive Federal financial assistance from HHS, either directly or indirectly through a subgrant or subcontract, are covered by this guidance. Covered entities would thus include any state or local agency, private institution or organization, or any public or private individual that operates, provides or engages in health, medical or social service programs and activities that receive or benefit from HHS assistance.

B. Ensuring Equal Access to LEP Persons

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

The key to ensuring equal access to benefits and services for LEP persons, is to ensure the service provider and the LEP client can communicate effectively, i.e., the LEP client should be given information about, and be able to understand, the services that can be provided by the recipient to address his/her situation and must be able to communicate his/her situation to the recipient service provider. Recipients are more likely to utilize effective communication if they approach this responsibility in a structured rather than on an ad hoc basis. ³

Developing policies and procedures for addressing the language assistance needs of LEP persons may best be accomplished through an assessment of the points of contact in the program or activity where language assistance is likely to be needed, the non-English languages that are most likely to be encountered, the resources that will be needed to fulfill this responsibility and the location and/or availability of such resources. In identifying available resources, recipients may find it

helpful to consult with national origin organizations and groups in their service areas. Achieving effective communication with LEP persons may require the recipient to take all or some of the following steps at no cost or additional burden to the LEP beneficiary:

- Have a procedure for identifying the language needs of patients/clients.
- Have a procedure for identifying the language needs of patients/clients.
- Have ready access to, and provide services of, proficient interpreters in a timely manner during hours of operation.
- Develop written policies and procedures regarding interpreter services.
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to LEP persons.

C. Interpreter Services

In determining the type of interpreter services that will be provided, a recipient has several options. To meet its Title VI responsibility with respect to the provision of interpreter services a recipient may:

- Hire bilingual staff
- Hire staff interpreters
- Use volunteer staff interpreters
- Arrange for the services of volunteer community interpreters
- Contract with an outside interpreter service
- Use a telephone interpreter service such as the AT&T Language Line⁴
- Develop a notification and outreach plan for LEP beneficiaries.

Factors that may be considered by a recipient in determining which option(s) will best meet its needs and the needs of its LEP beneficiaries are its size, the size of the LEP population it serves, the setting in which interpreter services are needed, the availability of staff members and/or volunteers to provide interpreter services during its hours of operation and the proficiency of available staff members or volunteers available to provide the needed services.

A recipient should not require a beneficiary to use friends or family members as interpreters. Use of such persons could result in a breach

of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations, to family or friends. In a medical setting, reluctance or failure to reveal critical personal information could have serious, even life threatening, health consequences. In addition, family and friends may not be competent to act as interpreters, since they may lack familiarity with specialized terminology. However, a family member or friend may be used as an interpreter if this approach is requested by the LEP individual and the use of such a person would not compromise the effectiveness of services or violate the beneficiary's confidentiality, and the beneficiary is advised that a free interpreter is available.

A recipient should ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, though this certification generally is preferable. However, the competency requirement does contemplate proficiency in both English and the other language, orientation or training which includes the ethics of interpreting, and fundamental knowledge in both languages of any specialized terms and concepts peculiar to the recipient's program or activity. For example, a hospital or medical clinic could use a nurse as a volunteer staff interpreter for a Hispanic beneficiary if the nurse speaks both English and Spanish proficiently. It can be assumed that in addition to language skills enabling the relay of critical information about the patient to medical personnel, the nurse will be sufficiently familiar with medical terminology to convey the medical meaning and importance of what is being communicated to the LEP patient. However, it would be inappropriate to use a person who had little knowledge of medical terms or a person who spoke English poorly. Similarly, it would be inappropriate to rely on a medical student who worked part-time and had learned some Spanish but did not speak the language proficiently. While the student would understand the medical terminology, and the use of part-time staff would be appropriate in many circumstances, it is unlikely that such a student would have sufficient Spanish language skills to communicate what is being said and its importance, by and to the LEP patient.

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

Use of staff or community volunteers may provide recipients with a cost-effective method for providing interpreter services. However, recipients should ensure that such a system is sufficiently organized

so that interpreters are readily available during all hours of its operation. In addition, recipients should ensure that such volunteers are qualified, trained and capable of ensuring patient confidentiality.

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

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

A telephone interpreter service such as the AT&T language line ⁴ may be a useful option as a supplemental system, or may be useful when a recipient encounters an unusual language that it cannot otherwise accommodate. Such a service often offers interpreting services in many different languages and usually can provide the service in quick response to a request. However, recipients should be aware that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service or may require special arrangements to use such persons.

III. Compliance and Enforcement

The recommendations outlined in Section II(B) are not intended to be exhaustive. Recipients are not required to use all of the suggested methods and options listed. However, recipients should establish and implement policies and procedures for fulfilling their Title VI equal opportunity responsibilities to LEP persons in the population eligible to be served.

In determining a recipient's compliance with Title VI, OCR's concern will be whether the recipient's system allows LEP beneficiaries to overcome language barriers and thus have equal access to, and an equal opportunity to participate in, health care and social service programs and activities. While a recipient is not required to use the options listed, and may use options that are equally effective, a recipient's appropriate use of the options and methods discussed in this guidance, will be viewed by OCR as evidence of a recipient's intent to comply with its Title VI obligations.

For example, a small health care clinic that accepts patients by appointment only and serves a small but significant LEP population may be able to meet its responsibility to its LEP clients by making arrangements for interpreter services on an as needed basis, and appropriately publicizing the availability of such arrangements.

On the other hand, the emergency room in a large hospital located in an area with a larger and more diverse LEP population may require a combination of language assistance options. In this setting, there are likely to be a variety of patient contact points, and immediate and accurate information to and from patients is usually critical. In such a situation the recipient also should have staff that are bilingual in English and other frequently encountered languages, in critical patient contact positions. If available staff is insufficient, the recipient should employ other staff interpreters and/or make other language assistance arrangements to ensure that there are no delays in providing medical care and no misunderstandings when conveying information to, or obtaining information or informal consent from, patients.

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

Questions regarding this guidance memorandum should be directed to the Office for Civil Rights

¹ The Lau decision affirmed the U.S. Department of Education's Policy Memorandum issued on May 25, 1970, titled "Identification of Discrimination and the Denial of Services on the Basis of National Origin", 35 Fed. Reg. 11,595. The memorandum states in part: "Where the inability to speak and understand the English language excludes national origin minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students."

² The DOJ coordination regulations at 28 C.F.R. Section 42.405 (d)(1) provide that "[w]here a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program (e.g. affected by relocation) needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take

APPENDIX D

GLOSSARY

January, 1998

North Carolina Association of Local Health Directors Policy and Planning Liaison Committee

RESOLUTION ON LANGUAGE SERVICES IN PUBLIC HEALTH

WHEREAS the linguistic and ethnic diversity of our communities, especially evident in the fast-growing Hispanic population, creates a critical need for interpreter services in local health departments serving these populations,

WHEREAS the right to equal access to public health services should not be contingent upon an individual's ability to communicate in the English language,

WHEREAS failure to provide equal access to services based on language places public health agencies receiving federal funds at risk of violating Title VI of the Civil Rights Act which states that *"No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."*

WHEREAS failure to provide qualified interpreter services places agencies at serious risk for civil litigation should the quality of health care services be compromised by miscommunications due to language barriers,

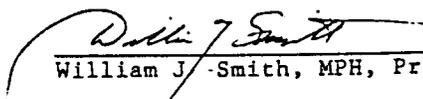
WHEREAS one objective of Healthy People 2000 is to increase to at least 50% the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic populations,

AND WHEREAS health departments must be able to communicate with clients and members of the community if they are to fulfill their mission of protecting the public's health,

THEREFORE, the North Carolina Association of Local Health Directors resolves that the following issues be supported:

- a. Public health agencies will accept responsibility for the communication needs of clients making reasonable efforts to ensure that non English-speaking and limited English proficiency individuals can receive an equal benefit of public health services.
- b. The size of North Carolina's Hispanic population makes it important that health departments address the communication needs of their Spanish-speaking clients.
- c. Local public health agencies should take a lead role in communicating to other county public service agencies the importance of adopting interpreter policies in keeping with Title VI of the Civil Rights Act, and should work with the community to develop local support and resources to provide language-appropriate services.

Resolved the 14th day of January, 1998, by the North Carolina Association of Local Health Directors.



William J. Smith, MPH, President

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