

CONFERENCE PROCEEDINGS
December 2007



**New York State Conference on Increasing
Language Access to Healthcare: Toward
Effective National and State Policy**

Conveners
Center for Women in Government & Civil Society,
University at Albany

The Education Fund of
Family Planning Advocates of New York State

Center for Immigrant Health,
New York University School of Medicine

**Conference endorsed by: NYS Black, Puerto Rican and Asian
Legislative Caucus & NYS Hispanic/Puerto Rican Task Force**





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Planning Committee Members

- **Catherine M. Abate, J.D.**, President and CEO of Community Healthcare Network (CHN), New York City
- **Wilma Alvarado-Little, M.A.**, Co-chair of the Board for the National Council on Interpreting in Health Care
- **Ignatius Bau, J.D.**, Program Officer of the California Endowment
- **Anne Beal, M.D., M.P.H.**, Program Officer of the Commonwealth Fund (CMWF)
- **Cornelia E. Brown, Ph.D.**, Founding Director of the Multicultural Association of Medical Interpreters (MAMI)
- **Karen Scott Collins, M.D., M.P.H.**, Deputy Medical Director for the New York City Health and Hospitals Corporations
- **Adam Gurvitch, M.S.**, Director of Health Advocacy for the New York Immigration Coalition
- **Elizabeth Jacobs, M.D., M.P.P.**, Assistant Professor of the Medical Outcomes Research Unit, Cook County Hospital and Rush University Medical School
- **Sandeep Bathala**, Coordinator of the Women's Health Initiative and Economic Empowerment Program at SAKHI for South Asian Women
- **Joan Malin, M.A.**, CEO of Planned Parenthood of New York City (PPNYC)
- **Bakary Tandia**, Case Manager and Policy Advocate at African Services Committee, Inc.
- **Wilma E. Waithe, Ph.D.**, Director of the Office of Minority Health (OMH), New York State Department of Health
- **Mara Youdelman, J.D., LL.M.**, Director of the National Language Access Advocacy Project of the National Health Law Program (NHLP)

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- Judith Saidel, Ph.D., Executive Director, **Center for Women in Government & Civil Society, University at Albany**
- Honorable Adriano Espaillat, **New York Assembly, 72nd Assembly District**
- Eric J. Hardt, M.D., Associate Professor of Medicine, **Boston University School of Medicine;**
- Francesca Gany, M.D., M.S., Director, Center for Immigrant Health, **New York University School of Medicine;**
- Nisha Agarwal, J.D., Attorney/Skadden Fellow, **New York Lawyers for the Public Interest, Inc.;**
- Mara Youdelman, J.D., LL.M., Director, National Language Access Advocacy Project, **National Health Law Program;**
- Catherine Abate, J.D., President/CEO, **Community Healthcare Network;**

- Jennifer K. Carroll, M.D., M.P.H., Assistant Professor, Department of Family Medicine **University of Rochester School of Medicine and Dentistry**;
- Kadija Abukar, Senior Staff Mentor, **Somali Bantu Community Association, Rochester NY**, and Interpreter, Brown Square Health Center;
- Sadiya Omar, Research Assistant and Interpreter;
- Anne Pearson, Director, **Reproductive Rights Unit, Civil Rights Bureau, NYS Office**;
- Grace Mose, D.A. Research and Program Associate, **Family Planning Advocates of New York State**;
- Joan Malin, M.A., President/CEO, **Planned Parenthood of New York City**;
- Stergios Roussos, Ph.D., M.P.H., Research Assistant Professor, Center for Behavioral Epidemiology and Community Health, **San Diego State University**, Graduate School of Public Health;
- Wilma Waithe, Ph.D., Director, Office of Minority Health, **NYS Department of Health**;
- Marsha Regenstein, Ph.D., MCP., Research Professor and Director, Speaking Together, **George Washington University School of Public Health and Health Services**;
- Amy Wilson-Stronks, **Joint Commission on Accreditation of Healthcare Organizations**;
- Cathy Cave, M.S., Director of Cultural Competency, **NYS Office of Mental Health**;
- Emily Ambizas, Ph.D. **St. John's University** & Linda Weiss, Ph.D., **New York Academy of Medicine**;
- Cornelia E. Brown, Ph.D., Founding Director, **Multicultural Association of Medical Interpreters (MAMI)**
- Siddharth Rastogi, M.B.A., Co-founder, **SimulTel Inc.**;
- Kathy Mirgalia, M.S., C.S.C. Director, Interpreter Services, **University of Rochester**;
- Sandhya Parathath, **New York City Health and Hospitals Corporation**;
- Gayle Tang, M.S.N., R.N., Director of National Linguistic & Cultural Programs, National Diversity, **Kaiser Permanente**;
- Virginia Tong, M.S.W., Vice President, Cultural Competence, **Lutheran HealthCare**;
- Lynn Stone, M.A., Director, Language Services Unit, Bureau of Refugee & Immigrant Assistance, **New York State Office of Temporary & Disability Assistance**;
- Wilma Alvarado-Little, M.A., Co-chair of the Board, **National Council on Interpreting in Healthcare**;
- Javier Gonzalez, Director of Language Initiatives, Center for Immigrant Health, **New York University School of Medicine**;
- Tammy Arnstein, Director, Language Access, **New York City Mayor's Office of Immigrant Affairs**; and
- Maysoun Freij, M.P.H., Health Policy Associate, **New York Immigration Coalition**

Foreword

This report documents proceedings from the New York State Conference on Increasing Language Access to Healthcare: Toward Effective State and National Policies. The Conference was held on Wednesday, April 25, 2007 at the University at Albany, New York. The conference was supported by the Agency for Healthcare Research & Quality (AHRQ), U.S. Department of Health & Human Services. The Center for Women in Government & Civil Society in partnership with the Education Fund of Family Planning Advocates of New York State and the Center for Immigrant Health, New York University School of Medicine co-convened the conference.

The report was compiled by Dina Refki and Swarna Ramakrishnan, Center for Women in Government & Civil Society, Karen Anderson, Family Planning Advocates of NYS, Grace Mose, Family Planning Advocates of New York State and Francesca Gany, Center for Immigrant Health, New York University School of Medicine.

1. INTRODUCTION

The New York State Conference on Increasing Language Access to Healthcare was held on Wednesday, April 25, 2007 in Albany, New York. With generous support from the Agency for Healthcare Research Quality (AHRQ), the conference brought together researchers, state policy makers, healthcare providers and advocates to foster adoption of collaborative strategies to increase language access to healthcare statewide and on the national level. Presenters and attendees included key national experts on linguistic barriers and key participants in the national policy reform process. The conference was attended by 150 invited participants.

The conveners organized the conference:

- **To promote the development of New York State and national language access policy.**
- **To transfer knowledge generated by recent research** which has documented the critical importance of removing language barriers to healthcare, the mechanisms for transcending those barriers, and improvements in clinical and health systems practices as a result of removing linguistic barriers;
- **To facilitate exchange of information and assessment of the growing experience of healthcare providers and policy makers** with different strategies, mechanisms, innovative technologies, and evidence-based best practices for enhancing linguistic access for LEP individuals; and
- **To increase researchers' attention to language access** by identifying additional needed knowledge areas.

All participants had the opportunity to discuss the policy implications of the presentations and their own experience during the workshops and at the final session, *Toward NYS and National Language Access Policies*. This report documents proceedings of the conference and includes participants' policy recommendations.

The conference represented a significant step towards addressing one of the most formidable obstacles to immigrant integration in New York and the nation. New York State has the fourth highest percentage of people who speak a language other than English at home. According to the 2005

American Community Survey, over 28% of New Yorkers speak a language other than English at home. This translates to just under 5 million New Yorkers, two million of whom are Limited English Proficient (LEP). LEP patients are tremendously disadvantaged by lack of access to quality healthcare. They are more likely than their English-speaking counterparts to receive fewer preventive services, experience denial of needed benefits and services, misunderstand treatment, receive the wrong benefits or services, encounter significant delays in treatment, and experience misdiagnosis and poor shared decision-making. Overcoming language barriers to healthcare is therefore critical to addressing this segment of NYS residents.

In 2000, the Office of Minority Health, U.S. Department of Health & Human Services, issued the first national standards for Culturally and Linguistically Appropriate Services (CLAS), urging the integration of the standards within healthcare organizations and encouraging partnerships with the communities being served. In September, 2006, New York State Codes, Rules and Regulations, Title 10 (Health) sections 405.7 and 751.9, were amended to strengthen patients' rights to language assistance and provide guidance to hospitals in developing language assistance programs for their LEP patients. This represented a solid start for addressing language access in healthcare. However, there is consensus among stakeholders that more needs to be done to address the healthcare disparities facing LEP New Yorkers in an effective, sustainable and comprehensive manner.

The conference offered a Plenary Keynote Presentation, a Plenary Lunch Presentation, two Workshop Breakout Sessions (three workshops per session) and one afternoon Policy Development Session, structured to involve all participants in discussion circles to develop state and national policy recommendations.

Judith Saidel, Ph.D., Executive Director, Center for Women in Government & Civil Society and Assembly Member Adriano Espaillat, New York State Assembly, 72nd Assembly District kicked off the conference with welcoming remarks. Eric Hardt, M.D., Associate Professor, Boston University, College of Medicine delivered the Plenary Keynote Presentation, ***Language Access Research, Key Findings and Evidence-based Policy Implementation***. He summarized key findings of research in language access, and described the Massachusetts experience using evidence-based approaches to change language access policy at the state level. Francesca Gany, M.D., M.S., Director, Center for Immigrant Health, New York

University School of Medicine moderated this presentation.

The Plenary Lunch Presentation, ***Providing Linguistic Access: Can We Afford Not To?*** was delivered by Marsha Regenstien, Ph.D., MCP., Research Professor and Director of Speaking Together, The George Washington University School of Public Health and Health Services and Amy Wilson-Stronks, Principal Investigator, Joint Commission on Accreditation of Healthcare Organizations. They discussed research findings on funding strategies for affordable, language-accessible healthcare systems, as well as the costs of not providing access. Cathy Cave, Director, Cultural Competency, NYS Office of Mental Health moderated this panel.

The conference featured two sessions with workshops; each offered participants a choice of three concurrent topics. **Workshops in Session I (Workshops A,B,C)** focused on the negative health consequences of language barriers, the benefits of providing language services, methods of assessing health outcomes for LEP individuals, and the legal and ethical framework of providing language access. **Workshops in Session II (Workshops D,E,F)** focused on promising models, innovative language access methods and technologies, the role of effective interpreters, the establishment of quality standards for interpreters and translators, and appropriate training for language service providers.

Workshop A: Legal, Ethical and Financial Parameters for Linguistic Access in Healthcare Settings discussed federal, state, and local legal mandates and ethical implications for the provision of linguistic access, as well as malpractice implications.

Workshop B: Case Studies: Providing Linguistically Competent Care to Perinatal and Reproductive Health Clients presenters shared research on the theoretical and practical foundations of patient-centered, linguistically competent approaches to care for LEP individuals. Lessons were drawn from specific experiences with perinatal and reproductive healthcare. Presenters analyzed the impact of language access in the provision of highly personal healthcare to illuminate the issues of culturally sensitive linguistic access to all healthcare.

Workshop C: Assessing Quality & Evaluating Healthcare Outcomes for LEP Individuals examined the use of practical health outcome

measures for LEP patients. Presenters explored the latest findings on development of outcome measures to assess the effectiveness of language services, as well as the relationship between patient satisfaction and outcomes of care. Participants learned about tools which can help them strengthen health agency capacity to assess the effective implementation of linguistic access.

Workshop D: Linguistic Access Technologies and Innovations in Healthcare Settings

examined the different methods and technologies through which providers can create language access for their LEP patients. Presenters shared knowledge about the appropriateness in different settings of using: in-person interpretation, remote simultaneous interpretation, bi-lingual staff, telephonic language lines and other innovative approaches. Speakers discussed issues of delivery, efficiency, cost-effectiveness, applicability to different geographic settings (urban, suburban and rural) and impact on healthcare outcomes. Presenters addressed the development of research and practice partnerships to expand work in this area. The workshop provided participants with guidance on prioritizing language assistance services for particular populations and needs.

Workshop E: Developing an Action Plan for a Linguistically Competent Organization: Lessons from the Field

featured the results of research on different healthcare organizations across the nation which have succeeded in transforming to linguistic and cultural competency. Speakers discussed lessons learned from these experiences: developing an environment respectful of LEP individuals, ensuring high quality of care and developing sustainable funding mechanisms. Participants considered how promising practices could be replicated and adapted for the creation of an effective local agency action plan.

Workshop F: Ensuring High Quality Interpretation and Translation

examined the establishment of standards and training for interpreters and translators to ensure high quality language access. Speakers shared information on the value of established standards and professional training for language service providers. Presenters discussed training systems developed across the country and efforts to establish professional standards.

Plenary Session & Discussion Groups entitled: Toward NYS and National Language Access Policies

Maysoun Freij, M.P.H., Health Associate, New York Immigration Coalition, Karen Anderson, M.Ed., M.P.H., Director of Public Policy, Family

Planning Advocates of New York State asked participants to assemble in their designated discussion circles to refine and revise the policy priorities expressed in the *Language Access Policy Development Framework* document. This document was developed by the conference conveners and the Planning Committee and was sent to each participant prior to the conference.

Dina Refki, D.A., Director, Immigrant Women & State Policy Program, Center for Women in Government & Civil Society concluded the conference.

2. CONFERENCE HIGHLIGHTS

2.1. Conference Opening Remarks

Judith Saidel, Ph.D., Executive Director, Center for Women in Government & Civil Society, University at Albany welcomed participants to the conference. She pointed out that the conference represented a historic day in New York State because it recognized the importance of removing language barriers to healthcare. It acknowledged that New York State is in a unique position to lead the rest of the nation in removing one of the most formidable obstacles to immigrant integration and become a model for language services provision throughout the country.

Saidel pointed out that NYS had the second largest immigrant population in the nation. Between 1990 and 2000, the New York City metropolitan region moved from the number two destination nationally for new immigrants to the number one chosen location. One-third of the NYS population is foreign-born or children of foreign-born parents. Sixteen counties in NYS have more than 4,000 people living in linguistically isolated households (households in which no member 14 years or older speaks English very well.) With NYS's foreign-born population numbering approximately 4 million, healthcare providers across the state are facing major challenges in developing adequate language services to communicate effectively for both prevention and treatment.

Research, Saidel pointed out, has proven that linguistic barriers create complex challenges for both providers and patients. These barriers keep Limited English Proficient individuals from accessing preventive services. They lead to denial and delay of services; provision of inferior quality of services; confusion about treatment plans;

ineffective decision making; inability to comply with patient care guidelines; and costly medical errors.

Saidel indicated that the conference's purpose was to share knowledge, identify gaps in existing knowledge, build collaborative relationships and develop policy recommendations for the State of NY and beyond. She explained that the conference was designed to help participants answer the following questions:

- How can specific linguistic access models and innovative approaches alleviate language barriers and ensure effective linguistic access?
- How can these multiple language access technologies and approaches be replicated and adapted in different healthcare settings?
- What sustainable funding mechanisms can ensure that the healthcare system secures the cost savings available from improved language access?
- What state and national language policy frameworks will most effectively meet healthcare needs?

Saidel expressed hope that the conference would make significant contributions to the national dialogue on improving linguistic competence and reducing healthcare disparities. She pointed out that there was momentum and a fertile climate for addressing linguistic access and instigating systematic reforms with the implementation of the 2006 NYS's Department of Health regulations requiring all private and public hospitals to provide language assistance to their Limited English Proficient patients. She urged participants to build on that momentum and help advance policies that can move linguistic access in the right direction.

Saidel introduced Assembly member Adriano Espaillat, who in turn shared welcoming remarks with participants. Drawing on personal experiences and his own struggle with communications as a young immigrant child, Assembly member Espaillat emphasized how important linguistic access to health care is to ensuring quality and curbing the cost of services.

2.2. Keynote Presentation: Language Access Research, Key Findings and Evidence-based Policy Implementation

Francesca Gany, M.D., M.S., Director, Center for Immigrant Health, New York School of Medicine introduced the keynote speaker, Eric J. Hardt, M.D., Associate Professor of Medicine, Boston University School of Medicine.

Hardt emphasized the importance of evidence based knowledge to change attitudes of law and policy makers, to remodel provider behavior and clinical systems, and to establish credibility for professional interpreters. He highlighted that there is a need to provide empirical evidence on the existence of healthcare disparities related to language barriers, the magnitude of the disparities, the groups affected and the areas impacted. There is also a need to document the costs.

Hardt narrated the case of a 30 year old Spanish-speaking patient admitted for an asthma exacerbation. Identified as LEP with minimal English, the patient was evaluated with hospital interpreters and improved slowly over 5 days. An RN using “broken English and some Spanish” conducted discharge education, including medications. The patient was instructed to take 1 theophylline tablet and 12 prednisone tablets daily the next day, with a subsequent taper. The patient was readmitted within 48 hours with life-threatening theophylline toxicity. The case, Hardt explained, signifies the danger of providing discharge instructions, for example, without interpretation or translation.

He narrated another case of an LEP patient who used her daughter as an interpreter. To highlight the issues in using family members as interpreters, Hardt referenced a study which documented the case of a 7 year old girl who was asked to interpret for her Spanish-speaking mother and tell her that her brother-to-be was dead.¹ Faced with this challenge, the child exclaimed, “I couldn’t explain to my mom everything the doctors were telling me.”

Hardt emphasized that research on language barriers in healthcare proves that those barriers affect (a) patient satisfaction; (b) access to care; (c) utilization of healthcare; (d) quality of care; (e) costs of care; and (f) interventions.

¹ Haffner L. Translating is not enough: Interpreting in a Medical Setting. West J Med 1992;157:255-259

2.2.1. Impact of Language Barriers on Patient Satisfaction

Hardt cited a study which surveyed 2333 patients in 5 urban academic Emergency Departments. 15% of those surveyed were non-English Speakers (NES). NES reported 52% satisfaction rate, while the rate for English Speakers (ES) was 71%. 86% of NES indicated willingness to return to the same hospital versus 91.5% of ES. NES patients were more likely to report overall problems with care, communication and testing.²

Hardt cited another study which surveyed 49,327 patients in 14 states to assess their satisfaction with their Medicaid Managed Care plans. NES reported lower ratings of care [access, timeliness, provider communication, staff helpfulness, & composite]. White NES and Hispanic Spanish-speakers were clustered in worse plans. Most observed racial/ethnic difference in ratings were attributable to within plan variation, including those for NES Asians.³

Hardt referenced a study which examined the effect of Spanish interpretation method on patient satisfaction. 233 English-speaking [ES] and 303 Spanish-speaking [SS] patients in an urban walk-in clinic were surveyed. The mean age was 32 years old. 128 of SS were seen by language concordant physicians [LC], 59 SS used AT&T, 69 SS used family members, and 47 SS used *ad hoc* interpreters. Overall satisfaction was identical for ES, LC, and AT&T at 77% versus 54% for those using family and 49% for those using *ad hoc* interpreters.⁴

Hardt noted that physician training in the use of interpreters is critical. He referenced a study which surveyed 158 physicians about their last clinic visit involving an interpreter. Previous training in interpreter collaboration was associated with better satisfaction with medical care.⁵

2.2.2. Impact of Language Barriers on Access to Care

Is language a barrier to the use of preventive services? Hardt cited a study of 22,448 women, 10% of whom were NES [4% French, 6% allophonic]. The French-speakers were less likely to receive breast exams or mammograms. Other

² Carrasquillo O et al JGIM 1999

³ Weech-Maldonado et al, JGIM 2004

⁴ Linda Lee et al, JGIM 2002

⁵ Karliner L et al, JGIM 2004

language speakers [allophones] were less likely to receive Pap testing.⁶

Another study found that 9% of children surveyed lacked a usual source of care. 6% were white, 12.5% were African Americans and 17.2% were Hispanics. Hispanics who were LEP were 27% as likely as Whites to have a regular source of primary care. There was no difference between English-speaking Hispanics and Whites.⁷ Another study found that one in five have gone without care when needed due to language obstacles, while 19% have not sought care when needed due to language barriers.⁸

A study conducted by the Commonwealth Fund reported that only 39% of Hispanic Spanish-speaking patients received smoking cessation counseling, as opposed to 67% of English-speaking Hispanics, 68% of Asian Americans, 78% of African Americans and 82% of White current smokers who were counseled by physicians to quit.⁹

2.2.3. Impact of Language Barriers on Utilization of Healthcare

Does a physician-patient language difference increase the probability of hospital admission? Hardt cited a study of adults and pediatric patients which found that non-English-speaking adults were more likely to be admitted than English-speaking patients. *No trained or professional interpreters were used.*¹⁰

Hardt noted that English language proficiency may impact the length of hospital stay. A study found that length of stay for LEP patients was longer than non-LEP for 7 of 23 conditions [unstable coronary syndromes and chest pain, CABG, stroke, craniotomy, diabetes, hip replacement, GI procedures]. Differences ranged from 0.7 to 4.3 days. Overall LEP length of stay was 6% longer [approximately 0.5 days].¹¹

2.2.4. Impact of Language Barriers on Quality of Care

A study which surveyed Hispanics and healthcare visits in the past two years found that non-English speaking Latinos experienced problems

communicating with their physicians.¹² Similarly non-English speakers encountered difficulties understanding instructions for prescription medications.¹³

18% of LEP respondents to a survey of outpatients reported having a drug complication (vs. 3% non-LEP). There were no differences based on age, gender, race, education level, or insurance status.¹⁴

Ethnicity, Hardt pointed out, was a risk factor for inadequate emergency department analgesia. Hispanics were twice as likely to get no emergency department pain medications. Non-English speaking status was a borderline significant predictor.¹⁵

2.2.5. Impact of Language Barriers on Costs of Care

Language barriers were found to lead to ordering of more costly tests, and to longer emergency room stay (165 vs. 137 minutes).¹⁶

One study investigated the average cost of interpreter services in HMO settings. It estimated that the average cost of interpreter services per LEP member was \$234/year. For the HMO, total costs averaged \$0.20 per member per month. The average cost of interpreter service encounters was \$79 at the time, which can be expected to decline with increasing efficiency.¹⁷

2.2.6. Impact of Language Barriers on Interventions

A comparative study of the quality of diabetes care for non-English-speaking patients found that LEP patients who had professional interpreters were more likely to get 2 or more Hgb A1Cs per year, 2 or more clinic visits per year, 1 or more dietary consults.¹⁸

A study found that interpretation method had an impact on clinic visit length. Interpreted patients spent longer in clinic [93.6 hours vs. 82.4 hours]

⁶ Woloshin et al JGIM 1997

⁷ Weinick RM et al Am J Public Health 2000

⁸ Wirthlin Worldwide 2002 RWJF Survey

⁹ The Commonwealth Fund 2001 Health Care Quality Survey

¹⁰ Lee ED et al Acad Emerg Med 1998

¹¹ John-Baptiste A et al, JGIM 2004

¹² The Commonwealth Fund 2001 Health Care Quality Survey

¹³ Andrulis D, et al. What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency, March 2002

¹⁴ Gandi TK et al JGIM 2000

¹⁵ Todd KH et al JAMA 1993

¹⁶ Tocher TM et al. JGIM 1997 and Kravitz RL, et al. Med Care 2000

¹⁷ Jacobs E, et al. AJP 2004; 94:366-369

¹⁸ Tocher TM et al West J Med 1998

and with the provider [32.4 hours vs. 28.0 hours]. Patients using telephone and patient-provided interpreters took longer; those using hospital interpreters did not. The authors calculated potential cost savings of reduced telephone usage and more efficient physician utilization in terms of potential hospital interpreters hired.¹⁹

A systematic review of the literature revealed that the use of professional interpreters is associated with improved clinical care more than the use of ad hoc interpreters, and professional interpreters appear to raise the quality of clinical care for LEP patients to approach or equal that for patients without language barriers.²⁰

Hardt cited existing mandates for medical interpreter services including CLAS Standards; Office of Civil Rights [OCR] guidance; state laws [26 states]; regulatory and review organizations (JCAHO, NCQA); risk management; possible cost savings, market opportunities; outcomes; quality and justice.

The CLAS Standards

The following language and access mandates are included among the CLAS standards:

- Offer and provide timely language assistance services without charge
- Inform patients of their right to receive language assistance services
- Access to Interpreters and/or bilingual staff
- Patient-related materials and signage

Executive Order 13166

President William J. Clinton on August 11, 2000 issued an executive order to improve access to services for persons with LEP. The order stated, "Each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency."

Office of Civil Rights Policy Guidance August 30th, 2000

Guidance issued by the Office of Civil Rights requires meaningful access for LEPs to all entities receiving federal money. The guidance mandates that entities receiving federal funding (a) assess language needs; (b) develop and implement written

policies for language access; (c) train staff; and (d) monitor vigilantly.²¹

The provider may not:

- Provide services to LEP clients that are more limited in scope or that are lower in quality than those provided to other persons
- Subject an LEP client to unreasonable delays in the provision of services
- Limit participation in program or activities on the basis of English proficiency
- Provide services to LEP persons that are not as effective as those provided to those who are proficient in English, or
- Require an LEP client to provide an interpreter or to pay for the services of an interpreter.

Hardt emphasized that the use of ad hoc interpreters leads to high risk of interpreter errors, omissions, distortions and redundancy. The risk is exceptionally high when the ad hoc interpreters are children.

The Massachusetts emergency department interpreter bill Section 25J states that "every acute-care hospital shall provide competent professional interpreter services in connection with all emergency room services and acute inpatient psychiatric services provided to a non-English-speaker or person who has difficulty in speaking or understanding the English language." Section 3c states that "any non-English-speaker denied effective health care services by a health care provider by reason of the provider's not providing competent professional interpreter services should have a right of action in a superior court." Governmental units are to reimburse the cost of interpreters for any mandated provider.

Does the use of trained medical interpreters affect emergency department services, charges, and follow-up? LEP patients not using interpreters had the shortest emergency department stay [p .001] and fewest tests [p .04] and prescriptions [p .03]. Patients using hospital trained interpreters were more likely to make clinic follow-up and less likely to return to the emergency department than patients not using interpreters. [p .03]. Among non-admitted patients, return visit to the emergency department, charges and total subsequent 30 day charges were reduced for patients using hospital interpreters compared to those not using interpreters.²²

¹⁹Fagan MJ et al JGIM 2003; 18: 634-638

²⁰ Karliner L et al Health Services Research 42:2 [April 2007]

²¹ www.hhs.gov/ocr

²² Bernstein J et al. Journal of Immigrant Health 2002; 4: 171-176.

Hardt noted that the Massachusetts Medical Society (MMS) had issued a report²³ stating that it:

- Recognizes the importance of language barriers and cultural sensitivity and supports the use of interpreter services when legally required or otherwise appropriate, whether for reasons of language, culture, or physical disability.
- Calls for the domains of language access and cultural competency to be separate as per CLAS.
- Encourages working with other interested parties in measuring, evaluating, and improving the quality of medical care provided to patients with significant language and/or cultural barriers.
- Urges support for the implementation of a standard statewide system of documentation of LEP status in health related documents and information systems, along with requirements for documentation of interpretation methods used.
- Supports collaboration with health plans and encourages legislative efforts to provide coverage for the increased costs of interpreter services necessary to provide high-quality medical care to patients who have significant language and/or cultural barriers or physical disabilities.
- Proposes making available to individual providers and groups educational resources related to mechanisms of reimbursement for interpreter services and for provision of cost-effective health services across language barriers.

Hardt noted that the Joint Commission on Accreditation in Healthcare Organizations announced that it is appointing an expert panel to help guide a study on language and culture issues in hospitals. The two-and-one-half year project, funded by The California Endowment, is the first comprehensive study to explore what hospitals are doing to address the cultural and linguistic needs of patients. Hardt quoted Paul M. Schyve, senior vice president of the Commission, who said that “providing culturally and linguistically appropriate services goes beyond patients’ rights. In fact, these

²³ Massachusetts Medical Society, Information Report 105, 2007

issues are critical in the delivery of safe, quality patient care.”

Hardt cited the following critical institutional responses to language barriers:

- Documentation of language status of patient; chart documentation of method of interpretation used;
- Organization of an Interpreter Services Department with training activity for hospital staff and interpreters; notification of rights for patients; and
- Monitoring of outcomes measures by language status.

Hardt posed the question, “Does language competence facilitate cultural competence?” He argued that skills training in language may invite and synergize with efforts to learn cultural competence. He added that the interpreter services department often catalyzes/leads organizational efforts at cultural competency. Furthermore, Hardt pointed out, the methodology of an organization’s approach to language-based disparities can model approaches to other areas of disparities.

Hardt tackled the issue of maintaining quality care continuum for LEP patients. He noted that well-developed interpreter services are needed to complement a linguistically and culturally diverse staff. He added that such systems may elevate the standard of care for patients with LEP up to our usual level. He pointed out that the systems are available, the costs are calculable and finite, interventions may even pay for themselves, and that social justice requires that we implement them.

2.3. Workshop Session I

Workshop A: Legal, Ethical and Financial Parameters for Linguistic Access in Healthcare Settings

Catherine Abate, J.D., President/CEO, Community Healthcare Network argued that a lot more is needed to be done in NYS, particularly in NYC, with respect to language access. She noted that every aspect of a LEP patient’s encounter with the healthcare system matters. She added that health information should be available to people to make informed decisions. Getting patients involved in care is critical. There is a need to move away from the outdated “doctors to patients” model to the new model of “self managed care”. She reminded participants that we should question: are there enough standards? Are there enough resources?

And is there enough training? She emphasized the need for “culturally respected healthcare.”

Nisha Agarwal, J.D., Attorney/Skadden Fellow, explained the mission of the New York Lawyers for the Public Interest (NYLPI), a nonprofit, civil rights law firm that strives for social justice. Agarwal noted that NYLPI partners with member law firms, corporate law departments, and other organizations. Its goals are to “help underrepresented people develop legal strategies and serve their vision for themselves and their communities.”

Agarwal described the different programs within NYLPI: The Pro Bono Clearinghouse; The Disability Law Center; The Environmental Justice Project; and The Access to Healthcare Program.

Agarwal described the new approach to language access advocacy adopted by her organization, which she termed advocacy from the “Outside In”. It is comprised of the following elements:

- Education & outreach
- Partnerships with community-based groups to survey LEP patients’ access to local hospitals
- Meetings and negotiation with hospital administrators to improve language access policies
- Filing of administrative complaints, if necessary
- Lobbying & law reform, and
- Research and collaboration with health care providers to understand what they know (and do not know) about LEP patients’ rights as well as their subjective attitudes toward LEP communities.

The goal is to shape the design and implementation of language access policies, and to improve provider education & training.

Agarwal argued that there is a gap between hospital administrators and frontline caregivers in terms of knowledge about legal obligations; communication about language assistance services available; and perceptions about how accessible services are. There is very little documentation of implementation failures which directly impact quality of care to LEP patients. Agarwal emphasized that understanding the provider’s perspective may lead to more patient-centered care.

Agarwal noted that provider perception is critical. She cited a study which found that despite a statistically insignificant difference in time spent between LEP and non-LEP patients, physicians

perceived that they spent more time with LEP patients and that they were more challenging.²⁴

NYLPI conducted a survey of 100-200 emergency medicine residents at a large teaching hospital in the Bronx. The study assessed (a) knowledge of communication assistance services available through the hospital; (b) knowledge of LEP laws & regulations; and (c) attitudes toward LEP patients. Residents were less familiar with available communication assistance services and/or LEP laws and more likely to have negative attitudes toward treatment of LEP patients than residents who had familiarity with the relevant laws and policies.

Implications for Research

Agarwal stated that there is a need to deepen understanding of:

- Provider constraints and “implementation failures.”
- Provider decision-making, heuristics employed in diagnostic evaluation, and the influence of patients’ race, ethnicity, gender, and social class on these decisions.
- Individual vs. institutional biases. Failure to properly implement language access policies may alienate patient and provider, entrenching negative attitudes of both.

Implications for Advocacy

Agarwal argued that there is a need for:

- More informed negotiations with hospitals for improved language access policies.
- More efforts to influence provider education.
- Provider-community collaboration.
- Innovative policy options and systemic reform.

Mara Youdelman, J.D., LL.M., Director, National Language Access Advocacy Project stated that the National Health Law Program (NHeLP) is a national, non-profit law firm working on health care access and quality. NHeLP began the National

²⁴TOCHER & LARSON 1999

Language Access Advocacy Project in 2003 and issued three “promising practices” reports on language services in healthcare settings.

Youdelman stated that the Federal Civil Rights Law, Title VI has been in existence since 1964. The law mandates 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” 42 U.S.C. § 2000d. “National origin” includes individuals with Limited English proficiency (LEP).

Youdelman stated that a number of recent initiatives have focused attention on linguistic access, including:

- August 11, 2000 – Executive Order 13166
- August 31, 2000 – Letter from Department of Health & Human Services to state Medicaid and SCHIP directors on the availability of matching funds to help pay for language services
- August 2003 – HHS Office for Civil Rights guidance on language access
- Recent federal legislation –
 - Patient Navigator Outreach and Chronic Disease Prevention Act of 2005
 - Ryan White HIV/AIDS Treatment Modernization Act
 - Homeland Security Appropriations Bill – FEMA

Youdelman pointed out that all (we just updated our survey so this is very current) states have language access laws, which are either comprehensive or targeted (e.g. emergency room, hospital). More and more states are enacting laws/policies to expand language access. These laws and policies, Youdelman stated, are not necessarily needed because of Title VI’s scope but they are appropriate given the limitations of enforcement.

Youdelman explained that only a handful of states have set up programs to provide direct reimbursement using federal matching funds to pay for language services. These states are District of Columbia, Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Virginia, Vermont, Washington, and Wyoming. She added that Texas will start a pilot program and North Carolina is initiating credentialing prior to reimbursement. California has established a Medi-Cal Language Access Taskforce and Massachusetts previously had reimbursement for hospitals. After the conference proceedings,

Connecticut passed a law in July, 2007 to initiate reimbursement.

There are 4 existing models for Medicaid reimbursement for language services although states have significant flexibility in designing a program that works for them:

- Contract with language service agencies (District of Columbia, Hawaii, Utah, Virginia, Washington).
- Reimburse providers for hiring interpreters (Idaho, Maine, Minnesota, Vermont).
- Reimburse interpreters (Montana, New Hampshire, Wyoming).
- Provide access to language line (Kansas).

Youdelman provided an overview of current state reimbursements (2007) and CME requirements. In New Jersey, each medical school must educate students on cultural competency; CME must include cultural competency for physician re-licensure. California requires all clinically oriented CME for physicians and surgeons to include cultural and linguistic competency. In Washington, each health professions training program must integrate issues of multicultural health into its curriculum.

Youdelman emphasized the need to identify individuals *being served* and *eligible to be served*. Determining the language needs at first points of contact, she added, is critical. This can be done in the form of notations in schedule/patient records; language notification flyers; or with “I Speak” cards/posters.

She shared practices used to record language needs. The Los Angeles Care Health Plan uses color-coded stickers to designate language needs. The Women’s Health and Education Center (Marshalltown, IA) notes language needs in the schedule and computer data system.

The Washington Department of Social and Health Services require the noting of the client’s primary language in its computer system. The Kentucky Cabinet for Health and Family Services collects language information and specifics on each encounter that uses language services. In Arizona, the Department of Economic Security database does not proceed past certain fields without noting the client’s language needs. Clients are asked their primary language at initial and renewal interviews. Forms include 68 language choices plus an open-ended option.

Los Angeles County Department of Public Social Services collects language information at initial

eligibility applications and renewals. The county compiles a report to show the number of LEP individuals in the Medicaid caseload, by language spoken, served by each eligibility office during the month. In Washington, D.C., the Medical Assistance Administration worked with community advocates to develop its “I Speak” poster and cards and a “Know Your Rights” pamphlet.

Youdelman noted that there is a need to identify both internal and external resources. She pointed out that NHeLP’s *Language Services Resource Guide for Healthcare Providers* helps identify external resources including interpreter/translator associations and providers; training programs; translated materials; symbols; etc.

On training, Youdelman stated that Neponset Health Center (MA) employs native Vietnamese speakers trained as medical interpreters through the MMIA or Massachusetts Department of Public Health. The L.A. Care Health Plan offers medical interpreter training for bilingual staff of participating clinics and medical groups and provides training for health care providers (for continuing medical education credit) on how to work with interpreters.

There are many other training options.

On testing and certification, Youdelman noted that there are no federal standards for interpreter certification.

- NCIHC has a National Code of Ethics and Standards of Practice.
- OR has state-wide standards, and other states are starting the discussion (Indiana, Massachusetts, California).
- Washington has had state-based certification since the early 1990’s. It has the only statewide interpreter certification (in the seven most common languages) and assessment (used for all other languages) program – candidates who want to work as DSHS interpreters (staff and contract) must pass the state test.
- Kentucky Cabinet for Health and Family Services worked with a consortium of local colleges and universities to develop an assessment program; only those who pass are “deemed qualified” to provide services in languages other than English or to act as interpreters.
- Nebraska Health and Human Services System plans to develop an assessment

test for new hires – only those who pass will be allowed to use their non-English language skills on the job. It also plans to develop an assessment test for outside interpreters.

- North Carolina Department of Health and Human Services is working with other agencies to develop system-wide standards and payment rates for interpreters and is establishing credentialing as a precursor to Medicaid reimbursement

On the assessment of competency, Youdelman cited the example of St. Joseph Health System Community Health Programs (California), which requires assessment of staff providing services in non-English languages or as interpreters. North DeKalb Health Center (GA) – requires all bilingual staff to attend training sessions and to pass a test.

Examples of best practices in hiring bilingual staff include the Kentucky Cabinet for Health and Family Services, which has a designated Language Access Section with four trained interpreters. Los Angeles County human resources division certifies the language skills of bilingual staff. Washington bilingual employees can provide interpretation only if certified as interpreters and it is documented in the employee’s classification questionnaire.

On compensation of bilingual staff, Youdelman cited the following examples: the AZ Department of Economic Security offers a stipend of \$1,000 a year, the North Carolina Department of Health and Human Services pays bilingual employees at a higher grade level, the Los Angeles County Department of Public Social Services gives \$100 monthly to certified bilingual workers, and the Kentucky Cabinet for Health and Family Services plans to pay qualified bilingual employees at a higher pay level.

The use of contract interpreters was prevalent in two examples that Youdelman provided. Kentucky Cabinet for Health and Family Service qualifies community partners (both individual interpreters and language agencies) to interpret for the agency. Washington DSHS implements a comprehensive process to certify contract employees. Only those who pass certification (in the state’s seven most common languages) or assessment (for other languages) may provide services to the agency.

Youdelman also shared models of collaboration with the community. These models included the Idaho Department of Health and Welfare, which contracts with local community organizations; the

North Carolina Division of Public Health is working with the United Hmong Association to translate its fact sheets; and the Illinois Department of Human Services funds the Illinois Coalition on Immigrant and Refugee Rights.

With respect to translation of written materials, NE uses designated translators with a degree from a translation program, and the ID Department of Health and Welfare works with the Idaho Migrant Council and the Hispanic Commission to review benefits forms for appropriate Spanish translation.

Youdelman concluded her presentation by emphasizing the need to (a) explore the potential for new state and federal laws and policies, including expectations for non-hospital settings (private insurance, nursing homes, etc.), and Medicaid reimbursement, funding for workforce/training, training/certification standards; and (b) link to quality of care to change the debate. She assured participants that given the continuing demographic changes, change is likely inevitable. She stated that the outlook for NY is very promising considering the high interest in the issue.

Workshop B: Case Studies: Providing Linguistically Competent Care to Perinatal and Reproductive Health Clients

Khadija Abukar, Senior Staff Mentor, Somali Bantu Community Association, Rochester NY, and Interpreter, Brown Square Health Center

In sharing her personal story, Abukar talked about being a Somali refugee from Mogadishu. As the civil war broke out in Somalia, Abukar was forced to live the traumatizing experience of a refugee camp for four years. Abukar spoke of her struggles with the effects of female “circumcision” which she underwent at age 19 as well as lack of reproductive healthcare services when they were most needed. In the difficult conditions of the refugee camp one of her children got very sick and died when she was unable to pay for medical services.

Abukar recalled the extreme barriers she had to deal with in the complex U.S. healthcare system after being resettled. Unable to speak English she was forced to depend on her husband for interpretation that was, in itself, a challenge. She noted that there are significant differences between Somalia and U.S. healthcare, making it difficult for Somali women in the U.S. For example, in Somalia women are not aware of cancer screening, mammography, pap tests and the many

appointments required for prenatal and general preventive care. When they get to the U.S. they are not aware that these services exist.

Abukar said she found it a lot easier to negotiate through the healthcare system years later after she learned English, which allowed her to end her reliance on her husband for interpretation. She has a better understanding of the importance of C-section and has been able to make a connection between the cultural practice of “circumcision” and its impact on a woman’s reproductive healthcare.

In 2006, Abukar and her husband started the Somali Bantu Community Association in Rochester to support the Somali Bantu refugee population in their struggle to overcome the barriers they experienced. Although the Abukar family has momentous challenges of their own such as fighting to stay financially stable, they are committed to helping others in need. Abukar expressed hope that this organization will grow to help many refugee families in Rochester.

Sadiya Omar, Research Assistant, Interpreter and a Somali refugee, shared how she spoke virtually no English when she came to the U.S., and that this is true of many women refugees, forcing them to rely on males for interpretation and translation. Having been a victim of war, Omar now feels she has been given a “second chance at life”, and as part of that life, she and all other refugees deserve health care.

Omar volunteered with family planning services in her refugee camp and was trained to educate other refugee women. This was a difficult task, given that any discussion of family planning is taboo in her culture, and women are often very secretive. Women never share concerns with their husbands, health care providers, or the community. Omar relayed the importance of needing to encourage women to seek family planning services, in Africa as well as when they come to the U.S. Now that she is here, Omar feels she is onto her third life.

Omar, like Abukar, noted that Somali women have no knowledge of Pap tests, mammograms, and other preventive services, and that, upon coming to the U.S., refugee women are very confused and do not understand the purpose of these many tests. There is a need to inform women, and that is now Omar’s mission. In Somalia, prenatal care consists of one, maybe two, visits to a doctor. Most often women deal exclusively with a midwife. She also reiterated the fear surrounding C-sections, and the belief that many Somali women have about C-sections, that they are very dangerous and fatal,

instead of a life-saving, practice. She also mentioned that how, in the U.S., we are obsessed with “due dates” and that it seems that we are “rushing” pregnancies. It takes a lot of time to understand pregnancy, child care and family planning here in the U.S, especially if you are a refugee woman with low literacy and limited English ability.

Jennifer K. Carroll, M.D., M.P.H., Assistant Professor, Department of Family Medicine University of Rochester School of Medicine and Dentistry started working with the immigrant and refugee communities in Rochester in 1996. She has worked with Abukar and Omar as part of the “Cultural Competency and Access to Women’s Health Services” project, which includes a community-based survey of Somali women’s views concerning health. They surveyed a total of 34 women, representing a wide range of ages, ethnicities, time spent in refugee camps, and time spent in the U.S. 15 of the 34 were Somali Bantu—a historically persecuted population.

Carroll shared the following findings from the study:

1. Lack of access due to language is the primary barrier to care, especially for recently resettled women.
2. Having a female interpreter is critical to ensuring that the woman feels trust.
3. A female provider is strongly preferred. The sex of the interpreter or provider can be the sole deciding factor in whether a refugee woman seeks care.
4. There is a lack of clarity with certain obstetrical services, but refugee women believe that the U.S. system is superior to Somalia’s.
5. There are differing definitions in the U.S. and Somali culture regarding gestational age and “due date.”
6. Religion is very important in making obstetrical decisions (i.e. many women believe that having a C-section signifies that you are not waiting for God’s help).
7. There are great fears of, and aversion to, C-section, specifically with beliefs that C-section leads to death or infertility, disability, inability to function as a caregiver, etc.

Carroll shared her personal vision for next steps with language access in general:

1. Expand interpreter services and make them a routine part of care;

2. Cut the “financial fat”, tap into the physician lobbying power, establish clear standards and financial mechanisms;
3. Collect data on benefits of good interpreter services;
4. Coordinate resources more efficiently, legislate a shared resource list;
5. Train clinicians on working with interpreters; and
6. Incorporate interpreter services into assessments; including medical records, documentation.

Anne Pearson, Director, Reproductive Rights Unit, Civil Rights Bureau, NYS Office of the Attorney General discussed the Attorney General’s investigations of New York hospitals and the resulting detailed agreements between the office and a total of 17 hospitals. She mentioned that in order for an investigation to begin, there must be complaints that the Office of the Attorney General evaluates and documents. The Office then interviews staff. In almost all investigations, Pearson noted that the hospital does have a “sincere desire” to serve LEP and non-English speaking patients. But often, if there is a language policy, hospital staff do not know of it. Also, hospitals may rely on bilingual staff that do not have the interpreting skills required. There is little assessment, documentation, tracking, and monitoring of linguistic and cultural needs, as well as inadequate education of LEP patients regarding their rights.

As a result, the Office of the Attorney General and the hospitals agreed to undertake a collaborative effort. The agreements incorporated best practices that include having a central language services coordinator/office, offering a range of interpreter services and detailing the specific circumstances in which one type of service may be better than another, instituting methods of measuring and ensuring high-quality interpretation, and monitoring and documenting needs and services.

Pearson noted that none of the agreements looked explicitly at reproductive health care needs, but many complaints did involve reproductive health. She relayed the following two stories:

- A deaf patient in a hospital in NYC sought prenatal care, and only received a sign language interpreter at 3 of all of her visits, although she requested one each time. The patient told the doctor that she wanted her “tubes tied” after the delivery, although the patient did not understand that this was an irreversible procedure. The doctor sent her

to talk with a social worker, but again there was no interpreter provided, and the patient signed the consent form without really understanding what would happen. During the delivery, there was a sign language interpreter present at the beginning but she left. Complications following the delivery required the patient to stay in the hospital for three weeks—during which the patient never had an interpreter and was not told why she had to stay. Hospital staff instead relied on another patient who knew minimal sign language to interpret. Much later, the patient realized the permanency of the tubal ligation procedure.

- A Spanish-speaking patient in NYC was brought to the Emergency Department after fainting. She was told she was pregnant but that there was a “complication”—in reality, it was an ectopic pregnancy. Relying on the patient’s brother to interpret, the woman came to understand that they needed to do “surgery to move the baby.” Much to the woman’s shock, they did not “move” the baby but had to terminate the pregnancy along with removing one of her Fallopian tubes. Nine months later, the same patient experienced another ectopic pregnancy, signed a consent form without fully understanding her situation, and ended up losing her other Fallopian tube. Only much later did the patient realize the gravity of the situation.

Pearson noted that both stories illustrate that legal violations are occurring, and that they have great and serious medical implications, especially in the area of reproductive health.

Pearson emphasized that all stakeholders in the field of language access in reproductive health care should be aware of the following factors:

- Prenatal care, pregnancy, delivery and postpartum care are all very communicative processes that require a complete understanding by both the patient and the provider. There is also an urgency surrounding labor and delivery.
- There are many privacy concerns regarding reproductive health that must be considered in language access.

Pearson emphasized that there is little documentation about language needs. Providers need to track this information. There is also difficulty associated with monitoring service provision. There

is inadequate education about patients’ rights to access language assistance. She commented that some best practices have been formalized but there should be centralized accountability, and a defined range of services and measures for high quality services.

Grace Mose, D.A., Research & Program Associate, Family Planning Advocates of New York State (FPA) explained that the mission of her organization is to advance public policies that fulfill the rights of individuals to access comprehensive sexual and reproductive health services and education, consistent with the principles of justice and fairness and respectful of diversity, personal dignity and privacy.

Mose discussed the project entitled, “Strengthening Cultural Competency among Family Planning Providers,” whose goals are to develop a strategy to help family planning providers assess and enhance their ability to provide culturally and linguistically competent services to diverse populations. According to Mose, FPA conducted the following activities to achieve the project goals:

- Identified 6 interested family planning centers.
- Solicited input from national experts in cultural competency.
- Conducted Organizational Cultural Competency Assessment and Institutional Checklists.
- Conducted data analysis and developed written report.
- Provided mini-grants to help clinics implement recommendations.
- Provided ongoing technical assistance.

The following were the selected assessment sites:

- Planned Parenthood Mohawk Hudson, Utica Center.
- Planned Parenthood New York City, Boro Hall Center, Brooklyn.
- Community Healthcare Network, CABS Health Center, Brooklyn.
- Planned Parenthood Hudson Peconic, New Rochelle Center.
- Planned Parenthood South Central New York, Binghamton Center
- Planned Parenthood of the Mid-Hudson Valley, Newburgh and Goshen Centers

Assessment Tools included:

Organizational Cultural Competency Survey

- Staff ratings on importance and satisfaction of published factors indicative

of culturally and linguistically appropriate health care.

- 10-minute written survey conducted during FPA's Assessment Day.

Institutional Audit

Six Checklists which included:

- Present and Future Patient Demographics.
- Present Staff Demographics.
- Assessment by Leadership.
- Current Actions to Enhance Cultural Competence.
- Patient/Community Access to Culturally Appropriate Care.
- Community Involvement and Support.

The survey was adapted from the CLAS standards and from Dr. Stergios Roussos' presentation, *Using the Federal CLAS Standards to Foster a More Culturally Competent Healthcare Environment*, from the 132nd APHA Annual Meeting.

Mose pointed out that FPA offered mini grants and technical assistance to the organizations that have undergone assessments. Each organization was provided with \$3,000 to address at least one of the organizational priorities derived from the assessment.

Outcomes included:

- Staff training on how to provide culturally and linguistically appropriate services.
- Medical interpreter training for bilingual staff.
- Bilingual signage and consent forms.
- Refinement of patient registration to capture relevant demographic and cultural data.

Mose pointed out that it is critical to engage leadership; include the entire staff; explore ways to train onsite evaluators; and include patient and community perspectives.

She outlined some of the challenges organizations face in continuing this important work, including the need to secure funding to implement the federal mandates; the need for ongoing technical assistance; the lack of qualified trainers and training resources; and the need to link cultural competency to larger political issues including immigration and immigrants' rights.

Mose explained that FPA is seeking additional funding to continue the assessments. In addition, FPA will pursue the development and piloting of a method to solicit patient feedback about cultural competency; and the establishment of an information/resource clearinghouse.

Ms. Mose also discussed the results of a pre-conference meeting that brought together 50 immigrant women and their allies to discuss priorities and make recommendations about language access in reproductive health care. The pre-conference meeting generated the following recommendations:

- There should be standards for translations and interpretation;
- Patients should have the choice of interpretation services (e.g. language line, an onsite trained interpreter);
- Translations should be culturally sensitive, presented at different levels of literacy, and should be age appropriate;
- Cultural and linguistic sensitivity should start at the school level;
- Recruitment of female interpreters from more diverse communities should be increased;
- Funding is critical;
- Existing technology should be utilized;
- A policy of one stop comprehensive health services should be promoted; and
- Outreach to immigrant volunteers should be intensified.

Mose explained that participants were asked to identify the roles that FPA could play to advance these recommendations. The following suggestions emanated from these discussions:

- FPA can be a cornerstone and a unifying force for most immigrant organizations and women across the state.
- FPA can do more grassroots mobilization with providers.
- FPA can educate and provide advocacy training and leadership skills.
- FPA can work with local communities with the goal of addressing issues specific to those communities.
- FPA can be a center for resources (clearing house); and
- FPA can push forward the policy agenda.

Workshop C: Assessing Quality & Evaluating Healthcare Outcomes for LEP Individuals

Francesca Gany, M.D., M.S., Director, Center for Immigrant Health, New York University School of Medicine informed participants that the Center was founded in 1989 and that its mission is to facilitate the delivery of linguistically, culturally, and

epidemiologically sensitive healthcare services to newcomer populations to reduce health disparities. The Center is a network of community members, providers, researchers, facilities and administrators, program and policy makers.

The 1990 Census, Gany pointed out, indicated that 31 million Americans spoke a language other than English; 14 million were LEP. The LEP population jumped to 21 million in 2000. 15 states had over a 100% increase in their LEP populations from 1990-2000 and 14 had a 50-99% increase. In NYC, 21% of the Filipino, 27% of the Indian, 36% of the Italian, 48% of the Pakistani, 50% of the Spanish, 64.5% of the Russian, and 70% of the Chinese immigrant populations are LEP.

One of the interpreting modes being evaluated at the Center is Remote Simultaneous Medical Interpreting (RSMI). RSMI is a UN-style interpreting where trained interpreters are located remotely and interpret simultaneously to keep communication between the provider and the patient flowing as in same language encounters. Interpreters are screened for simultaneous aptitude; then rigorously trained in ethics, role, medical terminology, confidentiality, and skills surrounding interpretation. Interpreters can get daily feedback on their work through listen-ins. There is a quality management program associated with RSMI, which has been implemented at the South Manhattan Network of the New York City Health and Hospitals Corporation, and at Kings County Hospital Center.

The Center conducted a randomized study of the impact of medical interpreting modes upon medical outcomes and costs and examined accuracy of the modes. Research Questions included:

- Does RSMI Improve Timely Diagnosis of Depression?
- Does RSMI Facilitate Appropriate Follow-up Care?
- Does RSMI Improve Adherence to Screening Guidelines?
- Does RSMI Improve Outcomes for Chronic Diseases? *Diabetes, Hypertension, and Hypercholesterolemia*
- Does RSMI lead to fewer interpreting errors?
- Is RSMI a more efficient form of interpreting?

- Does RSMI lead to improved understanding of exit instructions
- Are visit lengths different across different modalities?
- Are there fewer repeat visits to achieve the same outcomes?
- Are there differences in test ordering behaviors, hence, costs?
- What are the opportunity costs vis-à-vis staff time?
- Are Hospitalizations/ER visits prevented

The study methodology in the error analysis included audio-taping scripted encounters, transcribing and analyzing them. Linguistic errors, medical errors and their significance were examined and scored by a panel. Error rate per utterance was recorded. The panel examined the time, and then compared findings for each mode with RSMI.

Findings of the study included:

- RSMI was 30% less likely to result in error.
- Trained remote consecutives (over the phone) were most likely to have errors.
- Trained interpreters in the room were almost as error-prone as the telephone mode.
- Efficiency—RSMI was the quickest, followed by proximal ad hoc, with telephonic consecutive last.
- Spanish efficiency—RSMI 30% faster than the next fastest mode with no loss in accuracy; two times faster than telephonic consecutive.
- Different languages may be different. Mandarin analysis is currently underway.
- Training matters. 27% of errors made by untrained interpreters were of moderate or greater clinical significance vs. 8.5% of errors made by trained interpreters. Vocabulary precision rate was 0.69 for trained vs. 0.34 for the untrained.

Gany explained the series of randomized controlled medical outcomes studies which compared different modes of interpretation and their impact. Various methodologies were used, including exit interviews with patients to assess satisfaction, taping and analysis of emergency room encounters, and

following a cohort of patients in the general medicine clinic for one year.

- RSMI was associated with higher referral rate for colonoscopy; concordant encounters had lower referral rates;
- Does RSMI lead to improved management of diabetes? RSMI was better than usual and customary. (U&C)
- The depression diagnosis study which compared modes of interpretation found the diagnosis rate was best in language concordant (English-English) followed by RSMI—but not statistically significant.
- Patient satisfaction survey compared language concordant, RSMI and usual and customary. RSMI fell somewhere between the two in terms of how they would rate the doctor, overall satisfaction with care, how understandable were the doctor's instructions. When asked how well the interpreting protected their privacy, RSMI was statistically significantly better than usual and customary.

Implications for Policy

- Need systematic interpreter training;
- Consider investment in dissemination of RSMI to users of telephone interpreting services. RSMI should provide cost savings even without consideration of seemingly improved outcomes;
- Consider recommending use of RSMI for Spanish-language encounters. RSMI will likely provide the most accurate results, and lead to better patient outcomes.
- Need more research on cost at a system-wide level and use evidence based knowledge to drive policy.

Dialogue with Participants

- Need to collect data in a uniform manner.
- Need for education of providers so they can effectively identify LEP patients.

- Need to expand linguistic access mandates to other parts of the healthcare system, not just hospitals.

Stergios Roussos, Ph.D., M.P.H., Research Assistant Professor, Center for Behavioral Epidemiology and Community Health, San Diego State University, Graduate School of Public Health reminded participants that any entity receiving any federal funds is required to provide some level of interpreting. Roussos pointed out that his work involved working with organizations to democratize the process of doing an assessment around CLAS-culturally linguistically appropriate services. There is a need to understand why assessing CLAS at the organization level matters to quality and outcomes. There is a need to move from policy to action. Organizations need to be more accountable for collecting data as the first step to making sure policy gets implemented.

What are the CLAS standards?

- 14 standards divided into themes: culturally competent care, language access services and organizational support for cultural competence.
- Some are mandates, others are suggestions, and some are hard to enforce.
- Issues expressed in CLAS: racism, workforce diversity, access, patient safety, cost of health disparities, cultural competence.

Challenges to CLAS research

- Complexity: Multiple interventions are happening at the same time, so assessing impact of each intervention is difficult.
- Delayed outcomes: Outcomes are not felt for months or years. Need to have an in-house research team to monitor outcomes over time.
- Inadequate indicators: Performance indicators are not clearly defined.
- Establishing causality: Attributing cause and effect is difficult.
- The changing organizational climate: Organizations have an evolving and adaptive nature. Interventions in place today are changing tomorrow so research is difficult to conduct.

Roussos pointed out that an organizational assessment is a holistic examination of people,

their environments and policy and ways the organization behaves. He outlined the basic principles guiding organizational assessments:

- Developmental-focus on activities that change over time;
- Participatory-involvement;
- Complementary-design of performance measures that complement existing measures; and
- Multi-component design which combines multiple measures.

Roussos outlined the rationale for using the national standards for CLAS as a guide to organizational assessments. He cited the fact the standards were developed using a thorough applied process. They are comprehensive and inclusive of patients and communities. They target skills and resources. They encourage ongoing improvement and they build on a pre-approved standard.

Roussos pointed out there is a need to adopt a multilateral approach. In assessing an organization's competence, one needs to ask: What do patients understand? What is their experience? Are they satisfied? What do staff in critical roles across the organization think about patients' perspectives? How do administrators and decision makers view findings? There is a need to assess what needs to be done about the data in front of them.

Roussos explained that the development of assessment tools usually take approximately 1 week/15 hours. Implementation usually takes 2 days/6hours. Data analysis usually takes 2 weeks/10 hours. Organizational assessments can be done without research support.

Applying CLAS standards to survey items entails incorporating CLAS standards which mandate the provision of language assistance at no cost to each patient at all points of contact during all hours of operation in a timely manner. The survey questions, therefore, must include the following items:

- Is staff able to identify the different languages used by patients?
- What community resources are available to assist the patient?
- When is a medical interpreter called?
- Is confidentiality protected?
- Are interpreters readily available?

When designing assessments, Roussos advises, focus on activities that are high in importance and low in satisfaction; synthesize results into recommendations: identify strengths and areas that need improvement; assess continuity of training; and evaluate how organizations assess patients' need for language assistance in situations when the patient does not request assistance.

Roussos pointed out that there are small-medium sized grants that would support organizational assessments, and/or support implementation of recommendations emanating from the data.

Roussos pointed out several **common mistakes** to avoid:

- Important organizational decisions are not tied to assessment. Assessments produce data that is not used to drive change, but are confined to reports on the shelf.
- Assessment is launched before administrative and top-management buy-in.
- Organization builds assessment tools from scratch, not utilizing existing and tested tools.
- Operating under the assumption that language access can occur without cultural access. There is a need to evaluate the intersection of culture with language access and address the impact of cultural bias on widening the disparity gap. Staff cultural bias may impact language access.
- Pilot testing is not conducted. This is important in organizations that do not have a formal evaluator or researcher and need to practice conducting assessments.
- Only one tool or method is used. There is a need to combine qualitative and quantitative methods to probe what is working and what is not.

Challenges to assessment

- Engaging administrative and clinical leaders to champion the assessment. It is critical to involve board members because they might have a broader view.
- Balancing practical and academic needs for a valid and useful assessment. Involve quality assurance staff that can make this happen.
- Securing staff time and funds for assessment. There needs to be dedicated people for the process, including human resources, quality improvement and administrative personnel working as a team.
- Capturing real patient outcomes. Many patient satisfaction surveys are conducted with patients who are in disempowered situations. The chances of critiquing services are slim. Even culturally appropriate surveys have failed. Satisfaction surveys may not be indicative of real patient outcomes.
- Ensuring that assessment results are applied. Communicating findings with top administration and board members is critical to the effective application of assessment results.

Dialogue with Participants

■ Need to be careful with the use of terms, for example, the term immigrants may group together all American citizens who do not speak English. Limited English Proficient is a derogatory term that implies a lack and absence of fluent English. Oftentimes terms are coined to elicit a policy action targeting a specific group, but terms need to be carefully chosen.

■ Need to conduct cost analysis of interpreter services to provide evidence-based data that interpreter services actually save money.

■ Interpreter certification and quality assurance systems must be in place.

■ Need to assess cultural appropriateness as well as linguistic competency of services. Need to include questions that assess staff understanding of the genetic

and ethnic habits of the culture served in a way that would improve patient care.

■ Need to make an effort to bridge theory and practice and narrow the gap between academic researchers and practitioners. There are grants that target collaborations between community organizations and researchers, not just as subjects but as partners.

■ It is critical to train doctors in working effectively with interpreters. The training must weave in the cultural aspects as well.

■ Programs targeting specific populations reinforce stereotypical attitudes about immigrant groups. People seek quick fixes but it is critical to recognize the diversity within a cultural group, to make care patient-centered and refrain from harmful generalizations.

■ Need to be patient-centered on issues of religious interplay with healthcare.

■ Need to consider the unbalanced power relations between provider and patient.

■ Consider the nurses' role as the portal for sensitive and critical listening. The nursing literature pioneered discussions on competency in healthcare.

2.4. Lunch Presentation *Providing Linguistic Access: Can We Afford Not To?*

Marsha Regenstein, Ph.D., MCP., Research Professor and Director, Speaking Together*, The George Washington University School of Public Health and Health Services, Department of Health Policy described the program. She indicated that Speaking Together is a national program to improve quality of care for patients with limited English proficiency (LEP). It helps hospitals improve interpreter services by testing strategies and spreading best practices. It is comprised of learning collaborative of 10-hospitals⁺ from across the country.

Regenstein pointed out that there is a need for language services because (a) patients are increasingly diverse and multicultural; (b) one in six Americans speaks a language other than English at home; 20 million people speak or understand little English; (c) patients with limited English get less and poorer quality care; and (d) communication plays a major role in proper diagnosis, treatment, follow-up care and ongoing disease management—all contributors to quality of overall health care.

Regenstein cited studies which show that patients with language barriers have a higher risk of non-adherence to medications; are less likely to have a regular source of medical care; are more likely to

leave the hospital against advice and miss follow-up appointments; and do not fully understand their diagnosis and treatment. Regenstein indicated that half of the LEP patients in the Joint Commission's study experienced adverse events and suffered physical harm—compared to one-third of English speakers. LEP patients' rates of permanent or severe harm or death are more than twice that of English speaking patients.

Hospitals face the challenge of being required to provide interpreters to LEP patients at no charge with minimal federal guidance, without uniform standards for assessing the effectiveness of language services, and with limited information on best practices. There is a need to assess if current services are meeting patients' needs, and to identify institutions that implement successful models and to replicate those models.

Regenstein outlined the barriers facing hospitals in using language services. Those barriers include (a) cost (per encounter, costs range from about \$20-50); (b) inaccessibility; (c) unavailability; (d) advance scheduling requirements; (e) waiting time for service delivery; (f) clunky, inefficient and sometimes inconvenient modes of interpretation; (g) frequent problems with equipment; and (f) poor quality of interpretation.

Medical interpreters, when assessed and trained, can help in bridging this critical communication gap between provider and LEP patient. For this reason, the IOM lists supporting the use of interpreter services as a chief strategy for fighting disparities in health care and recommends that professional interpretation services be in place to eliminate language barriers in health care delivery. Unfortunately, providers in communities with rapid rates of growth among non-English speaking patient populations often do not have the knowledge or tools to enable them to design, develop and grow sufficient language service capacity in response to the needs of their linguistically diverse patient populations.

Regenstein outlined the goals of the *Speaking Together* Project:

- Identify and test models for providing language services by working with participating hospitals.
- Measure the effectiveness of language services at these participating hospitals; create performance benchmarks for improvement.
- Share success stories within and across hospitals and health systems.

Participating hospitals, Regenstein pointed out, receive grant funds and technical assistance to help them achieve the project goals including (a) setting and meeting improvement targets, (b) focusing improvements in of two clinical outcomes (diabetes, heart disease, or depression) *and* any general outcome with clinical significance; (c) using rapid cycle change to improve language services operations; (d) collecting, reporting and using data to assess progress; and (e) sharing best practices, tools and lessons learned in the collaborative.

Regenstein indicated that *Speaking Together* developed performance measures being used in the collaborative. Core measures being piloted include:

- What % of patients are screened for preferred language?
- What % receives assistance from assessed/trained interpreters or bilingual providers at assessment and discharge?
- What % waits longer than 15 minutes for interpreters?
- What % of interpreters wait longer than 10 minutes for encounters to begin?
- How much time do interpreters spend interpreting?
 - How long is the encounter?
 - How much time do interpreters spend providing other services?

Project Outcomes

Participating hospitals are now beginning to explore how they can approach delivery of language services differently in order to improve performance on the five language services measures and have begun to:

- Underscore the link between quality of care and effectiveness of interpreter services;
- Examine productivity and cost of interpreter services;
- Document demand for language services;
- Identify tested models for delivering high-quality interpreter services; and
- Enhance relationships between language services and other hospital components.

Lessons learned from the collaborative will be made available to hospitals nationwide at *Speaking Together's* May 2008 meeting. More information about the program and the participating hospitals is available at the web site, www.speakingtogether.org.

* *Speaking Together* is a national program funded by the Robert Wood Johnson Foundation aimed at improving the quality and availability of health care

language services for patients with limited English proficiency.

Participating Hospitals:

- Bellevue Hospital Center
- Cambridge Health Alliance
- Children's Hospital and Regional Medical Center
- Hennepin County Medical Center
- Phoenix Children's Hospital
- Regions Hospital (MN)
- UMass Memorial Health Care
- UC Davis Health System
- University of Michigan Health System
- University of Rochester Medical Center

Amy Wilson-Stronks, Principal Investigator, The Joint Commission, (formerly Joint Commission on Accreditation of Health care Organizations)

provided a brief overview of the importance of communication in patient safety. She emphasized the critical need to quantify the safety link to language services, and explore how hospitals are addressing the provision of language services. She cited a study that shows that LEP patients have a higher risk of adverse events in healthcare encounters than English speaking patients. Wilson-Stronks noted that there is a need for research to qualify and quantify the issues and have evidence-based policies.

Wilson-Stronks noted that The Joint Commission sought to understand the issues related to cultural competency and providing patient-centered care. Through a research study funded by The California Endowment, they approached hospitals to understand from their perspective what the challenges were and to identify best practices. The study employed a qualitative design. It sampled 60 hospitals which represented various hospital qualities and demographics. The sample included both hand-selected hospitals and those selected in a more random manner. In-person interviews were conducted with hospital CEOs and administrative leaders. A hypothetical case scenario was used to assess what clinicians would do to provide care to an LEP patient with particular cultural beliefs.

Wilson-Stronks outlined findings of the study:

- There are a wide range of practices occurring in hospitals. There appears to be a more focused effort to address language than culture. However, there is a gap between current practice and desired practice. Two possible reasons for the gap are missing

resources and processes and/or resources or processes not being used.

- Some hospitals are really committed to this issue and have been creative in identifying and gathering resources to make things happen.
- Language services available: 23 hospitals had in-house interpreters – not bilingual or dual role staff, but those hired solely for providing interpretation services. 19 hospitals used contract interpreters. 53 used bilingual staff as interpreters. 59 used telephone interpreters.
- Bilingual staff was used most often. However, only 29 hospitals trained or assessed their bilingual staff. Most of the hospitals that had conducted training were from the hand selected hospitals in the sample, which is not surprising.
- As part of the study, we used a hypothetical case scenario: LEP patient: Spanish speaking, 60 yr old widower, 12 yr old English speaking daughter, appendicitis in great pain, believes pain is caused by a hex that has been placed on him, visits ER, encounters triage nurse, ER physician, ER floor nurse, radiology tech, staff RN, housekeeper, social worker, interpreter.
 - According to administrative interviews, 32% of hospitals prefer using telephone interpreting services; 80% indicated phone was used frequently, often or regularly.
 - Interviews with physicians: only 5% indicated that they would use the telephone to communicate with Mr. Lopez. ("It's awkward and impersonal". "I can't see the patient's face/expressions.") 48% prefer communicating directly with Mr. Lopez.
 - Of the 48% of physicians who prefer direct communication, 8% indicated that their skill in the target language is rudimentary. 2% indicated that their communication would be non-verbal, and that they would use sign language to let him know he needs surgery.
 - Triage nurse: "Luckily we have a lady in housekeeping who speaks Spanish, 90% of our foreign speakers speak that language and she is able to help us."
 - "Most have kids that do a good job of interpreting."

Wilson-Stronks emphasized the need for language assistance policies. Hospitals, she

noted, need to assess linguistic proficiency because there is a preference for direct communication. They need to invest in training interpreters, staff interpreters or dual role bilingual staff, and in training staff to work with interpreters.

Hospitals indicate that financing is a challenge. One CEO, however, saw this as a risk management issue, the cost of not doing it outweighs the costs of doing it. There is a critical need for greater awareness of the distinction between a professional medical interpreter and someone who is bilingual. There is a need for enhanced access to telephonic interpretation as a complement to in-person professional interpretation. There is also a need to share promising practices for overcoming financial and other resource constraints to providing effective language services.

Wilson-Stronks noted that The Joint Commission will publish a report on Promising practices implemented in hospitals which participated in the study. She asserted that there is a need for enhanced education about the existing accreditation standards, and for consensus on what the standards mean and on how healthcare facilities can comply with these standards.

2.5. Workshop Session II:

Workshop D: *Linguistic Access Technologies and Innovations in Healthcare Settings*

Emily Ambizas, Ph.D., Assistant Clinical Professor of Clinical Pharmacy Practice, St. John's University & Linda Weiss, Ph.D., Senior Research Associate, New York Academy of Medicine discussed language access in the pharmaceutical context. They underscored the need to make available prescription medication instructions in languages other than English, including pharmacist provision of written prescription medication information, and counseling in languages other than English.

Ambizas and Weiss noted that as recipients of federal funds in payment for medications, pharmacies may be subject to the requirements of Title VI of the 1964 Civil Rights Act. Pharmacies may be required to provide language access services to comply with the branding and counseling provisions governing pharmacy practice. These provisions mandate that (a) medical labels or printed information must be rendered in a way that "is likely to be read and understood by the ordinary

individual under customary conditions of purchase and use;" and that (b) a pharmacist or pharmacy intern providing prescription services shall be required to personally counsel each patient or person authorized to act on behalf of a patient.

Hospital-based pharmacies may be required to follow the directives of the NYS Language Access and Patients Rights regulations adopted in September 2006, Ambizas and Weiss pointed out.

NYS pharmacies are required to print labels in English. They can print labels in a second language as well.

The speakers discussed their survey of 200 randomly selected pharmacies in New York City. Interviews were also conducted with a pharmacist on duty. The survey included questions on:

- Frequency and language of LEP customers.
- Languages spoken by pharmacy staff.
- Ability to print translated medication labels and leaflets.
- Frequency of translations.
- Policies and practices regarding multilingual medication information.

Interviews were conducted between February and August 2006 and took about 5 minutes each to complete. 59.5% of pharmacies surveyed were independent, 35.5% were chain, 3.5% were hospital outpatient and 1.5% were clinic pharmacies.

88% of pharmacies surveyed served LEP customers daily, 78% served Spanish-speaking customers daily, 14% served Russian-speaking customers daily. 7% indicated that they served LEP customers "les than daily," and 5% indicated that they have no LEP customers.

35.8% of pharmacies surveyed indicated that they provided daily translations of medical labels. 12.5% indicated that they provided weekly translations. 25.0% said they never translate, and 33% indicated that the customers request translations.

Understanding medication information is critical because this information may be complex. It refers to dosing, frequency and duration. There may be special instructions regarding food, liquids, and storage. Medications also may have side effects. The implications of medication errors include reduced efficacy, side effects, and drug resistance. 1.3 billion Medications were prescribed or provided during medical visits in 2002 alone and patients

have day-to-day responsibility for medication management and recognition of adverse events.

Common Efforts Made to Provide Information in Multiple Languages

- Utilization of dispensing software with translation capabilities.
- Handwritten translated instructions.
- Staffing with bilingual employees and/or language study.
- Telephone interpreting using language lines.
- Telephone medication counseling by bilingual pharmacists in other pharmacies.
- On-line medication and health information in multiple languages (e.g. walgreensespanol.com).

Less Common Efforts Made to Provide Information in Multiple Languages

- In-store kiosks with health information in multiple languages.
- Video-based interpretation services.
- Direct video link between the patient and a remote interpreter.
- “Talking” medication bottles with verbal instructions

Ambizos and Weiss cited the following existing barriers to increased language access:

- Pharmacists are concerned about translating into languages they don't understand and about liability if there is an error.
- Translation software is inadequate.
 - Programs may only print one language at a time. May need to print two labels to have English and a second language; and
 - Translations may be awkward, not grammatically correct.
- Demands on pharmacists' time are already very high. Some feel there is no time for translation.
- Qualified bilingual staff is found in inadequate numbers.
- Pharmacists' attitudes and level of awareness obstruct linguistic access.

Ambizos and Weiss indicated that there is a critical need to (a) raise awareness about the availability of software with translation capability and of

telephonic interpreting services; (b) include patient language preference in the patient profile; and (c) inform patients of available language services through proactive efforts.

They shared planned next steps for their program:

- Continuing education classes for practicing pharmacists;
- Pilot interventions at selected pharmacies;
- Review of label translations for accuracy and reliability;
- Outreach to LEP populations.

Cornelia E. Brown, Ph.D., Founding Director, Multicultural Association of Medical Interpreters (MAMI)

provided an overview of her organization which represents a model of a self-sustaining interpretation provider organization. She explained that the pioneering organization was established in Utica, NY in response to the need for interpreter services. Brown added that horror stories about poor communication, lack of patient self-determination, absence of confidentiality, hidden conflict of interest in domestic violence cases, and cultural barriers to access created a strong urgency to respond.

In the initial phases, there was a need to create a service to help patients and providers understand each other. Volunteer community interpreters met monthly in 1997. Hospitals, insurers, child protective services, perinatal providers, health departments, nurses, and college teachers joined. There was an interest to train interpreters locally and make them available to all. Initial hurdles included the cost of training interpreters, and the absence of incentives to provide for interpreters who would be trained for what seemed like a non-paying job. Start-up funds for training were received for the NY Task Force on Immigrant Health to train 17 interpreters in 4 languages. In 1998, the organization was incorporated as a 501(c) 3 and board members were recruited from existing partners.

In August 1999 the organization dispatched its first paid medical interpreter services. A medical interpreting certificate and an internship program were established. In 2001, MAMI had 200 appointments per month. In 2002-2003, a legal interpreting course for work with domestic violence victims was established, and in 2004, a mental health interpreting course was offered. In 2004, the organization started offering on-site 24/7 service. In

2006 Syracuse hospitals supported the creation of a Syracuse branch of MAMI.

In 2006, MAMI provided interpreter services to 900 patients in Utica and 20 in Syracuse. Now, MAMI is teaching its 20th course in medical interpreting. The organization has 9 office staff, 8 medical interpreting staff, and 65 independent contractors-interpreters in 28 languages. MAMI services include skilled on-site medical / legal interpreting, written translation, interpreter training (medical, legal, mental health, train-the-trainer apprenticeship), provider cultural competency, advocacy and labor-readiness.

A number of factors led to the success of MAMI. There were more hospital regulations as a result of lawsuits brought by the Attorney General's Office, the NYS DOH Law, JCAHO regulations, NCIHC Ethics and standards, CLAS standards and the fact that providers have started to be aware of the patients' viewpoints.

Brown indicated that there is always a danger of being rural/ suburban and independent. The isolation may lead to a detachment from new technologies, lack of access to qualified personnel and in turn lower quality standards. To meet these challenges, MAMI sought economic self-sufficiency, established its roots in the community and strove to provide skilled services.

95% of MAMI's operations are supported by fee-for-service. Despite the competition with free services, MAMI's quality of services, Brown asserted, manages to draw customers. MAMI survives on the gap between cost and fees. Interpreters are paid and grants were obtained only for establishing the agency and to launch new projects. MAMI offers a basic medical interpreting course. To date, 200 individuals have taken this course.

MAMI reaches out to LEP patients. Patients visit the office with interpreting requests. 1/3 of appointment requests are from patients. Patients also visit the MAMI office with advocacy requests to intervene in situations where communication is critical. MAMI also reaches out to interpreters. MAMI undertakes several activities to advocate on behalf of LEP patients. Browne pointed out that MAMI organizes LEP forums, publishes in newspapers, and publicizes the right to interpreter services.

MAMI's roots in the community go beyond merely working proactively with the LEP population. MAMI reaches out to providers, to district attorneys, judges, lawyers, police, and victims' services organizations, and partners with them in teaching a

legal interpreting course. Mental health providers helped with the mental health interpreting course.

MAMI operates a self-sustaining center for training/dispatch which is used by all local health care facilities. MAMI's community model is driven by the conviction that a trained onsite interpreter is a superior mode that facilitates communication and understanding; retains the visual: body language, checks for understanding; and makes it easier to intervene to clarify and serve as cultural broker.

Brown shared her perspectives on policy priorities that would accelerate language access to healthcare. She identified the following priorities:

- Provision of funding for recruitment and training of interpreters.
- Ensuring that publicly-funded agencies offer trained interpreting only.
- Enforcing interpreter competency standards at all healthcare facilities.
- Establishing a statewide clearinghouse for translated materials.
- Identifying promising practices.
- Establishing a collaborative of stakeholders in upstate and downstate.
- Establishing medical interpreter training and dispatch centers throughout the state and develop local capacity for medical and legal interpreting.
- Setting up a mechanism for community cost-sharing for economies of scale.

Siddharth Rastogi, M.B.A., Co-founder, SimulTel Inc. discussed the pilot project which developed and tested Remote Simultaneous Medical Interpretation (RSMI) technologies. The project was a partnership between the Center for Immigrant Health, NYU School of Medicine and the Health and Hospitals Corporation, New York City.

Rastogi pointed out that studies conducted by Center for Immigrant Health comparing errors in scripted encounters using RSMI versus non-RSMI revealed that RSMI was 30% as likely to result in potential medical error. Large scale randomized controlled trials compared RSMI with usual and customary methods of interpreting conducted by Center for Immigrant Health at Bellevue Hospital found that patients using RSMI experienced improved management of diabetes patients, and improved diagnosis of depression in clinic patients.

RSMI, Rastogi noted, was associated with reduced interpreting time. RSMI was found to be 30% faster than the next fastest mode (ad hoc). RSMI was two

times faster than over-the-phone consecutive. RSMI is as simple as talking on a telephone. It leverages existing telecom/computing infrastructure and can be accessed from anywhere, including satellite facilitates and via cellular phone.

Rastogi also pointed out that studies show that RSMI is associated with increased patient satisfaction and enhanced privacy. 57% of patients indicated that they were very satisfied with RSMI.

Ratogi noted that RSMI is associated with lowered error rates, improved medical outcomes, time savings, operational ease, and building of therapeutic relationships.

Workshop E: *Developing an Action Plan for a Linguistically Competent Organization: Lessons from the Field*

Sandhya Parathath, MPA., Associate Director, NYC Health and Hospitals Corporation (HHC), stated that just over one-half of the population in the HHC service areas speaks a “Language other than English at Home.” Hispanics who speak Spanish as a primary language have more problems communicating with their physicians than those who speak English as a primary language.

Parathath gave an overview of the Health and Hospitals Corporation and their efforts to provide linguistically and culturally competent care to their patients—efforts which were actually stimulated by a citation that one HHC hospital received.

Parathath outlined the 2003- 2007 HHC LEP Initiatives:

- Every network within HHC has an LEP coordinator. These coordinators meet regularly with HHC’s LEP office, and are the key contacts locally for all LEP related services. They identify issues to be addressed, disseminate information, share best practices, and reduce duplication. HHC is also piloting initiatives to document language and cultural data. Each network has an LEP policy and procedure manual for language assistance services; these are posted on HHC’s LEP website. New employees receive orientation and staff are trained on how to access in-person and over-the-phone interpreters, as well as cultural competency trainings.

Each network policy has guidelines for patients who want to use family members or friends as interpreters. Staff will initially inform the patient of the availability of free interpreter services, and, if the patient refuses these services, staff will document the patient’s refusal of services. Parathath quoted HHC’s policy on the use of interpreters under 16. “Absent extraordinary circumstances, staff should not use a person less than 16 years of age as an interpreter, even at the LEP patient’s request. If a patient insists on using a person under 16 years of age as an interpreter, staff should strongly discourage such use and secure an appropriate interpreter in a timely manner. Should it become necessary, under extraordinary circumstances, to use a minor as an interpreter, staff must document.”

- Signage at facilities identifies availability of free interpretation services.
- Translation of written material via corporate intranet, which is a growing resource for multi-lingual documents. Key documents translated include informed consents; HIPPA documents; patient instructions; patient education. Translations are conducted in 12 core languages: Arabic, Bengali, English, Spanish, Chinese, Russian, Polish, French, Haitian Creole, Korean, Urdu and Portuguese. Translation guidelines are developed and used to solicit contracts for vendors and corporate standards. HHC is also planning to provide translations for medication labels and instructions.
- Developing interpreter capacity. In terms of in-person interpreters, HHC conducts assessment of basic language/literacy skills, and provides training in medical interpretation to staff and volunteers. The goals are to meet standards for quality, accuracy, professionalism and ethics. HHC uses telephone services for languages not covered by in-person interpreters, and in circumstances where the patient is uncomfortable with a third person. Parathath stated that HCC is developing and implementing screening tools to identify appropriate potential candidates for training based on language skills. HHC is sponsoring training in medical interpretation by Cross Cultural Health Care Program (CCHCP) of more than 60 staff/volunteers at HHC facilities. It is also sponsoring a Training of Trainers (TOT) conducted by

CCHCP using their Bridging the Gap curriculum. 8 staff have been trained so far. HHC is collaborating with the Center for Immigrant Health to develop a web-based training program to increase access and flexibility in training schedules.

Parathath concluded with an overview of the regulations and compliance standards. She cited the following regulations issued by New York State Department of Health in 2006:

- ✓ Appoint language assistance coordinators, adopt policies and procedures to ensure language assistance services.
- ✓ Training on importance of effectiveness of communication and access to services.
- ✓ Identify patient language needs and document on patient medical record.
- ✓ Do not use family, friends and children under 16 years old.
- ✓ Make available translations of significant forms.

Parathath argued that government funding, specifically for LEP Services, is minimal. HHC, she pointed out, is doing the best it can with the resources it has. HHC is currently spending approximately \$1-2 million per year per facility for interpreter services, patient navigators, training, signage, translations, etc. HHC is also investing \$500,000 to \$1 million per year for intranet, multi-lingual patient materials, training (interpreters), and signage development. HHC spends more than \$20 million per year on language access services. However, Parathath estimates that an additional \$20 million is needed.

Gayle Tang, M.S.N., R.N., Director of National Linguistic & Cultural Programs, National Diversity, Kaiser Permanente (KP) emphasized the critical need for language access in healthcare encounters. She shared a story about a time in her life when she was going through a stressful and difficult health care encounter, and how, even though she speaks English fluently, she lost her language skills and reverted to her native language.

Ms. Tang discussed the start of a Linguistic and Cultural Services Department at one Kaiser Permanente facility, noting that there was a fear that by offering these services, it would open a floodgate to demanding even more comprehensive services. However, KP has since realized the

importance of instituting their linguistic and cultural programs. Tang discussed the early success in enrolling more Chinese members once the initiatives began in Northern California, and how the programs spread to other KP locations. The programs eventually evolved into a larger “Diversity Infrastructure.”

Tang emphasized the importance of action—In that journey of achieving cultural competence, one must take action based awareness, skills learned and knowledge gain in working in multicultural settings. Creating systems change is key to infusing and sustaining cultural competency efforts.

She also noted that a key area missing from the CLAS standards is marketing, and that KP has done a lot to reach out to diverse members. She stressed the importance of building capacity and capabilities through partnerships and gave several examples, including an award winning partnership; the HCI Institute.

Ms. Tang concluded her presentation with a discussion of the research agenda for language access at KP, which includes three separate but interrelated areas:

- Compare trained and untrained interpreters.
- Examine translation quality and standardization with a focus on consistency and cost.
- Develop linguistic and cultural proficiency tool for providers.

Virginia Tong, M.S.W., Vice President, Cultural Competence, Lutheran HealthCare stated that Lutheran HealthCare’s vision is that it “has no reason for being of its own; it exists only to serve the needs of its neighbors ... Lutheran HealthCare understands a hospital is not a collection of buildings, machines and beds, but a staff of talented, creative and committed people who serve the community as they are needed...Lutheran HealthCare works in partnership with its neighbors, each relying on the other as friends who care about and assist each other... “

Tong pointed out that Lutheran Healthcare is located in Sunset Park, Brooklyn, and was established in the 1880’s when the area was home to Norwegian immigrants. In the 1960’s, the area was inhabited by predominantly Scandinavian and Puerto Rican residents. The area’s demographic profile changed again in the 1980’s when Chinese immigrants made their home there. In the 1990’s,

Arabic, Russian, Dominican and Mexican immigrants settled into the area. Lutheran's catchment area eventually expanded to incorporate the Caribbean population from the Flatbush area of Brooklyn. There is an annual documented need for 40+ languages and dialects. Tong estimated that the Institution-wide average number of annual patient visits that require an interpreter is close to 200,000 (excluding part-time clinics). Another 200,000 visits do not require an interpreter because the staff are bilingual and speak directly to the patient in their language.

Tong pointed out that governance at Lutheran Healthcare is designed to ensure cultural access. Community members are members of the Health Council for Lutheran Family Health Center and the Board of Trustees of Lutheran Healthcare. The Vice President for cultural competence reports to the CEO. The Cultural Access Task Force is composed of senior management of the hospital, nursing home and ambulatory network, interdisciplinary staff, providers, administrators, representatives of major ethnic communities in Southwest Brooklyn. The Task Force's committees include: Dietary, Language Bank, Education, Telecommunications, HR, Signage, Translation, and Spiritual Care. Advisory Groups provide community and staff input to cultural and spiritual initiatives. They include; the Arab Initiatives Committee; Latino Advisory Board; Chinese Advisory Board; LGBT Advisory Board; Senior Initiatives and ADA Advisory groups; the AdHoc- Chinese Unit Advisory Board, Mosque Advisory Board, and various focus groups (i.e. Russian).

Tong provided an overview of the history of cultural competence at Lutheran Healthcare:

- 1990 Asian Initiative w/ Chinatown Health Clinic
- 1995 Cultural Access Task Force
- 1996 Partnerships with Russian providers
- 1997 Open Park Ridge Health Center (w/ mosque), Hire Cultural Initiatives Coordinator
- 1998 Open Caribbean Health Center
- 2000 Mexican Health Project
- 2002 Open Chinese Health Center
- 2004 Korean Initiative
- 2004 Appoint Vice President for Cultural Competence who is responsible for all matters related to cultural competence and for working with all staff on the planning and implementation of cultural competence initiatives in operations and program planning.

Lutheran Healthcare, Tong stated, accomplished the following milestones:

- Translated documents for most major consents and patient forms and signage in four languages;
- Established a foreign and sign language assistance service, managed by Patient Relations and the Cultural Initiatives Coordinator, which utilize a language bank, interpreter telephones, video conferencing, bilingual and bicultural patient relations agency and freelance interpreters.
- Hired eight representatives and advocates, who speak Lutheran Healthcare's four key languages.
- Established a centralized written translation service system consisting of professional resources and in-house reviewers, and sometimes community based organizations.
- Distributed immigrant policies and information to all HR staff.
- Included cultural competence measures in annual employee evaluations.
- Amended job descriptions to include a cultural competency statement and bilingual skills needs (required vs. preferred).
- Established a uniform language policy and procedure.
- Conducted numerous cultural trainings and incorporation of cultural competence into all trainings including: customer service, telephone techniques, conflict resolution, sexual harassment, patient safety, etc.
- Recruited bilingual/bicultural employees as dual role interpreters through active HR efforts: 58% of approximately 3,500 staff members self identify as bilingual – Lutheran Healthcare is a major employer in the community.
- Conducted language proficiency screening of job seekers' language skills in collaboration with HR.
- Established computerized reports of language capabilities of staff members by department.

Tong noted that the following factors were keys to the success of Lutheran Healthcare in providing cultural and linguistic competent care:

- The inclusion of cultural and linguistic competency in the organization's mission and vision;
- Support from the Board and key Leadership;
- Having staff dedicated to cultural initiatives, including the Vice President for Cultural Competence, and a Cultural Initiatives Coordinator;
- Having a dedicated budget for cultural initiatives;
- Including cultural competence in strategic planning;
- Having support from organized labor;
- Partnering with community organizations;
- Establishing collaboration, and communication channels with, critical departments; for example, Human Resources, Organizational Learning, Pastoral Care, Food Service,

Nursing, Medicine, External Affairs, Finance, Social Services, Facilities and IT.

Tong discussed the following challenges facing Lutheran Healthcare:

- Resistance to change amongst some staff.
- Allegations of racism, reverse discrimination.
- Lack of resources: marketing, translation, training, screening.
- Lack of pool of bilingual professional staff.
- Lack of “best practices”.
- Length of time to fill positions.
- Job requirements vs. language requirements.
- Need to develop alternate strategies.
- Issues with dual role interpreters and volunteers (linguistic competency, confidentiality, union issues).
- Lack of interpreter training and screening standards.

Dialogue with Participants

1. Gaining and maintaining executive and top level support means assigning the responsibility of cultural and linguistic competency to executive management (as in the case of HHC), or having staff responsible for cultural competency report directly to executive management (as in the case of Lutheran Healthcare).

2. A holistic framework which integrates linguistic and cultural competency must be embraced. Language policies are more tangible and possibly easier to achieve compared to the more ambiguous cultural policies.

3. Census data is discriminatory, lumps populations and misses a lot of important information. Providers must consider self-identified ethnicity.

Workshop F: Ensuring High Quality Interpretation and Translation

Wilma Alvarado-Little, M.A., Medical Interpreter and Trainer, focused on issues of determining the skills and qualifications of an interpreter or translator, certification, testing, educational programs for training staff as interpreters and translators, criteria for contracting interpreters and translators, and how to effectively utilize community-based interpreters.

Alvarado-Little has worked in the health care field for over 20 years. When an interpreter enters a room and services are requested, he/she is

expected to be interpreting for both the patient and the provider. What determines a qualified interpreter?, Alvarado-Little asked. "What can we do to practice until certification comes into being? How do the provider and patient know I'm doing a good job?"

When developing a language access plan, Alvarado-Little pointed out, an organization must assess language needs before starting an interpreter program, and must determine if an interpreter would be a staff member who maintains a different job description and will be paged when needed or whether the interpreter will be hired to provide the service. When using bilingual employees with dual roles, an organization needs to consider the burnout rate for someone with two roles and the potential loss of productivity if they will be pulled away from the job they have been hired to perform. The organization also needs to assess if a person is part of a union and consider the implications.

An interpreter's code of ethics was established by the National Council on Interpreting in Health Care were the Standards of Practice. At this time, national certification for healthcare interpreters is not in place. The American Translators Association provides certification for written translation.

Alvarado-Little discussed that an interpreter has several different roles, as follows:

- o The interpreter maintaining his or her transparency and serving as a conduit is a primary interpreter role. Anything uttered by the patient is interpreted, including profanity and nonsensical words; physicians need to know what the patient is saying just as the patient needs to know what the provider is saying

- o Interpreters must be sure to ask when they do not understand a term a patient or provider is using and also ask the patient to clarify a term that the interpreter is not familiar with.

- o An interpreter can help a provider and a patient reach cultural understanding and can be a resource to bridge the cultural gap.

- o The role of advocacy is a very sensitive one since it makes interpreters lose neutrality and transparency. Interpreters must have a good reason to speak up on behalf of the patient to the provider.

Depending on the training, the description of these roles might be different but the premise is similar.

How does one determine if an interpreter or translator is qualified? Alvarado-Little urged the setting of educational requirements, conducting oral and/or written assessments, as well as ensuring that an interpreter has experience in the medical field and training in interpretation, medical terminology, and ethical dilemmas. Also, an interpreter should have awareness of the different roles the interpreter might have to navigate

Alvarado-Little outlined criteria for selecting qualified interpreters, which includes expertise with terminology, abiding by the Code of Ethics, knowledge of the culture of the population served; She advised participants when contracting with interpreters and translators inquire if these professionals are insured for errors and omissions have undergone training, have flexibility and awareness of the population served.

For telephonic interpretations, factors affecting selection of services include: rates (fee-for-service vs. flat fee); languages offered; equipment needed, e.g. double receiver vs. cordless vs. portable; tracking of calls (monthly vs. quarterly); interpreter training.

Alvarado-Little, currently a NCIHC Board co-chair, pointed out that the National Council on Interpreting in Health Care (NCIHC) is a multidisciplinary organization whose mission is to promote culturally competent professional medical interpreting as a means to support equal access to health care for individuals with limited English proficiency. NCIHC, Alvarado-Little noted, provides valuable information, including monthly updates involving the interpreter profession, the NCIHC listserv for its members and a Working Paper Series which is available on the website along with other resources such as electronic versions of the National Code of Ethics for Healthcare Interpreters and the National Standards of Practice for Healthcare Interpreters.

NCIHC is currently exploring the development of standards for training and certification Alvarado-Little shared a list of references and resources with participants that can be found in the Appendix of this document.

Javier González, Director of Language Initiatives, Center for Immigrant Health, New York University School of Medicine stated that the mission of the Center is to facilitate linguistically and culturally appropriate health care services for

immigrant populations. For the last 10 years, González's main activities have been to develop curricula in the area of medical interpreting, including quality control, train medical interpreters, assess them for language proficiency and fluency and interpreting aptitude, work with all practitioners at medical facilities to help them identify whether interpreters are qualified, and train providers on working with medical interpreters.

González mentioned that "false fluency" is a prevalent phenomenon in health care. He showed a video of a practitioner who thought he was fluent in Spanish, but exemplified "false fluency." He added that there is a perception in the US that Spanish is very easy and can be learned in 48 hours.

The Center is studying and administering proficiency assessments of Spanish and other languages among providers and staff. There is also a need to assess those who are front line staff, but who will not be involved in clinical situations. Some may have a strong colloquial background but not medical proficiency, so there is a need for clear guidelines for every situation in the healthcare facility.

The test for oral proficiency consists of a survey in which participants declare their fluency in the other language, followed by an interview, a medical terminology test, a reading comprehension test, and the oral exam. The test for interpreting aptitude consists of a scripted role play in which the participant is graded in the area of accuracy, medical terminology, role and ethics. This test also includes a written multiple choice test that examines role and ethics.

González provided an overview of the training program offered at the Center. Introductory, intermediate, and advanced courses are offered. Each is 48 hours of class instruction, complemented by 12 hours of lab work. Courses use a multilingual model; the didactic part is done in English and the practical part is done in the target language. Specialized terminology includes both medical and colloquial terminology, which is critical because many patients do not express themselves in medical jargon and may use colloquial terms to explain their complaints, their pain and their mental status. It is also imperative, González argued, that interpreters learn to develop skills to recognize and address differences in dialects.

Trainings include ethics and a discussion on the role of interpreters. Trainings consider linguistics and acknowledge that tone matters. Cultural competence is an integral component of the

training. Politically correct terms in the US might not make sense in other languages, for example. Interpreters are not medical anthropologists, so providers, themselves, need to be able to elicit the patients' particular cultural beliefs. Interpreters are not cultural clarifiers, González pointed out. The course uses a creative and student centered approach using the classroom as a stage to enact various role-plays reflective of language discordant medical encounters where students participate in all different roles. The course also uses the Center's extensive videos as learning aids.

The Center, González stated, has created clear measures to evaluate students and declare whether they receive (a) a program certificate of proficiency (highest mark), (b) of completion, or (c) of attendance (did not pass the class) after they attend an interpreter training. There is a pre and post written multiple choice test, a medical terminology test, and oral scripted role play with a mock medical interview to evaluate accuracy, interpreting aptitude, including role and ethics. The Center will pilot an online training module in medical interpreting next month, emulating a classroom experience, and is constructing a virtual language lab where students can access a medical library to learn the terminology and practice their interpreting. They can complete interpreting exercises, evaluate themselves and others, listen to voice recordings and be recorded so they can be assessed. Most of the instruction will be done virtually with some face-to-face interaction. A pre- and post-test will be conducted to assess progress.

The Center has a quality control program where a pool of language specific coaches work with interpreters to assess whether they are complying with the standards set by the program in terms of role, ethics, and accuracy; record a sample of their encounters; listen to them; and score their accuracy. The Center also has medical terminology quizzes and role plays to assess whether interpreters are up to par with the standards. The Center developed, implemented, and supervises the language and interpreting assessment, training, and quality control program of the nationally recognized, award winning remote simultaneous medical interpreting TEMIS Program of the New York City Health and Hospital Corporation.

Dialogue with Participants

- Translations need to pay attention to the literacy level and recognize that a 6th grade level in English may not be the same as 6th grade Spanish. For every translation, there needs to be a proof reader and an editor. Back translations are also critical to ensuring the accuracy of the translated

material. Multiple people should be involved in the translation.

- Electronic translation software has been tested and it does not work.

- The role of the interpreter as a cultural broker and an advocate involve ethics and judgment. They are very sensitive roles. Interpreters must be proactive to ensure that the patient is being served.

- Interpreters must debrief. They must pay attention to self-care to avoid burnout. An interpreter is not allowed to show feelings; if interpreting for end of life, he/she cannot start crying. Being part of a medical team makes it easy for an interpreter to debrief with fellow interpreters, providers, pastoral care staff, and/or supervisors. Avoid debriefing in an elevator or in a cafeteria.

2.6. Plenary Session & Discussion Groups: *Toward New York State and National Language Access Policies*

Maysoun Freij, M.PH., Health Policy Associate, New York Immigration Coalition kicked off the final segment of the conference by providing an overview of advocacy activities that the New York Immigration Coalition has been engaged in with a wide range of partners, which resulted in the conception of the 2006 NYS Department of Health regulations.

The final session of the conference sought to refine and sharpen the policy recommendations developed by conference co-conveners and the Planning Committee prior to the conference. Participants were divided into small discussion circles. They were asked to review the three policy targets outlined in the executive Summary of the Policy Framework and brainstorm the following three questions:

- Are you in agreement with the policy priorities identified in the policy document? Is there anything missing?
- Do you have any problems with any of the priorities expressed in this document? If so, why?
- Of the priorities expressed in this document, which priority should be our starting point? Where should we devote our energies?

The section below outlines the policy recommendations which emanated from these small group discussions.

2.7. Participants' Recommendations for Effective State and National Policies

Overall Goal

Decrease healthcare disparities by ensuring that the healthcare system is linguistically-accessible to all Limited English Proficient (LEP) individuals.

Policy Priorities

- Ensure that healthcare providers are able to receive **Medicaid reimbursement** for the provision of interpretation and translation services to patients in all healthcare settings. Other states are already using Medicaid to cover these services.
- In the absence of adequate federal funding mechanisms/eligibility, establish **supplemental state funding** to cover interpretation services provided by competent and trained interpreters in all parts of the healthcare industry.
- Designate **worker recruitment and retention funds** for scholarships and educational incentives to increase the opportunity for staffing the healthcare system with bilingual and bicultural New Yorkers.
- In the absence of clear federal mandates, **strengthen state standards** and expand them to all parts of the healthcare industry.
- Create **interpreter competency standards** to ensure that interpreters have prerequisite knowledge and skills.
- Strengthen **accountability and enforcement** of the new regulations around language assistance services and patients' rights.
- Create a **multi-lingual communication initiative** based in a NYS agency that will translate vital forms, identify promising practices, and support interpreter training.
- Develop and implement a state-sponsored **workforce development initiative**.

Workgroups met to discuss the policy priorities and to make recommendations, as follows:

Defining Terms

Participants expressed a need to define what is meant in the preamble/introduction to policy recommendations by terms such as LEP, NES, etc. so that everyone is on the same page and has a similar understanding. It is key for refugees, immigrants and other new Americans need to know their rights.

Centralizing Language Access Resources

Several groups affirmed the importance of centralizing the many different departments/resources necessary in the implementation of language assistance services. Some suggested centralizing at the state level and then decentralizing at the implementation level. This will give leeway for people to adopt their own local models to address the different issues facing diverse communities.

- ◆ Centralization will allow for the sharing of best models and practices across the state.
- ◆ A few groups mentioned the necessity of having a central depository for all translated materials. One group cited a program in Idaho, where an intranet system allows hospitals throughout the state to pull up fact sheets in other languages. In New York City, e.g., there are already vital documents translated into 12 languages, but they cannot be shared among the state because they are currently proprietary. A central depository system would work for smaller languages so that each health center/hospital does not have to develop translated materials on its own.
- ◆ Participants emphasized that centralization will not only validate the importance of language access, but it will enable the state to benefit from economies of scale due to the sharing of resources. Consequently, government agencies such as social services and Medicaid, which do not have money for interpretation and translation, could benefit, as the cost of such services would decline.
- ◆ In addition, centralization will facilitate the creation of an enforcement mechanism in one place, which will alleviate several of the problems associated with interpreter/translator standards.
- ◆ One group proposed the creation of an office centralized either in the Governor's

Office or Department of Health, with its operational space and facilities outside the main office in order to reduce congestion.

- ◆ Examples were given of centralized interpreting services that were working well. These included Australia, which has national phone interpreters, and Medicaid in Kansas had a billing code set up that allowed for minimal paperwork and made the process very simple. Washington State has a centralized contract model with one broker.
- ◆ Another group proposed that Instead of an initiative based out of one NYS agency, a “coordinating council” be established that will coordinate all agencies, as this issue is interdisciplinary and interagency. This council could centralize and oversee:
 - A repository of shared resources (broad range of media types: print, video, etc)
 - Interagency policies, meetings, decision making
 - State-funded interpreter and dispatch centers
 - Dispatch centers (“hubs”), overseen by council, that can:
 - Combine medical, social, legal services
 - Cost savings and sharing
 - Improve standardization
 - Be integrated with existing programs (i.e. MAMI, CIH) or established independently
 - Be located where there is the greatest need
 - Could offer telephonic and video-based services on a statewide basis (again, cost savings)

Although several groups agreed that some sort of consolidation was necessary to provide widespread and high quality language assistance services, they still acknowledged challenges that would arise with centralization.

- ◆ Due to the very diverse needs of the LEP population in the state, working group participants emphasized the need to allow flexibility for local models. In order to allow for this to occur, one group suggested that centralization occur at the state level (which will reduce duplication) and then decentralization at the implementation level.

Leadership and Support

Working groups discussed the necessity of having support from top levels of leadership and from influential government agencies.

- ◆ Many conference participants felt that the Department of Health and the Governor’s office need to take an active role in many aspects of language access, particularly in the realms of policymaking and enforcement.

Data Collection

Working groups identified the lack of research and data collection as a significant obstacle to the efficient planning of language assistance services.

- ◆ One group stated that collecting data will help to create certain milestones of success because it will help to identify how large the need is for language services. With better data, the state could make clearer goals for the number of interpreters available in various facilities and agencies.
- ◆ Another group noted that data should be collected from numerous sources—schools, census reports, etc. In addition, a focus on federal data, which is often more accurate than state and local data, will help in guiding research and implementation.
- ◆ One working group emphasized the need for a study of health disparities in areas where language access is limited. They cited studies in Boston and St. Louis that illuminated the connection between limited language services and clinical outcomes, cost, etc.
- ◆ In addition, groups identified a need to do more research on clinics/community based facilities and their language access outcomes. These smaller-scale facilities work closely with LEP patients; however, their patients are not studied in as much detail as LEP patients in larger hospital facilities.

Funding and Reimbursement

Groups discussed the issue of funding at length, restating the benefits that covered interpretation services provide.

- ◆ Providers are much more likely to provide language services when they are covered. As such, more innovative ways of acquiring funding should be adopted to encourage providers to use language services.
- ◆ The court system was suggested as a model.

Groups also discussed the necessity to advocate for greater funding mechanisms so that whoever is mandated to provide language access services has both that capacity and the technical assistance necessary.

Conference participants discussed current funding structures and expressed confusion over Governor Spitzer's allocation of \$28 million toward language access. There was the point made that upstate facilities also needed such funding, as well as private physicians, and all healthcare facilities, not just a select group.

In addition, conference participants raised questions over who should take responsibility for providing financial resources for language assistance programs.

- ◆ One group in particular discussed whether the federal government should be responsible for these services. They wondered whether the Federal government is willing to encourage the state Medicaid program to pay for interpreting/translating services.
- ◆ Groups discussed the role of private insurers in reimbursement. They discussed the issue of demanding money from private insurers at a rate comparable to Medicaid reimbursement. The question was raised of whether state agencies mandate this through licensing or other regulatory methods?
- ◆ In addition to general funding sources, working groups discussed earmarking particular funds for specific areas, such as regulation, enforcement, etc.
- ◆ The financing discussion also included those without legal immigration status and who would take responsibility for the language access services that they would require. One group pointed out that the undocumented receive care through state dollars; however, this becomes confusing as some undocumented individuals are entitled to Medicaid for emergency services, which are paid for by the federal government.
- ◆ Many groups reflected on the complexities of Medicaid and reimbursement policies. Many hospitals are unaware of how to effectively bill and secure reimbursements from Medicaid, which would render problematic their ability to provide language services to their patients if these were funded by Medicaid.
- ◆ Groups asserted the need for grants to supplement Medicaid reimbursement, because many immigrants are ineligible for funding through Medicaid. Participants encouraged a new mixed funding paradigm, which would shift away from

thinking only about Medicaid as a source of funding for language access programs.

- ◆ With respect to new sources of funding, groups outlined the possibility of securing Medicare money. Another group expressed doubts about federal money, citing a need to explore other avenues, such as the state and insurance companies and HMOs for funding.

In addition, participants discussed non-traditional sources of care, and the need for them to receive reimbursement for language access services.

Standards, Training, and Certification

Conference participants spent time discussing the quality and availability of interpreter training.

- ◆ One working group stressed the need to have trainings conducted by educators, not outside proprietary agencies. Some suggested that perhaps the educational institution should be a public institution.
- ◆ Participants also stressed the need for interpreter training programs to conduct outreach so that providers know that they are available to train interpreters.
- ◆ Several working groups discussed the role of the medical community in trainings, stating that they should be as involved as possible in order to ensure that accurate information transmission and translations occur.
- ◆ Mandate an ongoing process that never ends—i.e. establish mentoring, continuing education opportunities, etc. (the process is as important as the actual benchmarks that someone may have to reach)
- ◆ A cultural competence component should be added (21 countries have Spanish language and people from those origins have different cultures).
- ◆ Concern was expressed about limitations of “bilingual and bicultural” because these do not automatically mean culturally and linguistically competent—make sure that this recommendation is clear in need for competence.
- ◆ Minimum practice and observations, mentoring should be included in training/certification. This needs to be an experience-based profession.

A certification process would require more funding. Certification cannot be achieved until standards are agreed upon.

- We need to work at the local/state level to create standards before we

- attempt to work on the national level. We will have a better success rate.
- It was suggested that the policy priorities explicitly state prohibiting the use of children. Even 16 years old was thought to be too young a cutoff as an interpreting age.

Confidentiality was a recurring concern of the discussion groups. Confidentiality considerations should be a major part of certification.

- ◆ Some immigrants are uncomfortable with telephone services because they cannot tell to whom they are speaking. Over the telephone, people may be concerned with divulging information to someone that they know in their community. The same could be said for in-person interpreters. Patient education and stricter codes for confidentiality are necessary in sustaining telephone interpreting programs.

Conference participants discussed the need for system-wide standards. There was the suggestion that the policy document state that standards should be developed, rather than strengthened.

- ◆ These interpreting standards should be applicable to providers in a variety of settings: pharmacies, mental health facilities, small-scale facilities, CBOs that provide interpreting, etc.
- ◆ There was the question of do we need one standard, or many different levels of proficiency in different areas?
- ◆ Participants explored different ways of measuring such standards and of holding facilities accountable. One suggestion was adding interpretation services to hospital report cards. However, any standards should take into account the varying natures of smaller clinics that do not have the same demographics or capacities as larger hospital facilities. The same standards and access should apply to rural communities. It was noted that CLAS standards are not regulated.

- ◆ Some argued for the institutionalization of certification programs for interpreters; however, they recognized the limitations of such processes, and thus were inclined to support certification achieved gradually, over the span of a few years.

- ◆ They stressed that interpreters must have medical knowledge, which would enable them to effectively communicate with both providers and patients.

Working groups questioned who would be accountable for the quality of interpreters and organizations that provide interpreting services. Some stated that the healthcare providers and the interpreters/interpreting organizations/ interpreting businesses should be held accountable to foster trust between groups. Examples were given of people needs not being met by the telephone interpretation services because people are consistently connected to the wrong interpreter who speaks a different dialect/language than the patient. Patients should be a part of the process as well. Some groups already test interpreter aptitude and quality.

Interpreting As a Career

- ◆ To provide competent interpreting services, facilities must pay interpreters and provide them with enough benefits that attract them to stay in the field.
- ◆ Interpreters must be given the job title of an interpreter so that facilities will only rely upon competent individuals to provide such services.
- ◆ Ethical issues should be a key part of interpreter training and certification.
- ◆ Participants discussed the possibility of having workforce grants and educational scholarships to encourage people to enter the interpreting field.

System Capacity

In their discussions of creating sustainable multilingual initiatives, working groups addressed concerns over system capacity. They stressed the need to make reasonable expectations and to gradually enhance system capacity through the creation of coordinating councils, ongoing certification programs, and centralized planning.

In addition, there were concerns raised over deaf populations and the importance of including them in

any policies developed. In addition to sign language interpreting, there should be assurances that adequate signage, including in Braille, would be available.

To improve system capacity, participants recommended conducting needs assessments, which could then be used to model out costs.

Enforcement

Participants explored the ramifications of different terms used in discussing enforcement. They argued that monitoring and compliance, which constitute separate actions, are both necessary in the enforcement of language access regulations.

Participations expressed confusion over the legal ramifications of noncompliance with language access provisions.

Broadening the Discussion

While conference participants focused on the role of language services in facilities of varying size, they constantly reinforced more holistic methods to improving the status of LEP communities.

- ◆ Groups expressed the need for language access to look the same across healthcare, education, housing, etc.
- ◆ Conference participants also discussed the need for outreach and English language education to LEP communities. While acknowledging that English language competency should not be stressed as a unilateral approach to addressing language access issues, working groups advocated for a need to have more effective programs and classes to teach English.
- ◆ Similarly, working groups explored the possibilities for a more multilingual society, with language instruction encouraged in schools.
- ◆ In addition, groups emphasized that language access is not sufficient in

reducing health disparities. Cultural issues should also be addressed through greater awareness and through competency trainings.

Overall Strategy

One group suggested a phase wise approach as follows:

Phase I (Competency improvement system)

- Build/enhance existing capacity in the community and organizations
- Develop standards and benchmarks
- More research to show outcomes
- Education/awareness of the communities and providers

Phase II (Reimbursement)

- Build infrastructure to reimburse the services appropriately
- Put an appropriate funding mechanism in place
- Explore novel innovative application of technology in the future

Phase III (Accountability)

- Establish accountability and enforcement of the new regulation
- Workforce development
- More inter-agency type collaboration established

There was the suggestion that language access resources be included in the revised policy document.

APPENDICES

NEW YORK STATE CONFERENCE ON INCREASING LANGUAGE ACCESS TO HEALTHCARE: TOWARD EFFECTIVE STATE AND NATIONAL POLICIES

Conference Agenda

Wednesday, April 25, 2007

University at Albany

Campus Center Ballroom

Convened by:

**CENTER FOR WOMEN IN GOVERNMENT & CIVIL
SOCIETY, UNIVERSITY AT ALBANY**

**THE EDUCATION FUND OF FAMILY PLANNING
ADVOCATES OF New York STATE**

**CENTER FOR IMMIGRANT HEALTH, New York
UNIVERSITY SCHOOL OF MEDICINE**

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Conference Agenda

8:00 – 9:00 Conference Registration

9:00 – 9:15 Welcome & Introductions

Judith Sidel, Ph.D., Executive Director, Center for Women in Government & Civil Society, University at Albany

Honorable Adriano Espaillat, New York State Assembly, 72nd Assembly District

9:15 – 10:15 Keynote Presentation: *Language Access Research, Key Findings and Evidence-based Policy Implementation*

Eric J. Hardt, M.D., Associate Professor of Medicine, Boston University School of Medicine

Moderator: Francesca Gany, M.D., M.S., Director, Center for Immigrant Health, New York School of Medicine

10:15 – 10:30 Break

10:30 – 12:00 Workshop Session I

Workshop A: *Legal, Ethical and Financial Parameters for Linguistic Access in Healthcare Settings (Terrace Lounge)*

Nisha Agarwal, J.D., Attorney/Skadden Fellow, New York Lawyers for the Public Interest, Inc.

Mara Youdelman, J.D., LL.M., Director, National Language Access Advocacy Project, National Health Law Program

Moderator: Catherine Abate, President/CEO, Community Healthcare Network

Workshop B: Case Studies: Providing Linguistically Competent Care to Perinatal and Reproductive Health Clients (CC 361)

Jennifer K. Carroll, M.D., M.P.H., Assistant Professor, Department of Family Medicine University of Rochester School of Medicine and Dentistry

Khadija Abukar, Senior Staff Mentor, Somali Bantu Community Association, Rochester NY, and Interpreter, Brown Square Health Center

Sadiya Omar, Research Assistant and Interpreter

Anne Pearson, Director, Reproductive Rights Unit, Civil Rights Bureau, NYS Office of the Attorney General

Grace Mose, D.A. Research and Program Associate, Family Planning Advocates of New York State

Moderator: Joan Malin, President/CEO, Planned Parenthood of New York City

Workshop C: Assessing Quality & Evaluating Healthcare Outcomes for LEP Individuals (CC 375)

Francesca Gany, M.D., M.S., Director, Center for Immigrant Health, New York University School of Medicine

Stergios Roussos, Ph.D., M.P.H., Research Assistant Professor, Center for Behavioral Epidemiology and Community Health, San Diego State University, Graduate School of Public Health

Moderator: Wilma Waithe, Ph.D. Director, Office of Minority Health, NYS Department of Health

12:00 – 1:30 Networking Lunch (Ballroom)

Lunch Presentation *Providing Linguistic Access: Can We Afford Not To?*

Marsha Regenstein, Ph.D., MCP., Research Professor and Director, Speaking Together, The George Washington University School of Public Health and Health Services

Amy Wilson-Stronks, Principal Investigator, Joint Commission on Accreditation of Healthcare Organizations

Moderator: Cathy Cave, Director, Cultural Competency, NYS Office of Mental Health

1:30 – 3:00 Workshop Session II

Workshop D: *Linguistic Access Technologies and Innovations in Healthcare Settings (CC 375)*

Emily Ambizas, Ph.D., Assistant Clinical Professor of Clinical Pharmacy Practice, St. John's University & **Linda Weiss, Ph.D.**, Senior Research Associate, New York Academy of Medicine

Cornelia E. Brown, Ph.D., Founding Director, Multicultural Association of Medical Interpreters (MAMI)

Siddharth Rastogi, M.BA., Co-founder, SimulTel Inc.

Moderator: Kathy Miraglia M.S., C.S.C. Director, Interpreter Services University of Rochester

Workshop E: *Developing an Action Plan for a Linguistically Competent Organization: Lessons from the Field (Terrace Lounge)*

Karen Scott Collins, M.D., M.P.H., Deputy Chief Medical Officer for the New York City Health and Hospitals Corporation

Gayle Tang, M.S.N., R.N., Director of National Linguistic & Cultural Programs, National Diversity, Kaiser Permanente

Virginia Tong, M.S.W., Vice President, Cultural Competence, Lutheran HealthCare

Moderator: Lynn Stone, M.A., Director, Language Services Unit, Bureau of Refugee & Immigrant Assistance, New York State Office of Temporary & Disability Assistance

Workshop F: *Ensuring High Quality Interpretation and Translation (CC 361)*

Wilma Alvarado-Little, M.A., Co-chair of the Board, National Council on Interpreting in Healthcare

Javier Gonzalez, Director of Language Initiatives, Center for Immigrant Health, New York University School of Medicine

Moderator: Tammy Arnstein, Director, Language Access, New York City Mayor's Office of Immigrant Affairs

3:15 – 3:30 Break

3:30 – 4:45 Plenary Session & Discussion Groups: *Toward New York State and National Language Access Policies (Ballroom)*

Kick Off Speaker: **Maysoun Freij, M.PH.**, Health Policy Associate, New York Immigration Coalition

Moderator: Karen Anderson, M.Ed., M.PH., Director of Public Policy, Family Planning Advocates of New York State

4:45 – 5:00 Concluding Remarks

Dina Refki, D.A. Director, Immigrant Women & State Policy, Center For Women in Government & Civil Society, University at Albany

NEW YORK STATE CONFERENCE ON INCREASING LANGUAGE ACCESS TO HEALTHCARE: TOWARD EFFECTIVE STATE AND NATIONAL POLICIES

BIOGRAPHIES OF PRESENTERS AND MODERATORS

CATHERINE M. ABATE

Catherine M. Abate's career spans several decades of public service. She began her professional life as an attorney at the Legal Aid Society in New York City, and eventually became Director of Training in its Criminal Defense Division. She taught criminal law and procedure and trial litigation practice to hundreds of newly hired attorneys.

In 1986, Governor Cuomo appointed Ms. Abate to the position of Executive Deputy Commissioner of the New York State Division of Human Rights and in 1988, to the position of Chair of the New York State Crime Victims Board. During the Dinkins administration, she served as Commissioner of both the New York City Departments of Correction and Probation. Ms. Abate was elected as a New York State Senator in Manhattan from 1994—1998. While in the Senate, she was the ranking Democrat on the Crime Victims, Crime and Correction Committee, as well as Investigations and Government Operations Committee.

Since June 1999, Abate has served as the President and CEO of Community Healthcare Network (CHN). Community Healthcare Network is a not-for-profit organization established in 1981 dedicated to providing accessible and comprehensive culturally competent, community-based primary care, mental health, and social services to diverse populations in underserved communities. The network of nine health centers and two mobile health units is located throughout New York City and is affiliated with the New York Presbyterian Healthcare System.

Ms. Abate is a frequent lecturer and panelist on human rights, criminal justice, health care and management/leadership. She serves on a number of Boards, to name a few: Chair of Family Planning Advocates of New York State, Citizen Action of New York City (former Chair), Vice President of the Correctional Association of New York, Criminal Procedure Law Committee convened by Chief Judge of the Court of Appeals, Eleanor Roosevelt Legacy Committee, Co-Chair of New York City Council's Anti-Harassment and Discrimination Commission, New York-Presbyterian Community Health Plan, Inc., and Prisoner's Legal Services.

Abate graduated *cum laude* from Vassar College and received her law degree from Boston University Law School.

NISHA AGARWAL

Nisha Agarwal is a recent graduate of Harvard Law School and is currently a Skadden Fellow at the New York Lawyers for the Public Interest (NYLPI), a non-profit civil rights law firm specializing in health advocacy, environmental justice and disability rights. As a member of NYLPI's Access to Health Care program, Nisha advocates on behalf of individual patients and community-based organizations in New York City to ensure that individuals with Limited English Proficiency have equal access to the health care system. Nisha received her B.A. in Social Studies from Harvard College and read for a DPhil in Economic & Social History at Oxford University

KHADIJA ABUKAR

Khadija Abukar was born in Mogadishu, Somalia. She is the sixth of ten children. Ms. Abukar, her husband, and children fled Somalia in 1990, lived in a refugee camp in Kenya, and came to Rochester in 1996. The Abukars founded the Somali Bantu Community Association in 2006 to provide outreach, case management, literacy and educational programs and advocacy services to Somali families in the Rochester area. Ms. Abukar also is employed as a medical interpreter at Westside Health Services, Brown Square Health Center. She is fluent in Somali, Arabic, Maay Maay (a dialect commonly spoken by the Somali Bantu), and English. Ms. Abukar worked as a medical interpreter and research assistant on the AHRQ-funded R-03 study with Dr. Carroll and Ms. Omar, "Cultural Competency and African Women's Health Services".

WILMA ALVARADO-LITTLE

Wilma Alvarado-Little is a medical interpreter and trainer with over 20 years of experience in the health care field. She is on the Board of Directors for the Chicago Area Interpreter Referral Service, providing interpreter services to the deaf and hard of hearing population, co-chair of the Board of the National Council on Interpreting in Health Care and Director of the Community Outreach and Dissemination Core for the Center for the Elimination of Minority Health Disparities at the University at Albany, State University of New York.

EMILY M. AMBIZAS, PHARM.D., CDM

Emily Ambizas received her B.S. in Pharmacy degree from St. John's University in 2000 and continued her studies at the University, earning her Doctor of Pharmacy degree in 2002. Following graduation, she completed her post-doctoral Pharmacy Practice Residency at Harbor Health systems Veterans Administration Hospital in New York. Since that time, she has held the position of Assistant Clinical Professor of Pharmacy Practice at St. John's University in Jamaica, New York where she also serves as a Clinical Specialist for Brooks/Eckerd, Inc.

KAREN ANDERSON, MPH, MEd

Karen Anderson is the director of public policy at Family Planning Advocates of New York State (FPA). In that role, she initiated and directs FPA's Immigrant Women's Health Initiative that works to help family planning providers in New York better serve immigrant women. Before coming to FPA, Ms. Anderson lived and worked in Chile for twenty years. She is the founder and former director of the *Fundacion Educacion Popular en Salud* (EPES Foundation), a non-profit health training and research center in Chile dedicated to serving and empowering the poor. Ms. Anderson has a MPH from Harvard University and a MEd from the University of Massachusetts, Amherst.

TAMMY ARNSTEIN

Tammy Arnstein is the Director of Language Access for the New York City Mayor's Office of Immigrant Affairs. Her position was created in response to the recommendations of the Commission for Economic Opportunity (CEO), a committee of distinguished community, nonprofit organization, government, and philanthropy leaders charged by Mayor Bloomberg with analyzing the causes, scopes and consequences of poverty. In this capacity as Director of Language Access, Tammy serves as a technical advisor to CEO agencies and initiatives in order to help them better serve low-income limited English proficient New Yorkers. She also coordinates the Interagency Task Force on Language Access, a working group of 33 New York City agencies that meets regularly to exchange information and ideas regarding best

practices in language access service provision. Tammy recently graduated from Teachers College, Columbia University, where she earned a Master of Education in International Educational Development. She has also worked in museum education and public television administration, and as a freelance video producer.

ANNE BEAL, M.D., M.P.H.

Anne Beal, M.D., M.P.H., is Senior Program Officer for the Program on Quality of Care for Underserved Populations. Dr. Beal is Senior Program Officer for the Program on Quality of Care for Underserved Populations at the Commonwealth Fund. The goal of the program is to improve quality and reduce disparities in healthcare for low income and racial/ethnic minority patients by promoting quality improvement innovations and addressing barriers to quality improvement adoptions that would benefit the underserved. The Commonwealth Fund is a private foundation that supports independent research on health and social issues and makes grants to improve health care practice and policy. The Fund is dedicated to helping people become more informed about their health care, and improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. The Fund's two national program areas are improving health insurance coverage and access to care and improving the quality of health care services. Prior to joining the Fund, Dr. Beal was a health services researcher at the Center for Child and Adolescent Health Policy at Massachusetts General Hospital. In addition, she was Associate Director of the Multicultural Affairs Office, an attending pediatrician within the division of General Pediatrics, and an Instructor in Pediatrics at Harvard Medical School. Dr. Beal's research interests include social influences on preventive health behaviors for minorities, racial disparities in health care, and quality of care for child health. She is also the author of *The Black Parenting Book: Caring for Our Children in the First Five Years*. Dr. Beal has been a pediatric commentator and medical correspondent for The American Baby Show, ABC News, and NBC News. Dr. Beal holds a B.A. from Brown University, an M.D. from Cornell University Medical College, and an M.P.H. from Columbia University. She completed her internship, residency, and NRSA fellowship at Albert Einstein College of Medicine/Montefiore Medical Center in the Bronx.

CORNELIA E. BROWN, PH.D.

Cornelia E. Brown, Ph.D. is Founding Director of the Multicultural Association of Medical Interpreters (MAMI) of Central New York, since 1998. MAMI is a non-profit community organization serving Central NY from Herkimer to Cayuga Counties, with offices in Utica and Syracuse. MAMI ensures that limited-English –proficient people can access services by providing highly-skilled language assistance, in medical and legal settings. In addition to directing the organization, Dr. Brown supervises the MAMI interpreter training program and interprets in Russian. She often presents and publishes in the interpreting and translating fields. Dr. Brown has the MAMI Certificate in Medical Interpreting and a license from the Cross Cultural Health Care Program (Seattle) to train interpreters using the curriculum "*Bridging the Gap*." She is accredited by the American Translators Association for translation from Russian into English. Brown has a doctorate in Russian and Comparative Literature from UC Berkeley, has taught as Visiting Assistant Professor at Hamilton College (1994-1995) and is now Scholar-in-Residence there.

JENNIFER CARROLL, MD, MPH

Jennifer Carroll is a family physician in Rochester, NY at Brown Square Health Center, a federally funded independent community center in Rochester, New York. She is a Research Assistant Professor in the Department of Family Medicine and at the Cancer Center, University of Rochester School of Medicine. Dr. Carroll has worked with refugees, asylum seekers, and torture survivors from over twenty different countries since 1996. She has worked closely with the Somali community since 1996, when many Somali families began

resettling in the Rochester NY area. She formerly worked at the Boston Center for Refugee Health and Human Rights assisting asylum seekers and torture survivors with medical affidavits and primary care services. She was the Principal Investigator of a R03 grant from AHRQ, "Cultural Competency and African Women's Health Services". She has published and presented extensively on the topics of refugee health and improving health care for Somali women. She is a member of CARE, Physicians for Human Rights, the American Public Health Association.

CATHY CAVE

Ms. Cave joined the OMH Staff in January 2001. In addition to her current policy position, she has twenty years of experience as a service provider and consultant in the arenas of mental health, child welfare, developmental disabilities and juvenile justice. She has been active in educating and mentoring private organizations in planful supervision, management and leadership development, strength-based treatment approaches, understanding oppression, community collaboration and cultural competence. She has partnered with consumers and survivors to coordinate collaborative mental health initiatives for survivors of sexual trauma within the mental health system as well as parents with psychiatric disabilities. In her role as the Director for Cultural Competence, Ms. Cave is helping to articulate the Office of Mental Health's commitment to cultural and linguistic competence, provision of culturally informed and responsive services and vision for disparities elimination. She participates in statewide and national workgroups to bring the principles of cultural competence to the practice level throughout the public mental health system.

ASSEMBLYMAN ADRIANO ESPAILLAT

In 1996, Adriano Espaillat became the first Dominican-American elected to a State House in the United States. He represents the 72nd Assembly District, which encompasses Washington Heights, Inwood and Marble Hill in Upper Manhattan. He is a member of the following Committees: Alcoholism and Drug Abuse; Children & Families; Corporations, Authorities & Commissions; Insurance; and Real Property Taxation. He is also first Vice-Chair of the Black and Puerto Rican Caucus and a member of the Puerto Rican & Hispanic Task Force. He was recently appointed by New York State Assembly Speaker Sheldon Silver to Chair of the New York State Task Force on New Americans.

During his first term in office, Assemblyman Espaillat introduced and voted on numerous legislative initiatives on education, public safety, tenants' rights and the environment. He supported successful passage of legislation that extended the J-51 Housing Program, which prevents landlords from hiking tenants' rents for major capital improvements to their buildings. Assemblyman Espaillat's voting record on environmental issues has been rated as excellent by the group Environmental Advocates in New York State. Perhaps his most important legislative initiative to date was his vote to reaffirm tenants' rights by supporting the extension of the rent control and stabilization laws of New York State to the year 2000.

During his first term in office, his District Office has served over 5,000 constituents.

Assemblyman Espaillat has brought government to the people by activating neighborhood legislative advisory groups on education, labor, economic development and quality of life. The membership of these advisory groups is composed of an ethnically and racially diverse group of local leaders and constituents, with full participation by both men and women.

Espaillat has an outstanding record as a community activist and supporter of issues that affect the disadvantaged, working people, families, and that protect economic development and neighborhood revitalization. In 1994, Espaillat became the Director of Project Right Start, a national initiative funded by the Robert Wood Johnson Foundation to combat substance abuse by educating the parents of pre-school children. This pilot program has now been implemented in six cities throughout the country and in the commonwealth of Puerto Rico. In 1991, Espaillat was chosen as a member of Governor Mario Cuomo's Dominican Advisory Board, where he

served for two years. The following year, he was elected Democratic District Leader for the 72nd Assembly District part A and was reelected in 1995. From 1992 to 1994, Espaillat served as Director of the Washington Heights Victims Services Community Office. This organization offered bilingual support groups for battered women, and provided relief, compensation, counseling and therapeutic services for families of homicide victims and other crime victims. Since 1986, Espaillat has actively served on Community Planning Board 12 as a member of the Executive Board. Espaillat became a strong voice in the community by organizing tenants and advocating for their rights. He successfully petitioned for greater police services in the community. His tireless efforts resulted in increased foot patrol, block watches, the creation of the new 33rd Police Precinct and other successful crime prevention initiatives in Northern Manhattan. Espaillat, however, consistently attributes all accolades to the community by stating: "It was the community's passion for public safety that allowed the changes to take place." He actively opposed budget cuts that devastated services to senior citizens and fought for more programs for local youth.

In 1980, Espaillat joined the NYC Criminal Justice Agency, a non-profit agency contracted by the city of New York to provide pre-trial services to the New York Criminal Court system, where he worked as the Manhattan Court Services Coordinator for eight years. Today, Espaillat has helped resolve hundreds of conflicts among his constituents during the past ten years by volunteering his services as a state certified mediator at the Washington Heights Inwood Conflict Resolutions and Mediation Center.

Espaillat believes that an effective leader must have the compassion to feel for our problems and the strength, vision and the leadership to provide viable solutions. Most importantly, however, is one's disposition to persevere in the face of adversity and humbly serve the entire community. He graduated from Bishop Dubois High School in 1974. In 1978, he earned his B.S. degree in Political Science from Queens College, and later completed postgraduate courses in Public Administration at the New York University Leadership for Urban Executives Institute.

MAYSOUN FREIJ, MPH, MA

Maysoun Freij is a Health Advocacy Associate at the New York Immigration Coalition (NYIC). The NYIC is an umbrella advocacy organization for more than 150 groups in New York State that work with immigrants and refugees. At the NYIC, Ms. Freij conducts trainings and community education events on immigrants' rights to health care and public health insurance. She also coordinates the Immigrant Health Access and Advocacy Collaborative. The Collaborative provides a forum for training, education, and advocacy among nine different immigrant community based organizations. Prior to joining the NYC, Ms. Freij worked with several different public health organizations, including the Centers for Disease Control in Atlanta, GA and Mount Sinai Adolescent Health Center in NYC, and has largely focused on the reproductive health of adolescents and women. Ms. Freij received a BA in Political Science from the University of Chicago, an MPH from Emory University, and an MA in Cultural Anthropology also from Emory University.

FRANCESCA GANY, M.D., M.S

As the founder and Director of the Center for Immigrant Health, and a member of the faculty of the New York University School of Medicine, Dr. Gany has extensive background in immigrant health research, curriculum development, education, and program development. Dr. Gany teaches primary care, immigrant health, and health policy and medical economics at the School. She has published and lectured widely on immigrant health issues and has facilitated the dissemination of model projects nationally. Dr. Gany holds a B.S. in Biology from Yale

University, an M.D. from Mt. Sinai School of Medicine, and an M.S. in Management and Health Policy from the Wagner Graduate School of Public Service

The Center for Immigrant Health is a network of over 1000 community members, social scientists, and health care and public health professionals working with the diverse immigrant groups in New York and nationally. The mission of the Center is to improve access to, and quality of, health care for New York's large immigrant populations. The Center accomplishes its mission through research, education, information dissemination, and program and policy development.

Dr. Gany has served as the Principal Investigator on a number of pioneering immigrant health projects. As a Robert Wood Johnson Generalist Physician Faculty Scholar, Dr. Gany conducted a study to elucidate barriers to the completion of tuberculosis screening and prophylaxis facing immigrants. Her reviews led to the development of long-term programmatic changes in tuberculosis screening for immigrants. Dr. Gany's tuberculosis activities have continued through the Center's Community Tuberculosis Prevention Program. To date, 45,000 community members have been screened, and if necessary, treated for latent tuberculosis. Dr. Gany also developed the NCI/NIH funded Cancer Awareness Network for Immigrant and Minority Populations (CANIMP). CANIMP responds to the disparities in utilization of, and participation of immigrants in, cancer prevention, detection, and treatment services. Currently in its eighth year, CANIMP works with the Haitian, Latino, Chinese, Korean, and English-speaking Caribbean immigrant communities. Through CANIMP Dr. Gany has also developed a junior minority intern and researcher mentorship program. A CANIMP outgrowth, the Immigrant Cancer Access Network (ICAN), is developing strategies to ensure that immigrant patients are enabled to complete cancer treatment and enroll in support services. Dr. Gany has a strong interest in the field of cultural competence in the practice of medicine, and has led various projects to enhance the provision of culturally competent services. These have included research into current and best practices on culturally competent health care delivery, knowledge-gathering efforts on cultural beliefs and practices and their impact on health-seeking behavior and decision-making, development of a comprehensive cultural competence curriculum, cultural competence trainings for health care and other institutions, and review, and analysis, of evaluation tools used to assess cultural competence. As part of the Center's language initiative programs, Dr. Gany spearheaded a medical interpreter project entitled, "Access through Medical Interpreter and Language Services (ATMILS)." The objective of this project was to create a comprehensive medical interpreter network in New York City. A national model analysis and New York City assessment led to the development of a medical interpreter screening and assessment tool, the implementation of a number of training curricula, and the revolutionary Remote Simultaneous Medical Interpretation System. Dr. Gany has also developed a medical interpreting studies program which is examining the impact of various interpreting strategies on the medical interview, on medical errors and medical outcomes, and on health care costs. The Center has also taken the lead in community based approaches to enrolling immigrants in insurance, specifically Child Health Plus, and in using technology to increase health care access. One of the Center's newest projects, the Immigrant Portal Project, is pairing immigrant community based organizations with the health care facilities in their neighborhoods to jointly develop solutions to access barriers faced by the immigrant population.

JAVIER GONZÁLEZ

Javier González is Director of Language Initiatives for the Center for Immigrant Health (New York University School of Medicine). As such, he has worked to develop curricula in the areas of interpreting and translating in healthcare, including screening, testing and evaluation, training, and standards. He worked to implement the Remote Simultaneous Medical Interpretation (RSMI) project, developed a simultaneous medical interpreting training curriculum and quality control program, and created the Center's translation service. He is also

an active participant in groundbreaking research in the nascent field of medical interpreting and has created educational videos. Javier is leading programs at the Center for Immigrant Health to facilitate the delivery of linguistically appropriate health services for immigrants and refugees in New York and elsewhere. Javier has a B.A. in Anthropology from George Washington University.

ERIC HARDT, M.D.

Dr. Eric Hardt is Associate Professor of Medicine at the Boston University School of Medicine. He is the Clinical Director and Firm Chief of the Geriatrics Section of the Department of Medicine at Boston Medical Center [BMC]. He obtained his B.A. from Yale University in 1970 and M.D. from Tufts Medical School (Boston, MA) in 1974. He is board certified in Internal Medicine, Medical Oncology, Geriatrics, and Palliative Care Medicine. He remains active clinically and currently follows a diverse group of elderly patients in their homes and in clinic at BMC. He is an active educator of medical students, residents, fellows, interdisciplinary medical staff, and of medical interpreters as well.

Dr. Hardt's activities in the area of language barriers and medical interpretation are well known around the country. He has produced print and videotape educational materials for medical interpreters and for health care workers working across language barriers. He has authored and co-authored book chapters and articles on medical interpretation, the bilingual medical interview, cultural factors in the medical interview, and related areas. He is a founding member of the Massachusetts Medical Interpreters Association and of the National Council on Interpretation in Health Care. For over twenty years he has served as a Medical Consultant to Interpreter Services at BMC.

Dr. Hardt has published on the issue of exclusion of non-English-speakers from medical research, on issues involving costs and outcomes related to the use of medical interpreters in the ED, and on inadequate medical interpretation as a cause of medical errors. He has been active as a consultant in the area of translation and interpretation methodology appropriate to include non-English-speaking patients in research efforts. He is an experienced speaker and trainer for providers of many types on issues related to Language Barriers and Medical Interpretation. He is regularly invited to consult on educational and program development related to interpreter services.

JOAN MALIN

Ms. Joan Malin was appointed CEO of Planned Parenthood of New York City (PPNYC) in March 2000. PPNYC provides the full range of women's reproductive health care services in three centers, educational programs for youth, training programs for clinical staff and youth serving professionals both locally and internationally, and advocacy on behalf of reproductive health. Ms. Malin came to PPNYC after four years as chief executive of the Bowery Resident's Committee, Inc. (BRC) - a multi-service agency which provides over 20 social services and housing programs for adults with limited resources including the homeless, hungry, chemically dependent, psychiatrically disabled, persons with AIDS and the aged.

Prior to BRC, Ms. Malin served in the New York City Department of Homeless Services for four years, first as Deputy Commissioner for Program Planning, then as Commissioner.

Ms. Malin is a veteran of three New York City Mayoral administrations during which she has overseen delivery of home-care and protective services for adults, has managed the City's senior centers and worked extensively to address the needs of the City's homeless population. Her work as both Deputy Commissioner and Commissioner included the provision of health care services, mental health and substance abuse treatment services as well as the development of transitional and permanent housing for the homeless.

A Fulbright Scholar, Ms. Malin holds a BA in Urban Studies from Case Western Reserve University and a Master of City Planning from the University of Pennsylvania. Ms. Malin

serves on the boards of the Youth Services Opportunities Project and the Mary McDowell Center for Learning Disabilities. Ms. Malin was also an Adjunct Assistant Professor, Public Policy at the Robert F. Wagner Graduate School of Public Service of New York University.

KATHY MIRAGLIA, M.S., C.S.C

Kathy Miraglia, M.S., C.S.C., is the Manager of the Interpreter Services Program at University of Rochester Medical Center. She also manages a newly created videoconference interpreter program called “Strong Connections”. Ms. Miraglia is certified by the Registry of Interpreters for the Deaf and has provided direct sign language interpreter services for the University of Rochester Medical Center for the past twenty years. She is the Project Director for a new RWJF grant called “Speaking Together – National Language Services Network”. Ms. Miraglia is a respected educator and consumer advocate in deaf healthcare topic areas. She is Adjunct Faculty at the Rochester Institute of Technology teaching “Intro to Health Care Interpreting” in their B.A. Educational Interpreting Program.

GRACE B. MOSE

Grace B. Mose is the Research and Program Associate at Family Planning Advocates of New York State. She has done research on health issues confronting women in the third world with a comparative perspective of women in the west. As a counselor and advocate for women, Grace brings a rich history of work in women’s healthcare. Grace’s focus is on the Immigrant Women’s Health Initiative and helps in managing programmatic activities related to the Immigrant Women’s Health Initiative. Prior to joining FPA, Grace worked as Director, Domestic Violence Hotlines for New York State Coalition Against Domestic Violence (NYSCADV). She worked as a part-time instructor at the State University at Albany in the Department of women’s Studies. Grace has worked as a Legislative Aid in the Assembly Woman Barbara Clark’s office. In her country of origin, Kenya, Grace worked as an instructor in high schools and college, where she spent time training basic education in courses such as child psychology, development and health as well as guiding and counseling young women on health and cultural issues affecting them. Grace holds a Doctorate in Women’s Studies at the State University at Albany.

SADIYA OMAR

Sadiya Omar was born in Somalia and lived in a refugee camp in Kenya for ten years before moving to Rochester in 1999. While in the refugee camp, she worked with the Education Department promoting girls’ education in the camp. Ms. Omar has been active in other community-based efforts in Africa to promote education and achievement for girls to improve opportunities for them in adulthood. Ms. Omar worked as an interpreter and research assistant on the AHRQ-funded R-O3 project “Cultural Competency and African Women’s Health Services” with Dr. Carroll and Ms. Abukar. She currently works as a certified nursing assistant at St. John’s Home. She is married with four children. Ms. Omar is fluent in Somali, Maay Maay, Swahili, and English.

ANNE PEARSON

Anne Pearson was appointed Director of the Reproductive Rights Unit at the New York State Attorney General’s Office in Fall 2006. The Reproductive Rights Unit, housed in the Attorney General’s Civil Rights Bureau, is charged with the enforcement of laws protecting rights to reproductive health care services and facilities. In addition to enforcing laws protecting reproductive choice, the Unit engages in extensive advocacy and analysis in such areas as contraceptive equity in insurance coverage, pregnancy discrimination, and hospital mergers. Ms. Pearson joined the New York State Attorney General’s Civil Rights Bureau as an Assistant Attorney General in 2003. From 2003 - 2006 she was involved in a wide array of

investigations, affirmative litigation and policy initiatives in the areas of discrimination in employment, mortgage lending, housing, and public accommodations. Prior to her work at the Attorney General's office, Ms. Pearson worked as a staff attorney at the Welfare Law Center and at Legal Services of Northern California. Ms. Pearson is a graduate of the University of Chicago and New York University School of Law.

SIDDHARTH RASTOGI

Siddharth Rastogi is co-founder of SimulTel Inc. whose patent-protected technology is being used to provide remote simultaneous medical interpreting to numerous facilities of New York City's Health and Hospital Corporation. SimulTel won the Social Entrepreneurship Track at the Annual Business Plan Competition held at New York University Stern School of Business in 2004. Siddharth also heads U.S. business development for the software business of i-flex solutions, a leading banking technology company incubated by Citigroup and majority owned by Oracle. Siddharth holds a bachelor's degree in Computer Engineering from the University of Bombay and an MBA from New York University.

DINA REFKI, D.A.

Dina Refki is the director of the Fellowship on Women & Public Policy and Immigrant Women & State Policy programs at the Center for Women in Government & Civil Society. Refki holds a doctorate in Humanistic Studies, a Masters in Africana Studies and Bachelors in English Literature.

MARSHA REGENSTEIN, PHD

Marsha Regenstein, PhD, is an associate research professor of health policy at The George Washington University and the director of Speaking Together: National Language Services Network, a project sponsored by the Robert Wood Johnson Foundation designed to improve the quality and availability of hospital-based language services. She also leads the cardiovascular market assessment component of Expecting Success: Excellence in Cardiac Care, a national program of the Robert Wood Johnson Foundation intended to improve the quality of health care provided to minority populations in the United States. Dr. Regenstein was previously the vice president of the National Association of Public Hospitals and Health Systems and vice president of the Economic and Social Research Institute.

STERGIOS ROUSSOS, PHD, MPH

Dr. Roussos is a researcher and educator for community health and health care initiatives, specializing in behavior change at the community and organizational levels. His current work aims to understand and improve how health and human services and collaborative partnerships contribute toward eliminating health disparities, especially among persons with limited English proficiency. Areas of interest and expertise include the evaluation design and support of community health initiatives and networks, and the design and research of programs and interventions targeting behavioral change, especially at a system or community-level. He completed with masters work at the Graduate School of Public Health at SDSU and his doctorate in child psychology and human development at the University of Kansas. Dr. Roussos is a principal investigator and lead evaluation contractor for programs addressing various healthcare and public health concerns, including breast cancer, diabetes, tobacco-related diseases, and HIV/AIDS. Current research and projects are funded by governmental and philanthropic agencies. Dr. Roussos leads research teams through the Graduate School of Public Health, SDSU, where he is a Research Assistant Professor, and as Director of the Alliance for Community Research and Development in Merced, California. Dr. Roussos works

with scientists and practitioners from various disciplines to provide research and evaluation services, training, and educational activities to organizations in the US and abroad.

JUDITH R. SAIDEL, PH.D.

Judith Saidel is Executive Director of the Center for Women in Government & Civil Society, and Associate Professor, Department of Public Administration and Policy, University at Albany, State University of New York, where she teaches courses on nonprofit management and policy. She also serves as director of the graduate Certificate in Nonprofit Management and Leadership, academic director of the Center's Fellowship on Women & Public Policy, and is founder of the Nonprofit Executive Roundtable at UAlbany's Rockefeller College of Public Affairs & Policy.

Dr. Saidel's research interests include interdependence issues between public agencies and nonprofit organizations, the implications of contracting for nonprofit governance, gender and political participation, and questions related to representative bureaucracy. For several years, she was principal investigator of *Governance Futures: New Perspectives on Nonprofit Governance, Discovery Phase*, a project under the leadership of BoardSource, based in Washington, D.C., in collaboration with the Hauser Center for Nonprofit Organizations, Harvard University. She also directs the multi-year *Appointed Policy Makers in State Government* project.

Dr. Saidel recently served as Vice President of the National Association for Research on Nonprofit Organizations and Voluntary Action (ARNOVA). She completed a six-year term as Book Review Editor of *Nonprofit and Voluntary Sector Quarterly* and is a member of the Advisory Editorial Board of *Nonprofit Management and Leadership*. Saidel has published articles, chapters, and reports on the government-voluntary sector relationship, nonprofit governance, and the representativeness of the gubernatorial appointee policy leadership cohort. She has also served on a number of nonprofit professional and community boards of directors.

KAREN SCOTT COLLINS, M.D., M.P.H

Dr. Collins joined the New York City Health and Hospitals Corporation in September 2002, with responsibility for initiatives in quality of care. Dr. Collins oversees the division of Health Care Quality and Clinical Services, which includes quality assurance, quality improvement and health services research. Dr. Collins is currently leading corporate-wide quality improvement initiatives in chronic disease management and critical care, and works on corporate strategies for delivering care to a culturally and linguistically diverse patient population. Prior to joining HHC, Dr. Collins was Vice President at the Commonwealth Fund, responsible for developing the Fund's program on Quality of Care for Underserved Populations, with a focus on minority and low income populations. She also had leadership roles in developing programs focused on improving the quality of healthcare received by low income young children and their families, and the Fund's Fellowship program in Minority Health Policy. During her 9 year tenure at the Fund, Dr. Collins worked extensively on issues of women's health, access to care, and quality of care. In addition, she was actively involved in the development and analysis of Fund surveys on these issues.

Dr. Collins has published articles and reports on trends and experiences with managed care, women's health, adolescent health and minority health. She is the co-editor of two books, *Women's Health: The Commonwealth Fund Survey*, and *Minority Health in America*, both published by Johns Hopkins University Press. In April 2002, Dr. Collins received the Healthcare Hero award from the Congressional Black Caucus.

Dr. Collins completed her undergraduate degree in History of Science at Harvard University, medical school at Cornell University Medical College, and master of public health degree at Bloomberg School of Public Health at Johns Hopkins University.

LYNN E. STONE

Lynn E. Stone is the Director of the Language Services Unit (LSU), within the Bureau of Refugee and Immigrant Assistance (BRIA), New York State Office of Temporary and Disability Assistance (OTDA). BRIA is the entity within New York State government responsible for coordinating services and benefits to the foreign-born. The BRIA LSU works to improve access to information on OTDA services and programs for those with limited ability in English; it now provides translation assistance for eight State agencies. Mr. Stone, holds a Master of Arts degree in Russian language and literature, and has had a life-long interest in Russian and Spanish languages and cultures. He is a professional translator of Russian and Spanish, and is a member of the American Translators Association.

GAYLE TANG, MSN, RN,

Director of National Linguistic & Cultural Programs in Kaiser Permanente's National Diversity, is a diversity champion and leader in the improvement of language access throughout Kaiser Permanente and the community. Gayle has led multiple strategic initiatives and created service delivery systems that have supported the provision of culturally and linguistically competent care to patients and their diverse communities. Gayle is the principal investigator on several research projects funded by The California Endowment and continues to build coalitions to ensure quality of care and patient safety thereby reducing health disparities. Gayle is the principal architect of the Health Care Interpreter Certificate Training Program and the Qualified Bilingual Staff Model Program. Both programs focus on building linguistic and cultural expertise capacity to serve the limited-English proficient population.

Gayle's community involvement includes serving as an advisory board member and former president of the Chinese Newcomers Service Center; and also as a former board member of Operation Access and Community United Against Violence. She also serves on various national committees addressing issues of health disparities.

Gayle completed her undergraduate studies in nursing at the University of San Francisco. She received her Masters of Nursing degree with a focus on leadership and diversity from Sonoma State University.

VIRGINIA S. TONG

Virginia S. Tong is the Vice President for Cultural Competence for the Lutheran Health Care system. In 1995, she was hired by Lutheran Medical Center to develop programs for the Chinese and other immigrant communities in Brooklyn, New York. She opened and managed a multi-service office and primary care clinic for Chinese immigrants, established programs and services for Arabic/Muslim patients and developed and operated 22 part-time Russian practices. She also developed and managed the patient relations department of the ambulatory network with bilingual staff in Spanish, Chinese, Arabic and Russian. Since 2004, she has chaired the hospital's Cultural Access Task Force, supervised the Cultural Initiatives Coordinator and overseen all cultural initiatives. Some of these have included opening of the Chinese patient unit, renovation of the hospital's mosque and creating and coordinating advisory groups for the Latino, Arabic, LGBT and Chinese communities.

Ms. Tong was born and raised in New York City's Chinese community. After receiving her B.A. from Vassar College and MSW from Fordham University, she worked in the Chinese community in the areas of social services, child welfare, domestic violence and health services. Ms. Tong has taught courses on Asian communities at City College, been a consultant on Chinese values and beliefs at Teachers College and trained staff at the NYC Dept. of Health, the Board of Education, the NYS Office of Mental Health as well as hospitals and service organizations. Ms. Tong was formerly the Assistant Executive Director of the Chinatown Health Clinic (aka Charles B. Wang Health Center) and served on the Governor's Health Care Advisory Board, the Mayor's Child Health Advisory Board and the Health and Hospital Corporation's Blue Ribbon Panel on Women's Health. Ms. Tong has also been a

member of the Advisory Committee of the New York Center for Immigrant Health for over 10 years.

WILMA E. WAITHE, RD., CDN., PHD

Dr. Waithe, known to many through her work as a clinical dietitian and community nutritionist, has influenced the delivery of nutrition services on state and national levels. Currently, she is serving as director of the Office of Minority Health in the New York State Department of Health. She is responsible for providing leadership on minority health issues.

Prior to joining this office, Dr. Waithe held a variety of other statewide leadership positions in the Department of Health. She served as the State WIC Nutrition Coordinator where she oversaw the development and implementation of several innovative WIC nutrition services initiatives, many of which remain cornerstones of the NYS WIC Program. In addition, she launched the Cornell Cooperative Extension Service Nutrition Program in the borough of Queens. Also, as director of Nutrition Services for the New York City Head Start Program, she is credited with implementing and evaluating a broad range of quality improvement projects.

Dr. Waithe holds degrees in Liberal Arts, Home Economics, and Nutrition and Food Science from New York City Technical College, Brooklyn College and New York University respectively. She earned her PhD in curriculum design and instruction at the State University of New York at Albany. She currently participates in a number of professional organizations and advisory boards; and she is an original member of the New York State Board for Dietetics and Nutrition. Her research interests include exploring the value of qualitative methods in health research, adult learning, and evaluation capacity building.

LINDA WEISS, PHD

Linda Weiss, PhD is a Senior Research Associate at The New York Academy of Medicine (NYAM). She has a doctorate in cultural anthropology from Columbia University and has examined health care access issues among diverse populations including immigrants, people living with HIV, the elderly, children, and substance users. She recently served as Principal Investigator on a study of the availability of translated medication information from New York City pharmacists. Other recent work includes participation in a study of the actual and potential role of Asian immigrant community institutions in HIV prevention and education, an examination of neighborhood predictors of health behaviors and health outcomes, and a multisite evaluation of programs to integrate substance abuse treatment into HIV primary care. Previous work at NYAM includes a study of the ethical responsibilities of hospital trustees, a study of barriers to health insurance and health care for children in immigrant families, studies of drug users' access to and experiences with health care, and an evaluation of programs to support adherence to HIV medications. Prior to joining the Academy, Dr. Weiss worked in the Division of General Medicine at Columbia University's College of Physicians and Surgeons.

AMY WILSON-STRONKS, M.P.P., C.P.H.Q

Amy Wilson-Stronks, M.P.P., C.P.H.Q., is the Project Director for Health Disparities Work in the Division of Standards and Survey Methods at The Joint Commission and the Principal Investigator for the Joint Commission study *Hospitals, Language, and Culture: A Snapshot of the Nation* funded by The California Endowment. She is the co-author of *Hospitals, Language, and Culture: A Snapshot of the Nation Report of Findings* released in March 2007. Amy has been a leader of the Joint Commission's work in the area of culturally and linguistically appropriate services and health care disparities. She is leading ongoing research investigations of the data collected during the *Hospitals, Language, and Culture* project. She is also directing the work of The Joint Commission to assess and evaluate accreditation standards related to culturally and linguistically appropriate services and is developing a comprehensive surveyor training program on issues related to culturally and linguistically

appropriate services. She has served on a number of National Advisory Committees on subjects related to the provision of culturally and linguistically appropriate services. Amy earned her Master of Public Policy in Health Policy and a Graduate Certificate in Health Administration and Policy from the University of Chicago, a Certified Professional in Healthcare Quality (CPHQ).

MARA YODELMAN, J.D., LL.M.

Mara Youdelman has worked at the National Health Law Program (NHeLP) since August 2000 on issues including Medicaid, language access, racial and ethnic disparities, and data collection. Mara is Director of the National Language Access Advocacy Project, funded by the California Endowment, to increase awareness of language access issues at the federal level. Mara coordinates a national coalition to develop a consensus-driven agenda to improve policies and funding for individuals with limited English proficiency. Mara is co-author of *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* and, from The Commonwealth Fund, *Promising Practices for Providing Language Services in Health Care Settings: Examples from the Field*, *Promising Practices for Providing Language Services in Small Healthcare Provider Settings: Examples from the Field*; and *Promising Practices for Providing Language Services in State and Local Benefit Offices: Examples from the Field* (forthcoming). Mara has participated on advisory panels for the Robert Wood Johnson Foundation; the National Committee for Quality Assurance; the American Medical Association Ethical Force Program; and the Joint Commission on Accreditation of Healthcare Organization. Prior to NHeLP, Mara completed a teaching fellowship at Georgetown University Law Center's Federal Legislation Clinic. Mara earned her J.D. from Boston University School of Law and her LL.M. in Advocacy from Georgetown University Law Center.