

Providing Health Care to Limited English Proficient (LEP) Patients:



A Manual of Promising Practices

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I. Introduction

Throughout the past 30 years, California has experienced a tremendous change in its demographics, primarily due to the arrival of new immigrants from around the world. Today, California is a “majority of minorities” with no one racial or ethnic group comprising a majority.¹ Because of the increase in newly arrived immigrants, California’s community clinics and health centers face new challenges in treating underserved communities, especially those comprised of Limited English Proficient (LEP) patients.

The growth of the LEP population is not unique to California. In recent years, the United States has become increasingly multilingual and diverse. Currently, there are almost 45 million people in the nation who speak a language other than English, and over 30 million who were born outside of the United States.² During the past decade, the number of Spanish and Asian language speakers grew by 50 percent.³ Over 17 percent of the nation’s population speak a language other than English at home.⁴ Within the United States, the percentage of selected states’ populations who speak a language other than English at home is 25.8 percent in Arizona, 39.5 percent in California, 22.1 percent in Florida, 26.1 percent in Hawaii, 21.8 percent in Nevada, 25.7 percent in New Jersey, 35.5 percent in New Mexico, 27.5 percent in New York, and 32.0 percent in Texas.⁵

Community clinics and health centers have been leaders in developing approaches for serving the LEP patient population because they often care for a large percentage of LEP patients. For example, approximately 44 percent of community clinic and health center patients in Califor-

nia claim English as their second language.⁶ These providers recognize that language interpretation services are an integral component to health care for LEP patients, and the lack of accurate language services results in decreased quality, increased medical errors, greater disparities, and diminished access to health care.

Founded in 1994, the California Primary Care Association (CPCA), together with the more than 500 community clinics and health centers it represents, has helped to ensure affordable, quality health care to California’s uninsured, low-income and minority communities. CPCA’s mission is to promote and facilitate equal access to quality health care for individuals and families through organized primary care clinics and clinic networks that, among other things, seek to maintain cost-effective, affordable medical services, as well as meet the linguistic and cultural needs of California’s diverse population.

As part of its efforts to improve language access for LEP patients, CPCA conducted a survey of community clinics and health centers throughout California on policies and procedures for providing care to LEP patients. The intent of this survey was three-fold: 1) to collect information on diverse abilities of community clinics and health centers to meet language needs, 2) to assist CPCA in its advocacy on behalf of community clinics and health centers and of the LEP patients served by these providers, and 3) to assist individual sites that participated in the survey and the broader community clinics and health center community to understand their obligations under Title VI of the Civil Rights Act.

¹ U.S. Census data, as reported in: “America 2000: A Map of the Mix,” *Newsweek* (September 18, 2000), p. 48.

² Westphal, D. (2001). “More speak Spanish in U.S.,” *Sacramento Bee*, August 6, 2001.

³ *Ibid.*

⁴ U.S. Census Bureau (2001). “Census 2000 Supplementary Survey National & State Profiles,” website <http://www.census.gov/c2ss/www/>.

⁵ *Ibid.*

⁶ Office of Statewide Health Planning & Development (2000). “Community Clinic Fact Book: 1998 edition.”

For this Manual, CPCA circulated 50 surveys to its members and requested information on promising practices from all other members. From the responses, follow-up interviews were conducted with 12 community clinics and health centers. Generally speaking, the survey respondents identified the top five challenges to serving LEP patients as: 1) the availability of interpreters, 2) the shortage of bilingual staff, 3) cultural norms that conflict with Western medicine, 4) the lack of interpreters trained in medical terminology, and 5) the language ability of interpreters. This Manual has presented different options on how community clinics and health centers may address these challenges.⁷

This Manual is a snapshot of how some of these health centers, of varying LEP population and organizational size, have addressed the needs of their LEP patients. It outlines the steps they have taken to improve service to their LEP patients, describes how California's community clinics and health centers provide language access services, and gives ideas and resources on how other community clinics and health centers may be able to do the same.

Ultimately, the purpose of the Manual is to help community clinics and health centers meet the challenge of serving LEP patients by promoting the sharing of promising practices in this area. The Manual does not focus on any particular set of promising practices, since many of them work in tandem with others and what works as a promising practice at one site may not work at another. Rather, the Manual highlights practices which are unique, interesting, and could potentially be duplicated. To promote this exchange, each profiled community clinic and health center has agreed to be a resource to others, and the contact information is provided with each profile.

Definitions

For the purpose of this manual, the following are the definitions for 'Interpretation' and 'Translation':

Interpretation is facilitating oral communication between individuals who do not speak the same language and may not share the same culture.

Translation is changing written documents from one language into another.

Although this Manual does focus on individual community clinics and health center promising practices (Section V), it also provides information on community clinics and health center advocacy organizations and state-sponsored promising practices in Sections VI and VII, respectively. Section II describes the obligations under Title VI of the Civil Rights Act of 1964 to serve LEP patients. Section III explains the guidance issued by the U.S. Department of Health and Human Services, which is intended to assist community clinics and health centers and other providers in complying with language access mandates under Title VI. Section IV describes other important standards and procedures in serving LEP populations.

⁷ If you are interested in a copy of the survey instrument, please contact egallardo@cpca.org.

II. Title VI of the Civil Rights Act of 1964

Since 1964, Title VI of the Federal Civil Rights Act has required 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.”⁸

Title VI was passed by Congress to ensure that federal fund recipients did not discriminate on the basis of race, color, or national origin.⁹ Since federal funding of health care is so pervasive, nearly every state and local government, health care provider, and health plan that receives federal monies is bound by Title VI.¹⁰ The requirements of Title VI apply to all recipients of federal funds, regardless of the amount of federal funds received.¹¹

Moreover, the “program or activity” language in Title VI has been broadly defined to apply to all the operations of the recipient, not just the corporate subsidiary or governmental sub-division or department that receives the federal funds.¹² This means that state/federally-sponsored health programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP), must com-

ply with Title VI. Therefore, commercial health plans, not just their managed care arms that participate in Medicaid and SCHIP, must comply with Title VI.

California community clinics and health centers receive a significant source of their funding from the federal government. Medi-Cal (California’s Medicaid program, jointly funded by the state and the federal government) is the largest source, representing 24 percent of total clinic revenues in California. Other federal funding includes the Community, Migrant, Public Housing and Homeless health grant programs, which nationally total approximately \$1.1 billion each year. Due to this receipt of federal funding, all programs and activities of community clinics and health centers must comply with Title VI requirements to ensure meaningful access for all LEP patients.

⁸ 42 U.S.C. Sec. 2000d; 45 C.F.R. Sec 80.

⁹ 110 Cong. Rec. 1658 (1964).

¹⁰ Perkins, Jane, & Vera, Yolanda, “Legal protections to ensure linguistically appropriate health care,” *Journal of Health Care for the Poor and Underserved*, Nashville, 1998, pp. S62-S80.

¹¹ Jane Perkins, Harry Simon, Francis Cheng, Kristi Olson, and Yolanda Vera, “Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, the National Health Law Program and the Henry J. Kaiser Family Foundation, January 1998, p. 21.

¹² 42 U.S.C. Sec. 2000d-4a; United States Department of Justice’s Policy Guidance on the Enforcement of Title VI, dated August 11, 2000, 65 Fed. Reg. 52762-52774, dated August 30, 2000; see also Perkins, Jane, & Vera, Yolanda, “Legal protections to ensure linguistically appropriate health care,” *Journal of Health Care for the Poor and Underserved*, *Supra*.

Title VI has been consistently interpreted by the courts and the agencies charged with its enforcement to require the provision of language access services. In 1974, for example, the United States Supreme Court in *Lau v. Nichols* held that the San Francisco School District violated Title VI by failing to take affirmative steps to assist LEP Chinese students.¹³

Lau and subsequent cases interpret Title VI as obligating recipients of federal funds to provide language services. However, in the past, the federal government had not done enough to assist recipients of federal funds in understanding the scope of Title VI or in assisting recipients in complying with Title VI.

The Supreme Court found:

“[T]here is no equality of treatment merely by providing students with the same facilities, textbooks, teachers and curriculum; for students who do not understand English are effectively foreclosed from any meaningful education.”



“[It is] obvious that the Chinese-speaking minority receive fewer benefits than the English speaking majority . . . which denies them a meaningful opportunity to participate in the educational program – all earmarks of the discrimination banned by the [Title VI] regulations.”¹⁴

¹³ *Lau v. Nichols*, 414 U.S. 563 (1974).

¹⁴ *Id.* at pp. 566-568.

III. Office of Civil Rights' Guidance on Serving LEP Populations and Keys to Compliance

In 2000, guidance was issued to assist recipients of federal funds in understanding their long-standing responsibilities of serving LEP populations under Title VI. According to the United States Department of Justice's most recent policy guidance on the enforcement of Title VI, "[c]ourts have applied the doctrine enunciated in *Lau* both inside and outside the education context."¹⁵ In the health care context, the U.S. Department of Health and Human Services' (DHHS) Office for Civil Rights (OCR) issued its own guidance on August 30, 2000 to assist health care providers in complying with Title VI and in improving their delivery of services to LEP patients.¹⁶ A copy of the federal OCR guidance is attached as part of Appendix A-1.

The Guidance made clear that it did not create new obligations but, rather, clarified existing Title VI responsibilities.¹⁷ The Guidance also made clear that:

- Title VI covers all entities that receive federal funding, including hospitals, primary care clinics, nursing homes, home health agencies, managed care organizations, schools with health and social service research programs, public or private contractors, sub-contractors, vendors, and physicians and other providers who receive federal funding.
- Federal fund recipients cannot exclude or limit, or have policies that have the effect of excluding or limiting the participation of any LEP person.
- Federal fund recipients must take steps to ensure that LEP persons who are eligible for their programs or services have "meaningful access" to health benefits. "Meaningful access" means that the LEP person can communicate effectively.
- Federal fund recipients must provide the language assistance necessary to ensure access at no cost to the LEP person.

The guidance also stresses flexibility in how providers can ensure meaningful access for their LEP patients. Because the focus is on the end result of whether LEP patients have "meaningful access," OCR recognizes that there is no "one size fits all" solution, and each situation will be assessed on a case-by-case basis. The guidance does, however, describe the components that assist programs to ensure "meaningful access."

B Keys To Compliance

Using its 30 years of experience in enforcing Title VI, OCR includes in the Guidance the four keys to compliance, i.e. the four elements generally found in programs that provide "meaningful access". The Promising Practices highlighted in Section V were selected because they illustrate different approaches to fulfilling one or more of the four keys to compliance and because they represent a variety of organizational challenges (i.e. small LEP populations, high diversity in LEP populations, etc.)

Keys to Title VI compliance include whether the federal fund recipient:

- B Key 1:** Assesses the language needs of the population served.
- B Key 2:** Develops a comprehensive written LEP policy to address those needs.
- B Key 3:** Trains its staff regarding the policy; and
- B Key 4:** Actively monitors compliance with that policy.

¹⁵ Department of Justice Policy Guidance, dated August 11, 2000.

¹⁶ 65 Fed. Reg. 52762-52774, dated August 30, 2000.

¹⁷ Id.

B Key 1: Assessment

The provider should conduct a thorough assessment of the language needs of the population to be served. The guidance suggests that compliant community clinics and health centers should review census and utilization data on a regular basis, record language information in a patient's file, identify points of contact where language assistance is needed, and identify/make arrangements with resources that will be needed to ensure "meaningful access."

B Key 2: Comprehensive Written Policy

Appendix A-2 contains an outline of the elements recommended for a comprehensive written policy on serving LEP patients.

The Provision of Oral Language Interpretation

The Guidance urges providers to develop comprehensive written policies on how the provider ensures "meaningful access." It discusses procedures on providing oral language interpretation, including the need for offering trained competent interpreters. In addition, it highlights various methods for obtaining these trained competent interpreters such as hiring bilingual staff, hiring staff interpreters, contracting with an outside interpreter services, formally arranging for voluntary community interpreters, and arranging for telephone language interpretation.

Translation of Written Materials

According to OCR, an effective language assistance program also ensures that written materials that are routinely provided in English are translated in regularly encountered languages other than English. Vital documents are particularly important. Vital documents include consent forms, notices advising of right to free language assistance, information on available services, as well as other important notices and documents.

The Guidance also provides information on "safe harbors" for the translation of written materials. According to the Guidance, if a provider

meets these safe harbors, the provider will be found compliant with Title VI requirements that relate to translation of written materials. The Guidance also makes clear that a provider that does not meet the safe harbor requirements is not necessarily out of compliance with Title VI.

"Safe Harbors"

for Translation of Written Materials

- ✓ Translation of written materials, including vital documents, for each eligible LEP language group that constitutes **10 percent or 3000** individuals, whichever is less, of the population in the service area.
- ✓ Translation of vital documents at minimum for LEP language groups that constitute **5 percent or 1000**, whichever is less, of the population in the service area.
- ✓ Notice in the primary language of each LEP language group of the right to receive competent oral translation of written materials, free of cost.

B Key 3: Training of Staff

According to OCR, effective training requires that employees are knowledgeable of LEP policies and procedures, are trained to work effectively with in-person and telephone interpreters, and understand the dynamics of interpretation between patients, providers, and interpreters. California has several models that not only meet these requirements but also surpass them by adding the element of cultural competency training.

B Key 4: Monitors Compliance

Compliant programs are also found to actively monitor compliance with LEP policies by annually looking at the assessment, staff training and ability to provide meaningful access to the current LEP make-up of the service area. The Guidance advocates seeking feedback from the LEP patients and community in order to gain a better understanding of the adequacy of LEP services.

IV. Other Important Standards and Procedures in Serving Limited English Proficient Populations

DHHS Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).

In addition to Title VI and the OCR Guidance, there are other standards and guidelines that encompass linguistic access issues. On December 22, 2000, the U.S. Dept. of Health and Human Services (DHHS) Office of Minority Health addressed the need for cultural competence in health care by publishing fourteen "National Standards for Culturally and Linguistically Appropriate Services in Health Care."¹⁸ Cultural competence has been commonly defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations.¹⁹ Although the broader issues of cultural competence are outside the scope of federal law, these national standards are a guide for health care providers to promote cultural competency. These standards were the result of input from a national advisory committee, health care providers, researchers, public hearings held throughout the United States, and written public comments.

The standards that relate most directly to language access are as follows:

- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- Health care organizations must provide to patients/consumers in their preferred language both

verbal offers and written notices informing them of their right to receive language assistance services.

- Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

The other standards relate to providing cultural competent care and establishing organizational supports for cultural competence.²⁰ Promoting cultural competence is a strategy to improve health outcomes for diverse populations by recognizing that the effects of the interactions of patients, providers, and health plans are mediated by cultural factors. Cultural competency attempts to ensure that the policies and practices of providers and health plans do not negatively impact the effectiveness of the services they provide. The logic of including cultural competence with linguistic standards is based on the fact that good interpretation and translation require knowledge of culture.²¹ A culturally competent health care system acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the ad-

¹⁸ 65 Federal Register 247, pp. 80865-80879.

¹⁹ Focal Point, vol. 3, no. 1, Fall (1988).

²⁰ The following are cultural competency care standards included in the National Standards for Culturally and Linguistically Appropriate Services in Health Care:

- Health Care Organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- Health Care Organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- Health Care Organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

aptation of services to meet culturally-unique needs.²²

Office of Civil Rights (OCR) Region IX Outline for Interpreter Procedures

The Office of Civil Rights (OCR) Region IX field office, responsible for a jurisdiction that includes California, Arizona, Guam, Hawaii, Nevada, and American Samoa, has also published an “Outline for Interpreter Procedures.” Its requirements are:

1. The [federal funds] recipient or public entity has primary responsibility to provide interpreter services, when necessary, at no cost to patients, program beneficiaries, family members or representatives who require interpreter assistance. Interpreter services should be available during all operating hours;

2. The recipient or public entity will inform limited-English speaking and hearing-impaired patients or program beneficiaries of the availability of interpreter services;

3. The recipient or public entity should not require a patient or program beneficiary to use friends or family members as interpreters. The recipient or public entity must make it clear that interpreters will be provided at no cost to the patient or program beneficiary. Notice can be oral or written. Written notices shall include non-English versions and identify the person(s) to con-

tact if the patient or program beneficiary needs an interpreter. After being notified of the availability of other interpreters, a patient or program beneficiary may request that a family member or friend serve as an interpreter;

4. The recipient or public entity will have procedures to ensure that all interpreters, regardless of whether they are staff, family members, friends, professional or community resources, possess adequate skills to effectively communicate in English and the other language. This includes a fundamental knowledge in both languages of any specialized terms and concepts peculiar to the recipient’s or public entity’s program. Interpreters will maintain the confidentiality of conversations between patients or program beneficiaries and staff; [and]

5. The recipient or public entity will make arrangements with external agencies for back-up interpreter assistance when needed. The interpreter procedures shall contain the name, address, telephone number, and contact persons of the interpreter resource.²³

According to the OCR Region IX field office, “a recipient’s or public entity’s bilingual and sign language interpreter procedures must contain these essential elements.”²⁴ The procedures should also be distributed to staff and placed in operations manuals and/or posted for ready reference.²⁵

²¹ Allen, Jane E., “Worlds and Words Apart – Inadequate Interpreter Services for non-English speaking patients has medical experts and civil rights advocates concerns,” *Los Angeles Times*, Nov. 6, 2000 (quoting Jean Gilbert, a medical anthropologist and former director of cultural competence for Kaiser Permanente).

²² See generally, Duffy, Margaret M. and Alexander, Amy, “Overcoming Language Barriers for Non-English Speaking Patients,” *ANNA Journal*, October 1999, Vol. 6, No. 4, p. 507; “The physician-patient relationship is built through communication and the effective use of language. Along with clinical reasoning, observations and nonverbal cues, skillful use of language endows the history with its clinical power and establishes the medical interview as the clinician’s most powerful tool. Language is the means by which a physician accesses a patient’s beliefs about health and illness, creating an opportunity to address and reconcile different belief systems. Furthermore, it is through language that physicians and patients achieve an empathic connection that may be therapeutic in itself. Because of language barriers, millions of U.S. residents cannot have this connection with their physician.” Woloshin, MD, Steven, et. al., “Language Barriers in Medicine in the United States,” *JAMA*, March 1, 1995, Vol. 273, No. 9, p. 724.

²³ Federal Office for Civil Rights of the U.S. Department of Health and Human Services, Region IX, “Outline for Interpreter Procedures,” U.S. Gov’t Printing Office (1993), attached hereto as part of Appendix A2.

²⁴ *Id.*

²⁵ *Id.*

V. Promising Practices in California's Community Clinics and Health Centers

This Section outlines promising practices of twelve community clinics and health centers. Community clinics and health centers have been at the forefront in providing culturally and linguistically competent care because of their commitment to serve all who come to their doors. Community clinics and health centers have always provided more than just a medical visit. Enabling services, such as outreach, transportation, interpretation and translation, have always been central to their mission.

In each description, different program elements will be highlighted. These elements refer back to the 'Keys to Compliance' outlined on pages 10 - 11 of this document.

The community clinics and health centers described in this section are of varying sizes, are in different geographic areas, and have different challenges in addressing the needs of their LEP patients. The first part is dedicated to rural/frontier community clinics and health centers with relatively small LEP populations. The second part highlights migrant community clinics and health centers with the commitment to serve a significant LEP population, namely farmworkers. The final group of community clinics and health centers in this section operate in California's highly diverse urban areas.

Rural/Frontier Community Clinics and Health Centers

Thirteen percent of California's population resides in areas that qualify as rural/frontier with fewer than 250 people per square mile.²⁶ Frontier areas are still more geographically isolated with only 11 individuals per square miles, as defined by the California Health Manpower Commission.²⁷ "Small health centers are lifelines in rural areas, and they face many challenges that put their roles as safety-net providers at risk, such as remote locations and a lack of resources."²⁸ Chronic recruitment and retention problems characterize many rural and frontier areas. All of these issues make the provision of linguistically appropriate care a particular challenge. The small size of the LEP population and often the diversity of this population add still other challenges. The following Promising Practices demonstrate that rural and frontier providers can meet these challenges with innovation.

1) Canby Family Practice Clinic - Translation Room

Contact: Greta Elliot,
Administrator (530) 233-4641, x122
Highway 299 & Centerville Rd., Box 322
Canby, CA 96015

The Canby Family Practice Clinic is a frontier clinic located in mountainous northeastern Modoc County. The clinic was founded in 1987. It has one clinic site and its service area includes Modoc, Lassen and Siskiyou counties. The clinic serves about 1000 patients per year and about 15 percent of its patients are limited English proficient. Spanish is the predominant language. Three to four percent of the population the clinic serves is also Native American. In 2000, the clinic conducted a Native American cultural competency training, which all of its staff was required to attend in order to improve their service to this population.

²⁶ As defined by the California Rural Health Policy Council.

²⁷ The California Health Manpower Commission has adopted a California frontier definition, which is defined as a medical study service area with 11 individuals per square mile.

²⁸ Gary Yates, President and CEO of the California Wellness Foundation.

At Canby, language is self-reported and tracked on a patient's chart. The clinic also records the patient's language on its database for scheduling purposes using the Merritt software program. Most of the clinic's LEP patients are seasonal farmworkers.

The clinic's total staff numbers 20; therefore sharing of medical personnel is often a necessity. The clinic shares a family nurse practitioner with the Modoc Medical Clinic about 20 miles away. Canby's medical director currently comes twice a week from his home near Cedarville, almost an hour away, and the Clinic shares him with Pit River Indian Health and Fort Bidwell clinic. Some of its staff is bilingual, but for the most part, the clinic relies on a dedicated and scheduled part-time Spanish interpreter who averages about ten hours per week at the clinic. Canby's hiring of this staff person demonstrates the commitment this small frontier health center has made to provide "meaningful access" to its LEP patients.

The clinic has developed a number of translated materials in-house, including consent forms. Patients' illiteracy in their own language, however, can sometimes be an obstacle to effective communication and raises privacy concerns. For example, when an individual is having difficulty completing necessary forms, oral translation of these necessary documents in a waiting room with other individuals often presents difficult situations. Typical medical history forms ask extremely sensitive questions such as reproductive health history. These questions are particularly sensitive in certain cultures. Yet, for individuals that are unable to read translated forms, oral translation is the only option.

To meet this challenge, minimize patient embarrassment, and maximize confidentiality, LEP patients' medical histories are taken in a private "Translation Room." The "Translation Room" contains a computer, a telephone, chairs and a small table. Individuals that have difficulty com-

pleting forms, understanding documents or simply those who need re-assurance are escorted into the "Translation Room". A trained, bilingual staff member orally translates the forms in order to ensure respectful communication.

B Key 2: Oral Language Interpretation

The use of the "Translation Room" to address issues of illiteracy represents an innovation in seeking compliance with oral language interpretation, as outlined in Key 2. Canby recognizes that competent language assistance may also necessitate reading assistance and addresses this issue in a simple, yet highly dignified manner.

2) Northeastern Rural Health Clinics - Strategic Planning

Contact: Janet Lasick,
Chief Executive Officer (530) 257-5563
1306 Riverside Drive
Susanville, CA 96130

Northeastern Rural Health Clinics opened its doors in 1977. It is located in the beautiful Northeastern Sierra Nevada mountains at an elevation of 4200 feet in the extreme northeast of Lassen County. This is one of the most sparsely populated areas of the state. Northeastern's service area includes 3,500 square miles from Susanville to Nevada. In this vast frontier area, ten percent of its patients are LEP and the predominant language is Spanish. Most of these patients are migrant farmworkers.

Northeastern provides physician and medical services through seven sites: 1) Lassen Family Practice, 2) Doyle Family Practice, 3) Westwood Family Practice, 4) Great Basin Primary Care, 5) Lassen Family Urgent Care, 6) Women's Health Center, and 7) Northeastern Occupational Medicine. Dental services are available through the Lassen Family Dental Practice.

Other services available include individual health education in stress management, exercise, Pre-Menstrual Syndrome (PMS), smoking cessation, and child health and safety. Nutrition counseling is available by a registered dietitian or health educator in weight management, diabetes, hypertension, and kidney disease. The clinics are the only providers in the area with Spanish speaking staff.

The clinic's mission is to provide quality, comprehensive, preventive and accessible health care services, regardless of ability to pay, and to meet the changing needs of their communities with creativity and innovation. The clinic's staff numbers 85, including five physicians, one dentist and nine mid-level providers. Eleven percent of the staff is bilingual.

In 2000, the clinic served 13,000 patients, with 53,000 patient visits. Simply based on recent patient population trends, the clinic expects its LEP population to rise. To meet this demand, the clinics went through an extensive strategic planning process with its staff last year. With the expected increase in its LEP population, Northeastern knew it would need help in providing language assistance. The clinic has encouraged Lassen Community College to offer Spanish and medical interpretation classes. Under its 2000-2003 Strategic Plan, the clinic is planning to provide onsite medical Spanish training for its staff, and hopes to increase the number of bilingual staff.

B Key 1: Assessment

A strategic planning process, which analyzes the growth in the LEP population, is a model for compliance with Key 1 - assessment of a provider's LEP population. Key 1 also discusses the identification of resources that will be needed to ensure "meaningful access". Northeastern's organizational goals of training Spanish speaking staff in medical terminology and the hiring of Spanish speaking staff address this element of Key 1.

B Key 1: Assessment, Continued

In addition, if Northeastern is successful in securing Spanish medical interpretation classes at its local junior college, then these classes will produce the staff Northeastern will need to address its growing LEP population. In rural areas where recruitment of appropriate staff is a significant challenge, helping to create appropriate staff from community members enhances recruitment and retention.

3) Shasta Community Health Center - Cordless Hands-free Phones and Cultural Competency Training of Residents

Contact: Robin Glasco,
Chief Operations Officer (530) 246-5739
2630 Breslauer Way
Redding , CA 96001

Shasta Community Health Center is located in Redding, and serves Shasta County and Trinity counties at six sites. The Center is a three-hour drive south of the Oregon border, and serves over 40,000 active patients each year and over 75,000 patient visits. Approximately ten percent of Shasta's population does not speak English, and there is a somewhat surprisingly diverse range of languages spoken. Some of the most common languages encountered are Spanish, Hmong, Lao, Mien, and Vietnamese.

As a rural clinic with a relatively small LEP population, yet such diversity in languages, Shasta faces unique challenges. Shasta has 1.5 full-time Southeast Asian language interpreters on staff who can also be contacted via Shasta's Southeast Asian phone line, a bilingual Community Health Worker, and one half-time Spanish Interpreter with a phone line specifically for Spanish speakers. Sign language interpretation is also considered another language group. Shasta has an American Sign Language interpreter on staff, and provides a dedicated Text Telephone (TTY)

phone line for hearing impaired patients to make appointments

Shasta has developed policies and procedures to identify LEP patients. For example, for scheduling purposes, the patient's primary language and need for language services are recorded in Shasta's Health Pro database and appointment notes. On-site interpreters and staff also have tele-interpreter or language line services available as a back up when more uncommon languages are encountered. For the tele-interpreter service, the clinic has access to 20 languages and uses cordless phones with hands-free capability to minimize the barriers between patients and providers and enhance their communication. Shasta makes it a point to inform patients of the availability of these services with information in the patient brochure and the posting of signs.

B Key 2: Oral Interpretation

The development of complex staffing and procedures for addressing the needs of less common LEP populations is an example of compliance with Key 2. Under Key 2, the guidance discusses having procedures in place for providing trained competent interpreters. Shasta has both on-site capacity and procedures for using off-site support.

The diversity of Shasta's LEP patient populations, as well as the relatively small percentages of LEP patients overall has necessitated the use of telephone interpreters. Shasta's use of cordless phones with hands-free capability allows this provider to deliver this service in an effective manner.

Shasta's roots are as a health center. There was, however, an increased need for its services as the result of the local county hospital closure in 1987 and the merger of two other area

hospitals in 1989. Now, Shasta in effect serves as a satellite for the two merged hospitals' doctors and nurse practitioners. There are 180 employees, and four of the ten doctors, 22 clinicians, and four dentists are bilingual.

The increasing use of Shasta's health care services and the increasing diversity of its patient population resulted in Shasta seeking a grant from The California Endowment for resident physician and mid-level provider student education on culturally-sensitive, patient-centered care. The three-year grant supports both culturally-responsive training for physician trainees and efforts to increase staffing. Training will include sending providers to Seattle for cultural and linguistic training.

B Key 3: Training of Staff

Shasta's training of resident physicians and mid-level provider students is an example of compliance with Key 3, training of staff. The training on culturally-sensitive, patient-centered care develops providers who are responsive to their patient's cultural as well as linguistic needs.

Shasta Community Health Center's mission is to provide quality health care services to medically underserved populations. It strives to improve the health status within the community it serves, particularly for those residents who are LEP or economically disadvantaged. It has worked with private and public health partners to create a seamless system of access to compassionate, high quality primary and preventive health care for all residents of the community it serves.

Migrant Community Clinics and Health Centers

In 1999, California's community clinics and health centers served 307,000 farmworkers, 20 percent of the state's farmworker population, and provided approximately 1 million farmworker encounters.²⁹ Throughout California, there are 114 sites that serve significant numbers of farmworkers.³⁰ Migrant community clinics and health centers are the largest providers of primary and preventive care to this population because of their commitment to serve anyone that arrives at their door and their mission to target low-income, hard-to-reach populations. Since farmworkers are predominantly a LEP population, migrant providers have developed many models to address the language needs of this population.

4) Family HealthCare Network - Language Proficiency Testing

Contact: Teresa Macias,
Chief Operations Officer (559) 791-7010
314 N. Main Street
Porterville, CA 93257

The Family HealthCare Network (the Network), with its five sites, has been a part of the fabric of Tulare County, the community it serves, for over 25 years. Born out of a necessity to provide medical services to those that experience cultural, linguistic and economic barriers, the Network considers its most important accomplishment the hiring of bilingual/bicultural staff at all levels of its organization. Seventy-nine percent of the Network's total patient population does not speak English. Of this LEP group within the Network, 90 percent speak Spanish, with the remaining population mostly speaking Hmong, Lao, or Tagalog.

The Network has prioritized the hiring of bilingual staff to minimize barriers between the patient and provider. Of the Network's 250 staff, over 90 percent are bilingual in English and Span-

ish. However, for other languages comprising a smaller percentage of the patient population, the Network uses interpreters and coordinates patient appointments with interpreter availability. The Network has also held several cultural competency workshops to better serve its diverse patient population.

Medical assistants and some support staff such as receptionists are required to be bilingual. However, because of the challenge in hiring bilingual medical professionals including physicians in family practice, obstetrics, and pediatrics, the clinic does not require doctors to be bilingual. Instead, monolingual physicians see patients with interpreters or bilingual staff and are encouraged to learn a second language.

For physicians who have self-declared their proficiency in a language, their proficiency is evaluated by bilingual staff who work side by side with them and step in when necessary to correct a phrase, misinterpretation, or any misimpression. In addition, the Network has developed a formal language proficiency test for its bilingual staff. This standardized testing, both oral and written, was developed to ensure uniformity in language competency standards. The Network supports language training because even with the testing it does, it recognizes that it is difficult to hire bilingual staff that is also knowledgeable in medical terminology and familiar with health care procedures. A sample of a language proficiency test the Network currently uses for administrative and support staff is attached as part of Appendix A-3.

In addition to written tests on language proficiency, a self-declared bilingual applicant is matched with a Network bilingual interviewer during the interview process. The bilingual interviewer conducts several interview questions in Spanish in order to test proficiency.

²⁹ Based on Office of Statewide Planning and Development (OSHPD) 1999 data

³⁰ These community clinics and health centers have a patient population that consists of at least 10 percent farmworkers and serve at least 100 farmworkers based on OSHPD 1999 data.

B Key 2: Competence of Oral Interpreters

The language proficiency test addresses Key 2 - the need for offering trained competent interpreters. This type of testing gives the Network a universal tool to test competency.

Promising Practice Example: Network’s Proficiency Test

Part of the Network’s proficiency test looks at an individual’s familiarity with terminology by asking staff or potential staff to identify the correct translation of an English sentence. The following is a short version of the test. The complete test is found at Appendix A-3.

Are you a new patient or have you been here before? _____
What are you needing an appointment for? _____
How may I help you? _____
What symptoms does the patient have? _____
Who is your appointment with? _____

1. ¿Con quien tiene su cita?
2. ¿Cuales son los sintomas de la persona enferma?
3. ¿Es usted paciente nuevo o a estado aqui antes?
4. ¿Para que necesita la cita?
5. ¿En que le puedo ayudar?

The Network has a history of hiring staff from within the Latino, Hmong and Lao communities and promotes employment from within the community it serves. For example, the Network is currently precepting a Physician Assistant student that was raised and lives in the community. Local staff members are usually well-regarded and trusted by the community. They are also familiar with the customs and cultural nuances that are important in understanding and serving their patients.

B Key 2: Staff Policies and Procedures

This kind of commitment addresses the hiring policies outlined in Key 2.

5) Golden Valley Health Centers - Cultural Mediators

Contacts: Dr. David R. Campa,
Chief Medical Officer; and
Christine Noguera-Golden,
Chief Operations Officer (209) 383-1848
737 West Childs Avenue
Merced, CA 95340

Since 1972, Golden Valley Health Centers (GVHC), a federally funded community and migrant health center, has served Merced and Stanislaus counties. GVHC is a nonprofit Joint Commission on Accreditation of Healthcare Organizations (JCAHO)- accredited system serving the Central Valley of California with an annual operating budget of approximately \$16 million. Through its community health centers, it provides comprehensive primary medical and dental care to an ethnically diverse population, including migrant and seasonal farmworkers, Southeast Asian refugees, and the homeless population of Modesto, California.

GVHC has developed a system of 14 clinical sites, five dental sites, including two free-standing Women's Health Centers, an Urgent Care Center, three school-based centers, and a homeless health care program. Among the other services offered by GVHC are prenatal care and counseling, childhood immunizations, treatment of diabetes and heart conditions, as well as dental care and pharmacy drug assistance. To properly serve its patients and ensure access to care, GVHC's health centers are located in the communities where its patients reside.

GVHC provides primary health care to over 50,000 Merced and Stanislaus County residents, with patient visits totaling approximately 170,000 annually. Merced County is the ninth most ethnically diverse county in California with the largest per capita resettlement of refugees in the state. Approximately 30 to 40 percent of the centers' patient population do not speak English. Of this group, 80 percent speak Spanish, 10 percent Hmong, 5 percent Cambodian, and 5 percent Lao.

Of GVHC's over 250 staff members, 90 percent of the patient service staff is bilingual, 20 percent of the primary care doctors are bilingual, and 30 percent to 60 percent of the nurse practitioners, physician's assistants and other medical professionals are bilingual. Due to the diversity of the languages spoken at the centers, international pictorial signage is used as much as possible in the common areas of the clinics.

In June 2000, GVHC, Healthy House, a local non-profit, and the Sutter/Merced Medical Center Family Practice Residency Training Program received a three-year grant from The California Endowment for the cross-cultural education and training of its providers. According to GVHC, this grant represented a milestone in the growth and development of the clinic. GVHC is committed to respecting the cultural diversity of its patients by maintaining an environment that is sensitive to individual differences. One of the

purposes of the grant is to develop a culturally responsive resident training program at GVHC. Key elements of the project include: 1) the training of both GVHC and Merced Medical Center Family Practice Residency Training Program faculty and staff in cultural competency and the development of a curriculum to do so; 2) the development of community educational interventions, including home visits, didactic education on traditional/folk healing practices and family systems of multi-cultural populations, and language training in Spanish and Hmong; and 3) the employment of Cultural Mediators or Advocates.

Cultural Mediators

Through a Memorandum of Understanding with GVHC, Healthy House provides training and supervision of two bilingual and bicultural individuals who provide interpretation and cultural mediation between healthcare providers and Latino, Hmong and Lao patients. These two individuals have an expanded knowledge of the non-English languages and cultural beliefs that impact effective communication. These enhanced interpreter positions are expected to actively share information about cultural beliefs and practices with healthcare providers. They participate in case conferences as team members and are expected to share social histories and current community conditions that allow the providers to learn valuable insights that can positively impact patient care. They are also available to make home visits with the healthcare providers. Problems such as isolation, trauma, depression, and mental health problems are more easily identified and addressed with the interpreter Cultural Mediator model. The interpreter Cultural Mediators are also expected to explain the complex healthcare system and American culture to patients and their families. Healthcare providers have expressed appreciation in having the interpreter Cultural Mediators who work as direct cultural trainers.

Although Cultural Mediators will receive a minimum of 40 hours of interpreter training at

Merced College and be tested for their language proficiency and familiarity with medical terminology, as described, they will be expected to do more than simply interpret for their LEP patients. In addition to medical interpretation, as mentioned, they will be asked to transmit cultural understandings, tenets, and beliefs between clinicians and patients to improve communication and health outcomes. In May 2001, the program kicked-off its second year by inviting Anne Fadiman, author of the 1997 book, "The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures," to speak about her experiences with the Hmong community in Merced and the writing of her book.

GVHC hopes that after exposure to this program, some resident physicians may return as staff physicians to work at GVHC or other similar clinics where LEP patient needs are great and the resources to help them are limited. Last year, Golden Valley Health Centers served 50,000 people, including 12,000 patients who had no health insurance and who otherwise would have been unable to access quality and cost-effective

primary care and preventive health services. Since community-based needs and demands drive community clinics and health centers, three-fourths of their funding comes from sources other than the federal government. Another hope of GVHC and other health care centers is to increase the reach of health centers to care for more low-income working families, LEP populations, and rural residents who represent a disproportionate number of California's and the nation's uninsured.

B Key 3: Training of Staff

GVHC is an example of extraordinary work in the area outlined in Key 3 - the training of staff on LEP policies. Along with its partners, GVHC is pioneering the training of current staff, and potential future staff, on the multifaceted barriers providers must overcome in serving the LEP population. Language assistance without adequate cultural competency can lead to misunderstandings and adverse health consequences. Trainings, such as the one by GVHC, provide a holistic approach to the needs of LEP populations.

Promising Practice Example: GVHCs' Training

Healthy House and the California Health Collaborative Training Activities
with Golden Valley Health Centers (GVHC)

Healthy House employees have provided a forty-hour healthcare interpreter training to many bilingual staff at GVHC who interpret as part of the job. The training orients bilingual staff to the role, responsibilities, and ethical considerations that stress the importance of accuracy and completeness as an interpreter. Interpreting skills to guide the flow of communication and medical terminology are also introduced.

In addition, Healthy House has provided training for the majority of providers and support staff entitled *How to Work Effectively with Interpreters*. One interactive exercise done during the training tests memory capacity in English using unfamiliar vocabulary to healthcare providers and support staff. Providers are amazed at how difficult it is to remember several sentences said at one time when they are not familiar with the subject. This reinforces the importance of managing the amount of information that is said by the provider before the interpreter is given time to interpret.

Four Healthy House trainers are paired with new GVHC trainers to provide a four-hour introduction to cultural competence to providers and support staff at all of the GVHC sites in Merced and Stanislaus counties. Following the training guidelines of the *Cultural Positivity, A Trainers Guide for Teaching Diversity and Cross-Cultural Concepts in Health Care*, all employees at GVHC received training that links cultural competence training with their organization's mission and vision.

6) National Health Services, Inc. – Policies that Ensure High Quality Care for LEP Patients

Contact: Eydie Abercrombie,
 Director of Operations (661) 764-6075
 277 East Front Street
 Post Office Box 917
 Buttonwillow , CA 93206

For over 22 years, National Health Services, Inc. (“National”) has been providing primary and preventive health care to the economically disadvantaged population of Kern County. At its Lost Hills site, 97 percent of the center’s population speaks Spanish. The average at its five other sites is 76 percent. National’s sites also have several smaller language groups.

Of National’s one hundred and fifteen staff members, 80 percent are bilingual in English and Spanish. It has a Human Resources Department requirement that all Medical Assistants and front office staff be bilingual in Spanish and English. National also strives to hire staff that live in the clinics’ service area. The reason for this effort is that Kern County’s ethnic population is increasing dramatically. Latinos are expected to increase by 67 percent over the next ten years and Asian and Pacific Islanders by 47 percent.

Whenever possible, bilingual providers are

also hired. National’s biggest challenge is hiring bilingual dentists, registered nurses, and dietitians. Currently, the Lost Hills clinic has one bilingual physician’s assistant and two bilingual doctors. Other language groups served at National’s sites are Korean, Japanese, Arabic, Armenian, and Tagalog. National has also brought in Spanish instructors to teach the language to providers and other staff members.

Prospective staff members are tested for their language proficiency during the job interview. Interviewers walk the prospective applicants through a typical patient contact. Applicants are asked to write down phrases in the language being tested, such as: What is your name? Where do you live? What medical problem brings you here today? The entire exercise takes about thirty to forty minutes.

National has a written policy on how it serves its LEP patients. The policy lays out who is responsible for its execution and enforcement. All of National’s departments, including Fiscal Management and Operations, Medical, and Dental, have the responsibility to assess culture and language barriers in their departments. The clinic requires staff to maintain a Language Barrier Log in order to use for the assessment of language needs.

Promising Practice Example: National’s Language Barrier Log

Patient Name	Date	Arrival	Time	Time Seen	Native Language

When an LEP patient arrives to National, their name, the date, the time they arrived, and their native language is recorded on the patient’s medical chart, and on the Language Barrier Log. When that LEP patient receives care, the time

the patient was treated is logged. In addition to using the Log to assess the different languages spoken by National’s patient population, the Log also tracks the length of time National takes to serve the LEP population.

As a JCAHO-accredited health care center, National implements quality and performance improvement surveys, patient satisfaction surveys, access studies, and patient comment sur-

veys. As part of its quality assessment, National reviews quarterly time reports and the Language Barrier Log to assure patients wait no more than 15 minutes for an interpreter or bilingual staff member.

B Key 4: Monitoring Compliance

National’s quality improvement tools (in particular, the Language Barrier Log) demonstrate a high level of responsiveness to Key 4, monitoring of compliance with LEP policies. Using the Language Barrier Log and quarterly time reports, National works to monitor its compliance in ensuring “meaningful access” in an extremely timely fashion (i.e. waits of 15 minutes or less).

Promising Practice Example: National’s Quality Improvement Tool		
Objective	Department	Monitoring/Evaluation
Assessment of cultural and language barriers in all departments	All Departments	Quarterly time reports to assess if the following requirements are being met: <ol style="list-style-type: none"> 1. No client should wait more than 15 minutes for an interpreter. 2. No client should be turned away because of language barrier. 3. Bilingual/multi-cultural staff to be available at all times during business hours. Compliance rate: __%

National ensures that front line staff members know how to address the needs of LEP patients using an in-service population sensitivity training done by the organization’s Quality Improvement Committee. The policy is communicated to new hires and periodically at staff meetings.

National’s protocol is to first match patients with a provider that speaks their language, whether a doctor, nurse practitioner, registered nurses, or licensed vocational nurse. For languages National cannot serve with staff or an interpreter, it utilizes the services of Blue Cross’ language line or the Kern Family Health Line for interpreting assistance.

B Key 2: Written Policy

National’s policy on serving LEP patients is a good example of a written LEP policy, as outlined in Key 2. Although all community clinics and health centers we interviewed had operational policies and procedures, many had not documented these policies and procedures. In general, we found that for all providers in this Manual, including National, policies and procedures for serving LEP patients are so integral to the operation of their sites that these policies and procedures are institutionalized.

National has also developed a number of written materials in-house. These materials are designed to be understood by anyone with a fourth grade reading level and use pictures when possible. An inventory of National's Spanish language pamphlets, books, and videos available at its various sites is attached as part of Appendix A-4.

**7) Salud Para La Gente –
100% Bilingual/Bicultural Staff**
Contact: Arcadio Viveros,
Executive Director (831) 763-3401
204 East Beach Street
Watsonville , CA 95076

Salud Para La Gente ("Salud") is a bilingual/bicultural semi-rural migrant clinic located in Watsonville, California. According to the U.S. Census, Watsonville is a city of 31,000 people. When Salud was founded in 1980, no primary care was available in the Pajaro Valley, the broader community it also serves. The Pajaro Valley is an agricultural region where Latinos, most of them Mexican-Americans, comprise 51 percent of the population. The proportion of pre-adolescent children in the Valley is one-fifth higher than in California as a whole. According to the Federal Bureau of Health Care Delivery and Assistance, the Valley's population is medically underserved, has a high poverty rate, a lack of medical providers, as well as barriers to medical access. In the medically underserved census tracts, over half the families fall below the poverty line. The clinic sees 14,000 patients per year. Seventy-four percent of the population the clinic serves is Latino. Sixty percent of this group are LEP and speak Spanish.

Salud provides comprehensive health care to farm workers and other low-income residents in and around Watsonville. Its services include complete medical examinations and checkups, urgent care, vaccinations, nutritional counseling,

educational programs, well-child care, parental care, and family planning. In its mission statement, Salud acknowledges that its patients and the general population it serves "need to be treated with special sensitivity to their age, language, sexual orientation, and place of origin, taking in consideration their different customs and beliefs."

Salud's staff numbers fifty-five, and one hundred percent are bilingual. Employee interviews are conducted in English. All prospective employees are asked to answer a standardized question in Spanish to test their language proficiency. Their performance is considered, scored, in the prospective employees overall evaluation for the position sought. One sample question that is asked in Spanish and that prospective employees answer in Spanish is, "¿Por favor, en español díganos como le explicaría a un paciente el problema de alta presión?" ("Please, tell us how you would explain to a patient the problems associated with high blood pressure?") Interviewers are encouraged in the interview instrument to follow-up this question in order to get a good idea of the applicant's ability to speak and understand Spanish.

To encourage the development of its own employees' language skills, Salud provides tuition reimbursement and paid time-off for language classes. Santa Cruz County's Latino Equity Funding Program also provides county contractors, of which the clinic is one, economic incentives to have a diverse staff and board of directors, and provide periodic cultural training. The biggest challenge faced by the clinic is finding culturally and linguistically competent medical specialists, to whom the clinic must sometimes refer its patients. As a matter of policy, the clinic does not use specialists who do not have bilingual capacity.

Salud's services extend beyond its walls. Through its bilingual Promotora program, the clinic

reaches out to the community and newcomers who may not have access to the health care system. Promotora staff go out to labor camps, conduct health education classes, perform screenings, and talk to workers about pesticides. This could not be done without Salud's bilingual capacity. A fuller description of this program appears below.

B Key 2: Hiring of Appropriate Staff

The hiring of a completely bilingual staff and a promotora program to access the most difficult to reach farmworkers are examples of how Salud complies with the portions of Key 2 that address the hiring of appropriate staff. Salud ensures "meaningful access" for its Spanish-speaking patients by direct interaction with bilingual staff. In addition, Salud uses incentives to ensure a high level of language skills among its staff.

Promising Practice Example: Salud's Promotora Program

Implementation:

Salud's outreach program is mobile and operates in a variety of community settings listed below:

- Migrant labor camps and farms where farmworkers congregate or work.
- The Pajaro River levy where homeless congregate.
- In churches and religious events by working in collaboration with religious organizations and faith community representatives to help improve our community's health, social and spiritual needs.

In order to implement the program, Salud:

- Collaborates and works with schools, community centers, universities and other educational institutions, to open opportunities for development of special programs and implement innovative ideas for an effective improvement of the overall health of our community.
- Organizes community health fairs and participates in community magnet events to expose Salud's programs and services provided.
- And finally, works with local, state, federal government and private funding institutions to improve its funding resources that would enhance or expand the quality of its services.

Sometimes, LEP patients ask questions about their medications that staff cannot readily answer in Spanish. In order to assist patients in the use of prescribed medications, Salud obtained a copy of the Mexican Physician's Desk Reference ("PDR") for drugs. Staff have found this book to be an invaluable and efficient resource in explaining the use and side effects of various medications to their patients since it saves time spent translating the American PDR.

8) Sequoia Community Health Foundation Inc. - Written LEP Policy

Contact: Lael Bensen, CQI Nurse
(559) 237-3212
2790 South Elm Avenue
Fresno , CA 93706

The Sequoia Community Health Foundation (Sequoia) has served the southwest and southeast areas of Fresno County for over twenty years. It has three sites and serves 17,103 patients per year with 53,288 annual visits. Historically, Se-

quoia has served migrant and seasonal farmworkers in the county. Specifically, the patient population it serves breaks down into 22 percent uninsured, 65 percent Medi-Cal, and 60 percent farm workers. It has developed particular expertise in working with the cultural and linguistic needs of this population.

Fifty-one to sixty percent of the patient population it serves does not speak English as their primary language. Spanish is the predominant language. Eighty five to ninety percent of the clinic's staff is bilingual in English and Spanish. Interviews for employment are conducted in Spanish and test the applicant's familiarity with medical terminology in Spanish. In addition, the center encourages staff to attend "Art of Interpretation" classes, which are taught locally and offered at no charge to nonprofit organizations. These

courses focus on various aspects of interpretation including ethical issues faced by interpreters and the dynamics of interpretation such as the role of the interpreter vis-à-vis the other participating parties.

For less common languages or after hours services, staff and patients have access to two 24-hours, seven days a week, language line services. For Blue Cross Medi-Cal patients, the center uses Blue Cross' Interpreting Service. Blue Cross, however, only pays for on-site interpreter services if the patient requires a sign language interpreter. Otherwise, Sequoia pays for the costs of on-site face to face interpretation. For all other patients, it uses "Language Line" Services. Sequoia's Language Line procedures to serve LEP patients are in writing in order to ensure that all staff can access the procedures.

Promising Practice Example: Sequoia's Language Line Services

1. DIAL Language Line Services at xxx-xxx-xxxx
2. GIVE the Answer Point your ACCOUNT INFORMATION in the following order:
 - Language Needed
 - Client I.D. Number
 - Organization Name: *Sequoia Community Health Foundation*
 - Personal Code
3. WAIT for the Answer Point to CONNECT the Interpreter
4. BRIEF YOUR INTERPRETER on the nature of the call. Summarize what you want to accomplish and give any special instructions. Be prepared to group your questions, so the interpreter can ask more than one answer at a time. I.e., "ask the patient what her name is, how does she spell that, and what is her home address and phone number."
5. PUT THE PATIENT on the line. If the phone is a SPEAKER PHONE, use that feature. If no speaker phone is available, put the patient on another phone, using the open line the interpreter is on, or, you can hand the phone receiver back and forth between you and the patient.
6. When you have obtained all the information you need through the interpreter, say "end the call."

Sequoia's policy on interpretation is as follows: "The organization will have 24 hours per day/7 days per week interpretation services to assist the delivery of medical care to our *non-English speaking clients* and *limited English proficient clients*." Sequoia's policy and procedures are communicated to staff during orientation and in the Personnel Policies Manual.

B Key 2: Written Policy

B Key 3: Training of Staff

Written procedures on accessing language assistance and the training associated with implementing these procedures are in sync with both Key 2 requirements regarding written policies and Key 3 requirements related to training of staff.

At admission, all patients are asked their language preference, and this information is recorded on Sequoia's database. This information is then used to schedule appointments and determine what printed materials, health education information, and forms should be provided to the patient. Over the years, Sequoia has developed an extensive library of Spanish and bilingual materials. For example, on intake, a patient's medical history is usually recorded on a bilingual "Health History" form. A copy of this bilingual Health History form is attached as Appendix A-5.

Sequoia has also translated its financial policy into Spanish. Appendix A-5 includes a copy of the Spanish version of the financial policy. This document informs Spanish-speaking patients that Sequoia accepts Medicaid, Medicare, as well as the majority of other insurance products. The document also describes various other programs available to uninsured patients including family planning services, child screening, and breast cancer screening. The document also describes Sequoia's sliding fee scale for uninsured patients. The description states the following:

Para pacientes que no califican para seguro o algun programa ofrecemos una escala de descuento basada en los ingresos al hogar y tamaño de familia. El paciente debe presentar prueba por escrito de los ingresos. Esto puede ser en forma de talones de cheques, cartas de donde trabaja o de donde recibe el pago. Si califica se le daran los descuentos apropiados.

The translation is as follows:

For patients that do not qualify for insurance or any program, we offer a sliding fee scale discount based on your income and the size of your family. The patient should present written proof of his/her income. This can be in the form of a check stub or a letter from your employer. If qualified, you will receive the appropriate discount.

Sequoia has also developed over eight different types of bilingual informed consent forms for a variety of services ranging from HIV testing to contraceptive removal. Copies of these bilingual consent forms are attached as part of Appendix A-5.

B Key 2: Translation of Materials

Under Key 2, the translation of vital documents, including consent forms, is considered particularly important in Title VI compliance. The guidance suggests, as a "safe harbor", that vital documents be translated at a minimum for LEP language groups that constitute 5 percent or 1000, whichever is less, of the population in the service area. The guidance also stresses the translation of documents that are typically available to English speaking patients.

Since literacy in English or Spanish is not a given in the medical setting, staff are trained to look for clues that the patient may not understand the materials given them. Staff trainers discuss the issue of illiteracy with new staff and explain how many illiterate patients may be hesitant to admit their inability to read. Illiterate patients may perceive the need to hide their inability to read for social acceptability. As mentioned, staff are trained to look for clues including patients expressing embarrassment, confusion, or excuses such as "I forgot my glasses" or "I'll read it later." Staff members are prepared to orally interpret the necessary forms or documents for the patient.

Sequoia's approach to serving its community is expressed in its philosophy. Sequoia's philosophy is that people have a right to have their basic health care needs met within a reasonable distance of their homes; health and human services should be accessible, acceptable, and affordable; the emphasis should be on promotion and prevention activities leading to health maintenance and self care; and services should be provided in the context of the socioeconomic environment.

Urban Community Clinics and Health Centers

California's urban areas are some of the nation's most diverse regions. Because employment is often easier to secure in large urban areas, new immigrant groups often choose these areas as their new homes. The diversity of urban LEP populations creates unique challenges for community clinics and health centers committed to serving these populations. In facing these challenges with innovation, urban community clinics and health centers have important promising practices to share.

9) Asian Health Services – Language & Cultural Access Program

Contact (s): Linda Okahara,
Community Services & Language
and Culture Program Director
Dong Suh,
Policy and Planning Director (510) 535-4013
818 Webster Street
Oakland, CA 94607

Founded in 1973, Asian Health Services (AHS) began offering direct medical services in Alameda County in 1974. Its central mission is to "serve and advocate for the immigrant and refugee Asian community regarding its health care rights and to assure access to health care services regardless of income, insurance status, language, or culture." The clinic offers a wide array of services ranging from obstetrics, pediatrics, adolescent, adult, geriatric, urgent care, as well as HIV testing, counseling and care.

Eighty-eight percent of the patient population AHS serves do not speak English. AHS expects this percentage to rise to over 90 percent in the next 5 years. Sixty to Sixty-five percent of AHS' LEP population speaks Cantonese. The use of Mandarin, however is also going up, due in large part to increased immigration from the People's Republic of China.

In 1999, AHS had 49,539 medical visits as compared to 10,095 in 1985. Since 1985, its staff

has grown from 45 to 122. Sixty-four percent of the patients it serves are below the federal poverty line; 35 percent are between 100 to 200 percent of poverty; and 1 percent are above 200 percent of poverty. Forty percent of AHS' patients are uninsured; 31 percent are covered by Medi-Cal; 4 percent are covered by Healthy Families; and 10 percent have private insurance. Fifty-six percent of AHS' funding sources are from earned income, thirty percent from federal, state, and local funds, and four percent from foundation grants. Fifty-two percent of the patients served by AHS are adults between the ages of 20 and 64. Twenty-three percent are over the age of 65. Seventeen percent are between zero and twelve years of age, and eight percent are adolescents between the ages of 13 and 19.

AHS is the health safety net for immigrants who have settled in the Alameda County from countries including China, Korea, Vietnam, Cambodia, Laos, and the Philippines. Sixty-four percent of its patients are Chinese; 10 percent Vietnamese; 7 percent Chinese/Vietnamese; 5 percent Korean; 3 percent Cambodian, 2 percent Filipino; 2 percent Mien; 1 percent Laotian; and 7 percent other, which includes Latinos, many of whom speak Spanish, and Iranians, some of whom speak Farsi, two other significant populations in Alameda County.

Promising Practice Example: Asian Health Services

AHS is a premier provider of language assistance. AHS' philosophy is simple: all patients must have language services available to them at all points of contact. Given the organization's philosophy and culture, multi-lingual, multi-cultural health care is Asian Health Services' goal. Commitment to its mission has resulted in a program that surpasses any language assistance requirements of Title VI.

AHS' health care providers are all at least bilingual and one clinic volunteer is fluent in five languages. AHS' total clinic staff numbers 122. Ninety-five percent of its physicians are bilingual. One hundred percent of its nurse practitioners are bilingual or multi-lingual and one hundred percent of its medical assistants speak more than one language. In addition to its medical multi-lingual/multi-cultural staff, AHS has 4 full-time interpreters. Since 1993, AHS has budgeted for 4 to 5 full-time interpreters. This, however, does not include the costs for all other staff members who assist in interpretation as part of their job duties.

All interpreters must go through AHS' "Health Care Interpretation" training program. This training is open to anyone, but priority is given to staff of health care facilities and for those who would like to be an interpreter for the Language Cooperative which is described below. The 50-hour, 6-week training covers various topics on interpretation in a health care setting including:³¹

- Role and Responsibility of the Health Care Interpreter,
- Legal and Ethical Issues,
- Interpretation Skills,
- Culture and Health,
- Culture and Communication,
- Anatomy and Physiology, and
- Medical Terminology.

Full time interpreters are also trained to perform basic job functions, such as reception and intake, thereby alleviating the need for another employee to perform these tasks. This method allows staff members to develop experience interpreting without other major job functions. It also prevents full-time interpreters from having conflicts with other job duties when interpretation needs arise.

B Key 2: Competence of Oral Interpreters

AHS's extensive "Health Care Interpretation" training program ensures that interpreters receive adequate training. The health center has a policy that recognizes interpreters should not only be language proficient, but also have skills that facilitate the "art" of interpreting. The addition of culture as a topic of the training ensures that interpreters are aware and familiar with various cultural issues that may arise during the patient visit.

In 1994, AHS initiated its Language and Cultural Access Program (LCAP). It began as a collaboration with local community, public, and private health organizations with support from Kaiser Family Foundation and Robert Wood Johnson Foundation through the Opening Doors initiative, and the Ridgecliff Foundation. It was developed out of concerns over the increased language barriers LEP patients were facing as a result of managed care.³² There are three program components to AHS' LCAP program:

- **Language Cooperative** – A community language bank specializing in health care, that provides oral interpretation services for local area hospitals, HMOs, and other entities under contract and written translation services for health care organizations across the county;³³
- **Health Care Interpretation Training** - A 50-hr, 6-week training for bilingual health care staff and interpreters, as described above. With funding from The California Endowment, LCAP is collaborating with four other community health organizations in California to write, implement, and develop interpreters to become trainers of *Connecting*

³¹ Classes are held twice a year, one in the fall and one in the spring. For information on the cost and dates of the next training you may call (510) 986-6867 ext. 323.

³² See Section VI *Supra* for a short history of the advent of managed care in California.

³³ Quotes are provided on a per job basis depending on factors, such as complexity, length, the need for word-processing and layout, and turn around time.

Worlds: A Training for Health Care Interpreting.

- **Cross-Cultural Health Care Training** – Trains health care staff on providing culturally competent services for their multicultural patients.

To become an interpreter for the Language Cooperative, candidates must: 1) pass a bilingual proficiency screening in English and Cambodian, Cantonese, Farsi, Korean, Mandarin, Mien, Spanish, or Vietnamese; 2) complete a course in Health Care Interpretation (if you have interpretation experience, AHS may waive some parts of the training); and 3) pass an orally administered interpretation competency and medical terminology exam and pass a written exam on interpretation concepts administered by the Language Cooperative.

LCAP's multilingual/multicultural materials development services include:

- Cultural adaptation of health materials,
- Multicultural focus group testing and field testing of health messages and materials,
- Translation by a primary translator,
- Editing by a second translator,
- Typesetting and formatting of document, and
- Proofreading by someone other than the typesetter.

AHS Language Cooperative program has been so successful that its client base has grown to include the major health care organizations in northern Alameda County as well as clients nationwide.³⁴

AHS interpreters are not only proficient in the languages they speak, but also familiar with medical terminology and common health beliefs and

practices of the communities for which they interpret. According to Linda Okahara of AHS, "It's a fallacy that just anyone can be an interpreter. You can't just throw an interpreter into rooms with patients, who might not understand their role. They must be trained in their role, interpretation skills, and medical terminology." One important challenge is that some languages, such as Cambodian or Lao, do not have equivalent words for "virus" and "bacteria." Although some folk/alternative practices such as herbs and acupuncture can also be very effective, reliance on folk medicine also sometimes results in delay in seeking treatment. For example, the custom in some cultures for new moms to stay home for the first month after giving birth can impact whether the child gets needed and early check ups. One option that is still respectful of the cultural custom is to have another family member bring the baby in for vaccinations or other care.

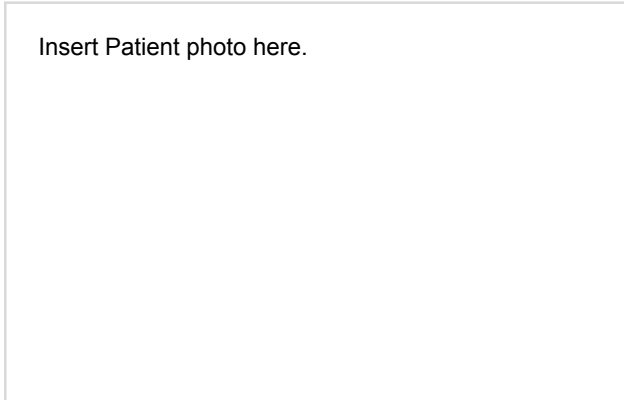
AHS provides its primary care, health education, in-house behavioral health, and member services in nine languages (Cambodian, Cantonese, English, Korean, Laotian, Mandarin, Mien, Tagalog and Vietnamese). AHS also translates health education materials and can convene multilingual focus groups.

AHS keeps track of patients' language preference on its Patient Data System, Practice Management System, Medical Charts, Member Records, and patient identification cards. When a patient calls AHS, chances are a multilingual member services representative will answer their call. Even for smaller language groups (such as Korean, Cambodian, Mien and Lao speakers who comprise 5% or less of AHS patient population), AHS has staffing. When initiating services for a

³⁴ LCAP's interpretation clients include: Alameda Alliance for Health; Alameda County Medical Center – Highland Campus; Alameda County Public Health Nursing, Alta Bates Summit Medical Center; Children's Hospital Oakland, Kaiser Permanente Oakland; and Kaiser Permanente Richmond. Translation clients include: Alameda Health Consortium, Bureau of Primary Health Care, Community Health Center Network, Education Program Associates/California Family Health Council, Health Care Financing Agency, Kaiser Permanente Regional Health Education.

new language community, AHS has a practice of hiring at least 2 staff members, usually one in support services and one in health education, who speak the given language. This policy ensures back-up language coverage when one staffer is on vacation or otherwise unavailable. AHS also pays an annual bilingual premium of \$600 per full-time equivalent if the staff person uses their Asian language skills at least 10 percent of the time.

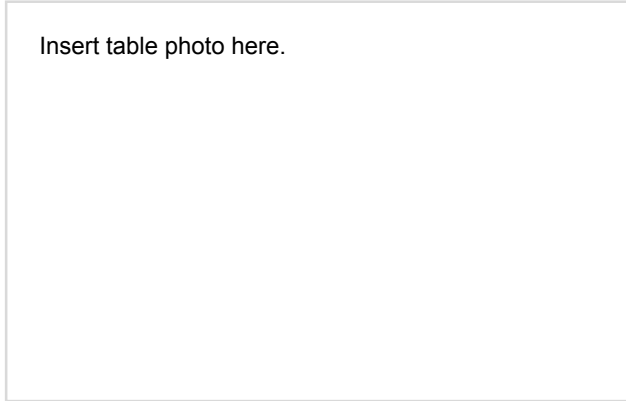
AHS staff sometimes accompany patients to other providers but more often offer phone interpretation given the large volume of patients and insufficient staff time. AHS' perinatal program train volunteer labor coaches who accompany our obstetric patients during their delivery. AHS also calls county agencies, health plans, physicians' offices, hospitals, the Social Security Administration on behalf of our patients. AHS staff assists many patients for translation of forms and intervention with the Social Security Administration and County Department of Social Services since many patients are assigned to county workers who do not speak the language of AHS patients. Patients also bring specialists' instructions or forms that they do not understand to AHS.



Patients attend an AHS Annual General meeting which is conducted by AHS in several languages simultaneously and puts to use headset technology.

Since some of AHS' patients have limited access to media and Internet information about changes in health care and patient rights, AHS

assumes the responsibility of providing them this information. AHS also uses educational forums to inform patients about changes in health care that will affect them. Each year, AHS conducts an annual general membership meeting usually attended by 300 to 400 patients. The meetings are conducted in nine different languages with the aid of AHS' simultaneous interpretation equipment.



AHS interpreters during the Annual General Meeting.

Since 1973, AHS has grown by leaps and bounds from an all-volunteer effort into a nationally-recognized comprehensive primary care provider and pioneer in establishing models of health care service and advocacy for the Asian and Pacific Islander community. AHS now operates on an over \$10 million budget serving the medical needs of a primarily low-income and uninsured Asian and Pacific Islander population in the East Bay.

Unfortunately, the need for AHS has not diminished since its inception in 1973. Instead, the health needs of the community continue to grow. Moreover, reforms in the financing and delivery of health care services, particularly in its impact on the low-income immigrant population which is AHS' main client base, are changing the environment significantly. A chronology of AHS' history and advocacy efforts is attached to the Manual as part of Appendix A-6.

10) Asian Pacific Health Care Venture, Inc. – Off-Site Interpretation

Contact: Mika Aoki,
Health Education Manager
(323) 644-3880
1530 Hillhurst Avenue, Suite 200
Los Angeles, CA 90027

The Asian Pacific Health Care Venture, Inc. (APHCV) is a non-profit health center whose mission is to provide culturally competent and effective health care services. While it offers services to all individuals, APHCV serves an urban community with a special emphasis on the underserved Asian and Pacific Islander (API) populations of Los Angeles County.

APHCV was founded in 1986 by concerned health and human service providers and organizations who adopted a collaborative approach for assessing, planning, and implementing community-relevant health care services for the API communities it hoped to serve. The APHCV started as a nonprofit coalition serving the API community in Los Angeles County. Its mission was to plan, promote, and coordinate accessible, affordable, culturally competent, and effective health services to the underserved. In 1997, APHCV became a direct provider and opened its own clinic. APHCV still maintains its coalition model for certain contracts.

APHCV's history demonstrates its recognition of the importance of cultural competency and collaborative approaches in promoting efficient and accessible health care. In response to rapid population growth, increasing ethnic diversity, the changing health care environment and the limited availability of resources, APHCV has evolved to effectively meet the health needs of API communities through innovative approaches. Approximately eighty-one to ninety percent of its patient population does not speak English. Fifty percent of its LEP patients speak Thai, fifteen percent

Khmer, fifteen percent Tagalog/Filipino, ten percent Vietnamese, and ten percent Spanish. APHCV offers direct language services in the following languages: Cambodian, Japanese, Tagalog, Thai, and Vietnamese.

APHCV addresses API language and cultural barriers in obtaining mainstream sources of health care by providing bilingual and bicultural health care services. Currently, APHCV's board of directors is comprised of experienced and qualified community health and human service experts, service providers, and client representatives from diverse API communities. APHCV's philosophy is to provide multi-language/multi-cultural services to its patients at every point of contact.

Ninety percent of APHCV's staff is multilingual (this includes administrative, fiscal, and the community health education department). APHCV, however, also has nine full-time and part-time interpreters. In its early hiring experience, it was found that many interpreters when first hired had limited medical interpretation experience. Accordingly, APHCV has developed an on-site and off-site interpreter training program using materials (i.e. medical terminology, anatomy and physiology) developed by the Health Promotion and Education, Government of Northwest Territories, Canada, ALABAMA Health Access by Language Advocacy (ALHABLA), the Alabama Department of Public Health and the Seattle Washington Cross-Cultural Health Care Program. (Contact information is included in Appendix A-7)

When an applicant seeks an interpreter position at APHCV, health education materials in English and in the non-English language that they speak are given to the applicant. Applicants who are applying for interpreter positions are asked to translate non-English materials into English and English materials into the non-English language they speak.

APHCV's Patient Support Service Unit provides supportive services to LEP and other clients to facilitate the overall patient flow and to navigate clients through the health care system. Specific tasks include:

- Assisting clients in history intake and financial screening process,
- Providing medical interpretation in exam rooms and off site facility for specialty care,
- Translating clinic related materials,
- Assisting clients in health care program enrollment,
- Providing referrals to social and other services, and
- Assisting clients with making appointments for specialty care services and providing follow-up/case management for referred clinical services.

As mentioned, APHCV also schedules patient appointments with both the provider and interpreter to avoid interpreter scheduling conflicts and delays. APHCV has also received limited Office of Minority Health funding for off-site interpretation services when their patients are referred to outside specialists.

APHCV has developed consent forms in seven different languages and maintains a multitude of written, audio, and video preventive and health education materials in other languages. For example, breast self-exam literature appears in Chinese, Japanese, Thai, Vietnamese, and Khmer. Hepatitis B materials appear in Khmer, Chinese, Korean, and Thai. Posters outlining patient rights & responsibilities appear in English, Tagalog, Khmer, Japanese, Thai, Vietnamese and Spanish. Grievance policy signs appear in English, Tagalog, Vietnamese, Thai, Khmer, and Japanese.

Lastly, APHCV conducts patient satisfaction surveys in seven languages, and the surveys specifically ask questions about any language-related difficulties the patient may have suffered. Copies of the survey are included in appendix A-7. In addition, any LEP related grievances or complaints are reviewed by the Health Education Manager, who supervises APHCV's interpreters, are shared with other managers and are discussed at monthly clinic staff meetings in order to reinforce APHCV's LEP policies and procedures.

Promising Practice Example: APHCV's Off Site Services

As with Asian Health Services, APHCV assists other providers in complying with Title VI. The difficulty in referring LEP individuals to linguistically appropriate specialists is one of the most common problems community clinics and health centers face. APHCV's depth and diversity in its language capacity, as well as their strong commitment to Asian and Pacific Islander communities, has resulted in their willingness to share their language assistance with outside providers. Off-site interpretation ensures that LEP patients receive "meaningful access" at all levels of care.

When possible, APHCV will send an interpreter to scheduled appointments for the following services: maternal/child health (OB, GYN, specialty services for children), diabetes related services (ophthalmology, podiatry), cancer, and others. Due to limited availability of interpreters, priority is given to appointments related to the named health conditions.

APHCV will also provide interpretation services for unscheduled/emergency visits. During office hours, APHCV provides verbal interpretation through the telephone or an interpreter will be sent to the facility when circumstances mandate.

B Key 4: Monitor Compliance

Key 4 outlines the need to monitor compliance with LEP policies. Key 4 recommendations include provider surveying of the LEP community to ensure the adequacy of language services. APHCV's patient satisfaction survey specifically asks about the adequacy of language assistance and has a process for addressing any identified problems.

11) La Clínica de La Raza - Cultural Competence Self-Assessment Survey

Contact: Anita Addison,
Planning and Development Director
(510) 535-4013
1515 Fruitvale Avenue
Oakland, CA 94601

In response to the lack of health care service for Latinos in East Oakland, a group of concerned students, health professionals and community activists came together in 1971 to establish a storefront multiple-service free clinic which would be controlled by the community it served. Staffed by five volunteers, La Clínica de La Raza ("La Clínica") initially offered free medical care. Later, as word spread about La Clínica, dental, vision and mental health students and professionals also began volunteering at the clinic. A revenue sharing contract with Alameda County in 1973 enabled La Clínica to stabilize its financial situation. Other contracts and grants from local, state, federal and private sources soon followed as La Clínica began to establish itself as a model health care provider for the Latino community.

In 1984, La Clínica established its first satellite clinic by merging with the San Antonio Neigh-

borhood Health Center, a previously independent clinic founded in 1977. Another satellite, Clínica Alta Vista, opened in 1987 and specializes in teen services. In 1993, La Clínica opened a school-based clinic at Hawthorne Elementary School in East Oakland. For thirty years, La Clínica has delivered affordable, culturally and linguistically appropriate health care services to thousands of Alameda and Contra Costa county residents. Today, La Clínica has an annual budget of over \$20 million, is funded by more than sixty different sources, employs over 250 people, and operates four primary care clinics in Oakland and Pittsburg and four school-based clinics in Oakland and San Lorenzo. Dedicated to serving the entire needs of the family, La Clínica provides a comprehensive array of services, such as medical, mental health, optometry, health education, nutrition, social services and dentistry.

La Clínica has one of the highest immigrant clientele among Alameda county clinics. Those who receive care at the clinic are primarily low income and people of color. Fifty-three percent are uninsured and thirty-one percent receive Medicaid. The majority of the clinic's 19,000 patients are women, children, and Latino. Eighty-two percent of La Clínica's patients are Latino, 8 percent are Asian and Pacific Islanders, and 5 percent are African American. Spanish is the primary language for 82 percent of the clinic's patients. Asian and Pacific Islander languages are spoken by eight percent of the clinic's patients.

Of La Clínica's staff, over 80 percent speak Spanish and 15 percent speak an Asian or Pacific Islander language. For less frequently encountered languages, La Clínica uses Asian Health Service's Language Cooperative service discussed previously. Sixty-six percent of staff members are Latino, and 13 percent are Asian/Pacific Islanders.

In light of La Clínica's diverse patient population and in an effort to assess the clinic staff's cultural competence, the clinic included a cultural competence assessment as part of its annual Quality Assurance Oversight Plan last year. The survey was given to all staff and 56 individuals (or 16 percent) responded. This was the first time La Clínica undertook such a survey. A copy of the survey instrument developed by La Clínica for this purpose and its results are attached hereto

as part of Appendix A-8.

While it was not surprising that the vast majority of the respondents had contact with Latinos (88 percent), 71 percent also had contact with Asian and Pacific Islanders, and more than half had contact with African American patients. A sample of the survey questions include the following:

Promising Practice Example: La Clínica's Cultural Assessment Tool

La Clínica asked its staff the following questions using the following scale:

1=Things done frequently; 2=Things done occasionally; 3=Things done rarely or never; N/A= not applicable

- For patients/clients who speak languages or dialects other than the languages I speak, I attempt to learn and use key words in their language so that I am better able to communicate with them.
- I attempt to determine any familial colloquialisms used by patients/clients that may impact on my service or interaction with them.
- When possible, I insure that all notices and communiques to patients/clients are written in their language of origin.
- I understand that it may be necessary to use alternatives to written communication for some patients/clients, as word of mouth may be a preferred method of receiving information.
- I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- In group situations, I discourage patients/clients from using racial or ethnic slurs by helping them understand that certain words can hurt others.
- I intervene in an appropriate manner when I observe other staff or patients/clients engaging in behaviors that show cultural insensitivity or prejudice.

According to respondents, there was a need to have more materials and signs in different languages and to reflect different cultures. Staff expressed a desire for more training and information about non-Latino cultures. There was strong recognition of the importance culture plays in de-

livering quality health care. The survey is a work in progress and future surveys may include questions intended to measure the staff knowledge of other cultures, which may reveal more about their actual cultural competence rather than their desire to achieve this level of sensitivity.

B Key 4: Monitoring Compliance

The cultural competence assessment conducted by La Clínica provides another innovative example of compliance with Key 4 - monitoring compliance. Key 4 asks providers to regularly review the assessment of LEP policies, staff training, and the overall ability to provide meaningful access. La Clínica takes the LEP assessment one step further in an effort to address the complexities of cultural competence. La Clínica, as well as many of the highlighted community clinics and health centers, recognize that language is only one barrier in caring for a diverse patient population. Through its internal cultural competence assessment, La Clínica knows where it can concentrate its efforts to improve its culturally and linguistically competent services.

12) Venice Family Clinic – Patient Satisfaction Survey

Contact: Susan Fleischman,
Medical Director (310) 664-7726
604 Rose Avenue
Venice, CA 90291

The Venice Family Clinic was founded in 1970 by Philip Rossman, MD and Mayer B. Davidson, MD. They were alarmed that even the most basic medical services such as immunizations, antibiotics and prenatal care were unavailable for the low-income families of Venice. Today, the small clinic that they began in a tiny storefront has grown into four sites, is a model of care, and is the largest free clinic in the United States.

Venice's mission is to provide comprehensive primary health care that is affordable, accessible and compassionate for people with no other access to such care. Although it was founded as a "temporary, stop-gap measure," it is still in operation after thirty years because the number of uninsured children and adults continues to grow, and no other solution for how best to provide (and pay for) health care to the uninsured has emerged.

Sixty-five percent of the clinic's patients have

jobs that do not provide affordable health care. Eighty-four percent live below the federal poverty level. Sixty percent are women, and 35 percent are children. Sixty to seventy percent speak Spanish. To the community, the clinic has proven itself to be an innovative, efficient and viable response to the need for primary health care services for the working poor of Los Angeles County.

The clinic also provides special teen services, addressing issues such as teen pregnancy, AIDS, abuse, family problems, depression and other topics that impede 'at risk' youth from staying in school and reaching their potential. The Women's Clinic ensures comprehensive prenatal services and prenatal classes. The clinic also gives annual pap smears and breast exams. It offers STD and HIV screening. The clinic is also a safe place to go to for women dealing with issues like domestic violence.

The clinic houses psychosocial services that include individual and family counseling, crisis intervention, weekly support groups for couples, parents, teens, diabetic patients, and social service referrals for housing, food, employment and other public benefits such as Healthy Families and Medi-Cal.

The clinic does all this with a combination of volunteer paid physicians. Front desk and medical assistant staff are all bilingual in English and Spanish. The clinic also has a 24 hour, seven days a week Spanish answering service. It conducts a bicultural training once a year. The clinic is also developing a quarterly patient satisfaction survey, which is not only bilingual (English & Spanish), but specifically asks such questions as: “Do you feel that the medical providers and staff are sensitive to your cultural beliefs?” and “Do you feel comfortable using an interpreter when your medical provider does not speak your native language?” These are questions that are not often seen in patient satisfaction surveys. A copy of the Venice Family Clinic’s draft survey is attached as part of Appendix A-9.

B Key 4: Monitoring Compliance

Key 4 is addressed with Venice’s patient satisfaction survey. Whereas the model highlighted for La Clínica is an internal assessment to comply with Key 4, the model highlighted from Venice focuses on seeking input from patients. Patients are asked to comment on the cultural and linguistic competence of Venice’s services. Key 4 seeks to monitor compliance with LEP policies and procedures and encourages providers to seek community input as an important part of monitoring its compliance.

13) Community Voices-Oakland – Multilingual Survey of Uninsured

Contact: Tomiko Conner
Project Director (510) 633-6292
7700 Edgewater Dr., Ste. 215
Oakland, CA 94621

Community Voices-Oakland is a project of Asian Health Services and La Clínica de la Raza in collaboration with the Alameda Health consortium and Alameda County. It is one of the thirteen learning laboratories nationwide funded by the Kellogg Foundation.

One identified need in Alameda County is the ongoing problem of the lack of county specific information about the uninsured population, particularly immigrants. Data is generally extrapolated from national and statewide statistics, which leaves many gaps in local data. For example, in the Current Population Survey (CPS) for Alameda County, a typical sample garners only 35 uninsured households; a sample too small for accurate projections on the uninsured. Additionally, the survey is only conducted in English and sporadically in Spanish, greatly limiting the information on immigrant populations.

A clearer picture was needed of “who the uninsured are” and “what their needs are” to be able to improve both access to care and quality of care, broadly defined. To help create this clearer picture, Community Voices-Oakland, along with Alameda County and the Alameda Alliance for Health, funded the County of Alameda Uninsured Survey (CAUS). CAUS is a unique randomized telephone survey conducted in seven languages - English, Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Dari (40 percent of the interviews of the uninsured were conducted in languages other than English). Sampling was completed in February 2001. A total of 11,039 households were initially screened and 1,673 core interviews of the uninsured were conducted. A copy of the CAUS Audit Questionnaire is included as Appendix 10.

CAUS provides:

- Demographics (including disaggregated race, ethnicity and primary language as well as age, gender, family composition, and immigration status),
- Health Insurance coverage,
- Access to health care,
- Utilization of services,
- Self-perceived health status,
- 2 chronic conditions (Asthma & Diabetes),
- Pap test and mammogram,

- Willingness to pay for insurance, and
- Public program eligibility.

Initial analysis shows:

- 140,000 uninsured non-elderly adults reside in Alameda County.
- Over 70 percent of the uninsured are people of color.
- Of the uninsured, 38 percent are Latino; 26 percent Non-Latino White; 18 percent Asian American and Pacific Islander; 18 percent African American and <1 percent American Indian/Alaskan Native.
- 40 percent of Latinos are uninsured. By subgroup: 40 percent of Mexican; 45 percent of Central American; and 23 percent Other.
- 15 percent of AAPIs are uninsured. By subgroup: 27 percent of Vietnamese; 20 percent of Korean; 20 percent of Native Hawaiian, Pacific Islander and other Asian; 14 percent of Chinese; 8 percent of Filipino; 6 percent Japanese; and 6 percent South Asian.

CAUS provides immigrant specific information because of more cohorts, greater sample, and multiple languages. As a result it shows that:

- Most of uninsured workers are immigrants,
- Immigrants work many hours,
- They fill unskilled and service jobs,
- They have lower odds of getting job-based insurance than US born,
- But odds go up with citizenship and tenure.

CAUS will make a difference in making policy and devising programs:

- Estimates on number of eligible children for Medicaid and the Healthy Families Program,
- Guidance for priority setting,
- Identifies target group characteristics AT LOCAL LEVEL, and
- In conjunction with other data sources it more fully describes the uninsured, particularly with regard to immigrant populations.

VI. Community Clinic and Health Center Advocacy Organization Promising Practices

By advocating for necessary changes on behalf of the community clinics and health centers, the goal of community clinic and health center advocacy organizations is to ultimately strengthen and improve the health care delivery system for all patients. The role is to assist community clinics and health centers in maximizing their ability to serve their entire community, including those community members that face linguistic isolation. This section highlights the work of these advocacy organizations in assisting community clinics and health centers to meet the obligations of Title VI.

1. Association of Asian Pacific Community Health Organizations

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a California-based national association founded in 1987. Its mission is to promote advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the US, its territories and freely associated states, primarily through its member community clinics and health centers.

Its vision is to establish a standard of excellence for community-based health care that is equitable, affordable, accessible and culturally and linguistically appropriate to the people served.

AAPCHO's state and national activities include: advocacy for policies and programs to improve health status for Asian Americans & Pacific Islanders (APIs), promotion of multilingual primary care service delivery models, development of programs to improve access to care for the underserved, data collection and analysis related to APIs in primary care, and technical assistance for the establishment and expansion of community clinics and health centers serving APIs. Funding sources include the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, the Office of Minority Health, the Bureau of Primary Health Care, and the American Legacy Foundation.

AAPCHO's current membership is composed of thirteen community clinics and health centers and the Native Hawaiian Health Systems that serve APIs throughout the United States. Located in communities with high concentrations of medically underserved APIs, AAPCHO member agencies are at the forefront of providing multilingual/multicultural primary health care services to approximately 135,000 patients annually. A majority of the patients served by these member agencies are non- or limited-English speaking. The majority of them are also living below poverty (up to 81 percent) and uninsured (up to 89 percent). AAPCHO member agencies work collaboratively with other health providers in their local areas, including state and local health departments, hospitals, and specialty service providers. Additionally, they also work with local community-based organizations to improve the coordination of services and to conduct outreach in API communities.

AAPCHO Current LEP Activities

AAPCHO, along with its partners (which includes the California Primary Care Association), worked to draft a provision in the Senate reauthorization of the Consolidation of Community Health Centers bill (S. 1533, The Health Care Safety Net Amendments of 2001). The legislation authorized \$10 million to help federally funded health centers, serving limited English Proficiency (LEP) clients, offset the cost of providing multilingual services. AAPCHO continues to work with its partners and membership of health centers to garner Congressional support for the bill. AAPCHO members encouraged their local representatives to support the legislation.

In 2001, AAPCHO worked with other legislators to include an acknowledgement in the House Labor/Health & Human Services/Education Appropriations bill. The acknowledgement states federally funded health centers should be reimbursed for the provision of multilingual services.

AAPCHO has also raised awareness around LEP issues through its *Frontline* newsletter. AAPCHO featured two cover stories related to both Title VI and the health care needs of LEP patients in its Winter 2000 and Summer 2001 issues. In both stories, AAPCHO emphasized the importance of delivering appropriate language access services to patients with limited English proficiency.

In addition to its newsletter, AAPCHO has used its website to publicize recent federal activities surrounding LEP issues and Title VI. Individuals interested in viewing the Title VI Guidance Memorandum from the Office of Civil Rights, can do so through AAPCHO website (www.aapcho.org).

AAPCHO Publications

Publications supporting Cultural and Linguistic Appropriate Services:

1. *The CARE Program Guide: A Community Approach to Responding Early to Breast and Cervical Cancer in AAPI Communities (Pending)*.
2. *The CARE Program Monograph: Case Studies of six Breast and Cervical Cancer Programs for AAPI Communities (Pending)*.
3. *Steps to Manage Your Diabetes (2001)*.
4. *BALANCE Program for Diabetes Community Assessment Report (2000)*.
5. *Cross Cultural Tuberculosis Guide: Cultural Influences on TB-related Beliefs and Practices of Filipinos, Vietnamese, Chinese and Koreans: A report to assist providers to improve communication about tuberculosis with patients from the Philippines, Vietnam, China and Korea (2000)*.
6. *Addressing the Nation's Mental Health Issues for Asian American Communities: Three Mental Health Program Models (2000)*.
7. *Pocket Guide for Medical Interpretation (1996)*.

Publications related to Policy and Data Analysis

supporting Cultural and Linguistic Appropriate Services:

8. *Policy Paper on Diabetes (2000)*.
9. *Development of Models and Standards for Bilingual/BiCultural Services for Asian and Pacific Islander Americans (1996)*.
10. *Taking Action: Improving Access to Health Care for Asians and Pacific Islanders (1995)*.
11. *Culturally Competent Health Services Delivery Under Managed Care for Asians and Pacific Islanders (1994)*.
12. *Health and Socio-economic Characteristics of Asians and Pacific Islanders (1994)*.

2. California Primary Care Association

Founded in 1994, the California Primary Care Association (CPCA), together with the more than 500 community clinics and health centers it represents, has helped to ensure affordable, quality health care to California's uninsured, low-income and minority communities. CPCA's mission is to promote and facilitate equal access to quality health care for individuals and families through organized primary care clinics and clinic networks that, among other things, seek to maintain cost-effective, affordable medical services, as well as meet the linguistic and cultural needs of California's diverse population.

Orientation Manual for New Clinicians

CPCA produced a manual to assist clinicians who are National Health Service Corp scholars in becoming oriented to their placement sites within California community clinics and health centers. The manual includes a section on Cultural Competency and Diversity.

The section on Cultural Competency and Diversity is included to offer a brief overview of important concepts to help clinicians serve the increasingly diverse community of patients seen in California's community clinics and health centers. More than seventy percent of patients in California are members of minority racial or eth-

nic groups, and almost half claim English as their *second* language. The manual recognizes that diversity exists in many areas beyond racial differentiation. The manual encourages providers to consider the countless possible combinations of culture, religion, mental or physical ability, heritage, age, gender, sexual orientation and income level that an individual may embody.³⁵

Healthy Newborns Program

CPCA's Healthy Newborns Program encompasses several different aspects. The first of which is a perinatal curriculum that was developed over the course of three years to provide community clinic and health center staff useful and relevant tools to teach perinatal education in an effective group session model. The curriculum includes a detailed teacher's guide and instructions and easily read patient materials. It is available in five languages: English, Spanish, Korean, Vietnamese and Chinese.³⁶

Healthy Newborns - Toll free service

Second, the Healthy Newborns Project has developed and implemented a statewide educational media campaign to respond to the declines in perinatal visits reported by community clinics and health centers throughout the state, a decline that has been concentrated in the immigrant community. The campaign addresses the importance of perinatal care and urges women to seek these and other health care services in the nearest community clinic or health center. Culturally and linguistically appropriate motivational public service announcements have been produced in Spanish and English for television and radio. The announcements advertise CPCA's bi-lingual toll-free community clinic and health center referral service.

This referral service is staffed by operators who utilize CPCA's database to determine the

clinic or health center closest to the caller that provides the requested health care services in the language required. Matches are first sought based on caller's residential zip code. If no match is found at the zip code level, the operator seeks a match within the city of residence or the nearest city. If no match can be made at the city level, the operator then searches the database for a match within the county of residence. Callers are given the name, address, and phone numbers for all community clinics and health centers in their area that can meet their needs, including their linguistic needs. If no community clinic or health center is identified, a referral is given to the county health system. No identifying information is requested of the caller other than their zip code.

Bilingual operators are available in English and Spanish. CPCA's toll-free number is (888) 895-0808.

Policy Focus on Language Access

CPCA has been extremely active in advocating for California's LEP patients. CPCA was in the forefront of the adoption of cultural and linguistic competency standards in California's State Children's Health Insurance Program (SCHIP), Healthy Families. CPCA provides comments on all regulations, guidance and standards issued at the federal level and facilitates participation by California's community clinic and health centers with sample comments. The Department of Health and Human Services Standards on Culturally and Linguistically Appropriate Services, the Office of Civil Right's Guidance on Serving LEP Patients, the elimination of the requirement that state's collect primary language data in SCHIP programs are a few examples of the federal issues on which CPCA has commented. Appendix A-10 includes CPCA's comments on the SCHIP interim regulations and comments on the Office of Civil Right's Guidance on Serving LEP patients.

³⁵ For copies of this document, contact Lucette DeCorde, Program Director, ldecorde@cpca.org.

³⁶ For more information on the Healthy Newborns Curriculum, contact ldecorde@cpca.org.

CPCA has sought to use innovative legislative vehicles for expanding language services to LEP populations. For example, this year CPCA sponsored SB 59 (Escutia), which creates Public Health Initiatives under SCHIP to address the unique barriers faced by special populations of children, including the lack of access to translation and interpretation services. If this bill passes, Community clinics and health centers will have a vehicle to seek reimbursement for interpreter and translation services for SCHIP eligible individuals. CPCA is also currently conducting extensive research on how other states reimburse for language access services. The next section presents a summary of this information. This research is intended to further develop a state model for California on reimbursement for language access services.

In addition, on the federal level, CPCA is advocating for the \$10 million to help federally funded health centers serving LEP clients. Although the provision was included in the Senate version of the safety net legislation and received bipartisan support in the Senate Health, Education, Labor & Pensions Committee, its prospects in the House are unknown. As mentioned in the previous description, because of the importance of this provision for federally funded health centers, CPCA is working with AAPCHO and the National Association of Community Health Centers (NACHC) to promote and advocate for these services at the federal level.

Finally, this Promising Practice Manual is an example of efforts PCAs can undertake to increase the adequacy of care for LEP populations.

VII. State-Sponsored Promising Practices

Due to the increasing necessity and demand for language interpretation and translation services, several states have developed programs to ensure providers have access to and are compensated for these services. The following are some examples of states that pay for language interpretation and translation services in the health care setting.

1. Washington³⁷ State Policies

Through Title VI of the Civil Rights Act of 1964, Revised Code of Washington (RCW) 74.04.025, other legal mandates, agreements, and department policies, the Washington Department of Social and Health Services (DSHS) provides equal access to department programs and services for all persons, including those with limited English proficiency. Currently, DSHS contracts with language agencies to provide interpreter services for LEP clients accessing DSHS programs and services. Language line services are available as well as translated materials.

The state contracts with 13 language agencies for interpretation services statewide, providing over 21,600 encounters per month. In addition, it has 3 language agencies that translate materials - 2500 forms/publications/brochures per year; 30-35,000 individual notices and case plans per month; and 3500 individual Temporary Assistance for Needy Families (TANF) notices per month.

The contracted language agencies bill the different DSHS administrations. For those language agencies that contract with the Medical Assistance Administration, they use the Medicaid Management Information System to bill electronically. Rates paid to each of the 13 language service agencies vary by region.

The state certifies interpreters and translators in 7 languages and provides testing for bilingual employees. The passage rate for interpreters and translators ranges from 36 percent to 62 percent. For other languages, the agency has a screening process. In addition, interpreters must attend an orientation during their first year of contract. For translators, the state contracts with independent reviewers to ensure that translations are done accurately and properly.

2. Hawaii³⁸ State Policies

Hawaii found an opportunity to provide in-person interpretation services for its providers and created a program. The state contracts with two language service organizations that help limited English proficient individuals who are Medicaid fee-for-service patients or disabled kids in their SCHIP program. Managed care organizations and hospitals cannot access state-funded language access services because they are required to provide these services on their own.

Medical providers can schedule interpretation services by calling the language service organizations directly. The most commonly requested languages are Samoan, Vietnamese, Chinese (Cantonese), Korean, Ilocano, and Tagalog.

The state pays the language service agency a rate of \$25-\$45 per hour. Interpreters are allowed to charge for travel, waiting time, or parking. For interpreters on staff or bilingual providers, there is no payment provided.

The state has guidelines on billing procedures and utilization, and the language service organizations are expected to monitor quality and assess the qualifications of the interpreters they

³⁷ Information obtained from the Medical Assistance Administration document entitled "Interpreter Services: Billing Instructions," August 1998, and a presentation by Bonita Jacques, DSHS Administrative Services Division, entitled "Language Services in State Government."

³⁸ Information from phone conversations with Dr. Lynette Honbo, Medical Director, MEDQUEST Division.

hire.

3. Minnesota³⁹ State Policies

The Minnesota Department of Human Services' (DHS) first language protocol was implemented in 1998, establishing a department-wide policy and procedure for providing effective communication with non- or limited English speaking recipients, including persons in need of sign language interpreting. Under the language protocol, as its primary means of communicating with recipients with limited English proficiency, DHS contracted with Language Line telephone interpreter services, used a vendor list certified by the state's Department of Administration to contract for interpretation and translation services through a state-wide contract, and utilized the interpretation services of bilingual staff.

In 1999 at the direction of the state legislature, DHS developed its second language protocol. This limited English proficiency plan (LEP plan), as it was called, led to a formal work plan, which today is the foundation for DHS's current Limited English Proficiency Program. Additionally, the terms of a lawsuit settlement agreement, effective December 2000, have shaped DHS's LEP work.

Under its state-supervised, county-administered service delivery model, DHS provides instruction to Minnesota's 87 county human services agencies on LEP plan development. Soon, each county agency will have its own LEP plan or methods of operation for providing access to language interpretation and translation services for recipients with limited English proficiency.

For the state agency, translation is done primarily through state contracted language service organizations. DHS initially started translating materials in the early 1990s and over the years these translated materials have developed into

applications, forms, brochures, booklets, and videotapes. The recent lawsuit focused on the translation of several documents, among other issues, which DHS has agreed to continue to translate into Cambodian, Hmong, Laotian, Russian, Somali, Spanish, and Vietnamese. Other DHS materials have been translated into more than these seven languages, with the additional languages being Hmong, Arabic, Serbo-Croatian, and Oromo.

The state also includes a language block with documents such as computer-generated program notices, applications, and case-specific forms, etc, that list a toll-free number for patients to call to be connected with someone who speaks their own language and who relays the caller's message to appropriate state or county staff, or interpreters, who speak the caller's primary language. The state has added Arabic, Serbo-Croatian, and Oromo to the list of languages for the language block.

The cost of translation varies dramatically from agency to agency. Some charge per word, usually about 30 cents per word, with other agencies charging anywhere from \$25 to \$100 per page depending on factors such as language font and whether the translation type is simple, difficult, or advanced. The state certifies the language service organizations through its bidding and contracting process. Providers may use non-contracted translators, but the translations must be reviewed by the state. With interpreters, the state has not yet established any certification process.

Effective July 1, 2001, Minnesota's Medicaid program separately reimburses any enrolled fee-for-service provider who provides language interpreter services. The service may be via phone or in person. The interpreter service must be provided in conjunction with a covered service. The provider hires, contracts, or arranges the inter-

³⁹ Information from phone conversations with Kathleen Cota and Paul Adalikwu, Minnesota Department of Health.

preter service, and then bills the state using the new billing code. Providers are paid the lesser of charges or \$12.50 per 15 minute unit. Enrollees in managed care receive language access services from their health plan, as required in managed care contracts.

4. Utah⁴⁰ State Policies

Utah contracts with five language service organizations to provide in-person interpretation, telephone interpreter services, and translation services to fee-for-service Medicaid, SCHIP, and medical indigent program patients. Through these language service organizations, the following languages are available: Alcholi, Albanian, Arabic, Armenian, Bari, Belorussian, Bosnian, Chinese, Dinka, Farsi, French, German, Hmong, Italian, Japanese, Kakwa, Madi, Mandarin, Nuir, Persian, Russian, Serbo-Croatian, Somali, Spanish, Swahili, Ukranian, and Vietnamese. For those patients in managed care, Utah requires health plans to provide language access services for their patients as part of the contract agreements.

Health care providers call contracted language service organizations to request both interpretation and translation services. They cannot bill Medicaid directly for using the interpretation services nor do they receive any rate enhancements for being a bilingual provider or having interpreters on staff. Instead, the contracted language service organizations are paid by the state an average of \$22 per visit for phone interpretation services. In-person interpretation costs \$35 per hour with 1-hour minimum. The state also pays \$35 per page for written translations.

A Request for Proposals (RFP) process is used to determine the contracted language service organizations. Criteria for assessing applications included information on quality, such as

standards for ethical interpreter behavior, the confidentiality policy, cultural competency standards, medical terminology training, etc.

5. Maine⁴¹ State Policies

Maine recently started reimbursing Medicaid and the SCHIP providers for services delivered to eligible recipients for in-person and phone interpretation services in January 2001. The state had already established reimbursement codes for interpretation services for deaf/hard of hearing clients, but decided to broaden coverage to include language interpretation services as well. The providers have flexibility in determining how to provide the interpretation. The provider may provide language interpreter services either through local resources, or through national language interpreter services such as the "Pacific Interpreters, AT&T Language Line," or comparable services.

In all cases, the provider is required to include the following in the billing document: date and time of the interpreter service, duration, language used, and the name of the interpreter.

Providers use designated billing codes to be reimbursed by the state. Providers are reimbursed up to \$30 per hour for interpretation provided during normal business hours and up to \$40 during non-business hours. The state will reimburse for phone interpretation services with proper documentation. Translation service costs are covered if the translation is necessary to provide a direct service that is covered under the Medicaid or SCHIP program.

At this time, there are no state standards for certifying the language interpreters. Certification standards do exist for interpreters for deaf/hard of hearing services, however. Individual provid-

⁴⁰ Information from phone conversation with Joyce Gaufin, Quality & Productivity Consultant, Utah Department of Health.

⁴¹ Information obtained from the Maine Medical Assistance Manual, Chapter 101 and phone conversation with Peter Ezzy, Policy Development, Bureau of Medical Services, Maine Department of Human Services.

ers determine and select the interpreters they use. They are responsible for ensuring interpreters submit a statement of qualifications to the state that outlines information such as training, language abilities, and skills. Also, providers are required to provide evidence that interpreters have read and signed a code of ethics that meets the core requirements of the model supplied by the State of Maine in Medicaid program guidelines.

6. Massachusetts⁴² State Policies

Legislation was passed earlier this year (2001) to require all emergency rooms to provide in-person or phone interpreter services for limited English proficiency patients. In order to comply with this requirement, hospitals are responsible for employing or contracting interpreters, with the use of phone interpreters only as a last resort. Depending on money allocated in the state budget, the legislation also outlined coverage of the reasonable cost of providing competent interpreter services as an operating expense for the hospitals. More specific details on the implementation of this program will be developed in the next several months.

7. California Managed Care Policies

California was the first state to adopt linguistic and cultural competency standards in its government-sponsored managed care program. Managed care organizations participating in Medicaid and SCHIP are required to provide language services to enrolled LEP individuals. The following describes California's managed care model.

Medi-Cal (California's Medicaid Program)

California prohibits managed care plans from

discriminating on the basis of ethnicity, including refusing to enroll non-English speaking or LEP Medi-Cal recipients.⁴³ The California Legislature also required the state Department of Health Services ("DHS") to consider a managed care plan's ability to render culturally and linguistically appropriate services before contracting with the health plan as a Medi-Cal provider.⁴⁴ DHS in turn used this authority to require all health plans that contracted with the state for Medi-Cal recipients to agree to certain cultural and linguistic obligations. Among the provisions required in DHS' model managed care contracts are:

- An assessment and mapping of the language capability of the health plan's proposed service area;
- The provision of linguistic services to Medi-Cal eligibles residing in the proposed service area who indicate their primary language as other than English and who meet a numeric threshold of 3000 in a county, 1,000 in a single zip code or 1500 in two contiguous zip codes;
- The development of cultural and linguistic service plans;
- The provision of 24-hour access to interpretation services; and
- The provision of linguistic services at key points of contact, including in-person contact with providers, telephone contact, and encounters regarding membership, services, and appointments.⁴⁵

In addition, in April 1999, the Medi-Cal Managed Care Division ("MMCD") of DHS released a set of policy letters to Medi-Cal managed care

⁴² Information obtained from Massachusetts legislation, Chapter 66 of the Acts of 2000, and a presentation by Loretta Saint-Louis, Director of Multi-Lingual Interpreting, Cambridge Health Alliance.

⁴³ Cal. Gov't Code Sec. 11135-11139.5.

⁴⁴ Cal Welfare & Institutions Coed Sec. 14016.5.

⁴⁵ Calif. DHS, Boilerplate Agreement between DHS and Contract (entered into under of provisions of Section 14087.3, Welfare & Institutions Code) 6.10.2.

health plans requiring them to develop and implement policies and procedures to ensure 24 hour access to interpreter services.⁴⁶ These services are required at defined medical and non-medical points of contact. Plan managers, staff, and providers are encouraged to participate in cultural and linguistic education, but this is not required. These provisions were largely the result of an extensive community input process that began in 1992.⁴⁷

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

In December 1999, the Managed Risk Medical Insurance Board (MRMIB) adopted model contract language related to cultural and linguistic competency for the Healthy Families Program, which are modeled after those for California's Medicaid program described above. Among the key provisions contained in MRMIB's model contract are:

- Prohibition of the use of minors as interpreters except in the most extraordinary circumstances, such as medical emergencies;
- 24-hour access to interpreter services for all LEP members with a stated preference for face-to-face interpreter services;
- Demonstration of appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories;
- Cultural and Linguistic Group Needs Assessment;
- Annual reporting on linguistically and culturally appropriate services;
- The inclusion of race, ethnicity and primary language as core data elements in all standard measures for assessment;⁴⁸ and

- The provision of translated materials to Healthy Families enrollees whose primary language meets a numeric threshold of 5 percent or 3000 health plan members.⁴⁹

California's Office of Multicultural Services in the Department of Mental Health

The Office of Multicultural Services, established in December 1997, provides leadership direction to the Department of Mental Health (DMH) in promoting culturally competent mental health services within California's Public Mental Health System.

The Chief of the Office of Multicultural Services serves as a member of the executive staff in developing policies and procedures to ensure that cultural and linguistic competence guidelines are incorporated within all facets of the Department of Mental Health. Mental health care providers and managers must understand the importance of language and culture in delivering appropriate mental health care.

The Office of Multicultural Services is charged with a leadership role in the development of the Cultural Competency Plan, ensuring culturally appropriate treatment intervention, services, and assessment in each of California's diverse counties. These elements are fundamental to the successful implementation and delivery of managed mental health services. Each county Mental Health Plan is responsible for providing an annual Cultural Competency Plan to DMH that enumerates the planned strategies for providing cultural and linguistically competent care.

⁴⁶ DHS letter to Medi-Cal Managed Care Health Plans Re: Release of Cultural and Linguistic Letters, dated April 2, 1999.

⁴⁷ Puebla Fortier, Julia, et. al., "Language Barriers to health care: Federal and state initiatives, 1990-1995," *Journal of Health Care for the Poor and Underserved*, Nashville, 1998, Vol. 9, pp. S81-S100.

⁴⁸ When fully implemented, this provision will greatly assist in assessing the quality of care provided to specific populations and assist in identifying areas where barriers related to cultural and linguistic issues should be addressed; Id.

⁴⁹ Id.

The Cultural Competency Plan is to lead to compliance with three standards for cultural and linguistic competence. The three standards address access, quality of care, and quality management. Each standard is followed by several indicators of performance that describe what shall happen and by when. Subsequently, each indicator is followed by measures that describe how compliance with indicators will be determined. Attachment A.11 includes the full description of these standards, indicators and measures.

VIII. Conclusion

Community clinics and health centers recognize that the benefits of language access services far outweigh the costs. Accurate communication between providers and their patients is essential for ensuring quality of care, reducing medical errors, and promoting trust in the patient-provider relationship. These outcomes improve health care for patients, reduce health disparities, and result in substantial savings over time due to fewer incidents of inappropriate care, misdiagnosis, and incorrect medications. However, language access services (i.e. interpretation and translation) are expensive; and there needs to be greater resources on the part of payors to help support those costs.

Title VI of the Civil Rights Act has stated federal requirements for serving limited English proficient patients for almost 40 years. The OCR guidance simply offers suggestions on ways that health care providers can comply with existing law. It offers flexibility by explicitly stating that “OCR will review the totality of the circumstances to determine whether LEP persons can meaningfully access the services and benefits of the recipient/covered entity” and does not outline a specific approach for ensuring compliance.

The California Primary Care Association (CPCA) strongly supported the publication of the OCR guidance last year and has taken steps to assist our members, including the development of this Promising Practice Manual.

Language access services for limited English proficient patients is more than just a California issue. Although Census Bureau statistics show that the largest percentage of the foreign-born population resides in the West, there are still large percentages of the population living throughout the rest of the country - 26.8 percent in the South, 22.6 percent in the Northeast, and 10.7 percent in the Midwest. Other states are responding to the increasing immigrant populations in their regions by highlighting the importance of serving

limited English proficient patients adequately and by leveraging resources for these services. As described, states including Minnesota, Washington, and Utah have developed programs to reimburse providers for these services.

Community clinics and health centers are unique health care providers that respond to community needs. With beginnings in the civil rights movement, community clinics and health centers have a strong sense of mission in providing health care for all regardless of ability to pay. This mission necessitates doing all possible to ensure meaningful access to LEP patients. Community clinics and health centers address this mission with leadership and innovation.

Appendix

Excerpts
from
Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office for Civil Rights Title VI of the Civil Rights Act of 1964;

Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency

AGENCY: Office for Civil Rights, HHS.

ACTION: Notice of policy guidance with request for comment.

SUMMARY: The United States Department of Health and Human Services (HHS) is publishing policy guidance on Title VI's prohibition against national origin discrimination as it affects limited English proficient persons.

Policy Guidance Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency

A. Background

English is the predominant language of the United States. According to the 1990 Census, English is spoken by 95% of its residents. Of those U.S. residents who speak languages other than English at home, the 1990 Census reports that 57% above the age of four speak English "well to very well."

The United States is also, however, home to millions of national origin minority individuals who are "limited English proficient" (LEP). That is, they cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. Because of these language differences and their inability to speak or understand English, LEP persons are often excluded from programs, experience delays or denials of services, or receive care and services based on inaccurate or incomplete information.

In the course of its enforcement activities, OCR has found that persons who lack proficiency in English frequently are unable to obtain basic knowledge of how to access various benefits and services for which they are eligible, such as the State Children's Health Insurance Program (SCHIP), Medicare, Medicaid or Temporary Assistance to Needy Families (TANF) benefits, clinical research programs, or basic health care and social services. For example, many intake interviewers and other front line employees who interact with LEP individuals are neither bilingual nor trained in how to properly serve an LEP person. As a result, the LEP applicant all too often is either turned away, forced to wait for substantial periods of time, forced to find his/her own interpreter who often is not qualified to interpret, or forced to make repeated visits to the provider's office until an interpreter is available to assist in conducting the interview.

The lack of language assistance capability among provider agency employees has especially adverse consequences in the area of professional staff services, such as health services. Doctors, nurses, social workers, psychologists, and other professionals provide vitally important services whose very nature requires the establishment of a close relationship with the client or patient that is based on

empathy, confidence and mutual trust. Such intimate personal relationships depend heavily on the free flow of communication between professional and client. This essential exchange of information is difficult when the two parties involved speak different languages; it may be impeded further by the presence of an unqualified third person who attempts to serve as an interpreter.

Some health and social service providers have sought to bridge the language gap by encouraging language minority clients to provide their own interpreters as an alternative to the agency's use of qualified bilingual employees or interpreters. Persons of limited English proficiency must sometimes rely on their minor children to interpret for them during visits to a health or social service facility. Alternatively, these clients may be required to call upon neighbors or even strangers they encounter at the provider's office to act as interpreters or translators.

These practices have severe drawbacks and may violate Title VI of the Civil Rights Act of 1964. In each case, the impediments to effective communication and adequate service are formidable. The client's untrained "interpreter" is often unable to understand the concepts or official terminology he or she is being asked to interpret or translate. Even if the interpreter possesses the necessary language and comprehension skills, his or her mere presence may obstruct the flow of confidential information to the provider. This is because the client would naturally be reluctant to disclose or discuss intimate details of personal and family life in front of the client's child or a complete stranger who has no formal training or obligation to observe confidentiality.

When these types of circumstances are encountered, the level and quality of health and social services available to persons of limited English proficiency stand in stark conflict to Title VI's promise of equal access to federally assisted programs and activities. Services denied, delayed or provided under adverse circumstances have serious and sometimes life threatening consequences for an LEP person and generally will constitute discrimination on the basis of national origin, in violation of Title VI. Accommodation of these language differences through the provision of effective language assistance will promote compliance with Title VI. Moreover, by ensuring accurate client histories, better understanding of exit and discharge instructions, and better assurances of informed consent, providers will better protect themselves against tort liability, malpractice lawsuits, and charges of negligence.

Although OCR's enforcement authority derives from Title VI, the duty of health and human service providers to ensure that LEP persons can meaningfully access programs and services flows from a host of additional sources, including federal and state laws and regulations, managed care contracts, and health care accreditation organizations. In addition, the duty to provide appropriate language assistance to LEP individuals is not limited to the health and human service context. Numerous federal laws require the provision of language assistance to LEP individuals seeking to access critical services and activities. For instance, the Voting Rights Act bans English-only elections in certain circumstances and outlines specific measures that must be taken to ensure that language minorities can participate in elections. See 42 U.S.C. 1973b(f)(1). Similarly, the Food Stamp Act of 1977 requires states to provide written and oral language assistance to LEP persons under certain circumstances. 42 U.S.C. Section 2020(e)(1) and (2). These and other provisions reflect the sound judgment that providers of critical services and benefits bear the responsibility for ensuring that LEP individuals can meaningfully access their programs and services.

OCR issued internal guidance to its staff in January 1998 on a recipient's obligation to provide language assistance to LEP persons. That guidance was intended to ensure consistency in OCR's

investigation of LEP cases. This current guidance clarifies for recipient/covered entities and the public, the legal requirements under Title VI that OCR has been enforcing for the past 30 years. This policy guidance is consistent with a Department of Justice (DOJ) directive noting that recipient/covered entities have an obligation pursuant to Title VI's prohibition against national origin discrimination to provide oral and written language assistance to LEP persons. It is also consistent with a government-wide Title VI regulation issued by DOJ in 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs," 28 C.F.R. Part 42, Subpart F, that addresses the circumstances in which recipient/covered entities must provide written language assistance to LEP persons.

C. Policy Guidance

1. *Who is Covered*

All entities that receive Federal financial assistance from HHS, either directly or indirectly, through a grant, contract or subcontract, are covered by this policy guidance. Covered entities include: (1) Any state or local agency, private institution or organization, or any public or private individual that; (2) operates, provides or engages in health, or social service programs and activities and that; (3) receives federal financial assistance from HHS directly or through another recipient/covered entity. Examples of covered entities include but are not limited to hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health or social service research programs, state, county and local health agencies, state Medicaid agencies, state, county and local welfare agencies, programs for families, youth and children, Head Start programs, public and private contractors, subcontractors and vendors, physicians, and other providers who receive Federal financial assistance from HHS.

The term Federal financial assistance to which Title VI applies includes but is not limited to grants and loans of Federal funds, grants or donations of Federal property, details of Federal personnel, or any agreement, arrangement or other contract which has as one of its purposes the provision of assistance. (See, 45 CFR Section 80.13(f); and Appendix A to the Title VI regulations, 45 CFR Part 80, for additional discussion of what constitutes Federal financial assistance).

Title VI prohibits discrimination in any program or activity that receives Federal financial assistance. What constitutes a program or activity covered by Title VI was clarified by Congress in 1988, when the Civil Rights Restoration Act of 1987 (CRRRA) was enacted. The CRRRA provides that, in most cases, when a recipient/covered entity receives Federal financial assistance for a particular program or activity, all operations of the recipient/covered entity are covered by Title VI, not just the part of the program that uses the Federal assistance. Thus, all parts of the recipient's operations would be covered by Title VI, even if the Federal assistance is used only by one part.

2. *Basic Requirements Under Title VI*

A recipient/covered entity whose policies, practices or procedures exclude, limit, or have the effect of excluding or limiting, the participation of any LEP person in a federally-assisted program on the basis of national origin may be engaged in discrimination in violation of Title VI. In order to ensure compliance with Title VI, recipient/covered entities must take steps to ensure that LEP persons who are eligible for their programs or services have meaningful access to the health and social service benefits that they provide. The most important step in meeting this obligation is for recipients of Federal financial assistance such as grants, contracts, and subcontracts to provide the language assistance necessary to ensure such access, at no cost to the LEP person.

The type of language assistance a recipient/covered entity provides to ensure meaningful access will depend on a variety of factors, including the size of the recipient/covered entity, the size of the eligible LEP population it serves, the nature of the program or service, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. There is no “one size fits all” solution for Title VI compliance with respect to LEP persons. OCR will make its assessment of the language assistance needed to ensure meaningful access on a case by case basis, and a recipient/covered entity will have considerable flexibility in determining precisely how to fulfill this obligation. OCR will focus on the end result—whether the recipient/covered entity has taken the necessary steps to ensure that LEP persons have meaningful access to its programs and services.

The key to providing meaningful access for LEP persons is to ensure that the recipient/covered entity and LEP person can communicate effectively. The steps taken by a covered entity must ensure that the LEP person is given adequate information, is able to understand the services and benefits available, and is able to receive those for which he or she is eligible. The covered entity must also ensure that the LEP person can effectively communicate the relevant circumstances of his or her situation to the service provider.

In enforcing Title VI and its application to LEP persons over the last 30 years, OCR has found that effective language assistance programs usually contain the four elements described in section three below. In reviewing complaints and conducting compliance reviews, OCR will consider a program to be in compliance when the recipient/covered entity effectively incorporates and implements these four elements. The failure to incorporate or implement one or more of these elements does not necessarily mean noncompliance with Title VI, and OCR will review the totality of the circumstances to determine whether LEP persons can meaningfully access the services and benefits of the recipient/covered entity.

3. *Ensuring Meaningful Access to LEP Persons*

(a) Introduction—The Four Keys to Title VI Compliance in the LEP Context

The key to providing meaningful access to benefits and services for LEP persons is to ensure that the language assistance provided results in accurate and effective communication between the provider and LEP applicant/client about the types of services and/or benefits available and about the applicant’s or client’s circumstances. Although HHS recipients have considerable flexibility in fulfilling this obligation, OCR has found that effective programs usually have the following four elements:

- Assessment—The recipient/covered entity conducts a thorough assessment of the language needs of the population to be served;
- Development of Comprehensive Written Policy on Language Access—The recipient/covered entity develops and implements a comprehensive written policy that will ensure meaningful communication;
- Training of Staff—The recipient/covered entity takes steps to ensure that staff understands the policy and is capable of carrying it out; and
- Vigilant Monitoring—The recipient/covered entity conducts regular oversight of the language assistance program to ensure that LEP persons meaningfully access the program.

The failure to implement one or more of these measures does not necessarily mean noncompli-

ance with Title VI, and OCR will review the totality of the circumstances in each case. If implementation of one or more of these options would be so financially burdensome as to defeat the legitimate objectives of a recipient/covered entity's program, or if there are equally effective alternatives for ensuring that LEP persons have meaningful access to programs and services, OCR will not find the recipient/covered entity in noncompliance.

(b) Assessment

The first key to ensuring meaningful access is for the recipient/ covered entity to assess the language needs of the affected population. A recipient/covered entity assesses language needs by:

- identifying the non-English languages that are likely to be encountered in its program and by estimating the number of LEP persons that are eligible for services and that are likely to be directly affected by its program. This can be done by reviewing census data, client utilization data from client files, and data from school systems and community agencies and organizations;
- identifying the language needs of each LEP patient/client and recording this information in the client's file; identifying the points of contact in the program or activity where language assistance is likely to be needed;
- identifying the resources that will be needed to provide effective language assistance; •identifying the location and availability of these resources; and
- identifying the arrangements that must be made to access these resources in a timely fashion.

(c) Development of Comprehensive Written Policy on Language Access

A recipient/covered entity can ensure effective communication by developing and implementing a comprehensive written language assistance program that includes policies and procedures for identifying and assessing the language needs of its LEP applicants/clients, and that provides for a range of oral language assistance options, notice to LEP persons in a language they can understand of the right to free language assistance, periodic training of staff, monitoring of the program, and translation of written materials in certain circumstances.

(1) *Oral Language Interpretation*—In designing an effective language assistance program, a recipient/covered entity develops procedures for obtaining and providing trained and competent interpreters and other oral language assistance services, in a timely manner, by taking some or all of the following steps:

- Hiring bilingual staff who are trained and competent in the skill of interpreting;
- Hiring staff interpreters who are trained and competent in the skill of interpreting;
- Contracting with an outside interpreter service for trained and competent interpreters;
- Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting;
- Arranging/contracting for the use of a telephone language interpreter service. See Section 3(e)(2) for a discussion on "Competence of Interpreters."

The following provides guidance to recipient/covered entities in determining which language assistance options will be of sufficient quantity and quality to meet the needs of their LEP beneficiaries:

Bilingual Staff—Hiring bilingual staff for patient and client contact positions facilitates participation by LEP persons. However, where there are a variety of LEP language groups in a recipient's service area, this option may be insufficient to meet the needs of all LEP applicants and clients. Where this option is insufficient to meet the needs, the recipient/covered entity must provide additional and timely language assistance. Bilingual staff must be trained and must demonstrate competence as

interpreters.

Staff Interpreters—Paid staff interpreters are especially appropriate where there is a frequent and/or regular need for interpreting services. These persons must be competent and readily available.

Contract Interpreters—The use of contract interpreters may be an option for recipient/covered entities that have an infrequent need for interpreting services, have less common LEP language groups in their service areas, or need to supplement their in-house capabilities on an as-needed basis. Such contract interpreters must be readily available and competent.

Community Volunteers—Use of community volunteers may provide recipient/covered entities with a cost-effective method for providing interpreter services. However, experience has shown that to use community volunteers effectively, recipient/covered entities must ensure that formal arrangements for interpreting services are made with community organizations so that these organizations are not subjected to ad hoc requests for assistance. In addition, recipient/covered entities must ensure that these volunteers are competent as interpreters and understand their obligation to maintain client confidentiality. Additional language assistance must be provided where competent volunteers are not readily available during all hours of service.

Telephone Interpreter Lines—A telephone interpreter service line may be a useful option as a supplemental system, or may be useful when a recipient/covered entity encounters a language that it cannot otherwise accommodate. Such a service often offers interpreting assistance in many [[Page 52767]] different languages and usually can provide the service in quick response to a request. However, recipient/covered entities should be aware that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service. It is important that a recipient/covered entity not offer this as the only language assistance option except where other language assistance options are unavailable (e.g., in a rural clinic visited by an LEP patient who speaks a language that is not usually encountered in the area).

(2) *Translation of Written Materials*—An effective language assistance program ensures that written materials that are routinely provided in English to applicants, clients and the public are available in regularly encountered languages other than English. It is particularly important to ensure that vital documents, such as applications, consent forms, letters containing important information regarding participation in a program (such as a cover letter outlining conditions of participation in a Medicaid managed care program), notices pertaining to the reduction, denial or termination of services or benefits, of the right to appeal such actions or that require a response from beneficiaries, notices advising LEP persons of the availability of free language assistance, and other outreach materials be translated into the non-English language of each regularly encountered LEP group eligible to be served or likely to be directly affected by the recipient/covered entity's program. However, OCR recognizes that each federally-funded health and social service program has unique characteristics. Therefore, OCR will collaborate with respective HHS agencies in determining which documents and information are deemed to be vital.

As part of its overall language assistance program, a recipient must develop and implement a plan to provide written materials in languages other than English where a significant number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English to communicate effectively. 28 CFR Section 42.405(d)(1). OCR will determine the extent of the recipient/covered entity's obligation to provide written translation of documents on a case by case basis, taking into account all relevant circumstances, including the nature of the recipient/covered entity's services or benefits, the size of the recipient/covered entity, the number and size of the LEP language groups in its service area, the

nature and length of the document, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which translated documents are needed, and the cost of translation.

One way for a recipient/covered entity to know with greater certainty that it will be found in compliance with its obligation to provide written translations in languages other than English is for the recipient/covered entity to meet the guidelines outlined in paragraphs (A) and (B) below.

Paragraphs (A) and (B) outline the circumstances that provide a “safe harbor” for recipient/covered entities. A recipient/covered entity that provides written translations under these circumstances can be confident that it will be found in compliance with its obligation under Title VI regarding written translations. However, the failure to provide written translations under these circumstances outlined in paragraphs (A) and (B) will not necessarily mean noncompliance with Title VI.

In such circumstances, OCR will review the totality of the circumstances to determine the precise nature of a recipient/covered entity’s obligation to provide written materials in languages other than English. If written translation of a certain document or set of documents would be so financially burdensome as to defeat the legitimate objectives of its program, or if there is an alternative means of ensuring that LEP persons have meaningful access to the information provided in the document (such as timely, effective oral interpretation of vital documents), OCR will not find the translation of written materials necessary for compliance with Title VI.

OCR will consider a recipient/covered entity to be in compliance with its Title VI obligation to provide written materials in non- English languages if:

- (A) The recipient/covered entity provides translated written materials, including vital documents, for each eligible LEP language group that constitutes ten percent or 3,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected by the recipient/covered entity’s program
- (B) Regarding LEP language groups that do not fall within paragraph (A) above, but constitute five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected, the recipient/covered entity ensures that, at a minimum, vital documents are translated into the appropriate non- English languages of such LEP persons. Translation of other documents, if needed, can be provided orally; and
- (C) Notwithstanding paragraphs (A) and (B) above, a recipient with fewer than 100 persons in a language group eligible to be served or likely to be directly affected by the recipient/covered entity’s program, does not translate written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral translation of written materials.

The term “persons eligible to be served on likely to be directly affected” relates to the issue of what is the recipient/covered entity’s service area for purposes of meeting its Title VI obligation. There is no “one size fits all” definition of what constitutes “persons eligible to be served or likely to be directly affected” and OCR will address this issue on a case by case basis.

Ordinarily, persons eligible to be served or likely to be directly affected by a recipient’s program are those persons who are in the geographic area that has been approved by a Federal grant agency as the recipient/covered entity’s service area, and who either are eligible for the recipient/covered

entity's benefits or services, or otherwise might be directly affected by such an entity's conduct. For example, a parent who might seek services for a child would be seen as likely to be affected by a recipient/covered entity's policies and practices. Where no service area has been approved by a Federal grant agency, OCR will consider the relevant service area for determining persons eligible to be served as that designated and/or approved by state or local authorities or designated by the recipient/covered entity itself, provided that these designations do not themselves discriminatorily exclude certain populations. OCR may also determine the service area to be the geographic areas from which the recipient draws, or can be expected to draw, clients/patients. The following are examples of how OCR would determine the relevant service areas when assessing who is eligible to be served or likely to be affected:

- A complaint filed with OCR alleges that a private hospital discriminates against Hispanic and Chinese LEP patients by failing to provide such persons with language assistance, including written translations of consent forms. The hospital identifies its service area as the geographic area identified in its marketing plan. OCR determines that a substantial number of the hospital's patients are drawn from the area identified in the marketing plan and that no area with concentrations of racial, ethnic or other minorities is discriminatorily excluded from the plan. OCR is likely to accept the area identified in the marketing plan as the relevant service area.

- A state enters into a contract with a managed care plan for the provision of health services to Medicaid beneficiaries. The Medicaid managed care contract provides that the plan will serve beneficiaries in three counties. The contract is reviewed and approved by HHS. In determining the persons eligible to be served or likely to be affected, the relevant service area would be that designated in the contract.

As this guidance notes, Title VI provides that no person may be denied meaningful access to a recipient/covered entity's benefits and services, on the basis of national origin. To comply with the Title VI requirement, a recipient/covered entity must ensure that LEP persons have meaningful access to and can understand information contained in program-related written documents. Thus, for language groups that do not fall within paragraphs (A) and (B), above, a recipient can ensure such access by, at a minimum, providing notice, in writing, in the LEP person's primary language, of the right to receive free language assistance in a language other than English, including the right to competent oral translation of written materials, free of cost.

Recent technological advances have made it easier for recipient/ covered entities to store translated documents readily. At the same time, OCR recognizes that recipient/covered entities in a number of areas, such as many large cities, regularly serve LEP persons from many different areas of the world who speak dozens and sometimes over 100 different languages. It would be unduly burdensome to demand that recipient/covered entities in these circumstances translate all written materials into dozens, if not more than 100 languages. As a result, OCR will determine the extent of the recipient/covered entity's obligation to provide written translations of documents on a case by case basis, looking at the totality of the circumstances.

It is also important to ensure that the person translating the materials is well qualified. In addition, it is important to note that in some circumstances verbatim translation of materials may not accurately or appropriately convey the substance of what is contained in the written materials. An effective way to address this potential problem is to reach out to community-based organizations to review translated materials to ensure that they are accurate and easily understood by LEP persons.

(3) *Methods for Providing Notice to LEP Persons*—A vital part of a well-functioning compliance program includes having effective methods for notifying LEP persons regarding their right to language assistance and the availability of such assistance free of charge. These methods include but are not limited to:

- Use of language identification cards which allow LEP beneficiaries to identify their language needs to staff and for staff to identify the language needs of applicants and clients. To be effective, the cards (e.g., “I speak cards”) must invite the LEP person to identify the language he/she speaks. This identification must be recorded in the LEP person’s file;
- Posting and maintaining signs in regularly encountered languages other than English in waiting rooms, reception areas and other initial points of entry. In order to be effective, these signs must inform applicants and beneficiaries of their right to free language assistance services and invite them to identify themselves as persons needing such services;
- Translation of application forms and instructional, informational and other written materials into appropriate non-English languages by competent translators. For LEP persons whose language does not exist in written form, assistance from an interpreter to explain the contents of the document;
- Uniform procedures for timely and effective telephone communication between staff and LEP persons. This must include instructions for English-speaking employees to obtain assistance from interpreters or bilingual staff when receiving calls from or initiating calls to LEP persons; and
- Inclusion of statements about the services available and the right to free language assistance services, in appropriate non-English languages, in brochures, booklets, outreach and recruitment information and other materials that are routinely disseminated to the public.

(d) Training of Staff

Another vital element in ensuring that its policies are followed is a recipient/covered entity’s dissemination of its policy to all employees likely to have contact with LEP persons, and periodic training of these employees. Effective training ensures that employees are knowledgeable and aware of LEP policies and procedures, are trained to work effectively with in-person and telephone interpreters, and understand the dynamics of interpretation between clients, providers and interpreters. It is important that this training be part of the orientation for new employees and that all employees in client contact positions be properly trained. Given the high turnover rate among some employees, recipient/covered entities may find it useful to maintain a training registry that records the names and dates of employees’ training. Over the years, OCR has observed that recipient/covered entities often develop effective language assistance policies and procedures but that employees are unaware of the policies, or do not know how to, or otherwise fail to, provide available assistance. Effective training is one means of ensuring that there is not a gap between a recipient/covered entity’s written policies and procedures, and the actual practices of employees who are in the front lines interacting with LEP persons.

(e) Monitoring

It is also crucial for a recipient/covered entity to monitor its language assistance program at least annually to assess the current LEP makeup of its service area, the current communication needs of LEP applicants and clients, whether existing assistance is meeting the needs of such persons, whether staff is knowledgeable about policies and procedures and how to implement them, and whether sources of and arrangements for assistance are still current and viable. One element of such an assessment is for a recipient/covered entity to seek feedback from clients and advocates. OCR has found that compliance with the Title VI language assistance obligation is most likely when a recipient/covered entity

continuously monitors its program, makes modifications where necessary, and periodically trains employees in implementation of the policies and procedures.

4. OCR's Assessment of Meaningful Access

The failure to take all of the steps outlined in Section C. 3, above, will not necessarily mean that a recipient/covered entity has failed to provide meaningful access to LEP clients. As noted above, OCR will make assessments on a case by case basis and will consider several factors in assessing whether the steps taken by a recipient/covered entity provide meaningful access. Those factors include the size of the recipient/covered entity and of the eligible LEP population, the nature of the program or service, the objectives of the program, the total resources available, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. The following are examples of how meaningful access will be assessed by OCR:

- A physician, a sole practitioner, has about 50 LEP Hispanic patients. He has a staff of two nurses and a receptionist, derives a modest income from his practice, and receives Medicaid funds. He asserts that he cannot afford to hire bilingual staff, contract with a professional interpreter service, or translate written documents. To accommodate the language needs of his LEP patients, he has made arrangements with a Hispanic community organization for trained and competent volunteer interpreters, and with a telephone interpreter language line, to interpret during consultations and to orally translate written documents. There have been no client complaints of inordinate delays or other service related problems with respect to LEP clients. Given the physician's resources, the size of his staff, and the size of the LEP population, OCR would find the physician in compliance with Title VI.
- A county TANF program, with a large budget, serves 500,000 beneficiaries. Of the beneficiaries eligible for its services, 3,500 are LEP Chinese persons, 4,000 are LEP Hispanic persons, 2000 are LEP Vietnamese persons and about 400 are LEP Laotian persons. The county has no policy regarding language assistance to LEP persons, and LEP clients are told to bring their own interpreters, are provided with application and consent forms in English and if unaccompanied by their own interpreters, must solicit the help of other clients or must return at a later date with an interpreter. Given the size of the county program, its resources, the size of the eligible LEP population, and the nature of the program, OCR would likely find the county in violation of Title VI and would likely require it to develop a comprehensive language assistance program that includes all of the options discussed in Section C. 3, above.
- A large national corporation receives TANF funds from a local welfare agency to provide computer training to TANF beneficiaries. Of the 2000 clients that are trained by the corporation each month, approximately one-third are LEP Hispanic persons. The corporation has made no arrangements for language assistance and relies on bilingual Hispanic students in class to help LEP students understand the oral instructions and the written materials. Based on the size of the welfare agency and corporation, their budgets, the size of the LEP population, and the nature of the program, OCR would likely find both the welfare agency and the corporation in noncompliance with Title VI. The welfare agency would likely be found in noncompliance for failing to provide LEP clients meaningful access to its benefits and services through its contract with the corporation, and for failing to monitor the training program to ensure that it provided such access. OCR would likely also find the corporation in noncompliance for failing to provide meaningful access to LEP clients and would require it to provide them with both oral and written language assistance.

5. *Interpreters*

Two recurring issues in the area of interpreter services involve (a) the use of friends, family, or minor children as interpreters, and (b) the need to ensure that interpreters are competent, especially in the area of medical interpretation.

(a) *Use of Friends, Family and Minor Children as Interpreters*—A recipient/covered entity may expose itself to liability under Title VI if it requires, suggests, or encourages an LEP person to use friends, minor children, or family members as interpreters, as this could compromise the effectiveness of the service. Use of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations. In a medical setting, this reluctance could have serious, even life threatening, consequences. In addition, family and friends usually are not competent to act as interpreters, since they are often insufficiently proficient in both languages, unskilled in interpretation, and unfamiliar with specialized terminology.

If after a recipient/covered entity informs an LEP person of the right to free interpreter services, the person declines such services and requests the use of a family member or friend, the recipient/covered entity may use the family member or friend, if the use of such a person would not compromise the effectiveness of services or violate the LEP person's confidentiality. The recipient/covered entity should document the offer and declination in the LEP person's file. Even if an LEP person elects to use a family member or friend, the recipient/covered entity should suggest that a trained interpreter sit in on the encounter to ensure accurate interpretation.

(b) *Competence of Interpreters*—In order to provide effective services to LEP persons, a recipient/covered entity must ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, though certification is helpful. On the other hand, competency requires more than self-identification as bilingual. The competency requirement contemplates demonstrated proficiency in both English and the other language, orientation and training that includes the skills and ethics of interpreting (e.g. issues of confidentiality), fundamental knowledge in both languages of any specialized terms, or concepts peculiar to the recipient/covered entity's [[Page 52770]] program or activity, sensitivity to the LEP person's culture and a demonstrated ability to convey information in both languages, accurately. A recipient/covered entity must ensure that those persons it provides as interpreters are trained and demonstrate competency as interpreters.

E. Model Plan

The following is an example of a model language assistance program that is potentially useful for all recipient/covered entities, but is particularly appropriate for entities such as hospitals or social service agencies that serve a significant and diverse LEP population. This model plan incorporates a variety of options and methods for providing meaningful access to LEP beneficiaries:

- A formal written language assistance program;
- Identification and assessment of the languages that are likely to be encountered and estimating the number of LEP persons that are eligible for services and that are likely to be affected by its program through a review of census and client utilization data and data from school systems and community agencies and organizations;
- Posting of signs in lobbies and in other waiting areas, in several languages, informing applicants and clients of their right to free interpreter services and inviting them to identify them-

- selves as persons needing language assistance;
- Use of “I speak” cards by intake workers and other patient contact personnel so that patients can identify their primary languages;
- Requiring intake workers to note the language of the LEP person in his/her record so that all staff can identify the language assistance needs of the client;
- Employment of a sufficient number of staff, bilingual in appropriate languages, in patient and client contact positions such as intake workers, caseworkers, nurses, doctors. These persons must be trained and competent as interpreters;
- Contracts with interpreting services that can provide competent interpreters in a wide variety of languages, in a timely manner;
- Formal arrangements with community groups for competent and timely interpreter services by community volunteers;
- An arrangement with a telephone language interpreter line;
- Translation of application forms, instructional, informational and other key documents into appropriate non-English languages. Provision of oral interpreter assistance with documents, for those persons whose language does not exist in written form;
- Procedures for effective telephone communication between staff and LEP persons, including instructions for English-speaking employees to obtain assistance from bilingual staff or interpreters when initiating or receiving calls from LEP persons;
- Notice to and training of all staff, particularly patient and client contact staff, with respect to the recipient/covered entity’s Title VI obligation to provide language assistance to LEP persons, and on the language assistance policies and the procedures to be followed in securing such assistance in a timely manner;
- Insertion of notices, in appropriate languages, about the right of LEP applicants and clients to free interpreters and other language assistance, in brochures, pamphlets, manuals, and other materials disseminated to the public and to staff;
- Notice to the public regarding the language assistance policies and procedures, and notice to and consultation with community organizations that represent LEP language groups, regarding problems and solutions, including standards and procedures for using their members as interpreters;
- Adoption of a procedure for the resolution of complaints regarding the provision of language assistance; and for notifying clients of their right to and how to file a complaint under Title VI with HHS.
- Appointment of a senior level employee to coordinate the language assistance program, and ensure that there is regular monitoring of the program.

F. Compliance and Enforcement

The recommendations outlined above are not intended to be exhaustive. Recipient/covered entities have considerable flexibility in determining how to comply with their legal obligation in the LEP setting, and are not required to use all of the suggested methods and options listed. However, recipient/covered entities must establish and implement policies and procedures for providing language assistance sufficient to fulfill their Title VI responsibilities and provide LEP persons with meaningful access to services.

OCR will enforce Title VI as it applies to recipient/covered entities’ responsibilities to LEP persons through the procedures provided for in the Title VI regulations. These procedures include com-

plaint investigations, compliance reviews, efforts to secure voluntary compliance, and technical assistance.

The Title VI regulations provide that OCR will investigate whenever it receives a complaint, report or other information that alleges or indicates possible noncompliance with Title VI. If the investigation results in a finding of compliance, OCR will inform the recipient/ covered entity in writing of this determination, including the basis for the determination. If the investigation results in a finding of noncompliance, OCR must inform the recipient/covered entity of the noncompliance through a Letter of Findings that sets out the areas of noncompliance and the steps that must be taken to correct the noncompliance, and must attempt to secure voluntary compliance through informal means. If the matter cannot be resolved informally, OCR must secure compliance through (a) the termination of Federal assistance after the recipient/covered entity has been given an opportunity for an administrative hearing, (b) referral to DOJ for injunctive relief or other enforcement proceedings, or (c) any other means authorized by law.

As the Title VI regulations set forth above indicate, OCR has a legal obligation to seek voluntary compliance in resolving cases and cannot seek the termination of funds until it has engaged in voluntary compliance efforts and has determined that compliance cannot be secured voluntarily. OCR will engage in voluntary compliance efforts, and will provide technical assistance to recipients at all stages of its investigation. During these efforts to secure voluntary compliance, OCR will propose reasonable timetables for achieving compliance and will consult with and assist recipient/covered entities in exploring cost effective ways of coming into compliance, by sharing information on potential community resources, by increasing awareness of emerging technologies, and by sharing information on how other recipient/covered entities have addressed the language needs of diverse populations.

OCR will focus its compliance review efforts primarily on larger recipient/covered entities such as hospitals, managed care organizations, state agencies, and social service organizations, that have a significant number or percentage of LEP persons eligible to be served, or likely to be directly affected, by the recipient/covered entity's program. Generally, it has been the experience of OCR that in order to ensure compliance with Title VI, these recipient/covered entities will be expected to utilize a wider range of the language assistance options outlined in section C. 3, above.

The fact that OCR is focusing its investigative resources on larger recipient/covered entities with significant numbers or percentages of LEP persons likely to be served or directly affected does not mean that other recipient/covered entities are relieved of their obligation under Title VI, or will not be subject to review by OCR. In fact, OCR has a legal obligation under HHS regulations to promptly investigate all complaints alleging a violation of Title VI. All recipient/covered entities must take steps to overcome language differences that result in barriers and provide the language assistance needed to ensure that LEP persons have meaningful access to services and benefits. However, smaller recipient/covered entities—such as sole practitioners, those with more limited resources, and recipient/covered entities who serve small numbers of LEP persons on an infrequent basis—will have more flexibility in meeting their obligations to ensure meaningful access for LEP persons.

In determining a recipient/covered entity's compliance with Title VI, OCR's primary concern is to ensure that the recipient/covered entity's policies and procedures overcome barriers resulting from language differences that would deny LEP persons a meaningful opportunity to participate in and access programs, services and benefits. A recipient/covered entity's appropriate use of the methods

and options discussed in this policy guidance will be viewed by OCR as evidence of a recipient/covered entity's willingness to comply voluntarily with its Title VI obligations.

G. Technical Assistance

Over the past 30 years, OCR has provided substantial technical assistance to recipient/covered entities, and will continue to be available to provide such assistance to any recipient/covered entity seeking to ensure that it operates an effective language assistance program. In addition, during its investigative process, OCR is available to provide technical assistance to enable recipient/covered entities to come into voluntary compliance.



Elements in a Model Comprehensive Written Policy on Language Access

The guidance from the Office of Civil Rights (OCR) on serving limited English proficient (LEP) patients outlines the elements in a model comprehensive written policy on language access.

According to OCR, each health center should have the following elements - related to serving LEP patients - in the form of a written policy or procedure:

1. Procedures for identifying and assessing the language needs of its LEP patients

The guidance seeks to have health centers estimate the number of LEP persons that are eligible for health center services. The guidance discusses looking at utilization and/or Census data to identify and assess the language needs of the service population. Procedures for identifying the language needs of each LEP patient and recording this information in the patient's file should also be in a written document. Many health centers track language assistance needs through Health Pro, MegaWest and other database programs. Written policies under this element should also include the identification of points of contact where language assistance is likely to be needed and the resources that are identified to address the language assistance needs at all points of contact.

2. Policies and procedures that provide a range of oral language assistance options

Health centers provide oral language assistance services using different models including the hiring of bilingual staff/providers, the use of in-person interpreters, and phone interpreters. A policy under this element should inform staff of the range of language assistance services the health center provides and how to access the language assistance. For example, a health center may have a policy to use a phone language interpreter service for uncommonly-encountered languages. The procedure for accessing the phone language interpreter services should be outlined for staff. Under this element, procedures for ensuring competency of oral language assistance should also be outlined.

3. Procedures ensuring that notice is given to LEP persons in a language they can understand of the right to free language assistance

Each health center should have a mechanism to ensure that adequate notice is given to LEP persons of the right to free language assistance. A written policy would outline the mechanism for providing this information. For example, a policy may describe the use of signage in a patient waiting room or a language identification card as the mechanism for providing notice.

4. Policies and procedures that outline periodic training of staff

A description of how a health center ensures that employees are knowledgeable and aware of LEP policies and procedures, are trained to work effectively with in-person and telephone interpreters, and understand the dynamics of interpretation between patients, providers, and interpreters.

5. Procedures that outline the monitoring of the language assistance program

The guidance recommends that a health center monitor all policies and procedures of its language assistance program at least annually. A written comprehensive policy should include the procedures for this annual review. The guidance also recommends seeking feedback from patients on as part of the review.

6. Policies and procedures that ensure the translation of written materials in certain circumstances

The circumstances outlined in the guidance recommend that written materials that are routinely provided in English should be translated in regularly encountered languages other than English. Vital documents are particularly important. Vital documents include consent forms, notices advising of right to free language assistance, information on available services, as well as other important notices and documents. Policies under this element should outline how a health center ensures the appropriate translation of written materials.

**Family Health Care Network
Language Proficiency**

Spanish Test

PERSON TAKING TEST: _____

DATE: _____

Please Select the Correct Translation

- 1. How may I help you? _____
- 2. What are you needing an appointment for? _____
- 3. What is your telephone number? _____
- 4. What is your address? _____
- 5. What is your social security number? _____
- 6. Are you a new patient or have you been here before? _____
- 7. Do you have Medi-Cal, insurance or are you a self-pay patient? _____
- 8. Who should we notify in case of an emergency? _____
- 9. What is your place of employment? _____
- 10. What is your gross monthly income? _____
- 11. What symptoms does the patient have? _____
- 12. Are you a patient here at the center? _____
- 13. What is the patient's date of birth? _____
- 14. What is the patient's full name? _____
- 15. Can you come right away? _____
- 16. Please arrive 15 minutes prior to your appointment so that you may fill out some forms. _____
- 17. Who is your appointment with? _____

- 1. *Cuales son los sintomas de la persona enferma?*
- 2. *En caso de emergencia, a quien notificamos?*
- 3. *Cual es su numero de seguro social?*
- 4. *Favor de llegar a su cita 15 minutos antes para preparar su expediente y llenar los documentos.*
- 5. *Cual es su numero de telefono?*
- 6. *Es usted paciente aqui en esta clinica?*
- 7. *Es usted paciente nuevo o ha estado aqui antes?*
- 8. *Cual es su domicilio?*
- 9. *En que le puedo ayudar?*
- 10. *En donde trabaja?*
- 11. *Cual es su ingreso total mensual?*
- 12. *Con quien tiene su cita?*
- 13. *Puede venir enseguida?*
- 14. *Cual es su nombre completo?*
- 15. *Para que necesita la cita?*
- 15. *Tiene tarjeta de Medi-Cal, aseguranza o va a pagar en efectivo?*
- 17. *Cual es la fecha de nacimiento del paciente?*

National Health Services, Inc. Library List

(Amended list; Spanish language selections only)

Pamphlets

1. What is Pre-Term Labor (Spanish & English)
2. What is PIH (Spanish & English)
3. Vinculos entre la madre y el bebe
4. La ictericia en los recién nacidos
5. Algunas ideas para bocado sanos
6. Mas Vale Prevenir que Lamerter (recien nacido -6 meses)
7. Mas Vale Prevenir que Lamerter (7- 12 meses)
8. Mas Vale Prevenir que Lamerter (1 -2 años)
9. Mas Vale Prevenir que Lamerter (3 -4 años)
10. AFP Prueba de Sanpe
11. Dientes Sanos Sonrisas Felices
12. Breastfeeding Spanish La Lactancia
13. Los Primeros Doce Meses
14. Coma Alimentos Altos En Hierro para Tener Sanpe Fuerte
15. Alimentos con Hierro
16. A Mi Me Quieren
17. Estan Seguros sus ninos? Asegurelos es la ley.
18. Usted puede escojer (pero Su Bebe no)
19. Manual Mama Sana Bebe Sano
20. El humo u su alrededor
21. La e simbolo ejercicio
22. Consejos Utiles Para Ninos Saludables
23. 4 Pasos Para Controlar Su Peso
24. Mas Infonnacion de Piojos
25. el Cancer Del Pulmon
26. Como vivir con la precion alta
27. control de La natilidad con la peldina
28. IUD Information (Spanish)
29. Opciones para su salud -Lo que debe eaer sobre lo Estul
30. Cual es mejor para Usted? & Lo mejor para usted.
31. Nos Afecta a Todos
32. Las enfermedades de transmision sexual
33. Como usar un condon (front) & How to use a condom (back)
34. HIV -Think about it (Eng. & Span.)
35. HIV/AIDs Piensalo (Spanish/English)
36. Should I take the Test? (Spanish)
37. Despues del Examen
38. Debo Tomar el Examen
39. ETS Lo que debe Saber
40. Genital Warts -What you need to know - Mezquinos Lo Que Debe Saber
41. Chlamydia Lo Que Debe Saber
42. PID -What you need to know- La Infeccion Pelvica
43. Lo Que significa la Vasectomy
44. Entiendo la Esterilizacion para la mujer
45. Lo Que Usted Puede Hacer sobre el cancer de los senos
46. El Mamograma me sauo la vida
47. NHSI Pamphlet Spanish

Books

1. Diccionario De Especialdades Farmaceuticas (29)
2. Diccionario De Especialdades Farmaceuticas (32)

Videos

1. Tubal Cauterization (Spanish and English)

Health History

NAME/NOMBRE	CASE #	D.O.B./ Cuando Nacio	Date / FECHA
Story of Past Illness/Enfermedades Pasadas: Have you had? (Ha tenido)			

Measles / Sarampion	No / Yes / Si	Rheumatic fever / Fiebra Reumatica	No / Yes / Si
Mumps / Paperas	No / Yes / Si	Heart Disease / Enfermedad del Corazon	No / Yes / Si
Chickenpox / Viruela	No / Yes / Si	Tuberculosis	No / Yes / Si
Diabetes	No / Yes / Si	Venereal Disease/Enfermedades Venera	No / Yes / Si
Strokes/Embolia	No / Yes / Si	Serious Disease/Enfermedades Graves	No / Yes / Si
Pregnancies/Embarazos	No / Yes / SiHow many/Cuantos _____ Miscarriages/Abortos	No / Yes / Si
Ever Hospitalized / Ha sido hospitalizado	No / Yes / SiExplain / Explicacion _____	
Ever had surgery / Ha tenido operaciones	No / Yes / SiExplain / Explicacion _____	
Broken bones / Ha tenido fracturas	No / Yes / SiExplain / Explicacion _____	
Had concussions or injuries	No / Yes / SiExplain / Explicacion _____	
Golpes o Heridas de cabeza	No / Yes / SiExplain / Explicacion _____	
Date of Tetanus Shot/La Fecha de su ultima injeccion del Tetano	_____		

FAMILY HISTORY/ HISTORIA FAMILIAR: Has anyone in your family ever had? / Ha habido en su familia?

Cancer.....	No / Yes / Si.....	Quien _____
Diabetes.....	No / Yes / Si.....	Quien _____
Tuberculosis.....	No / Yes / Si.....	Quien _____
Heart trouble/Enfermedad del corazon.....	No / Yes / Si.....	Quien _____
High blood pressure/Presion alta.....	No / Yes / Si.....	Quien _____
Stroke / Embolias.....	No / Yes / Si.....	Quien _____
Convulsions / Epilepsia.....	No / Yes / Si.....	Quien _____
Suicide / Suicidio.....	No / Yes / Si.....	Quien _____

SOCIAL HISTORY / HISTORIA SOCIAL;

Single / Soltero _____ Married / Casado _____ Separated / Separado _____ Divorced / Divorciado _____ Widowed / Viudo _____

Alcoholic Beverages / Bebidas Alcoholicas: Never / Nunca _____ How much / Cuanto _____

Tobacco / Cigarettes / Tobacco / Cigarillos: Never / Nunca _____ How much / Cuanto _____

What is your job? / Cual es su trabajo? _____

Education Level / Nivel de Educacion: 1 2 3 4 5 6 7 8 9 10 11 12 College / Colegio Superior: 1 2 3 _____

SYSTEMIC REVIEW / REVISION DE SISTEMAS: GENERAL

Recent weight change / Reciente cambio de peso? No / Yes / Si

Have you been in good general health most of your life? /

Ha tenido buena salud la mayor parte de su vida? No / Yes / Si

HAVE YOU EVER HAD PROBLEMS WITH? / ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin / Piel.....	No / Yes / Si.....	Explain / Explicacion _____
Head-Eyes-Ears-Nose-Throat /		
Cabeza-Ojos-Oidos-Nariz-Garganta.....	No / Yes / Si.....	Explain / Explicacion _____
Neck / Cuello.....	No / Yes / Si.....	Explain / Explicacion _____
Lungs / Pulmones.....	No / Yes / Si.....	Explain / Explicacion _____
Heart and Circulation / Corazon o Circulacion	No / Yes / Si.....	Explain / Explicacion _____
Blood / Sangre.....	No / Yes / Si.....	Explain / Explicacion _____
Emotions / Emociones.....	No / Yes / Si.....	Explain / Explicacion _____
Nerves / Nervios.....	No / Yes / Si.....	Explain / Explicacion _____
Muscles and bones / Musculos o Huesos.....	No / Yes / Si.....	Explain / Explicacion _____
Stomach and bowles / Estomago o Intestinos	No / Yes / Si.....	Explain / Explicacion _____
Sex Organs / Organos Sexuales.....	No / Yes / Si.....	Explain / Explicacion _____
Urinary / Urinarios.....	No / Yes / Si.....	Explain / Explicacion _____
Any other / Cualquier otro.....	No / Yes / Si.....	Explain / Explicacion _____

ALLERGIES OR REACTIONS TO FOOD OR MEDICATION / ALERGIAS O REACIONES A

ALIMENTOS O MEDICINAS _____

PATIENT SIGNATURE / FIRMA _____ **Date / Fecha** _____

**SEQUOIA COMMUNITY HEALTH FOUNDATION, INC.
POLIZA FINANCIERA**

1. **Aceptamos Medi-Cal, incluyendo la de Blue Cross y Health Net. Tambien aceptamos Medicare.**
2. **Aceptamos la mayoría de seguros; nuestros doctores participan en algunos HMO's como California Care, Blue Shield, Health Net, United Healthcare, Foundation Health, Medicare y otros.**
3. **Para pacientes que no califican para seguro o algun programa ofrecemos una escala de descuento basada en los ingresos al hogar y tamaño de familia. El paciente debe presentar prueba por escrito de los ingresos. Esto puede ser en forma de talones de cheques, cartas de donde trabaja o de donde recibe el pago. Si califica se le daran los descuentos apropiados.**
4. **Pacientes de pago privado o en el descuento se les pedira por lo menos un deposito de \$20.00 o co-pago si es que tienen algun seguro. Si queda algun balance se les mandara un cobro por correo.**
5. **Los doctores son proveedores del programa CHDP (Children's Health and Prevention Disability Program). Este programa ofrece fisicos y vacunas para niños con Medi-Cal o los que califiquen segun sus ingresos y tamaño de familia.**
6. **Sequoia ofrece el programa SOFP (State Office of Family Planning Program). Este programa ofrece servicios de planificacion familiar para personas sin seguro o sin seguro adecuado.**
7. **Sequoia participa en el Programa BCEDP (Breast Cancer Early Detection Program). Este programa ofrece a mujeres de 40 años de edad y arriba un examen de los senos gratis por año y posiblemente un mamograma si el examen lo indica. Si califican no hay costo alguno.**
8. **Sequoia ofrece asistencia para llenar aplicaciones para el programa del Estado de California - Healthy Families. Este programa ofrece un seguro medico de bajo costo para niños que no califican para Medi-Cal. El costo puede ser de \$4.00 por mes por niño(a) y no mas de \$27.00 por familia de 3 o mas niños. Los beneficios incluyen visitas a medicos y especialistas cuidado de prevencion y vacunas, medicinas con receta, salud mental, cuidado dental y de la vista. El co-pago para la mayoría de los servicios es de \$5.00.**
9. **No se le negara servicios medicos solamente por no tener recursos monetarios.**

SAMPLE

NAME _____

CHART # _____

SEQUOIA COMMUNITY HEALTH FOUNDATION, INC.

CONSENT FOR CONTRACEPTIVE SUPPOSITORIES,
FOAM AND/OR CONDOMS (RUBBERS)

When you sign this consent form, you are saying that you have freely chosen the Suppositories, Foam and/or Condoms as a method of birth control.

- I am aware that there are several birth control methods to choose from including:

- Suppositories, Condoms, Foam
- Norplant Implant
- Diaphragm
- Ovulation
- Pill
- Sterilization for Men or Women
- IUD

- I understand how Contraceptive Suppositories, Foam and/or Condoms work to prevent pregnancy.

- I have been informed that if used exactly as instructed, Foam or Condoms used alone prevent pregnancy in 97% of women using them. Foam and condoms when always used correctly together, can prevent pregnancy in 99% of women.

However, in actual use, about 22 percent of women using only Foam become pregnant. About 10 percent of women become pregnant when only using Condoms. The exact effectiveness rate of Contraceptive Suppositories is not known.

- I have been informed of the benefits, disadvantages, and known risks of Contraceptive Suppositories, Foam and/or Condoms.

- I have been informed that sometimes Contraceptive Suppositories Foam and/or Condoms can cause a rash.

- I have received instructions as how to use Foam, Condoms, and Contraceptive Suppositories. I understand that in order for these methods to prevent pregnancy, I must use them everytime I have sex.

- I have had all my questions answered. I agree that it is my responsibility to return to the clinic as advised.

Based on my understanding of the above, I choose to use _____ method.

SIGNED _____

DATE _____

WITNESS _____

SAMPLE

NOMBRE _____

NUMERO DE ARCHIVO _____

SEQUOIA COMMUNITY HEALTH FOUNDATION, INC.

PERMISO PARA USAR LOS SUPOSITORIOS CONTRA-CONCEPTIVOS CONDONES

Y/O LA ESPUMA

Cuando usted firme esta forma, esta diciendo que ha escogido libremente los Supositorios Contra-Conceptivos, la Espuma o los Condones (Hules) como su metodo para prevenir el embarazo.

- Yo se que hay varios metodos para prevenir el embarazo. Puedo escoger entre:
 - o La Pildora
 - o El Metodo Natural (basado en la ovulacion)
 - o El Depositivo Intrauterino (IUD)
 - o Esterilizacion para hombres o mujeres
 - o Norplant (Implante)
 - o El Diafragma
 - o Los Supositorios, Condones, Espuma
- Entiendo como funcionan los Supositorios contra-ceptivos, la Espuma y/o los Condones (Hules) para prevenir el embarazo.
- He estado informada que la Espuma o los Condones usados solos previenen el embarazo en 87 mujeres de cada 100 si usan exactamente segun las instrucciones. La Espuma y los Condones usados juntos previenen el embarazo en 99 mujeres de cada 100 si se usan correctamente. Sin embargo, en el uso real 22% de mujeres que usan la Espuma sola y 10% que usan los Condones solos quedan embarazada. No se sabe la eficaz de los supositorios.
- He estado informada de las ventajas y riesgos sabidos de los Supositorios Contra-Conceptivos, la Espuma y los Condones.
- He estado informada que los Supositorios, la Espuma o los Condones pueden causar un salpullido.
- He recibido instrucciones sobre el uso de la Espuma, los Condones y los Supositorios anti-ceptivos. Entiendo que para prevenir el embarazo es necesario usar el metodo cada vez que tengo relaciones sexuales.
- Todas mis preguntas han sido contestadas. Estoy de acuerdo que es mi responsabilidad de regresar a la clinica cuando se me aconseje.

Basado en mi entendimiento de las declaraciones antes mencionadas, he decidido usar la Espuma, los Supositorios y/o los Condones.

FIRMA _____

FECHA _____

TESTIGO _____

SAMPLE

SEQUOIA COMMUNITY HEALTH FOUNDATION, INC.

CONSENT FOR PARAGARD T380A (Intrauterine Contraceptive)

I have read the patient information Paragard T380A brochure in its entirety and discussed its contents with my provider. My provider has answered all of my questions and has advised me of the risks and benefits associated with the use of the ParaGard T380A, with other forms of contraception, and with no contraception at all.

I have considered all these factors and voluntarily choose to have the ParaGard T380A inserted by

_____ on date _____
Provider

Patient Signature _____

The patient has signed this consent in my presence after I counseled her and answered all her questions.

_____ Date
Provider

This ParaGard T380A is scheduled for removal on _____

CONSENTIMIENTO DEL PACIENTE CONTRACEPTIVO INTRAUTERINO (ParaGard T380A)

He leído el texto de información de paciente ParaGard T380A por completo y he consultado su contenido con el médico. Mi médico ha contestado todas mis preguntas con el uso del ParaGard T380A, con otros métodos contraceptivos, y con ningún método contraceptivo.

He considerado todos estos factores y voluntariamente decido que me coloquen el ParaGard T380A el (la)

_____ (fecha) _____
Médico

Firma del paciente _____

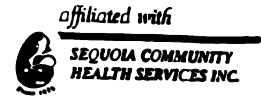
El paciente ha firmado este consentimiento en mi presencia después de darle mi consulta y contestado todas sus preguntas.

_____ Fecha
Médico

Este ParaGard T380A se extraerá el _____
Fecha



2031 Divisadero
Fresno, CA 93701
(209) 495-0124



CONSENT FOR NORPLANT REMOVAL

When you sign this consent form, you are saying you have freely chosen to have Norplant removed. Please initial each part you agree with.

_____ I have been told that as soon as Norplant is taken out, it can no longer keep me from getting pregnant.

_____ I am aware that .. I don't want to get pregnant after Norplant is taken out, I can have a new set of Norplant implants put in or choose a different birth control method today.

_____ I have been told what to expect when Norplant is taken out of my arm. It will take around 20 to 30 minutes to take out Norplant. First the skin over the implants will be cleaned and numbed. Next, a small cut will be made close to the tips of the implants. Then all six implants will be removed. I am aware that I may feel some discomfort.

_____ I have been told about possible problems that may happen when taking out Norplant:

- Allergic response to anesthetic
- Bruising or soreness where the implants were removed
- Infection where Norplant is removed
- One or more implants could break
- A second cut could be needed to take out all of the implants
- A second visit could be needed to take out all of the implants

_____ I have been told how to care for my arm after Norplant is removed. I have been told what to watch out for and know how, when, and where to get medical care if I need it.

_____ I have had all of my questions answered.

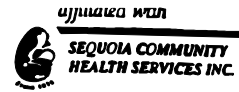
_____ Using the information given to me, I choose to have Norplant taken out at this time.

Signed _____ Date _____

Witness _____ Date _____



2031 Divisadero
Fresno, CA 93701
(209) 495-0124



AUTORIZACIÓN PARA QUITAR NORPLANT

Cuando usted firma esta autorización, usted nos confirma que ha decidido por su propia voluntad pedir que le quiten los implantes de Norplant del brazo. Por favor, ponga sus iniciales en el lado de cada sección con la que está de acuerdo.

_____ Se me ha informado que en cuanto me quiten los implantes. Norplant ya no me va a proteger de un embarazo.

_____ Entiendo que si no quiero salir embarazada después que me quiten Norplant, puedo pedir que me pongan nuevos implantes o puedo escoger otro método anticonceptivo.

_____ Me han informado qué puede suceder cuando me quiten los implantes:

- Tomará 30 minutos
- Primero, limplan y adormecen la piel alrededor de los implantes.
- Después, le hacen una incisión pequeña cerca de una de las puntas de los implantes.
- Po último, le quitan los 6 implantes.

Entiendo que me puedo sentir incómoda mientras le hacen a uno este procedimiento.

_____ Me han informado que me pueden ocurrir ciertos problemas cuando se quitan los implantes de Norplant:

- La anestesia me puede dar una reacción alérgica
- Me puede doler o me pueden salir moretes alrededor de donde me quitaron los implantes.
- Me puede dar una infección.
- Uno o dos de los implantes se pueden quebrar.
- Tal vez necesite otra incisión para que me quiten todos los implantes.
- Tal vez necesite regresar para que me quiten todos los implantes.

_____ Se me ha informado cómo debo de cuidar de mi brazo después que me hayan quitado Norplant. Reconozco las señales de infección y sé cómo, cuándo y dónde puedo conseguir ayuda médica si la necesito.

_____ Han contestado todas mis preguntas.

Basada en la comprensión y entendimiento que tengo sobre lo antes mencionado, he decidido que quiero que me quiten Norplant.

Firma _____ Fecha _____

Testigo _____ Fecha _____



Sequoia Community Health Foundation Inc.

CONSENT FOR SPECIAL PROCEDURES

Patient's Name: _____ Chart #: _____

Physician: _____

Procedure to be performed: _____

I, _____, authorize the above named physician to perform the above named procedure on _____. The nature of this procedure has been explained to me, including possible side effects and/or complications, and no warranty or guarantee has been made as to the results or cure of this procedure.

Date: _____ Signature of Patient

Date: _____ Signature of Parent or Guardian

Date: _____ Witness

CONSENTIMIENTO PARA PROCEDIMIENTO ESPECIAL

Nombre del Paciente: _____ Archivo #: _____

Medico: _____

Procedimiento: _____

Yo, _____, autorizó al médico nombrado arriba para que ejecute el procedimiento arriba mencionado. La naturaleza de este procedimiento me ha sido explicado, incluyendo las posibles consecuencias y/o complicaciones y no me han hecho garantía sobre los resultados o el remedio de este procedimiento.

Fecha: _____ Firma del paciente

Fecha: _____ Firma del padre o madre o guardian

Fecha: _____ Firma del testigo

Ventura P. Huerta Health Center
2790 S. Elm Ave.
Fresno, CA 93706
209/233-5747
209/485-2769 Fax (Admin)
209/485-3816 Fax (Clinical)

Sequoia Southeast Community Health Center
1350 S. Orange Ave.
Fresno, CA 93702
209/237-6193
209/445-2624

Sequoia Community Health Center - Selma
1041 Rose Ave.
Selma, CA 93662
209/896-6660
209/896-8626 Fax

Sequoia Family Care Center
1330 E. Olive Avenue
Fresno, CA 93728
209/498-6093



Sequoia Community Health Foundation Inc.

Correspondence Mailing Address • P.O. Box 2457 • Fresno, CA 93745

AUTHORIZATION FORM

CONSENT TO TREAT: Information on registration form is true and correct to the best of my knowledge. Based on this, I wish to register as a Sequoia Community Health Center patient and I give my consent to any and all service ordered by the attending physician when appropriately informed of the reason and consequences of said services.

Signature of patient, or parent if minor

Date

CONSENTIMIENTO PARA SERVICIOS MEDICOS: La información en el registro verdadera y correcta según mi conocimiento. Basado en eso deseo registrar como paciente de las clinicas de Sequoia y doy mi consentimiento para recibir los servicios ordenados por el doctor cuando me haya informado bien de las razones y consecuencias de dichos servicios.

Firma del paciente, o padre si es menor

Fecha

.....
FOR INSURANCE PATIENTS ONLY

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Sequoia Community Health Center to release any information acquired in the course my examination or treatment.

Signature of patient, or parent if minor

Date

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment of professional benefits to which I am entitled, directly to Sequoia Community Health Foundation.

Signature of patient, or parent if minor

Date

.....
FAMILY MEMBERS (Miembros de Familia)

Father (Papá) _____

Mother (Mamá) _____

- *Child 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

*Only under 18 years (menores de 18 años)

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1350 S. Orange Ave. • Fresno, CA • 93702 • 559/237-6193 • Fax 559/445-2624
2790 S. Elm Ave. • Fresno, CA • 93706 • 559/233-5747 • Fax (Admin) 559/485-2769 • Fax (Clinic) _____

SEQUOIA COMMUNITY HEALTH FOUNDATION, INC.

CONSENT FOR ORAL CONTRACEPTIVES (PILL)

NAME _____ CHART # _____

When you initial and sign this consent form, you are saying that you have freely chosen the Pill as a method of birth control and understands each statement.

INITIALS

_____ I am aware that there are several birth control methods to choose from including:

- Pill
- IUD
- Norplant Implant
- Diaphragm
- Suppositories, Condoms, Foam
- Ovulation Methods
- Sterilization for Men or Women

_____ I have been told how the Pill works to prevent pregnancy.

_____ I have been informed that as long as the Pill is taken exactly as instructed, pregnancy is prevented in almost 100% of women using the method.

_____ I have been informed of the possible side effects of the Pill.

_____ I have been informed that possible complications of taking the pill may contribute to the following health problems such as:

- blood clots in the legs or lungs
- stroke
- heart attack
- high blood pressure
- gallbladder disease
- liver disease
- death (rare)

_____ I have been informed that the risk of serious health problems is increased for women who smoke and take the pill.

_____ I have received instructions about how and when to take the Pill.

_____ I have been informed of the Pill Danger Signs and know how and when to get medical care.

_____ I have had all my questions answered. I agree that it is my responsibility to return to the clinic as advised.

Based on my understanding of the above, I choose to use Oral Contraceptives (Pill).

SIGNED _____ DATE _____

WITNESS BY _____

SAMPLE

SEQUOIA COMMUNITY HEALTH FOUNDATION, INC.

CONSENTIMIENTO PARA LA PILDORA CONTRA-CONCEPTIVA

NOMBRE _____ NO. DE ARCHIVO _____

Cuando usted firme esta forma, esta diciendo que ha escogido libremente la Pildora como su método para prevenir el embarazo.

INICIALES

_____ Yo se que hay varios métodos para prevenir el embarazo. Puedo elegir entre:

- La Pildora
- El Deposito Intrauterino (IUD)
- El Diafragma
- Norplant (Implante)
- Los Supositorios, Condones, Espuma.
- El Método Natural (basado en la ovulación).
- Esterlización para hombres o mujeres.

_____ Estoy informada como funciona la Pildora para prevenir el embarazo.

_____ Estoy informada que la Pildora previene el embarazo casi el 100% de las mujeres si se toma exactamente según las instrucciones.

_____ Estoy informada de los efectos posibles de la Pildora.

_____ Me han informado de las complicaciones posibles al tomar la pildora que puede contribuir a los siguientes problemas de salud tales como:

- coagulos de sangre en las piernas o los pulmones
- ataque al cerebro (embolio)
- ataque al corazón (cardíaco)
- alta presión de sangre
- enfermedad de la vesícula biliar
- enfermedad del hígado
- muerte (es raro)

_____ Estoy informada que el riesgo serio de problemas de salud esta aumentando para mujeres que fuman y toman la pildora.

_____ He recibido instrucciones acerca de como y cuando tomar la Pildora.

_____ Estoy informada de las Señales de Peligro de la Pildora y se como y cuando buscar cuidado médico.

_____ Me contestaron todas mis preguntas. Estoy de acuerdo que es mi responsabilidad de regresar a la clinica cuando se me aconseje.

Basado en mi entendimiento de las declaraciones antes-mencionadas, escojo usar la Pildora Contra-Conceptiva.

FIRMA _____ FECHA _____

TESTIGO POR _____



Sequoia Community Health Foundation Inc.

Correspondence Mailing Address • P.O. Box 2475 • Fresno, CA 93745

**AUTHORIZATION FOR THIRD PARTY TO CONSENT TO
TREATMENT OF MINOR LACKING CAPACITY TO CONSENT**

(I) (We), the undersigned, parent(s)/person having legal custody/legal guardianship of [name of agent] _____, a minor.

Do hereby authorize [name of agent] _____ as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgement, deem advisable.

This authorization is given pursuant to the provisions of Civil Code section 25.8.

(I) (We) hereby authorize any hospital which has provided treatment to the above-named minor pursuant to the provisions of Civil Code section 25.8 to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment. This authorization is given pursuant to Health and Safety Code section 1283.

These authorizations shall remain effective until [month and day] _____ 19____, unless sooner revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: _____
[parent/legal guardian/person having custody] (circle relationship)

Signature: _____
[parent]



Sequoia Community Health Foundation Inc.

Correspondence Mailing Address • P.O. Box 2475 • Fresno, CA 93745

AUTORIZACION PARA QUE UNA TERCERA PARTE PUEDA DAR SU CONSENTIMIENTO AL TRATAMIENTO DE UN MENOR DE EDAD

(Yo) (Nosotros), (el) (los) suscrito(s), (soy) (somos) (el) (los) padre(s)/la madre/la persona con custodia legal/tutor de [nombre del menor de edad] _____, una persona menor de edad.

Por medio de la presente autorizo/autorizamos a [nombre del representante] _____ en calidad de representante(s) del suscrito (o suscritos) a que dé su consentimiento a cualquier examen de rayos-X, anestesia, diagnóstico o tratamiento médico o quirúrgico, o atención de hospital que se considere aconsejable por, y lo cual será prestado(a) bajo la supervisión general o especial de cualquier médico o cirujano con licencia bajo las disposiciones de la Ley Sobre el Ejercicio de la Medicina (Medical Practice Act) y que forma parte de cuerpo médico de cualquier hospital, sin importar si el diagnóstico o el tratamiento se prestan en la oficina de dicho médico o en dicho hospital.

Se entiende que esta autorización se concede por anticipado a cualquier diagnóstico tratamiento o atención de hospital específicos que se precisen, y que se concede para conferir la autoridad y facultad a (mi) (nuestro(s)) representante(s) antes mencionado(s) para que de el consentimiento específico para tal diagnóstico, tratamiento, o atención de hospital que un médico que reúna los requisitos de esta autorización pueda considerar aconsejable en el ejercicio de su mejor criterio.

Esta autorización se concede de acuerdo con las disposiciones de la Sección 25.8 del Código Civil de California.

(Yo) (Nosotros) por medio de la presente autorizamos a cualquier hospital que haya suministrado tratamiento al menor arriba-mencionado de acuerdo con las disposiciones de la Sección 25.8 del Código Civil de California para que ceda la custodia del menor a mi(s)/nuestro(s) representante(s) al concluirse el tratamiento. Esta autorización se concede de acuerdo con la Sección 1283 del Código de Salubridad de California (Health and Safety Code of California).

Esta autorizaciones seguirán en vigencia hasta el _____ de _____ de 19____, salvo su previa anulación por escrito, lo cual, en tal caso, deberá entregarse (al) (a los) representante(s) ya mencionados.

Fecha: _____

Firma: _____
[padre/madre/tutor/conservador] (marque con un circulo la relación)

Firma: _____

SAMPLE

INFORMED CONSENT FOR HIV TESTING

The Human Immunodeficiency Virus (HIV, HIV-III, Aids associated virus) is the agent responsible for the Acquired Immune Deficiency Syndrom (AIDS). Exposure to the virus may be detected by a serologic test which detects antibody to the HIV. It is possible that individuals with a positive test may have no symptoms of AIDS, yet their blood and body secretions may be infectious for close personal contacts. Individuals with a negative HIV antibody test may also be infectious since antibody formation may be delayed or not occur at all in some individuals. I understand that even if the test result is positive, I may not necessarily develop symptoms of AIDS. I fully understand the implications of a positive and a negative HIV antibody test and recognize this is not a diagnostic test for AIDS. I consent to the performance of the HIV antibody test on my serum.

(Patient Signature)

(Date)

(Physician Witness)

Place label from Request Form

HERE

SPECIMEN FOR HIV TESTING
(Instructions to the Physician)

Place label from Request Form

HERE

1. Explain the implications of the HIV Antibody Test to the patient.
2. Have the patient read the attached Informed Consent Form and if patient fully understands it, have the patient sign the form.
3. Draw a 10 ml. red top tube after the patient signs the consent.
4. Put one label from the blue Allied Clinical Laboratories Request Form on the Consent Form, one on the specimen tube, and one on this form.
5. Staple this portion to the blue Request Form and submit the specimen with it. DO NOT submit the patient name.
6. Retain the Informed Consent Form in the patient's record. The specimen results will be identified only by the number on the blue Request Form to maintain confidentiality.
7. These steps are to comply with California law which requires the physician to obtain consent of the patient before testing for antibody to the causative agent of AIDS and requires confidentiality of results. Failure to comply with this law may expose the physician or laboratory to fines and civil penalties or litigation.
8. We will bill your office since we do not have the patient's name and wish to insure patient confidentiality. If it is not convenient for you to collect from the patient, we would prefer you provide us with a responsible party other than the patient to eliminate the possibility of an inadvertent disclosure of results.

FORMA DE CONSENTIMIENTO PARA EL EXAMEN DE HIV

El agente responsable del Syndrome de Inmunodeficiencia Adquirida es el virus (HIV, HIV-III). El contacto con el virus puede ser detectado con un examen serológico que detecta el anticuerpo desarrollado por el virus. HIV. Es posible que una persona con resultado positivo no presente síntomas de SIDA. Sin embargo la sangre y secreciones del cuerpo pueden ser contagioso con el contacto personal. Personas con resultados de anticuerpos (HIV) negativos también pueden contagiar a otras personas dado que la formación del anticuerpo puede ser retrasado, o no se formen el lo absoluto en algunas personas.

Tengo en entendido que aun si el resultado es positivo, yo no necesariamente tengo que desarrollar los síntomas de SIDA. Entiendo completamente las implicaciones de un resultado ya sea positivo o negativo del examen de anticuerpos hacia (HIV), y reconozco que este no es un examen de diagnostico para la enfermedad del SIDA.

Doy mi consentimiento para que se efectue el exame para la deteccion del anticuerpo HIV en mi suero.

(Firma del Paciente)

(Fecha)

(Testigo del Dr.)

Coloque el numero de la
Requisicion de Allied
Clinical Laboratories, Inc.

AQUI

MUESTRA PARA EL EXAMEN HIV
(Instrucciones para el Medico)

Coloque el numero de la
Requisicion de Allied
Clinical Laboratories, Inc.

AQUI

1. Explique las implicaciones del examen del anticuerpo HIV an paciente.
2. Haga que el paciente lea la forma de consentimiento informativo y si el paciente entiende completamente devera firmar la forma de consentimiento.
3. Obtenga 10 ml de sangre en un tubo rojo despues que el paciente halla firmado la forma.
4. Coloque un numero de la requisicion azul de Allied Clinical Laboratories el la forma de consentimiento, uno en el tubo de sangre, y otro en esta forma.
5. Engrape esta porcion a la forma azul de Allied Clinical Laboratories y someterlas al la Laboratorio junto con la sangre. No proporcione el nombre del patient.
6. Conserve la forma de consentimiento (parte superior) en el registro del paciente. Los resultados de la muestra solo sera identificado por el numero de la forma azul de la requisicion para mantener el nombre del paciente anonimo.
7. Estos pesos son tomados para cumplir con la ley del estado de California que requiere al medico obtener el consentimiento del paciente ante de hacer el examen HIV y a la vez mantener el resultado confidencial. Al no cumplir con esta ley se puede exponer al medico o Laboratorio a multas y demandas civiles.
8. Nosotros mandaremos el cobro a su oficina ya que no tenemos el nombre del paciente, y asi deseamos asegurar la confidencia del paciente. (si no le es conveniente a usted cobrarle al paciente, preferimos que nos proporcione la persona responsable aparte del paciente para eliminar la posibilidad de descubrir accidentalmente la identidad del paciente).

CHRONOLOGY OF ASIAN HEALTH SERVICES' HISTORY AND ADVOCACY**1974**

- Asian Health Services is incorporated.
- Services are provided in Cantonese, Mandarin, and Tagalog.
- Provision of direct medical services begins with 2 half-day clinics per week on Harrison Street in Oakland Chinatown.

1976

- First Annual General Membership Meeting is held

1978

- AHS Language capacity expands to Vietnamese and Korean.
- A formal health education component is established.
- AHS organizes patients to protest human service funding cuts that resulted from Proposition 13, the "Taxpayer's Revolt" to hold down property tax rates.

1979

- Federal Urban Health Initiative (Community Health Center Program) funds allow for a much needed expansion of services.

1981

- AHS and other agencies file an Administrative Complaint with the Office of Civil Rights against HigWand Hospital for discriminating against non-English speaking person by its lack of language accessible services.
- AHS moves into the Asian Resource Center.

1982

- Highland Hospital negotiates with Office of Civil Rights to establish a core interpretation unit to settle the Administrative Complaint filed in 1981.

1983

- Alameda County contracts with AHS to provide medical services to medically indigent adults.
- United Way Agency membership funds are obtained to establish a Prenatal Clinic in 1984.

1984

- State Maternal & Child Health contract launches a comprehensive Prenatal Program, including our award-winning Labor Coach Program.

1986

- AHS assists in the founding of the Asian & Pacific Islander American Health Forum, a national advocacy organization that promotes policy, program, and research efforts to improve the health status of Asian & Pacific Islanders.

1987

- AHS helps establish the Association of Asian Pacific Community Health Organization, a national network of community health centers serving the API population.

1988

- HIV education and prevention services are established.

1989

- AHS language capacity expands to Laotian and Mien mv testing and counseling in 6 languages is added.
- Smoking and health promotion/disease prevention work begins with a behavioral risk factor survey of the Oakland Chinatown "community."

1990

- AHS is a major organizer in the first-of-its-kind public hearing on health issues affecting California's Asian & Pacific Islander population.

1991

- HIV primary care and case management services, youth AIDS prevention services, and adolescent clinical services are added.

1992

- AHS participates in the establishment of the Oakland Community Health Academy, aimed at training local residents for health professions and promoting community-based research and teaching.

1993

- AHS is profiled on ABC Evening News as a model health care provider to the Asian community.
- AHS receives a grant from the Robert Wood Johnson and Kaiser Family Foundation Opening Doors Program to develop a "language bank" of trained medical interpreters. Funding is supplemented by the Ridgecliff Foundation.
- General Membership Meeting attracts over 350 patients —the largest attendance ever — to discuss national health care reform in 8 languages using simultaneous interpretation equipment.

1994

- CDC grant is received to establish a national API tobacco control network.
- TV health promotion spots are aired in Cantonese on the local ethnic cable channel.
- AHS 20- Year Anniversary Celebration at the Paramount Theater launches the start of our Capital Campaign to buy our own building.

1996

- Asian Medical Center opens its doors (818 Webster Street)

1998

- AHS receives a \$2.5 million grant along with La Clinica de La Raza, and the Community Health Center Network from the W.K. Kellogg Foundation to develop a plan to expand health care for the underserved.

2000

- AHS' Millennium Ball -celebrating twenty-six years of service to the community

Medical Terminology Contact information

Organization	Phone #	Email/Website	Materials	Available languages
Pacific Asian Language Services	(213) 622-1791	palshealth@earthlink.net	Medical Terminology	Asian Languages
Association of Asian/Pacific Community Health Organizations	(510) 272-9536	www.aapcho.org	1. Obstetric Work List 2. Pocket Guide for Medical Interpretation	1. Asian Languages 2. Vietnamese, Korean
The international Refugee Center of Oregon			Medical Glossary: A Phrasebook For Bilingual Health Care	Asian Languages
Asian and Pacific Islander American Health Forum	(415) 954-9988	www.apiahf.org	Glossaries of Common HIV/AIDS/STD Terminology	Asian Languages
The Cross Cultural Health Care Program	(206) 326-4161	Xculture@pacmed.org www.xculture.org	Medical Glossary	various languages
Health Access By Language Advocacy/The Alabama Dept. of Public Health	1(800) 255-1992		Medical Terminology/Vocabulary List	Spanish
Vista Community Clinic			Medical Terminology Glossaries	Spanish

SAMPLE

Patient Satisfaction Survey

Instructions: Results of this survey will be used only to improve our services for the patients. Please leave questions you do not want to answer. Thank you for your cooperation.

General Questions (Please check)

1. Patient's age? 0-9 10-19 20-29 30-39 40-49 50-59 60-69 70-79
 80 and over
2. Patient's sex? Female Male
3. Patient's first language?
 English Thai Cambodian Vietnamese Tagalog Japanese
 Others (Please specify it) _____
4. How many times have you used clinic services?
 First time Second time 3-10 times More than 10 times

Staff Members (Please rate the following questions and circle the number)

- N/A poor -----excellent
1. Courtesy and respect shown by the receptionist.....0 1 2 3 4 5
 2. Courtesy and respect shown by the financial screener.....0 1 2 3 4 5
 3. Courtesy and respect shown by the support service liaison.....0 1 2 3 4 5
 4. Courtesy and respect shown by the provider.....0 1 2 3 4 5
 5. Courtesy and respect shown by the nurse.....0 1 2 3 4 5
 6. Explanation by the provider about your health problems.....0 1 2 3 4 5
 7. Amount of time the provider spent with you.....0 1 2 3 4 5

Others (Please rate the following questions and circle the number)

- N/A not satisfied-----satisfied
1. Length of waiting time..... 0 1 2 3 4 5
 2. Cleanliness of rooms.....0 1 2 3 4 5
 3. Did you have any difficulty when you made the appointment? Yes No
 4. Did you have any language difficulty in the clinic? Yes No
 If "Yes" for question 3 or 4, please write the difficulty you had at the bottom.
 5. Did you understand what your health conditions are? Yes No
 6. Would you recommend this clinic to your friends? Yes No

Please write your suggestions to the clinic. (e.g. what kind of services do you want us to offer?)

Please check if above answers were filled in by a liaison. Date: ___/___/___

SAMPLE

Patient Satisfaction Survey

記入方法： この質問紙は、患者の皆さんにとって、今後、よりよい医療サービスが提供できるよう、ご意見ご感想をうかがうものです。回答したくない質問については、空白にして構いません。ご協力ありがとうございます。

一般事項 (該当するものに印をして下さい)

1. 年齢 0-9 10-19 20-29 30-39 40-49 50-59 60-69 70-79
 80歳以上
2. 性別 女性 男性
3. 言語 英語 タイ語 カンボジア語 ベトナム語 タガログ語
 日本語 その他 _____
4. 今までに、何回、クリニックをご利用されましたか？
 1回 2回 3-10回 10回以上

スタッフ (該当する番号に印をつけて下さい)

- | | 該当なし | 悪い | ----- | 良い |
|----------------------------|------|----|-------|-------|
| 1. 受付の対応 | 0 | 1 | 2 | 3 4 5 |
| 2. 所得審査係の対応 | 0 | 1 | 2 | 3 4 5 |
| 3. 通訳の対応 | 0 | 1 | 2 | 3 4 5 |
| 4. 医師の対応 | 0 | 1 | 2 | 3 4 5 |
| 5. 看護婦の対応 | 0 | 1 | 2 | 3 4 5 |
| 6. あなたの健康問題についての医師の説明..... | 0 | 1 | 2 | 3 4 5 |
| 7. 医師の診察時間..... | 0 | 1 | 2 | 3 4 5 |

その他 (該当する番号に印をつけて下さい)

- | | 該当なし | 不満足 | ----- | 満足 |
|-----------------------------------------------------|----------------------------------------------------------|-----|-------|-------|
| 1. 待ち時間..... | 0 | 1 | 2 | 3 4 5 |
| 2. 診療室の衛生..... | 0 | 1 | 2 | 3 4 5 |
| 3. 予約をとる際に、何か問題はありましたか？ | <input type="checkbox"/> はい <input type="checkbox"/> いいえ | | | |
| 4. クリニックで、何か言葉に困りましたか？ | <input type="checkbox"/> はい <input type="checkbox"/> いいえ | | | |
| (質問3・4番で、"はい"とお答えになった方は、具体的にどのようなことだったか、下の余白ご記入下さい) | | | | |
| 5. あなたの健康状態について理解されましたか？ | <input type="checkbox"/> はい <input type="checkbox"/> いいえ | | | |
| 6. クリニックをお友達に紹介されますか？ | <input type="checkbox"/> はい <input type="checkbox"/> いいえ | | | |

その他、ご意見がありましたら、お願いいたします。(例、他にどのようなサービスがあったらいいと思うか?)

この質問紙を、通訳と一緒に記入された場合は、印をして下さい。

日付: ___/___/___

Japanese Patient Satisfaction Survey

แบบสำรวจความคิดเห็นของคนไข้

คำแนะนำ: เหตุผลที่ทำแบบสำรวจนี้เพื่อจะช่วยให้เราปรับปรุงการให้บริการแก่คนไข้
กรุณาเว้นคำถามที่ท่านไม่ต้องการตอบ ขอบขอบคุณสำหรับความร่วมมือ

คำถามทั่วไป (กรุณาใส่เครื่องหมายถูกหน้าข้อที่เลือก)

๑. อายุ () ๐-๕ () ๑๐-๑๕ () ๒๐-๒๕ () ๓๐-๓๕ () ๔๐-๔๕ () ๕๐-๕๕ () ๖๐-๖๕ () ๗๐-๗๕ () ๘๐ ปีขึ้นไป

๒. เพศ () หญิง () ชาย

๓. ภาษาที่ท่านใช้

() อังกฤษ () ไทย () เขมร () เวียดนาม () ดากาล็อก () ญี่ปุ่น () อื่นๆ (กรุณาระบุ) _____

๔. ท่านมาที่คลินิกกี่ครั้ง

() ครั้งแรก () ครั้งที่ ๒ () ครั้งที่ ๓-๑๐ () มากกว่า ๑๐ ครั้ง

เจ้าหน้าที่ซึ่งให้ความช่วยเหลือแก่ท่าน (กรุณาจัดอันดับคำถาม แล้ววงกลมตัวเลข)

๑. เจ้าหน้าที่แผนกต้อนรับบริการท่านด้วยอัธยาศัยและมารยาท

ไม่มีคะแนน ไม่ดี ← → ดีมาก

๐ ๑ ๒ ๓ ๔ ๕

๒. เจ้าหน้าที่แผนกสืบรายโคบริการท่านด้วยอัธยาศัยและมารยาท

๐ ๑ ๒ ๓ ๔ ๕

๓. เจ้าหน้าที่คานภาษาบริการท่านด้วยอัธยาศัยและมารยาท

๐ ๑ ๒ ๓ ๔ ๕

๔. แพทย์บริการท่านด้วยอัธยาศัยและมารยาท

๐ ๑ ๒ ๓ ๔ ๕

๕. พยาบาลบริการท่านด้วยอัธยาศัยและมารยาท

๐ ๑ ๒ ๓ ๔ ๕

๖. แพทย์/พยาบาลได้อธิบายปัญหาสุขภาพของท่านโดยละเอียด

๐ ๑ ๒ ๓ ๔ ๕

๗. แพทย์ใช้เวลากับการเจ็บป่วยของท่าน

๐ ๑ ๒ ๓ ๔ ๕

ด้านอื่นๆ (กรุณาจัดอันดับคำถาม แล้ววงกลมตัวเลข)

๑. ระยะเวลาที่รอ

ไม่มีคะแนน ไม่ดี ← → ดีมาก

๐ ๑ ๒ ๓ ๔ ๕

๒. ความสะดวกของสถานที่

๐ ๑ ๒ ๓ ๔ ๕

๓. ท่านมีปัญหากับการนัดตรวจหรือไม่

(กรุณาใส่เครื่องหมายถูกหน้าข้อที่เลือก)

() มี () ไม่มี

๔. ท่านมีปัญหากับคานภาษาหรือไม่

() มี () ไม่มี

ถ้าท่านตอบว่ามีปัญหาในข้อ ๓-๕ กรุณาระบุปัญหาเหล่านั้นด้วย

๕. ท่านทราบปัญหาสุขภาพซึ่งท่านเป็นอยู่หรือไม่

() ทราบ () ไม่ทราบ

๖. ท่านจะแนะนำคลินิกนี้แก่เพื่อนๆ หรือไม

() แนะนำ () ไม่แนะนำ

กรุณาเขียนคำแนะนำ (การบริการด้านไหนที่ท่านต้องการให้เราเพิ่ม)

กรุณาใส่เครื่องหมายถูกหน้าคำตอบข้างบนกรอกโดยเจ้าหน้าที่ในหน่วยงาน ()

วันที่ ____/____/____

Thai Patient Satisfaction Survey

SAMPLE

ការស្ទង់មើលមតិរបស់អ្នកជម្ងឺ

លទ្ធផលនៃការស្ទង់មតិអ្នកជម្ងឺនេះ គ្រាន់តែបង្កើនការបំរើរបស់យើងចំពោះអ្នកជម្ងឺតែប៉ុណ្ណោះ
តែប្រសើរឡើង។ អ្នកអាចមិនបាច់ឆ្លើយនូវសំណួរណាមួយដែលអ្នកមិនចង់ឆ្លើយ។ សូមអរគុណ!
សំណួរជាទូទៅ (សូមគូសខ្ទង់)

១. អាយុរបស់អ្នក ០០-៩ ០១០-១៩ ០២០-២៩ ០៣០-៣៩ ០៤០-៤៩ ០៥០-៥៩ ០៦០-៦៩ ០៧០-៧៩ ០៨០ឡើង

២. ភេទ ប្រុស ប្រុស

៣. ភាសាដើមរបស់អ្នក អង់គ្លេស ថៃ ខ្មែរ ជប៉ុន កូរ៉េ ចិន ប៊ែរម៉ា ឈីន ជប៉ុន ផ្សេងទៀត _____

៤. តើអ្នកមកមន្ទីរព្យាបាលនេះប៉ុន្មានដងហើយ? លើកទី១ លើកទី២ លើកទី៣-១០ លើសពី១០ដង
បុគ្គលិកធ្វើការ (សូមពិនិត្យទៅបុគ្គលិកធ្វើការតើបានបំពេញចិត្តលោកអ្នកនិយាយដោយគូសរង្វង់លើលេខនៃសំណួរខាងក្រោម)

មិនល្អ _____ ល្អណាស់

១. ការគ្រួសារនិងការគោរពអំពីអ្នកទទួលភ្ញៀវនៅខាងមុខ ០ ១ ២ ៣ ៤ ៥

២. ការគ្រួសារនិងការគោរពអំពីអ្នកពិនិត្យពិច្ចុយខាងប្រាក់កាស(ប្រាក់ចំណូល) .. ០ ១ ២ ៣ ៤ ៥

៣. ការគ្រួសារនិងការគោរពអំពីអ្នកជំនួយខាងផ្នែកប្រែភាសា ០ ១ ២ ៣ ៤ ៥

៤. ការគ្រួសារនិងការគោរពអំពីគ្រូពេទ្យ ០ ១ ២ ៣ ៤ ៥

៥. ការគ្រួសារនិងការគោរពអំពីគិលានុប្បវាយិកា (Nurse) ០ ១ ២ ៣ ៤ ៥

៦. ការយល់អំពីបញ្ហាជម្ងឺរបស់អ្នក នៅពេលគ្រូពេទ្យពន្យល់ ០ ១ ២ ៣ ៤ ៥

៧. ការពេញចិត្តនូវពេលវេលាដែលគ្រូពេទ្យចំណាយជាមួយអ្នក ០ ១ ២ ៣ ៤ ៥

ផ្សេងទៀត (សូមពិនិត្យលើសំណួរខាងក្រោមដោយគូសរង្វង់លើលេខ)

មិនពេញចិត្ត _____ ពេញចិត្ត

១. ពេលវេលាដែលរង់ចាំ ០ ១ ២ ៣ ៤ ៥

២. ភាពស្អាតក្នុងមន្ទីរព្យាបាលរោគ ០ ១ ២ ៣ ៤ ៥

៣. តើអ្នកមានការពិបាកក្នុងការណាត់ជួបគ្រូពេទ្យឬទេ? បាទ ទេ

៤. នៅក្នុងមន្ទីរព្យាបាលរបស់យើង តើអ្នកមានការពិបាកផ្នែកខាងភាសាឬទេ? បាទ ទេ
ចំពោះសំណួរ ទី ៣ និង ទី ៤ បើមានសូមសរសេរនៅខាងក្រោម

៥. តើអ្នកបានយល់ ដឹងអំពីលក្ខណៈសុខភាពរបស់អ្នកឬទេ? បាទ ទេ

៦. តើអ្នកនឹងប្រាប់ទៅមិត្តភក្តិរបស់អ្នកអំពីមន្ទីរព្យាបាលរបស់យើងឬទេ? បាទ ទេ

បើមានសំណួរអ្វីសូមមេត្តាសរសេរមកមន្ទីរព្យាបាលរបស់យើង (ការបំរើអ្វីដែលអ្នកចង់ឲ្យយើងផ្តល់ជូនអ្នក)
សូមគូសខ្ទង់លើការឆ្លើយខាងលើត្រូវបានជួយបំពេញដោយអ្នកជួយបកប្រែភាសា ០ ខែ/ថ្ងៃ/ឆ្នាំ ____/____/____

Serbeyo para sa (Satisfaction) ng mga Pasyente

Tagubilin: Ang resulta ng serbeyong ito ay gagamitin lamang upang mapagbutiang aming serbisyo sa mga pasyente. Maaring iwanang blanko ang mga tanong hindi gustong sagutan. Salamat sa inyong kooperasyon.

Pangkalahatang mga Katanungan (Paki-lagyan ng tsek ang naaangkop)

1. Edad ng Pasyente? 10-19 20-29 30-39 40-49 50-59 60-69
 70-79 80 at higit pa.

2. Kasarian ng Pasyente? Babae Lalake

3. Ang wikang iyong unang sinalita?

Ingles Thai Cambodian Vietnamese Iba pa
(pakisulat kung ano ito.) _____ (Tagalog, Ilocano, Bisaya at iba pa.)

4. Ilang beses na kayong Komunsulta sa klinik?

Isang beses Dalawang beses 3-10 beses Lampas sa 10

Mga Kawani (Paki-bilugan ang bilang sa kanan na naaangkop sa pagtatasa sa katanungan na katapat nito. 0 (hindi angkop) 1(isa) bilang pinakamababa, 5 (lima) bilang pinakamataas

1. Kagandahang loob at paggalang na ipinakita ng receptionist	0 1 2 3 4 5
2. Kagandahang loob at paggalang na ipinakita ng financial screener	0 1 2 3 4 5
3. Kagandahang loob at paggalang na ipinakita ng support service liaison	0 1 2 3 4 5
4. Kagandahang loob at paggalang na ipinakita ng mangagamot	0 1 2 3 4 5
5. Kagandahang loob at paggalang na ipinakita ng nurse	0 1 2 3 4 5
6. Pagpapaliwanag ng mangagamot tungkol sa iyong problema	0 1 2 3 4 5
7. Haba ng oras na inukol sa iyo ng mangagamot	0 1 2 3 4 5

Karagdagang Katanungan (Paki bilugan ang bilang sa kanan na naaangkop sa pagtatasa sa katanungan na katapat nito.)

	H/A	hindi nasiyahan ----- nasiyahan				
	0	1	2	3	4	5
1. Tagal ng Paghihintay	0	1	2	3	4	5
2. Kalinisan ng Kwarto	0	1	2	3	4	5

(markahan ng tsek)

3. Nagkaroon ba kayo ng problema sa pag-kuha ng appointment? oo hindi

4. Nagkaroon ka ba sa wika sa klinik? oo hindi

Kung ang sagot sa 3,4 ay oo maari po lamang ilahad sa ibaba ang naging problema

5. Naiintindihan mo ba ang inyong kalagayan pangkalusugan? oo hindi

6. Mairerekomenda mo ba ang aming klinika sa inyong mga kaibigan? oo hindi

Paki-sulat ang iyong mga mungkahi para sa klinika (halimbawa, anong uri ng mga serbisyo ang nais mong ibigay-namin?)

Paki-lagyan ng tsek kung ang mga sagot sa itaas ay pinunan ng liaison.

Petsa: ___/___/___

Tagalog-Patient Satisfaction Survey

Encuesta de Satisfaccion Para el Paciente

Instrucciones: Resultados de esta encuesta seran utilizados para mejorar el servicio del paciente. Favor de no contestar a las preguntas que no desee contestar. Gracias por su cooperacion.

Preguntas en General (Favor de marcar)

1. Edad del paciente? 0-9 10-19 20-29 30-39 40-49 50-59
 60-69 de 80 para arriba
2. Sexo del paciente? Femenino Masculino
2. Lengua primaria del paciente?
 Espanol Ingles Tailandes Camboyano Tagalo
 Japonés si habla alguna otra lengua (especifique) _____
4. Cuantas veces ha usado los servicios de la clinica?
 Primera vez Segunda vez 4-10 veces Mas de 10 veces

Miembros de la Administracion (Favor de valorar las siguientes preguntas)

	N/A	pobre.....	exelente
1. Cortesia y respeto dado por la recepcionista.....	0	1	2	3 4 5
3. Cortesia y respeto dado por el verificador financiero.....	0	1	2	3 4 5
4. Cortesia y respeto dado por el servicio intermediario.....	0	1	2	3 4 5
5. Cortesia y respeto dado por el proveedor (doctor).....	0	1	2	3 4 5
6. Cortesia y respeto dado por la enfermera (o).....	0	1	2	3 4 5
7. Explicacion dada por el proveedor acerca de su salud.....	0	1	2	3 4 5
8. Cantidad de tiempo que el proveedor uso con Ud.....	0	1	2	3 4 5

Otros (Favor de valorar las siguientes preguntas y circule el numero)

- | | N/A | pobre..... | | exelente |
|------------------------------------------------------------------------------------------------------------------|--------------------------|------------|-------|-----------------------------|
| 1. Tiempo de espera..... | 0 | 1 | 2 | 3 4 5 |
| 2. Higiene en los cuartos de examenes..... | 0 | 1 | 2 | 3 4 5 |
| 3. Tubo alguna dificultad al hacer su cita? | <input type="checkbox"/> | Si | | <input type="checkbox"/> No |
| 4. Tubo alguna dificultad con el language en la clinica? | <input type="checkbox"/> | Si | | <input type="checkbox"/> No |
| Si es que contesto "Si" a las preguntas 3 o 4, favor de escribir el problema que tubo a el final de esta pagina. | | | | |
| 5. Entendio cual es su condicion fisica? | <input type="checkbox"/> | Si | | <input type="checkbox"/> No |
| 6. Ud. recomendaria esta clinica a sus amigos? | <input type="checkbox"/> | Si | | <input type="checkbox"/> No |

Favor de escribir sus sugerencias a la clinica. (e.g. Que clase de servicios le gustaria que nosotros ofrecieramos?)

Favor de marcar si las preguntas fueron contestadas por el servicio de ayuda intermediaria

Fecha: ___/___/___

Phiếu phê bình của bệnh nhân

Cách chỉ dẫn: chúng tôi chấp nhận phiếu phê bình để hầu phục vụ quý bệnh nhân cho tốt đẹp hơn. Có những câu hỏi qui vị không muốn trả lời thì xin để trống. Cảm ơn.

Những câu hỏi thông thường (xin đánh dấu vào ô vuông)

- Xin cho biết số tuổi là? 0-9 10-19 20-29 30-39 40-49 50-59 60-69
70-79 80 hoặc cao hơn
- Xin phân biệt là? Phái nữ Phái nam
- Xin cho biết tiếng mẹ đẻ là?
Anh ngữ Thái Cambodian Việtnam Nếu khác biệt (xin nêu rõ ra) _____
- Đây là lần thứ mấy quý vị đã đến tổ hợp y tế này?
Lần đầu Lần thứ nhì Từ 3-10 lần Hơn 10 lần

Nhân viên (Xin cho điểm những câu hỏi dưới đây và nhỏ khoanh tròn những con số điểm)

	không ý kiến	thấp	----->			cao
1. Sự nhã nhặn và lịch sự của người thư ký tiếp khách	0	1	2	3	4	5
2. Sự nhã nhặn và lịch sự của người lo về thủ tục tái khám	0	1	2	3	4	5
3. Sự nhã nhặn và lịch sự của người giúp đỡ phân thông dịch	0	1	2	3	4	5
4. Sự nhã nhặn và lịch sự của bác sĩ	0	1	2	3	4	5
5. Sự nhã nhặn và lịch sự của người y tá	0	1	2	3	4	5
6. Sự giải thích của bác sĩ về tình trạng bệnh của quý vị	0	1	2	3	4	5
7. Thời gian bác sĩ dành cho quý vị	0	1	2	3	4	5

Điều khác (Xin cho điểm những câu hỏi dưới đây và nhỏ khoanh tròn những con số điểm)

	không ý kiến	không hài lòng	---->			hài lòng
1. Thời gian chờ đợi	0	1	2	3	4	5
2. Sự sạch sẽ của những căn phòng	0	1	2	3	4	5

(xin đánh dấu vào ô vuông)

- Quý vị có gặp trở ngại khi gọi để lấy hẹn không? Có Không
- Quý vị có bị trở ngại về ngôn ngữ khi đến tổ hợp y tế không? Có Không

Nếu quý vị trả lời có cho câu hỏi số 3 hoặc số 4, xin viết sự trở ngại quý vị có vào phần dưới.

- Quý vị có biết quý vị bị bệnh gì không? Có Không
- Quý vị sẽ giới thiệu tổ hợp y tế này tới những người quen không? Có Không

Xin cho biết những ý kiến của quý vị về tổ hợp y tế (chẳng hạn những dịch vụ nào chúng tôi có thể lo được cho quý vị?)

Xin đánh dấu vào ô vuông nếu những câu trả lời phần trên được điền bởi một người tiếp trợ.

Vietnamese Patient Satisfaction Survey

Ngày: ____/____/____

Cultural Competence Self Assessment Survey (excerpt)

December 2000

Statements that Received the Most “Frequently” Responses (80% and above)

1 = Things done frequently; 2 = Things done occasionally; 3 = Things done rarely or never; N/A = not applicable

- I accept that religion and other beliefs may influence how patients/clients respond to illnesses, disease, and death.
- I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- When interacting with patients/clients I always keep in mind that
 - Language proficiency is in no way a reflection of their level of intellectual functioning.
 - Limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
 - They may or may not be literate in their language of origin or the dominant culture.
- I recognize that the meaning or value of treatment, health education, counseling, and other services may vary greatly among cultures.
- I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).
- I recognize and accept that folk and religious beliefs may influence a patient's/client's reaction and approach to having a disability or special health care needs or having a child born with a disability or later diagnosed with a disability or special health care needs.
- I recognize and accept that individuals from culturally diverse backgrounds may not want to fully acculturate into the dominant culture.

Statements that Received the Most “Rarely: or Never” Responses (10% and above)

1 = Things done frequently; 2 = Things done occasionally; 3 = Things done rarely or never; N/A = not applicable

- I screen books, movies, and other media re-sources for negative cultural, ethnic, or racial stereotypes before sharing them with patients/clients.
- I intervene in an appropriate manner when I observe other staff or patients/clients engaging in behaviors that show cultural insensitivity or prejudice.

- For patients/clients who speak languages or dialects other than the languages I speak, I attempt to learn and use key words in their language so that I am better able to communicate with them.

Communication styles

1 =Things done frequently; 2= Things done occasionally; 3=Things done rarely or never; N/A= not applicable

- I attempt to determine any familial colloquialisms used by patients/clients that may impact on my service or interaction with them.
- I use visual aids, gestures, and physical prompts in my interactions with patients/clients when I am unable to speak their language.
- I use other bilingual staff or interpreters when interacting with patients/clients I am unable to communicate directly with.
- When possible, I insure that all notices and communiques to patients/clients are written in their language of origin.
- I understand that it may be necessary to use alternatives to written communications for some patients/clients, as word of mouth may be a preferred method of receiving information.

Values and attitudes

1 =Things done frequently; 2= Things done occasionally; 3=Things done rarely or never; N/A= not applicable

- I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- In group situations, I discourage patients/clients from using racial and ethnic slurs by helping them understand that certain words can hurt others.
- I accept and respect that male- female roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, play and social interactions expected of male and female children).
- I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).
- Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

- I understand that traditional approaches to disciplining children are influenced by culture.
- I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self help skills.
- Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations which are unique to patients/clients of specific cultures and ethnic groups.
- I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse patients/clients I serve.

Draft



Patient Satisfaction Survey

The Venice Family Clinic wants to improve its programs. In order to do this, we would like to know how you feel about our services. Your participation is voluntary and your answers are confidential and anonymous.

FOR OFFICE USE ONLY

Survey ID Number (To be filled out later during data entry)

Patient's ZIP code:

Appointment Date:

Appointment Time: AM PM

Time of Sign-in: AM PM

Provider arrival time: AM PM

Time of Discharge: AM PM

First time patient? (survey stays with chart)

General Information

1. Your age: (choose one)
 Under 18 18-25 26-35 36-45 46-55 56-65 66 and above

2. Gender Male Female

3. Marital status: Single Married Divorced Partner

4. Your ethnicity: (choose one)
 African-American(non-Hispanic) Asian/Pacific Islander
 Caucasian(non-Hispanic) Latino/Hispanic
 Native American
 Multiracial (specify) _____
 Other (specify) _____

5. What is the last grade of school you finished? (choose one)
 Elementary (K-5th) Junior High School (6-8th)
 High School (9-12th) GED/High School Equivalency Exam
 Technical/Trade School 2-year College
 College +

Satisfaction

1. Do you feel it is easy to set up appointments with a primary care medical provider when you need them? (choose one)
 All the time Most of the time Some of the time Not at all

2. Do you feel the front desk staff treats you respectfully? (choose one)
 All the time Most of the time Some of the time Not at all

3. Do you feel your medical providers spend enough time with you so that you can ask all of your questions? (choose one)
 All the time Most of the time Some of the time Not at all

4. Do you feel your medical providers act too businesslike and impersonal toward you? (choose one)
 All the time Most of the time Some of the time Not at all

5. Do you feel that the medical providers and staff are sensitive to your cultural beliefs?
 All the time Most of the time Some of the time Not at all

6. Do you feel comfortable using a translator when your medical provider does not speak your native language? (choose one)
 All the time Most of the time Some of the time Not at all
 I do not need a translator

7. Have you ever felt like you wanted to tell your medical provider what you needed but did not?
 Yes No

7a. Why did you feel you could not tell them? (check all that apply)
 I felt intimidated I did not know I was allowed to
 I did not feel my wishes would be respected
 I did not know how to tell them I did not have time
 The medical provider knows what is best for me

8. Do you feel the health education materials you receive at the Clinic are helpful? (choose one)
 All the time Most of the time Some of the time Not at all
 I never received health education materials

9. Do you feel it is easy to set up appointments with medical specialists when you need them? (choose one)
 All the time Most of the time Some of the time Not at all
 I never needed a medical specialist

10. Do you feel you understand the instructions the pharmacist gives you when you pick up your medications? (choose one)
 All the time Most of the time Some of the time Not at all
 I never needed a pharmacist

11. At the Clinic, which person do you feel you could call or talk to if you had questions after your visit?
 Social Worker Clinic Coordinator Medical Provider
 Nursing Staff Pharmacist
 I didn't know the Clinic had someone I could talk to
 No one Other (specify) _____

12. Overall, how would you rate your experience at the Clinic? (choose one)
 Excellent Very Good Good Fair Poor

13. Please list any suggestions that will help the Clinic serve you better.

14. How much time passed from your appointment time to when you actually saw your medical provider?
 _____ Hours _____ Minutes

Draft



Encuesta a los Pacientes

La Clínica Familiar de Veince (The Venice Family Clinic) desea mejorar sus programas. Para hacer esto, deseamos saber como usted se siente sobre nuestros servicios. Su participación es voluntaria y sus respuestas son confidenciales y anónimas.

PARA USO DE OFICINA

Survey ID Number (To be filled out later during data entry)

Patient's ZIP code:

Appointment Date:

Appointment Time: AM PM

Time of Sign-in: AM PM

Provider arrival time: AM PM

Time of Discharge: AM PM

First time patient? (survey stays with chart)

7. ¿Ha sentido alguna vez que quiere comunicarle lo que necesita a su proveedor(a) médico, pero no pudo?
 Sí No

7a. ¿Por que sintió que no pudo? (chequea todos los que apliquen)
 Me sentí intimidado No sabía que estaba permitido
 No pensé que mis deseos serían respetados No tenía tiempo
 El proveedor sabe lo que es mejor para mí

8. ¿Siente usted que los materiales educacionales de salud que recibe en la Clínica son de ayuda?
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca
 Nunca recibo materiales educacionales

9. ¿Siento que es fácil hacer una cita con los especialistas médicos cuando usted la necesita?
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca
 Nunca necesité un especialista

10. ¿Siente que entendió las instrucciones que el farmacista le dio cuando recogió su medicamento? (elijá uno)
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca

11. ¿A quién crees que puedes llamar en la clínica si tienes preguntas después de tu visita?
 Trabajador Social Coordinadora de clínica Proveedor médico
 Personal de Enfermería Farmacista
 No sabe que la clínica tenía personal al que yo pudiera consultar
 Nadie Otro (especifique) _____

12. ¿En general, cómo calificaría la experiencia que usted tuvo en la Clínica? (elijá uno) Excelente Muy buena Buena Justa Pobre

13. Por favor escriba algunas sugerencias que ayuden a la Clínica a servirle mejor.

14. ¿Cuanto tiempo pasó desde la hora en que tenía su cita hasta que vió a su proveedor médico?
 Horas Minutos

Información General

1. Edad: (elijá uno)
 Menos de 18 26-35 46-55 66 y mas
 18-25 36-45 56-65

2. Género: Masculino Femenino

3. Estado Marital: Soltero(a) Casado(a)
 Divorciado(a) Con compañero(a)

4. Raza: (elijá uno)
 Afro-Americano(no Hispano) Asiático/Island del Pacífico
 Caucasico(no Hispano) Latino/Hispano
 Nativo Americano
 Multiracial (especifique) _____
 Otro (especifique) _____

5. ¿Cuál es el grado de estudios más alto que completó? (elijá uno)
 Elementaria (K-5th) Junior High School (6-8th)
 High School (9-12th) GED(Examen de Equivalencia al High School)
 Escuela Técnica Colegio de 2 años
 Colegio o más

Satisfacción

1. ¿Siente que es fácil hacer una cita con un proveedor médico cuando usted la necesita?
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca

2. ¿Siente que la persona en la recepción le trata respetuosamente? (elijá uno) Todo el tiempo Mayoría del tiempo Algunas veces Nunca

3. ¿Siente que los proveedores médicos le dedican el tiempo suficiente para que les pueda hacer preguntas (elijá uno)
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca

4. ¿Siente que los proveedores médicos actúan demasiado profesionales e impersonales hacia usted? (elijá uno)
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca

5. ¿Siente que los proveedores y el personal son sensitivos a sus creencias culturales? (elijá uno)
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca

6. ¿Se siente cómodo(a) usando un traductor cuando su proveedor(a) médico no habla su idioma nativo? (elijá uno)
 Todo el tiempo Mayoría del tiempo Algunas veces Nunca
 No necesité un traductor

CAUS Questionnaire Screener
County of Alameda Uninsured Survey
(CAUS)

Adapted from UCLA's CHIS/CHCF/FIELD's
Survey of the Non-Poor Uninsured

JUNE, 2000

County of Alameda Uninsured Survey
Adult Questionnaire

SAMPLE INTRODUCTION:

Hello, my name is _____. I am calling from the Institute for Scientific Analysis on behalf of the Alameda County Health Alliance and Alameda County. We are doing a survey on the health, access to health care and health insurance of residents in Alameda County. The results will help improve existing health services in Alameda County.

Are you 18 years of age or older?

[IF YES GO TO B]

[IF NO ASK]

Is there anyone living in your household 18 years old or older?
Could I please speak to him or her?

[REPEAT INTRO AND CONTINUE TO B]

[IF ADULT IS NOT AVAILABLE, ASK FOR A CONVENIENT TIME TO CALL BACK]

B. You have been selected to participate in an important health survey for Alameda County residents. Your participation is completely voluntary. All the information will be kept confidential and will only be used for statistical purposes. The interview will take about 10 to 15 minutes.

I'd like to do this interview now, if that is ok.

[IF YES, CONTINUE TO C]

[IF NO, ASK:]

If another time is more convenient for you, we can schedule a better time.

[NOTE RESULT ON TRACKING SHEET]

A4a. **What race do you identify yourself as? You may choose more than one.**

- (1) _____ American Indian or Alaska Native [GO TO B1] (8) _____ Don't know [GO TO B1]
 (2) _____ Native Hawaiian or Other Pacific Islander [GO TO A5 if only one] (9) _____ Refused [GO TO B1]
 (3) _____ Black or African American [GO TO B1 if only one]
 (4) _____ Asian [GO TO A5 if only one]
 (5) _____ White [GO TO B1 if only one]

[IF A4a="Native Hawaiian or Other Pacific Islander" or "Asian", ASK A5]

A5. **Of which Asian or Pacific Islander group(s) are you? Such as Chinese, Filipino, Samoan, etc. If you identify with more than one, tell me all of them.**

- | | | |
|---------------------|---------------------------|--------------------------------|
| (1) _____ Cambodian | (7) _____ Korean | (12) _____ Native Hawaiian |
| (2) _____ Chinese | (8) _____ Laotian | (13) _____ Tongan |
| (3) _____ Chamorro | (9) _____ Vietnamese | (14) _____ (American) Samoan |
| (4) _____ Filipino | (10) _____ Indian (India) | (15) _____ Other Pac. Islander |
| (5) _____ Hmong | (11) _____ other Asian: | (Specify) _____ |
| (6) _____ Japanese | (specify) _____ | |
- (88) _____ Don't Know (99) _____ Refused

B1. **In what country were you born?**
 _____ (country)

B2. **Are you a citizen of the United States?**
 _____ YES
 _____ NO

B3. **How many years have you lived continuously in the United States?**
 _____ (Number of years)

B4. To get a sense on what area you live in Alameda County please tell me your zip code.

_____ (Zip code)

C1. Are you covered by any type of health insurance plan that pays for doctor visits or other types of care?

- YES
- Don't know [GO TO D1]
- NO [GO TO D1]
- Refused [GO TO D1]

C1a. Is your insurance from a current or former employer or union, through school, purchased directly from an insurance company, Medi-Cal, CHAMPUS, VA, Indian Health Service, or some other type of coverage?

[SELECT ALL MENTIONED]

- (1) _____ Through current or former employer/union
- (2) _____ Through school, professional association, trade group, or other organization
- (3) _____ Purchased directly from health plan (by R or anyone else)
- (4) _____ MediCARE
- (5) _____ Medi-Cal
- (6) _____ CHAMPUS/CHAMP-VA, TRICARE, VA or some other military health care
- (7) _____ Indian Health Service, Tribal Health Program or Urban Indian Clinic
- (8) _____ Other government health plan
- (9) _____ Other non-government plan
- (10) _____ Other _____

(88) _____ Don't know [GO TO C1b]

(99) _____ Refused [GO TO C1b]

C1b. During the past 12 months, was there any time when you had no health insurance at all?

- YES
- NO [GO TO D1]

C1c. For how many months of the past 12 months did you have no health insurance at all?

_____ (Number of months) (0-12)

C1d. **What is the ONE MAIN reason why you did not have any health insurance during those months?**

- (1) _____ Employment
- (2) _____ Personal or family changes
- (3) _____ Insurance problems or beliefs or health
- (4) _____ Medi-Cal reason
- (5) _____ Cost too high/too expensive
- (6) _____ Other
- (8) _____ Don't know
- (9) _____ Refused

D1. **Do you have any children covered by Medi-CAL?**

[NOTE: Include HMO or managed care plans, as well as the traditional Medi-Cal.]

- _____ YES _____ Don't know
- _____ NO _____ Refused

D2. **Do you have any children covered by the Healthy Families Program?**

[NOTE: Healthy Families is a state program that pays for health insurance for children of lower income working parents.]

- _____ YES _____ Don't know
- _____ NO _____ Refused

[IF PERSON DOES NOT HAVE HEALTH INSURANCE CONTINUE WITH CORE QUESTIONNAIRE]

[IF THE PERSON DOES HAVE HEALTH INSURANCE, THEN END THE INTERVIEW]

Those were my final questions. Thank you so very much for your time and cooperation. You have helped with a very important health survey for Alameda County. Thank you, again and good-bye.



October 27, 2000

Carole Brown
Office of Civil Rights
Department of Health and Human Services
200 Independence Avenue, S.W. Room 506F
Washington, D.C. 20201

RE: Comment on Guidance on Serving the Limited English Proficient Population

Dear Ms. Brown:

As safety-net healthcare providers to California's diverse population, the California Primary Care Association applauds the Office of Civil Rights for the release of guidance on how they will monitor and enforce Title VI of the Civil Rights Act of 1964. Title VI of the Civil Rights Act of 1964 states "No person in the United States shall, on 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." Because major programs such as Medicare, Medicaid, and the State Children's Health Insurance Program are federally funded, few health care providers are exempt from the provisions of this law.

The clarification on Title VI focuses on the responsibilities of health and social service providers to provide language access for persons with limited English proficiency (LEP). The guidance does not impose any new obligations on providers but instead, provides important clarification of the legal requirements that have been in place for over three decades.

As community-based providers of care, the California Primary Care Association and our member clinics have worked to ensure appropriate access to quality care, which necessitates the provision of language services. In 1999, California's community health centers provided almost 1 million encounters to persons with limited English proficiency. With almost one-third of our patients requiring linguistic services, we understand the responsibility and costs associated with developing the capacity to serve the special needs of these patients.

Although in general, we are in support of the release of this guidance, we take this opportunity to comment on several issues included in the guidance.

General Comments

The guidance is extremely helpful for organizations, such as ours, which represent health service providers. The guidance gives us the opportunity to educate our providers on their existing responsibilities and to provide our members with concrete examples of what the Office of Civil Rights (OCR) will be looking for in terms of compliance. The guidance allows our providers to look at their own programs and affirm their compliance with Title VI and/or to evaluate areas of concern.

The guidance reiterates several times that flexibility will be a guiding principal in enforcing Title VI. According to the guidance, the OCR will make assessments on a case by case basis and will consider several factors in assessing compliance. For service providers, such as our members, flexibility in ensuring compliance with Title VI is extremely important and necessary. It is impossible to derive a universal plan for compliance with Title VI considering the tremendous diversity and differences of almost every service area and the populations within that area. We strongly support the emphasis on flexibility.

- **Factors for Assessment of Meaningful Access (65 Fed. Reg. 52769)**

As mentioned previously, the OCR will make assessments on a case by case basis and will consider several factors in assessing compliance. Safety-net non-profit entities committed to serving all individuals that come to our doors have extremely limited resources to provide for a multitude of challenges. In looking at the totality of a provider's circumstances, we suggest that OCR also look at the kinds of enabling services beyond translation and interpretation that are also necessary to serve an LEP population and look favorably upon those providers that commit resources to these services also. As a relatively poor population other enabling services, such as transportation and weekend/evening hours, maybe just as critical for the LEP population. For example, if a geographically isolated, non-English speaker is unable to reach the door of a provider because of inadequate or non-existent public transportation, meaningful access is clearly unavailable. An LEP individual may not seek the service to begin with if the visit necessitates a loss of a day's pay. Many providers commit already limited resources to provide for the multitude of needs of this population. This kind of commitment must be taken into consideration when looking at the totality of circumstances.

- **Technical Assistance (65 Fed. Reg. 52772)**

The guidance contains a brief section on technical assistance that merely states the availability of such assistance for covered entities. We strongly urge the OCR to elaborate on the kind of technical assistance that is available. Can providers call the OCR and ask for an informal evaluation of their current policies and practices in addressing the needs of LEP individuals? Is the OCR available to do an assessment and provide an analysis of areas of concern as part of an informal process? Are there other materials or publications that OCR has produced to assist providers in complying with Title VI?

- **Federal Financial Participation**

According to a Health Care Financing Administration (HCFA) letter dated August 31, 2000 to all State Medicaid Directors, "under both the SCHIP and Medicaid programs, Federal matching funds are available for States' expenditures related to the provision of oral and written translation administrative activities and services provided for SCHIP or Medicaid recipients." We strongly

urge HCFA and the OCR to further elaborate on how States can secure Federal matching funds for staff interpreters, contract interpreters, or through a telephone service, etc.

We strongly suggest that HCFA insure that States are allowed to use service versus administrative funds to provide linguistic services. The provision of oral interpretation services, particularly within the context of a medical visit, cannot be seen as separate from the medical service being provided and therefore should be a covered benefit. Large immigrant States such as California, Texas, and Florida face tremendous challenges if HCFA considers these services as administrative costs especially within the SCHIP program. Administrative allocations are limited to 10 percent of a State's SCHIP allocation. Since our States have significant LEP SCHIP eligible individuals, our States will have less ability to use Federal funds to assist with the costs of oral and written translation services. The States with the largest LEP needs will have the least ability to address these needs.

In addition to providing guidance to States on securing a Federal match to assist with the costs associated with serving an LEP population, HCFA and the OCR should also specifically encourage States to act on this option.

Once again, we thank the Office of Civil Rights for the long awaited guidance on serving this community.

Sincerely,

Elia V. Gallardo, Esq.
California Primary Care Association



July 20, 2001

Centers for Medicare and Medicaid Services
AKA Health Care Financing Administration
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Attention: HCFA-2006-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

**Re: HCFA-2006-IFC - State Child Health; Revisions to the Regulations
Implementing the State Children's Health Insurance Program.**

To Whom It May Concern:

The California Primary Care Association (CPCA) is writing in response to the CMS' request for comments regarding the above-described regulations, entitled "Revisions to the Regulations Implementing the State Children's Health Insurance Program," and published in the Federal Register on June 25, 2001. While we would like to commend you for the inclusion of SCHIP reporting requirements by race, ethnicity, and gender, we are deeply concerned that the revised rules allow States to require collection of social security numbers for applicants and eliminate SCHIP reporting requirements of primary language data.

CPCA represents the State of California's community, free and migrant health centers. These private, non-profit clinics provided over 1 million health care encounters to persons with limited English proficiency in 1999. Approximately 38 percent of clinic patients are under the age of 20, and for many children in immigrant families, SCHIP is a valuable program that ensures their access to health care. We strongly urge you to prohibit states from requiring social security numbers and to require reporting or primary language data in order to improve SCHIP coverage of eligible immigrant children.

Centers for Medicare and Medicaid Services/
AKA Health Care Financing Administration
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Twenty percent of the nation's children under the age of 18 are immigrants or members of an immigrant family, and a third of them reside in California. Immigrant children are three times more likely to be uninsured and four to five times as likely to lack a regular source of medical care as children in U.S.-born families. For many children, SCHIP coverage is the only way they can receive adequate health care. However, both provisions of allowing states to require social security numbers and of eliminating reporting requirements for primary language data will have an adverse impact on SCHIP's success in reaching immigrant children and their families.

We wish to indicate our support for the comments submitted to you by Families USA, and to make the following specific comments as well.

State Plan Requirements: Eligibility Standards (Section 456.320) – Expanded Use of Social Security Numbers

Allowing states to require social security numbers also has an adverse affect on various categories of immigrants. Experience, especially with the issue of public charge, shows that immigrant communities are wary of applying for public benefits if there is a perceived danger in doing so. Focus groups conducted by the Kaiser Family Foundation found that many participants were afraid of interacting with government programs because they thought it would affect their immigration status or their application for citizenship.

Although many states have endeavored to enroll all eligible children into SCHIP, they have found that children in immigrant families are extremely hard-to-reach. In recognition of the large numbers of uninsured children in the immigrant community, many states have established intensive outreach efforts. Requiring social security numbers would undo much of the successful outreach made to this community and make this population even more difficult to reach, contrary to the goals set by states.

Because of the distrust and fear towards government programs that exists within the immigrant community, requiring states to collect social security numbers, even if only for the applicant, is a strong deterrent to completing the application process. Although parents often prioritize the health care needs of their children above their own, non-citizen parents may be reluctant to enroll their eligible children in SCHIP if they perceive that providing a social security number may jeopardize their or their child's immigration status.

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Annual Reports (Section 457.750) – Primary Language Data Collection

Eliminating the reporting of primary language data also adversely impacts the immigrant community because the lack of this data impedes monitoring, evaluation and assessment of SCHIP and its coverage of immigrant children. Health disparities based on limited English proficiency still exist and translate into greater barriers to the SCHIP program. Families may not be acquainted with the eligibility determination process and have difficulty completing the application with supporting documentation. The process is further complicated by the lack of interpreters to assist in enrollment. According to UCSF Institute for Health Policy Studies, one-quarter of Spanish-speaking Latinos had difficulty understanding the Medi-Cal (CA’s Medicaid) and Healthy Families (CA’s SCHIP) application as compared to 14.2% of non-Latinos.

Primary language data is essential for addressing these barriers to care, targeting outreach strategies, and ensuring equal access to services for all low-income children. In recognition of the importance of ensuring linguistically appropriate services for immigrant children, 40 states currently already collect primary language data and 13 of them do so on their SCHIP applications. Because states are already collecting this data, reporting does not result in significant additional costs or administrative burdens.

We thank you for the opportunity to comment on these proposed regulations, and appreciate your consideration of our concerns. Should you have any questions or comments, please do not hesitate to contact me.

Sincerely,

CALIFORNIA PRIMARY CARE ASSOCIATION

By: _____
Carmela Castellano, Esq.
Chief Executive Officer

STANDARDS

This document establishes three *standards* for cultural and linguistic competence. The three standards address access, quality of care, and quality management. Each standard is followed by several *indicators* of performance that describe what shall happen and by when. While the indicators are not intended to be all-inclusive, they do represent key components that are likely to contribute to attainment of each standard. Subsequently, each indicator is followed by *measures* that describe how compliance with indicators will be determined.

Consistent with the philosophy that attaining cultural and linguistic competence is an ongoing, developmental process, there are some indicators that are required to be in place on the day that MHPs begin operation under Phase II consolidation. There are other indicators, however, that will require additional time for development and implementation. MHPs are expected to address each indicator that is required to be in place beginning on the plan implementation date in their Cultural Competence Plan submission due July 1, 1998. On that date, MHPs are expected to begin to operationalize plans to meet the standards and remaining indicators.

I. ACCESS

Standard:

MHPs shall demonstrate evidence of medically necessary culturally and linguistically accessible services under the consolidation of Medi-Cal specialty mental health services.

A. Language Accessibility

Indicators:

1. MHPs have a 24-hour phone line with statewide toll-free access that has linguistic capability for all Medi-Cal beneficiaries beginning on the plan implementation date.

Measure:

- a. Evidence of operation of a 24-hour phone line with statewide toll free access that has language capabilities for all Medi-Cal beneficiaries.
2. MHPs have identified populations meeting the threshold language requirement of 3,000 beneficiaries, or five (5) percent, of the Medi-Cal beneficiary population, whichever is lower, whose primary language is other than English, prior to the plan implementation date. (Note: DMH has provided to MHPs data on primary language obtained from the 1990 Decennial Census.)

Measure:

- a. Identification of threshold languages for the MHPs total service area which is defined as the county.

Appendix 12

3. MHPs have policies and procedures for meeting consumer language needs beginning on the plan implementation date.

Measures:

- a. Documented evidence of policies and procedures for meeting consumer language needs.
- b. Documented evidence of training on the use of bilingual staff or interpreters, including the core curriculum and training programs and how bilingual staff and interpreters will be utilized.

4. MHPs have at least interpreters available for the threshold languages at mandated key points of contact beginning on the plan implementation date.

Measures:

- a. Evidence of at least interpreters for the threshold languages at mandated key points of contact.
- b. Documented evidence of ethnic consumer access to staff or interpreters who are linguistically proficient in threshold languages at mandated key points of contact.
- c. Evidence of, or plans for, providing contract or agency staff who are linguistically proficient in threshold languages during regular day operating hours, at mandated key points of contact.
- d. Document what services are available for ethnic Medi-Cal beneficiaries in their primary language, and record the response to the offer of interpreter.

5. MHPs have policies and procedures and the capability to refer and otherwise link Medi-Cal beneficiaries who do not meet the threshold language criteria who encounter the mental health system at a mandated key point of contact, with appropriate services, on the beginning date of plan implementation.

Measures:

- a. Documented evidence that Medi-Cal beneficiaries who do not meet the threshold language criteria are assisted to secure or linked to appropriate services.
- b. Document the progressive steps to assist ethnic Medi-Cal beneficiaries to obtain services in their primary language, i.e., if linguistically proficient staff or interpreters are unavailable.

6. MHPs have policies and procedures and the capability to link Medi-Cal beneficiaries who encounter the mental health system at a non-mandated key point of contact, with appropriate services, beginning on the plan implementation date.

Measures:

- a. Documented evidence that Medi-Cal beneficiaries (both who meet or do not meet the threshold language criteria) are assisted to secure or linked to appropriate services.
- b. Document the progressive steps to assist ethnic Medi-Cal beneficiaries to obtain services in their primary language, i.e., if linguistically proficient staff or interpreters are unavailable.

B. Written Materials Should Be Available and Understandable

Indicators:

1. MHPs have available culturally and linguistically appropriate written information for identified

threshold languages that assist Medi-Cal beneficiaries in accessing medically necessary specialty mental health services beginning on the plan implementation date.

Measure:

- a. Demonstrate the availability in threshold languages of general program literature used by the MHP to assist Medi-Cal beneficiaries access medically necessary specialty mental health services. The literature shall be at the appropriate literary level to reflect the population to be served. General program literature includes member service handbook or brochure, general correspondence, beneficiary problem resolution and fair hearing materials, beneficiary satisfaction surveys, orientation and community and health education materials.
2. MHPs have field tested the written information specified under #1 above within 180 days post plan implementation.

Measure:

- a. Evidence of field testing of the specified information and appropriate modification of the materials as indicated by the field test(s).
3. MHPs have policies and procedures for the utilization and distribution of translated materials that assure availability to Medi-Cal beneficiaries beginning on the plan implementation date.

Measure:

- a. Evidence of policies and procedures to appropriately distribute and utilize translated materials.
4. MHPs have included communication with consumers in a threshold language in consumer satisfaction surveys within 180 days post plan implementation.

Measure:

- a. At least 75 percent of Medi-Cal mental health clients in a threshold language responding to consumer satisfaction surveys shall indicate that they had access to written information in their primary language.

C. Responsiveness of Specialty Mental Health Services

Indicators:

1. MHPs have available, as appropriate or feasible, alternatives and options that accommodate individual preference and cultural and linguistic differences (Ongoing).

Measures:

- a. A listing of available cultural/linguistic services and practitioners for populations meeting the threshold language(s) within 180 days post plan implementation.
- b. Compare the percentages of culturally, ethnically and linguistically diverse professional staff to the same characteristics of the Medi-Cal beneficiary population within 180 days post plan implementation.
- c. A list and definition of available and appropriate alternatives and options to accommodate individual preference and cultural and linguistic differences within 180 days post plan implementation (Ongoing)

Appendix 12

- d. Monitor objectives identified in the plan under "c" above (Ongoing)
2. MHPs have available program options in the system that include culture-specific MHP and community providers and programs (Ongoing)
Measures:
 - e. Identification, and the number, of culture-specific community providers and services (as well as their specialized skills) evidenced in the range of programs offered by the MHP within 180 days post plan implementation.
3. MHPs have policies, procedures and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services beginning on the plan implementation date.
Measures:
 - a. Evidence of a community information and education plans that enable Medi-Cal beneficiaries to access specialty mental health services.
 - b. Evidence of informing ethnic consumers regarding the availability of cultural and linguistic services and programs e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.
4. MHPs have assessed factors and developed plans to facilitate the ease with which culturally diverse populations can obtain services, within 180 days post plan implementation. Such factors should include:
 - location, transportation, hours of operation or other relevant areas;
 - adapting physical facilities to be comfortable and inviting to persons of diverse cultural backgrounds; and
 - locating facilities in settings that are non-threatening, including co-location of services and /or partnerships with community groups.**Measures:**
 - a. Evidence of a study or analysis of the above factors.

II. QUALITY OF CARE

Standard:

To ensure that accurate and appropriate clinical decisions are made relative to the consumers' concerns and that appropriate treatment and referral decisions are the result.

A. Consumer and Family Role in Service Development

Indicator:

1. MHPs have policies, procedures and practices that ensure that all consumers participate in the development of their medically necessary specialty mental health treatment services, beginning on

the plan implementation date. Parents, family members and other advocates can be included in this process as selected by the adult consumer.

Measures:

- a. Evidence of policies, procedures and practices that assure the involvement of consumers and families in mental health treatment services.
- b. Clinical records will indicate consumers and/or family involvement, by ethnicity and primary language.

B. Competent Evaluation, Diagnosis, Treatment and Referral Services

Indicators:

1. MHPs have policies and procedures that contain requirements to assure that culturally and linguistically competent medically necessary services are available to meet the needs identified in the MHPs Population Assessment and Organizational and Service Provider Assessment. (Ongoing)

Measures:

- a. Evidence that MHP policies and procedures contain appropriate requirements to assure the delivery of competent mental health services.
 - b. MHP contracts for services will ensure an appropriate array of providers.
2. MHPs have policies, procedures and practices to assure that consumer requests to use culture-specific community providers, who are credentialed as network providers to render medically necessary specialty mental health services that are reimbursable under Medi-Cal, will be honored when feasible, within 180 days post plan implementation.

Measures:

- a. Evidence that records identify consumer requests for culture-specific community providers, number actually referred to such providers, and the number receiving services from the available culture-specific community providers.
 - b. Availability of a listing of service providers available to provide culture-specific services within 180 days post plan implementation.
 - c. When appropriate, records indicate cross-cultural instruments are used in the diagnosis, evaluation/assessment, treatment and referral process.
3. MHPs have a process to certify or otherwise ensure that staff are able to provide culturally competent medically necessary specialty mental health services for Medi-Cal beneficiaries under consolidation of specialty mental health services. (Ongoing)

Measures:

- a. Evidence that MHPs are working toward a process to evaluate the competencies of staff in providing culturally competent specialty mental health services.
- b. Evidence that MHPs are considering staff training needs to ensure the provision of culturally competent evaluation, diagnosis, treatment and referral services for the multicultural groups in their service area.

Appendix 12

4. MHPs have a process to certify or otherwise assure the demonstrated ability of bilingual staff or interpreters to address the following cultural competency issues:
 - Ability to communicate the ideas, concerns, and rationales, in addition to the translation of the words used by both the provider and consumer.
 - Familiarity with the consumer's culture and degree of proficiency in the consumer's spoken, as well as non-verbal, communication.
 - Familiarity with divergent world views and variant beliefs concerning the definition, presentation and clusters of symptoms, causal explanations and treatment of mental illness, as well as the risk that deviant behavior presents to the indigenous community. (Ongoing)

Measures:

- a. Existence of, or plan to develop, core curriculum or training programs within 180 days post plan implementation.
 - b. Implement core curriculum or training program plan ("a" above) within one year post plan implementation.
5. Evidence of trained staff and interpreters who are linguistically proficient in threshold languages within 180 days post plan implementation.

Measures:

- a. Existence of, or plans for evaluating the linguistic proficiency and training of staff and interpreters.
- b. Existence of policies that comply with Title VI requirements prohibiting the expectation that family members provide interpreter services.

III. QUALITY MANAGEMENT

Standard:

To assess the access, appropriateness and outcomes of services delivered by the MHP under the consolidation of Medi-Cal specialty mental health services.

A. Utilization

Indicator:

1. Persons of diverse ethnic background access the service system in numbers consistent with their representation in the Medi-Cal beneficiary population and relevant incidence and prevalence data. (Ongoing)

Measures:

- a. Track utilization rates by ethnic group.
- b. Compare utilization rates across ethnic groups.
- c. Compare utilization rates by ethnic group to the Medi-Cal beneficiary population.
- d. Analyze utilization rates by factors including age, diagnosis, gender, ethnicity, and primary language of Medi-Cal mental health clients to identify potential problem areas.

B. Outcome of Service

Indicator:

1. Specialty mental health services are rendered by staff who are culturally competent and linguistically proficient to meet the needs of the population(s) served. (Ongoing)

Measures:

- a. A description of methods and approaches which are designed to obtain consumer satisfaction responses from Medi-Cal beneficiaries from ethnically and linguistically diverse backgrounds.
- b. Records indicate the level of satisfaction experienced by ethnically diverse consumers will be equivalent to that of service recipients in general.
- c. Factors contributing to access (as identified above) will show similar patterns of consumer satisfaction among ethnic group recipients in general.
- d. Outcomes achieved for ethnically diverse communities will be equivalent to that of the service recipients in general.

C. Continuous Quality Improvement (CQI) Plan

Indicator:

1. MHPs have addressed issues of cultural competence and linguistic proficiency in their approved CQI plan required in the general consolidation plan requirements within one year of plan implementation.

Measures:

- a. Evidence of incorporation of issues of cultural competence and linguistic proficiency in CQI plans.
- b. Evidence of progress in achieving objectives related to cultural competence and linguistic proficiency within the CQI plan.