

Language Equity Guide



Advancing health equity through sharing of information and resources for health professionals and other service providers to learn more about culturally and linguistically appropriate services

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We envision a nation free of health disparities in health and healthcare

Dear Community Partner,

Complying with language, cultural, and health literacy policies is an important first step to effective communication when providing health and other essential services. But compliance can be challenging. The National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards, or CLAS) provides the framework for all health organizations to best serve the nation's diverse communities (HHS, 2015). However, going beyond compliance is increasingly critical as our population becomes more diverse. Recognizing this, members from the Region X Health Equity Council came together to create a resource for "*raising the bar*" on Culturally Linguistically Appropriate Service Standards (CLAS).

The Region X Health Equity Council (RHEC X) is a council formed in 2011 as a result of efforts through Health and Human Services National Partnership for Action to End Health Disparities (NPA). It is voluntary group made up of health equity leaders in Oregon, Idaho, Washington and Alaska. In 2019, RHEC X renamed itself the Pacific Northwest Regional Health Equity Council (PNW RHEC) and it continues the work started by RHEC X and the NPA. This Language Equity Guide is one of these efforts.

You and your organization can positively impact health by using this resource for health professionals and other service providers. We invite you to:

1. First view the short animated video (<https://www.pnwhealthequity.com/resources>) as an introduction and to become acquainted with the guide and tips on how best to use it.
2. Use this guide to learn more about and apply culturally and linguistically appropriate standards with the people you serve.
3. Help make this guide a great success by sharing it with colleagues and those on your contact list. This will assure that thousands of our most under served community members receive culturally and linguistically appropriate education, services and advocacy as we all work towards a more equitable system throughout the United States.

If you have questions or would like more information visit our website at www.pnwhealthequity.com or e-mail us at: PNWhealthequity@gmail.com.



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Terminology: About a Term for Non-English Speakers

People who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English are often called “Limited English Proficient”, or “LEP”. Below, in alphabetical order, are the terms which states and institutions have used over time:

- Bilingual Students (BS)
- Emerging Bilingual Students (EBS)
- English for Speakers of Other languages (ESOL)
- English Language Learners (ELL)
- English Learners (EL)
- English as a Foreign Language (EFL)
- English as a Second Language (ESL)
- Language Minority Students (LMS)
- Limited English Fluent (LEF)
- Limited English Speakers (LES)

- Limited English Students (LES)
- People whose Home Language is Other Than English (PHLOTE)
- Non-English Language Background (NELB)
- Non-English Proficient (NEP)
- Non-Native English Speakers (NNES)
- Linguistically and Culturally Diverse (LCD)
- Second Language Learners (SLL)
- Second Language Speakers (SLS)

Limited English Proficiency (LEP) and similar terms such as Limited English Speakers (LES) and Non-English Proficient (NEP) are often used when addressing language access and its lack thereof. We recognize that LEP is the term used for Title VI and therefore has legal meaning and compliance. In addition, we recognize that LEP also describes a limitation in the level of English language skills. This helps to clarify why people with LEP may experience barriers to inclusion and access to health care.

At the same time, we recognize that using the term “LEP” is deficit based and negative. James Crawford of the Institute for Language and Education Policy states there is an increased effort to refer to learners of English in a more positive way rather than in a negative or deficit-based way. Some educators already prefer using “English Learner”, while usage varies based on audience and context.

In this guide, we have made a deliberate choice to use “English Language Learner” (ELL). We made this choice to be consistent with our asset-based advocacy for new national standards for language equity that take us beyond the Culturally and Linguistically Appropriate Services (CLAS) Standards. We have chosen this in place of “Limited English Proficiency” (LEP) or any other deficit-based term.

Professionals in the field concur that most English Language Learners already speak, read, and or write at least one other language prior to learning English. In line with that, we advocate for using a term that is more linguistically pragmatic, asset based, culturally sensitive, and socially inclusive—and, therefore, more positive— to identify people in the United States who have a limited proficiency in English. So we will use “English Language Learner (ELL)” throughout this guide with the exception of citations with the term “LEP”.



Glossary

Affordable Care and Patient Protection Act (ACA) Section 1557 “Ensuring Meaningful Access for Individuals with Limited English Proficiency”

This provision of the ACA states that people cannot be subject to discrimination based on their race, color, national origin, sex, age, or disability. Section 1557 enhances language assistance for people with limited English proficiency and helps ensure effective communication for individuals with disabilities. An implementation requirement of 1557 requires health programs and activities receiving funding from the Department of Health and Human Services (HHS), or administered by HHS, or by Health Insurance Marketplaces and all plans that participate in Health Insurance Marketplaces, to post notices of nondiscrimination and tag lines that English language learners (ELLs) that language assistance services are available to them. These notices must be made available in at least the top 15 languages spoken by ELLs in the relevant state or states.

Community health workers (Promotores de salud)

Similar to patient navigators (see below), health advocates, and community health representatives, these are primary members of communities and cultures who are informed about the healthcare system as well as of a particular culture itself. They help patients negotiate through unfamiliar healthcare systems. They coordinate services, assist with patient-to-provider communications, and resolve access issues that might otherwise delay care.

Cultural and linguistic competence

The ability of healthcare providers and healthcare organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the healthcare encounter. Cultural and linguistic

dynamics of difference, acquire and institutionalize cultural knowledge; and adapt to diversity and the cultural contexts of individuals and communities served.

English language learners (ELL)

A term used in place of limited English proficiency (LEP), limited English speakers (LES), non-English proficient (NEP), and similar terms. The preference for the term ELL is derived from the knowledge that most English language learners already speak, read, and/or write at least one other language prior to learning English. Hence, ELL is more linguistically pragmatic, asset based, culturally sensitive, and socially inclusive—and, therefore, is perceived as a more positive way to identify people in the US who have a limited proficiency in English. Note, however, that the term LEP has legal meaning for Title VI.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency” Requires federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency, and develop and implement a system to provide those services so LEP persons can have meaningful access to them. The executive order also requires that the federal agencies work to ensure that recipients of federal financial assistance provide meaningful access to their LEP applicants and beneficiaries.

Field-testing (also known as “user-testing”)

Involves conducting interviews or holding focus groups with speakers of a given language. Given that most languages have variations of language and dialects, it is important to have a representation of individuals speaking the specific language that accurately reflects the ratio of a particular country of origin or ancestry. For instance, if you were going to have 100 Spanish speakers across the US review a health product or service, you would need to interview 64 people of Mexican origin or descent, nine Puerto Ricans, four Cubans or Cuban Americans, four Salvadorans, three Dominicans, two Guatemalans, etc. This honors and reflects the ratio of country of origin or ancestry of Spanish speakers in the US.

Health disparities

Health disparities exist when a health outcome is seen to a greater or lesser extent between populations. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual’s ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations (Healthy People, 2020).

Health equity

Exists when all people have full and equal access to opportunities that allow them to lead healthy lives. Requires identifying health disparities for different groups and populations and then identifying steps to address and, ideally, eliminate these disparities.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Privacy Rule of HIPAA is to ensure that a person’s health information is properly protected while allowing the flow of health information needed to provide and promote high-quality health care and to protect the public’s health and well-being. Effective April 14, 2003, the Privacy Rule limits the ways in which protected health information about people can be used or disclosed. Where use of disclosure is permitted, a written agreement that contains the required privacy language detailing the limits of the use or disclosure is required.

Health Literacy

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (National Academy of Medicine).

Healthy People 2020

The fourth generation of an HHS initiative with a set of goals and objectives designed to guide national health promotion and disease prevention efforts to improve the health of all people in the US. Four overarching goals are: (1) to attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) to achieve health equity, eliminate disparities, and improve the health of all groups; (3) to create social and physical environments that promote good health for all; and (4) to promote quality of life, healthy development, and healthy behaviors across all life stages. This iteration of Healthy People tracks approximately 1,200 objectives organized into two public health topic areas.

Indian Health Service (IHS)

An agency within HHS that addresses healthcare disparities and bridges the social and political gap among American Indians and Alaska Natives by facilitating comprehensive healthcare services and access to health care. This agency looks at social and political factors—including culture, geographic isolation, poor sewage removal disposal, and poverty—that affect these groups.

Informed consent

Permission granted in the knowledge of the possible consequences, typically that which is given by a patient to a doctor for treatment with full knowledge of the possible risks and benefits. To provide consent, patient must possess not only legal competence but a reasonable amount of knowledge or understanding about the proposed treatment or service. Patients who do not fully understand the language in which information is provided do not possess a reasonable amount of knowledge about their care.

In-person assister

An individual trained to help people sign up for health insurance in their own language.

Legal liability

When adverse health outcomes occur as a result of communication issues, providers and organizations are at risk for legal liability, defined as “legal responsibility for one’s acts or omissions.” A few examples of liability are breach of contract, negligence, and intentional tort.

Limited English Proficiency (LEP) Federal Inter-agency Website

www.lep.gov aims to promote “a positive and cooperative understanding of the importance of language access to federally conducted and federally assisted programs” (LEP, 2015). Links provide information, tools, and technical assistance (on both the federal and state levels) regarding “limited English proficiency and language services for federal agencies, recipients of federal funds, users of federal programs and federally assisted programs, and other stakeholders.”

Linguistic competence (also see cultural competence)

Providing readily available, culturally appropriate oral and written language services to ELL members through such means as bilingual/bi-cultural staff, trained medical interpreters, and qualified translators (Agency for Healthcare Research and Quality).

Linguistic isolation

Refers to households in which all of the members 14 and over speak a language other than English and none of them can speak English very well.

Literacy

The ability to read, write, speak, listen, and view in order to communicate with others effectively. Literacy is also the ability to think and respond critically in a wide variety of complex settings.

National Healthcare Disparities Report (2015)

This AHRQ annual report concluded that overall disparities in healthcare quality and access remained unchanged or worsened for poor and racial/ethnic minority populations. The report cited continued or widening gaps for specific health outcomes such as immunization rates, HIV/AIDS diagnoses, and prenatal care. In addition, the report concluded that the rate of foreign-born residents without health insurance has more than doubled compared with that of native-born populations. Lack of health insurance was noted as a persistent major barrier to eliminating health disparities (Agency for Health Care Research and Quality).

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Aim to improve healthcare quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. The principal standard is to: (1) provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred language, health literacy, and other communication needs.

The *governance, leadership, and workforce standard* is to: (2) advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources; (3) recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area; and (4) educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

The *communication and language assistance standard* is to: (5) offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services; (6) inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing; (7) ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided; and (8) provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

The *engagement, continuous improvement, and accountability standard* is to (9) establish culturally and linguistically appropriate goals, policies, and management accountability, and to infuse them throughout the organizations' planning and operations; (10) conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities; (11) collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery; (12) conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area; (13) partner

with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness; (14) create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints; and (15) communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (Office of Minority Health)

Negligence

The failure to comply with established standards for the protection of others; departure from the conduct expected of a reasonably prudent person acting under the same or similar circumstances. Failure to provide adequate interpretation and translation services has served as the claim of medical negligence in many legal battles between patients or their families and providers.

Patient navigator

Person who helps guide a patient through the healthcare system. This includes help going through the screening, diagnosis, treatment, and follow-up of a medical condition, such as cancer. A patient navigator helps patients communicate with their healthcare providers so they get the information they need to make decisions about their care. Patient navigators may also help patients set up appointments for doctor visits and medical tests

and get financial, legal, and social support. They may also work with insurance companies, employers, case managers, lawyers, and others who may have an effect on a patient's healthcare needs. Also called patient advocate.

Plain language adaptation

Making materials easy to read and understand, clear, concise, and well-organized. It is also an approach for communicating in a way that fits the needs, interests, and abilities of the intended audience. Plain language can be used in all forms of communication—oral, print, web, multimedia, and social media. The recommended reading grade level for health materials for the general public in the US is 6th grade.

Plain Writing Act of 2010

This Obama legislation requires all federal agencies to write plainly when they communicate with the public. The US Department of Health and Human Services (HHS) has continued efforts to maintain and upgrade a consistent use of plain writing through ongoing compliance, communication, tracking, and training.

Qualified interpreter

Trained, qualified, and certified professionals need to be the ones to offer language interpretation and translation. Professional translation includes translation by a trained professional, with review and check by a second professional. Both translators discuss any discrepancy and come to agreement on accurate translation to arrive at the final version. For compliance with Section 1557 of the Affordable Care Act (ACA), healthcare could consider healthcare and medical interpreters with the following qualifications: (1) Adherence to ethical standards, such as client confidentiality; (2) formal training and testing; and professional recognition.

A qualified interpreter demonstrates proficiency in speaking and understanding both spoken English and at least one other spoken language and can interpret effectively, accurately, and impartially with ELL individuals in their primary language using any necessary specialized vocabulary and phraseology. (<https://telelanguage.com/qualified-interpreter-section-1557/>)

Social determinants of health (SDoH)

These are the conditions in the places where people live, learn, work, worship, play, and age; and they affect a wide range of health risks and outcomes. SDoH include housing, access to services, religion, employment, education, sexual orientation and gender identity, age, language, transportation, and national origin.

Title VI of the Civil Rights Act of 1964 (also known as “National Origin Discrimination Against Persons with Limited English Proficiency”)

Title VI prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal funds or other federal financial assistance. Programs that receive federal funds cannot distinguish among individuals on the basis of race, color or national origin, either directly or indirectly, in the types, quantity, quality or timeliness of program services, aids or benefits that they provide or the manner in which they provide them.

User-testing (see “Field-testing”)



Chapter 1: Introduction

Defining Health Literacy

Health literacy, as defined by the Institute of Medicine (IOM), is the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” The increase in the number of non-English speakers in the United States makes “health literacy, health equity, and health disparities connected, both in practice and in research” (Logan et al., p.1). Health literacy also has become the focus of unprecedented attention from government officials, hospitals, and insurers who regard it as an inseparable link to implementing overhaul of the Affordable Health Care Act (ACA), controlling medical costs, and achieving health equity.

Language Barriers and Challenges Related to Health Illiteracy

Aminatou is a Somali immigrant who needs insulin. A mother of five, she was discharged from the hospital with instructions to maintain a healthy diet and control blood sugar levels. However, because she could not understand English, Aminatou could not follow the instructions. She returned to the emergency department in critical condition due to complications made worse by her inability to understand English.

Ibrahim from Iraq was recently diagnosed with chronic high blood pressure and high cholesterol. He was prescribed the proper medications. Labels on the bottles require regular doctor follow-up for blood work before the prescriptions expire. Since he was not able to read and follow instructions in English, Ibrahim failed to contact his doctor for over a year. This resulted in permanent kidney damage.



These are just two examples of frequent miscommunication that is widespread in the immigrant communities of Oregon, Washington, Alaska, and Idaho. They illustrate one of the most pervasive and under-recognized problems in medicine: Immigrants' low levels of health literacy, accompanied by distrust, lead to disparities in patient access and care for non-English speakers. Historically, people have gone to their healthcare providers to receive credible health information; such visits provide an opportunity for exchange between a patient and a healthcare professional. Yet, this method has challenges related to health literacy (Schillinger, Bindman,

Wang, Stewart, & Piette, 2004). Health information is now widely available via the Internet. Even so, people who are less educated, have less money, and are "racial and ethnic" minorities are more likely to have inadequate health literacy (Paasche-Orlow & Wolf, 2007). They often do not have regular access to the Internet and continue to receive most of their health information from healthcare providers they may not trust.

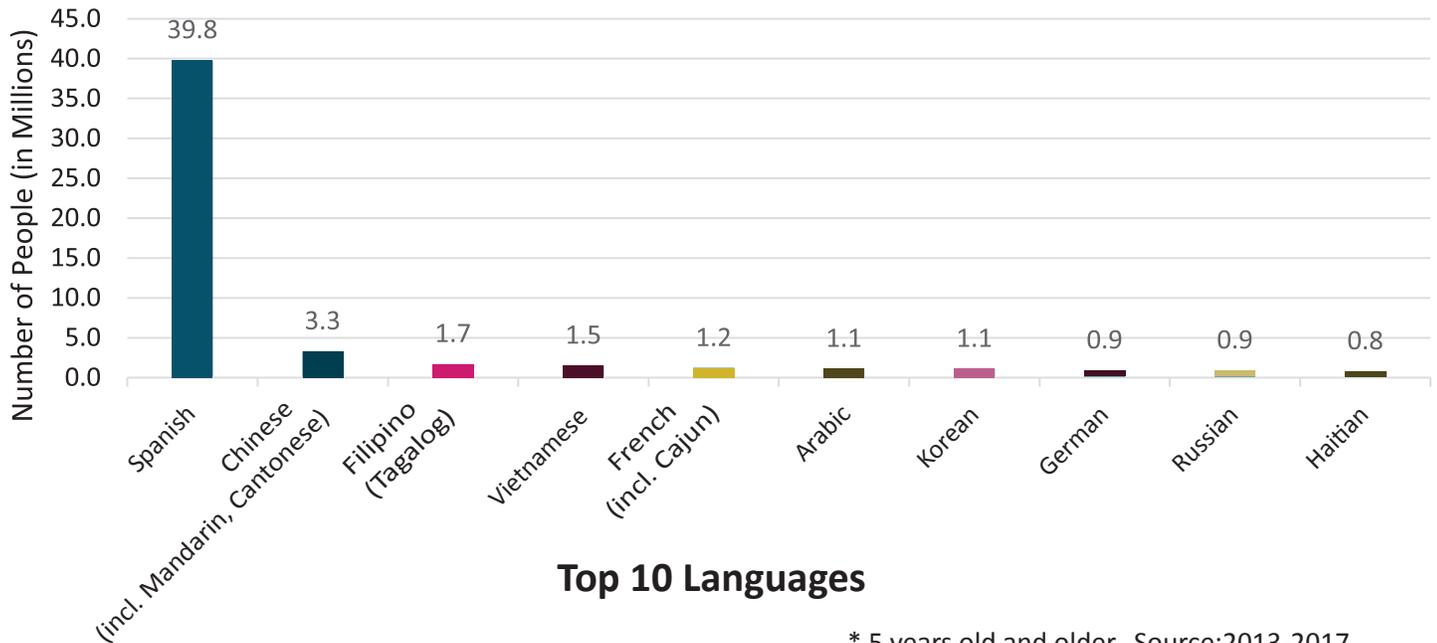
One of the most difficult challenges healthcare providers face is how to gain the trust of their patients with low health literacy. When the providers of age, ethnic background, education, and socio-economic status are different from those of the patient, the patient may not feel comfortable asking questions or disclosing personal health information. Other immigrants have failed to communicate to doctors their symptoms related to schizophrenia and sexually transmittable diseases such as HIV due to fear of the stigma attached to their conditions. Because they are embarrassed or do not want to challenge the provider, many patients work hard to hide the fact that they do not understand. (Barrett & Sheen Puryear, 2006). Many often do not see the same provider each time they seek care. This makes it even more challenging to develop and maintain trust-based relationships. Time often is in short supply during medical interviews and exams. In these cases, it is difficult for providers to determine what the patient does not understand and to adequately address this knowledge gap. Although much has been done to clarify the challenges, a disconnect remains between these research findings and best practices in healthcare organizations.

Demographics

The 2013 US Census Bureau data show that the number of people who speak a language other than English at home reached an all-time high of 61.8 million—up 2.2 million since 2010. The largest increases from 2010 to 2013 were for speakers of Spanish (up 1.4 million; 4 percent growth), Chinese (up 220,000; 8 percent growth), Arabic (up 188,000; 22 percent growth), and Urdu – the national language of Pakistan (up 50,000; 13 percent growth).

Figure 1 below shows the number of people in the U.S., 5 years old and older, who speak languages other than English at home. This data reflect languages with over 1 million speakers and comes from the 2013-2017 American Community Survey 5-Year Estimates.

Figure 1. Number of People in the U.S. Who Speak a Language Other than English at Home



* 5 years old and older. Source: 2013-2017 American Community Survey 5-Year Estimates.

Not all who speak a foreign language at home are immigrants. Of the nearly 62-million foreign-language speakers, 44 percent (27.2 million) were born in the US.

According to the US Census Bureau, more than 23 million Americans speak English less than “very well” and thus have limited English proficiency; this includes 10.5 million native-born and naturalized citizens and up to 4.2 million documented immigrants.

According to Census Bureau data from 2010 to 2013 on foreign-language speakers, Washington was up 60 percent, Idaho was up 47 percent, and Oregon was up 42 percent among states with the largest percentage increase.

Socioeconomic Factors and Health Literacy

Health literacy is an important predictor of health outcomes, as are socioeconomic status, education, gender, and age. Persons with inadequate health literacy have poorer health regardless of the illness in question (DeWalt, Berkman, Sheridan, Lohr, & Pignone, 2004). Inadequate health literacy is more prevalent among minorities, persons with lower education, and persons with chronic diseases (DeWalt et al.). The consequences for people with low to moderate healthcare literacy skills include higher medical costs due to more medication and treatment errors, more frequent hospitalizations, longer hospital stays, more visits to their healthcare



providers, and a lack of necessary skills to obtain needed services (DeWalt et al.). Access to translation and other language services is essential to ensuring that one's language does not negatively affect health or mortality. When people encounter language barriers in attempting to use the healthcare system, they are not likely to obtain and understand basic health information. Inadequate health literacy is associated with poorer self-management skills, lower use of preventive services, less knowledge among patients with chronic diseases, and higher mortality (DeWalt et al.). In the healthcare system, where complex medical terminology and

legal documents leave many English speakers confused or misinformed, language barriers only worsen the problem.

For English Language Learners (ELLs), the lack of language facility threatens access and quality of care. For example, non-English-speaking patients are less likely than English speakers to use primary and preventive care and public health services. They are also more likely to use emergency rooms (ERs). Once at an ER, such people receive far fewer services than do English-speaking patients.

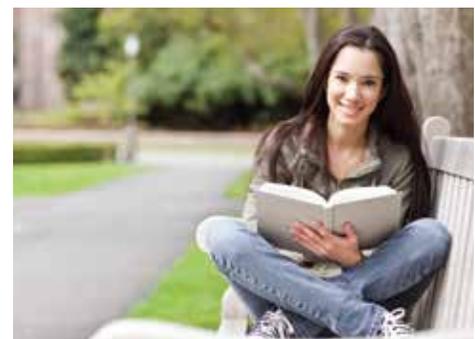
Legal Mandate

The 1964 Civil Rights Act continues to be the single most important basis for ensuring English Language Learners (ELL) receive language assistance services. Since that legislation was passed, linguistic diversity in the US has grown rapidly, with more than 200 different languages now spoken across the country. With this increased diversity comes increased pressure—including new legal requirements—on healthcare systems and clinicians to ensure equal treatment of limited-English speakers.

President Obama signed the Plain Writing Act in 2010 requiring all federal agencies to write plainly when they communicate with the public. The US Department of Health and Human Services (HHS) has continued efforts to maintain and upgrade a consistent use of plain writing through ongoing compliance, communication, tracking, and training.

The Centers for Disease Control and Prevention (CDC) reinforces compliance with the Plain Writing Act through coordination of plain language activities and an agency operational policy. The Agency for Toxic Substances and Disease Registry (ATSDR) Health Literacy Council (HLC), with representatives from across CDC, meets regularly to develop guidance to help centers, institutes, and offices (CIO) comply with the Plain Writing Act and with the CDC Action Plan to Improve Health Literacy.

The healthcare system can meet the needs of ELLs by recognizing that competent language services are essential to ensuring that all patients receive the same quality of care. The system must demand, as a matter of professional ethics, that healthcare providers comply with existing federal and state requirements to ensure language access.



Initiatives to Ensure Language Access in Washington, Alaska, and Idaho

Washington

Washington was the first state to establish a healthcare interpreter certification program. In the 1980s and early 1990s, its Department of Social and Health Services (DSHS) entered into an agreement with the Office for Civil Rights to ensure that ELL clients received equal access to DSHS services. As a result, the Language Interpreter Services and Translations (LIST) was formed in 1991 with the purpose of overseeing language testing and certification of department bilingual staff, contracted interpreters, and translators. A 2008 scan of health literacy activities conducted by the Washington State Governor’s Interagency Council on Health Disparities reported the following resources:

- The Washington State Health Care Authority partnered with the University of California Los Angeles (UCLA) School of Management to provide grant funding to Head Start, Early Childhood Education, and Assistance Programs and qualifying community clinics to improve health literacy. The Health Literacy Pilot Program aimed to reach 6,800 families through 18 sites in 13 counties. Training was given on how to make informed decisions about their children’s health; this included when to go to the emergency room and how to take care of common illnesses. A train-the-trainer session for 83 participants was held in May 2008, with parent trainings held in fall 2008.
- The Puget Sound Health Alliance (PSHA) launched a health literacy initiative that focuses on four areas:
 - (1) Develop a website clearinghouse with health literacy information and tools;
 - (2) Support libraries to better meet the health literacy needs of their communities;
 - (3) Provide tools and resources to help doctors and other healthcare providers communicate more effectively with their patients; and
 - (4) Identify opportunities to work with patient navigators and other trusted sources to provide consumer- friendly health information and other tools to enable patients to take a more active role in their health and self-care.

As part of this initiative, PSHA surveyed librarians in Seattle and in King, Pierce, Snohomish, and Thurston counties. Then, the Alliance met with library representatives to discuss the results. About 75 percent of about 250 librarians who responded to the survey indicated that they receive requests for health information “often” or “very often”. In response to the survey and follow-up discussions, the Alliance launched a three- month “Prescription for Health Information” pilot. The aims of the pilot are to:

- (1) Raise awareness and use of library health information resources;
 - (2) Support librarians in responding to health information needs; and
 - (3) Support patients in taking a more proactive role in their own health.
- According to its website, the University of Washington Medical Center has produced a guide to health literacy for clinicians: <http://depts.washington.edu/pfes/PDFs/Patient%20Health%20Literacy.pdf>. There are a number of adult basic education, adult literacy, and family literacy programs throughout Washington State, many of which incorporate health literacy into their curricula to varying degrees. The State Board for Community and Technical Colleges (SBCTC) funds and supports literacy services at community and technical colleges and community-based organizations, and it provides guidance on incorporating health literacy into many of these programs. Health literacy resources for instructors are available on the SBCTC website at www.sbctc.ctc.edu/college/_eabepds_teachersresources.aspx.

- Community health workers (CHWs), promotores de salud, and patient navigators are primary members of communities and cultures who are informed about the healthcare system as well as the culture itself. They help patients negotiate through the unfamiliar system. They coordinate services, assist patient-to-provider communications, and resolve access issues that might otherwise delay care. There are currently a number of CHW, promotores de salud, and patient navigator programs in Washington, each with different goals, activities, and target populations. The WA State CHW/Promotores Network first began in 2003 with the goal of helping to eliminate health disparities mainly with the Spanish-speaking community. This was through a formal partnership with the Northwest Regional Primary Care Association and the Washington Association of Community and Migrant Health Centers.
- The Cross Cultural Health Care Program (CCHCP) recently has completed an analysis of existing patient navigator programs which documents current practices and successful strategies. CCHCP will use this assessment to form the foundation for a patient navigator curriculum. The Health and Recovery Services Administration of the Department of Social and Health Services has an initiative to create patient navigator programs for Medicaid clients. It has selected four successful bidders from among 14 applicants. The Washington navigator programs will be among the first in the nation for Medicaid clients.

Oregon

- In 2006, in response to a legislative mandate, the Oregon Office of Multicultural Health released Standards for Registration, Qualification and Certification of Health Care Interpreters.
- The Oregon Primary Care Association featured the Reach Out and Read program at its Spring Symposium in April 2013. The organization hopes to “weave health literacy into their Patient Centered Medical Home fully, along with motivational interviewing and other core skills”. (www.orpca.org/component/jevents/icalrepeat_detail/).
- In 2013, the Oregon Health Authority’s Office of Equity and Inclusion sponsored a webinar on health-literate organizations for the 17 new coordinated care organizations in the state.
- Legacy Health is a non-profit health system composed of six hospitals and many clinics. Participants reported that Legacy hosted the only health literacy conference in Oregon and Washington. In 2013, the conference had 500 registrants from 81 organizations (www.legacyhealth.org/en/our-legacy/legacy-values/healthliteracy/making-it-clear-conference.aspx). Annual conferences are ongoing. In addition, Legacy is “moving forward with a system-wide senior management authorized health literacy initiative to become a health literate culture/organization”. Beyond the Legacy Health system, the organization is “reaching out to the community to improve health literacy and reduce disparities for communities most at risk by providing a \$170,000 grant to a safety-net clinic serving primarily Hispanic patients to improve the health literacy communication with their patients”. Wallace Medical Concern and Legacy Health launched a three- year health literacy project in the Rockwood Multi-Service Center, a hotspot hub serving the Portland metropolitan area. The goal is to increase the health literacy of patients and those served by building partners such as Head Start, Loaves and Fishes, Human Solutions, and Metropolitan Family Services.
- From 2015 to 2017, The Next Door, Inc. offered five plain language communications trainings to agency staff in the Mid-Columbia Gorge region. About 100 agency staff from more than 15 agencies attended in this rural region. This was an effort to promote health literacy in the broader context of social determinants of health, thereby promoting health equity.

Alaska

The Anchorage Health Literacy Collaborative is a group of agencies interested in improving the health literacy of residents and reducing disparities in health care and access. Activities reported include:

- Health literacy classes for ELLs of all levels
- Health literacy training for healthcare providers
- Health fairs with topics responsive to the stated needs of the adult ELL population
- Practice and internships for university students in health literacy

Idaho

- Both the Idaho Oral Health Plan 2008–2013 and the Idaho Oral Health Plan 2010–2015 address health literacy as a barrier to oral health care, particularly relative to the connection between oral health and overall health. The 2010–2015 plan states, “Efforts to improve oral health literacy by the public should begin with policy makers, oral health professionals, health professionals, and public health working together.” (www.healthandwelfare.idaho.gov/Portals/0/Health/OralHealth/StatePlan.pdf). Specifically, Goal 4 of the 2008–2013 plan calls for increasing oral health literacy. Objectives under this goal specify targets to “increase the amount of oral health educational materials that are available from a statewide clearing house” and to “incorporate oral health messages with at least 10 other public health message delivery systems (i.e. other health program messages)”. Specific strategies and activities listed to meet those objectives and Goal 4 include efforts to:
 - Promote early, comprehensive intervention involving a community approach to prevention;
 - Increase Idaho-specific oral health data that is accessible to the public;
 - Increase oral health educational materials in a statewide clearing house; and
 - Incorporate oral health messages with other health messages that promote the integration of oral health, such as oral cancer prevention, and tobacco-use reduction efforts, diabetes and heart disease and the link to periodontal disease.
- (<http://healthandwelfare.idaho.gov/Portals/0/Health/OralHealth/2008OralHealthStatePlan>)



Chapter 2: Overcoming Anti-Immigrant Sentiment

Historical Background

The longest standing group of people in Pacific Northwest (Alaska, Washington, Idaho and Oregon) are the First Nation Peoples, or tribal peoples. Today, there are 271 tribal entities (IHS, 2018; NPAIHB, 2018). Region X has a rich history of immigration that dates back to the summer of 1774 by Spanish explorers (Sanchez, 2004; HistoryLink.org). In the 1880s, Japanese immigrants also came to the Pacific Northwest. As such, they became the largest Asian group on the West Coast by the early 20th Century (Niewart, 2005). Post World War I, federal land laws introduced new land restrictions that eventually became the foundation for an anti-Japanese movement. During World War II, the Mexican Farm Labor, or Bracero, Program, was created to bring Mexican workers into the United States on 6-to-12-month contracts in order to address the shortage of agricultural workers (OE, 2017). This influx of Mexican migration into the United States, including the Pacific Northwest, led to the creation of informal networks of labor migration which has shaped demographics to this day (OE, 2017). Currently, there are many social and political challenges for immigrants, including language isolation, immigration policy resistance, and disrupted social welfare throughout Alaska, Oregon, Idaho, and Washington.

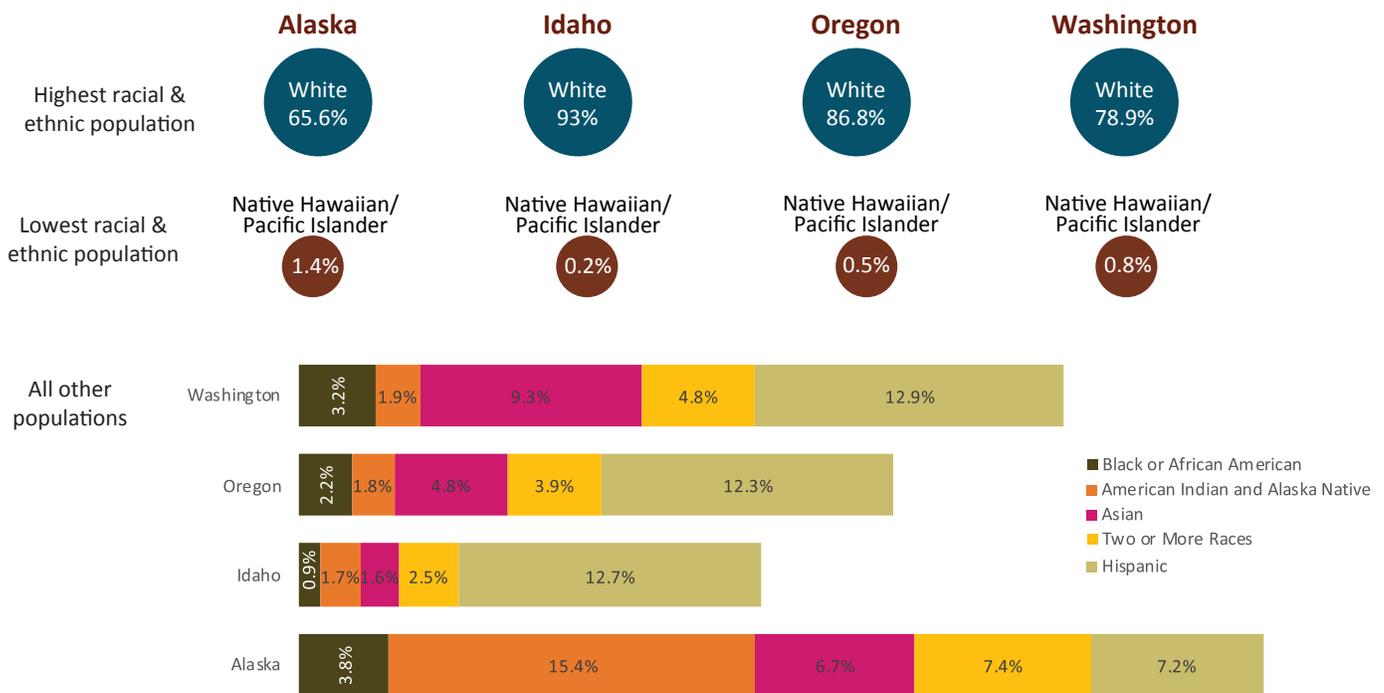
Pacific Northwest Demographics and Health Disparities

Demographics for Pacific Northwest (population: 14,217,950) are expected to change over the next decade. According to the U.S. Census Bureau, Population Division Annual Estimates of Resident Population, April 2, 2010 to July 1, 2018 population among Alaska, Idaho, Oregon, and Washington:

- 82 percent of the population is white
- 12.7 percent identifies as Hispanic of any race
- 6.9 percent is Asian
- 3.2 percent is Black or African American
- 2.6 percent is Native American or Alaska Native
- 0.6 percent is Native Hawaiian or Pacific Islander
- 4.4 percent identifies as two or more races

Demographics and Geographic Distribution within the Region

U.S. Census Bureau, Population Division Annual Estimates of Resident Population, April 2, 2010 to July 1, 2018



In 2015, The Agency for Health Care Research and Quality (AHRQ) presented its National Healthcare Disparities Report. It concluded that overall disparities in health care quality and access remained unchanged or worsened for poor and racial/ethnic minority populations. The report cited continued or widening gaps for specific health outcomes such as immunization rates, HIV/AIDS diagnoses, and prenatal care. In addition, the rate of foreign-born residents without health insurance has more than doubled compared with that of native-born populations

(AHRQ, 2015). Lack of health insurance was noted as a persistent major barrier to eliminating health disparities (AHRQ, 2015). Also, low health literacy can potentially contribute to declining health outcome rates. “Linguistic isolation” affects more than a quarter of Spanish- and Asian/Pacific Islander language-speaking households (NPA, 2015, p. 17). Healthcare providers communicating health advice to ELLs also is often overlooked. The complicated roots of health disparities include poor and minority populations facing social and political factors that negatively impact health. They include living environment, education, employment, and communication opportunities. These factors are often called social determinants of health (SDoH).

One agency that works toward addressing healthcare disparities and bridging the social and political gap among American Indians and Alaska Natives is HHS’s Indian Health Service (IHS). Other immigrant and refugee populations face immigration policy that affects legal status. This policy also has a social and political aspect that impacts access to care and compounds barriers for individuals who face chronic diseases. In providing access to health care, IHS also considers social and political factors including culture, geographic isolation, poor sewage removal disposal, and poverty. For example, the Alaska Area IHS works in conjunction with Alaska Native Tribes and Tribal Organizations to provide comprehensive health services to 143,078 Alaska Natives (Eskimos, Aleuts, and Indians) (IHS, 2015). Also, IHS provides access to health care for an estimated 150,000 American Indian/ Alaska Native residents of Oregon, Washington, and Idaho (IHS, 2015).



Other racial and ethnic minority populations experience limited health advocacy. In Washington State, for example, a health advocate might be a community health representative (CHR), a community health worker (CHW), or an in-person assister who helps people sign up for health insurance in their own language.

Innovative Resource for Overcoming Anti-Immigrant Sentiment

An innovative resource to address the anti-immigrant climate is available through Health Outreach Partners (HOP), a national organization based in Oakland, California that works toward building strong, effective, and sustainable grassroots health models by partnering with community-based organizations across the country. The purpose of its work is to improve the quality of life for low-income, vulnerable, and underserved populations.

HOP created and recently updated *The Silent Crisis: How to Do Outreach in an Anti-Immigrant Climate* (<https://outreach-partners.org/wp-content/uploads/2018/02/Silent-Crisis-2018.pdf>), a useful resource. Two Pacific Northwest Health Equity Council members are co-authors of this resource, which shares innovative ideas to reach and support immigrants and their family members, many of whom are choosing to live quietly and stay out of view due to fear and mistrust (HOP, 2018). This “silent crisis” has many consequences, one of which is that people are choosing to forgo necessary health services, resulting in complications for their physical, mental, and behavioral health.

This is a valuable tool for health and service programs, as well as schools, to help address the many barriers immigrant groups face. The resource identifies key barriers and related solutions and resources for immigrants based on input from a national survey as well as community health workers (CHWs) and other frontline workers. Equitable access to quality health care and other services is the primary goal of the resource and toolkit.



References

- Agency for Healthcare Research and Quality (AHRQ). (2015). 2014 National Healthcare Disparities Report. US Department of Health and Human Services, Agency for Healthcare Research and Quality; Rockville, MD. Retrieved from <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/2014nhqdr.pdf>
- Alaska Dispatch News. (2013). Hometown U: Data show Mountain View is most diverse neighborhood in America. April 6, 2013. Retrieved from <http://www.adn.com/article/20130406/hometown-u-data-show-mountain-view-most-diverse-neighborhood-america>
- Barton, Melissa A. (2011). Immigration in America: Anti-immigrant movements and policies. Retrieved from <http://immigrationinamerica.org/330-alaska.html>
- Ford, Jamie. (2015). Hotel at the Corner of Bitter and Sweet. Retrieved from <http://www.amazon.com/Hotel-Corner-Bitter-Sweet-Jamie/dp/0345505344>
- Guzman, Gonzalo. (2006). Latino History of Washington State. Essay7901. Retrieved from www.historylink.org
- Health Outreach Partners. (2015). Outreach in an Anti-Immigrant Climate. Retrieved from <http://www.outreach-partners.org/home>; *The Silent Crisis*. Retrieved from <https://outreach-partners.org/2013/03/26/outreach-in-an-anti-immigrant-climate/>

Indian Health Services. (2015). Health Literacy Universal Precautions Toolkit. Healthcare communication. Retrieved from http://www.ihs.gov/healthcommunications/index.cfm?module=dsp_hc_health_literacy
<http://www.ihs.gov/alaska/>
<http://www.ihs.gov/portland/>

Indian Health Services. (2018). Alaska Area. Retrieved from <https://www.ihs.gov/alaska/>

Klinge, M. (2015). A History Bursting With Telling: Asian Americans in Washington State. Center for the Study of the Pacific Northwest University of Washington, Department of History. Retrieved from <http://www.washington.edu/uwired/outreach/cspn>

Mercier, L. (2015). Japanese Americans in the Columbia River Basin: Historical Overview. Retrieved from <http://archive.vancouver.wsu.edu/crbeha/ja/ja.htm>

Niewert, David. (2005). Strawberry Days: How Internment Destroyed a Japanese American Community, p. 42. New York: Palgrave MacMillan.

Northwest Portland Area Indian Health Board. (2018). Our Member Tribes. Retrieved from <http://www.npaihb.org/member-tribes/>

Sanchez, A. (2004). Spanish Exploration: Juan Perez Expedition of 1774. First European Discovery and Exploration of Washington State Coast and Nueva Galicia (the Pacific Northwest). Essay 5677. Retrieved from www.historylink.org

Southern Poverty Law Center (SPLC). (2015). Anti-Immigrant. Retrieved from <http://www.splcenter.org/get-informed/intelligence-files/ideology/anti-immigrant>

The Nation Partnership for Action to End Health Disparities (NPA). (2015). Region X Health Equity Council Blueprint for Action. Retrieved from <http://region10.npa-rhec.org/in-the-spotlight/blueprint>

The Oregon Encyclopedia. (2017). Bracero Program. Retrieved from https://oregonencyclopedia.org/articles/bracero_program/#.Wp2JOhFIKU

Wikipedia. (2015). List of Alaska Native tribal entities. Retrieved from http://en.wikipedia.org/wiki/List_of_Alaska_Native_tribal_entities



Chapter 3: Beyond Compliance

The Limited English Proficiency (LEP) Federal Interagency Website, www.lep.gov aims to promote “a positive and cooperative understanding of the importance of language access to federally conducted and federally assisted programs” (LEP, 2015). Links provide information, tools, and technical assistance (on both the federal and state levels) regarding “limited English proficiency and language services for federal agencies, recipients of federal funds, users of federal programs and federally assisted programs, and other stakeholders” (LEP, 2015). The website also is a source for information on implementing Executive Order 13166, Title VI of the Civil Rights Act of 1964 (Title VI) and the Title VI regulations regarding language access. The order requires federal agencies to examine services they provide and identify any need for services to those with limited English proficiency, and to develop and implement a system to provide those services, ensuring meaningful access to them.

According to the Center on Enhancing Early Learning Outcomes (2014), literacy is defined as the ability to read, write, speak, listen, and view in order to communicate with others effectively. Literacy is also the ability to think and respond critically in a wide variety of complex settings. Higher averages of literacy proficiency are reported for midwest and western states (Kirsch, Jungeblut, Jenkins & Kolstad, 2002, p. 44-46). Other studies have looked more closely at the misalignment between patients’ literacy levels and the readability of patient materials. These studies have investigated the issue of literacy from the perspective of patients’ interactions in the healthcare setting resulting in:

- Exclusion of some patients because of their low literacy skills;
- Difficulty some patients have in navigating the healthcare system;
- The quality of the communication between doctors and their patients including the cultural overlay of such exchanges; and
- The effect of low literacy on health outcomes.



Health literacy is the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. The American Medical Association (2015) recommends four critical focus areas for health literacy compliance:

- (1) Health literacy screening
- (2) Improving communication with low-literacy patients
- (3) Costs and outcomes of poor health literacy
- (4) Causal pathways of how poor health literacy influences health

Former US Surgeon General Vice Admiral Vivek H. Murthy recently identified three evidence-based priorities to improve health literacy among our citizens: public health preparedness; health care disparities; and prevention (CDC, 2015).

Going beyond compliance is becoming even more critical as our population becomes more diverse. Complying with health literacy policies is the initial step to effectively communicating health services. However, compliance can be challenging for some communities. The National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards, or CLAS) provide the framework for all health organizations to best serve the nation's diverse communities (HHS, 2015).

The US Department of Education's National Adult Literacy Survey (NALS) 2002 report provides evidence that limited health literacy is deeply rooted within the healthcare system. Several findings conclude that health materials have not been modified to close the communication gap between healthcare providers and patients. Results from the Health Literacy of America's Adults 2003 National Assessment of Adult Literacy show that white and Asian/Pacific Islander adults had higher average health literacy than black, Hispanic, American Indian/Alaska Native, and multiracial adults. Hispanic adults had lower average health literacy than adults in any other racial/ ethnic group (Kutner, Greenberg, Jin & Paulsen, 2006, p.11).

Finally, the impact of new information technologies has been studied by a number of health literacy researchers. Much of the current health literacy literature is concerned with the vast amount of health information now available on the Internet and is focused on issues of quality and the doctor-patient relationship. Some current research focuses on consumer health interventions. A small number of studies report controlled experiments measuring the effects of such interventions.



References

- American Medical Association (AMA). (2015). Health Literacy Program. Health literacy: report of the Council on Scientific Affairs. Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association. *JAMA* 281(6):552–7.
- Center on Enhancing Early Learning Outcomes. (2014). Definitions and Approaches to Measuring Reading Proficiency. Retrieved from http://ceelo.org/wp-content/uploads/2014/05/ceelo_fast_fact_reading_proficiency.pdf.
- Centers for Disease Control and Prevention (CDC). (2015). Tools for Cross-Cultural Communication and Language Access Can Help Organizations Address Health Literacy and Improve Communication Effectiveness. Retrieved from <http://www.cdc.gov/healthliteracy/culture.html>.
- Centers for Disease Control and Prevention (CDC). (2015). Learn About Health Literacy. Retrieved from <http://www.cdc.gov/healthliteracy/learn/index.html>.
- Kirsch, I. S., Jungeblut, A., Jenkins, L., & Kolstad, A. (2002). Adult Literacy in America: A first look at the findings of the National Adult Literacy Survey. Washington DC: US Department of Education, Office of Education Research and Improvement; NCES 1993–275. Retrieved from <https://nces.ed.gov/pubs93/93275.pdf>.
- Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). Health Literacy of America’s Adults Results from the 2003 National Assessment of Adult Literacy. Washington DC: U.S. Department of Education, Office of Education Research and Improvement; NCES 1993–275. Retrieved from <https://nces.ed.gov/pubs2006/2006483.pdf>.
- Limited English Proficiency (LEP) Federal Interagency. (2015). Retrieved from www.lep.gov.
- US Department of Health and Human Services (HHS). (2015). The National Standards for Culturally and Linguistically Appropriate Services (CLAS). Office of Minority Health. Retrieved from <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>.



Chapter 4: Making a ‘New Case’

Language Services Disparities

A key component for achieving health equity is providing meaningful language services to people who speak languages other than English. Millions of people in the US continue to experience language discrimination, including barriers to obtaining access to quality medical care. The cost of inadequate language services can be personally devastating. This guide is offered to support work that public health practitioners across this country continue to provide on behalf the millions of people who do not speak English as their primary language. The following is an example of the critical need for language equity in the US.

In 1999, a young girl named Gricelda Zamora arrived in an emergency room accompanied by her Spanish-speaking parents. Unable to receive Gricelda’s interpreting as normal, her parents stood by while a physician quickly diagnosed and discharged their daughter. No one offered them interpreting services, and the parents were given follow-up instructions in English. They believed that the doctor told them to come back in three days. Gricelda’s condition worsened; after two days, her parents brought her back to the hospital. By then, the girl’s condition was severe. She passed away shortly thereafter of a ruptured appendix. (Lo, 2011). The outcome was tragic and avoidable. Why did no one contact interpretation services, despite the availability of those services? What could have been done differently to avoid such an outcome? Why did medical staff give important discharge and follow-up instructions in a language her parents could not understand?



Title VI of the Civil Rights Act of 1964 is also known as “National Origin Discrimination Against Persons with Limited English Proficiency”. More than 50 years after its passage, enforcing the law continues to be one of the most difficult challenges; public health advocates across the country continue to report violations of the law. Language differences have become one of the major barriers to equal access to health care.

In many rural communities within the states that comprise the Pacific Northwest, people who work with ELLs continue to report widespread language discrimination. Regrettably, for many of those affected, fear of deportation prevents them from reporting being denied information in their language.

Translation and interpretation issues vary in breadth and scope. In one case, a mother lost temporary custody of her daughter after a doctor misinterpreted two Spanish words, “se pegó” to mean “I hit her” instead of “she hit herself”. Another study revealed that healthcare providers used people from local restaurants, strangers from a hospital waiting room, taxi drivers, and children under the age of six as interpreters (Wilson, 2013). In Florida, an 18-year-old man ended up quadriplegic after his healthcare team mistook the word “intoxicado” to mean “intoxicated” and treated him for a drug overdose instead of a brain aneurysm. “Intoxicado” can mean a number of things including different types of poisoning (Wilson, 2013).

While outcomes vary, they do have one common factor: More often than not, negative consequences are preventable.

How Important is Language Access to Health Equity?

Healthy People 2020 defines access as “the timely use of personal health services to achieve the best health outcomes” (Office of Disease Prevention and Health Promotion, US Department of Health and Human Services, 2017). It requires three distinct steps:

- (1) Gaining entry into the healthcare system
- (2) Accessing a healthcare location where needed services are provided
- (3) Finding a healthcare provider with whom the patient can communicate and trusts

Quality of care and equity also are inherent in the Healthy People 2020 definition of access. These three elements intersect and must be considered in discussing language access and its relation to achieving health equity.

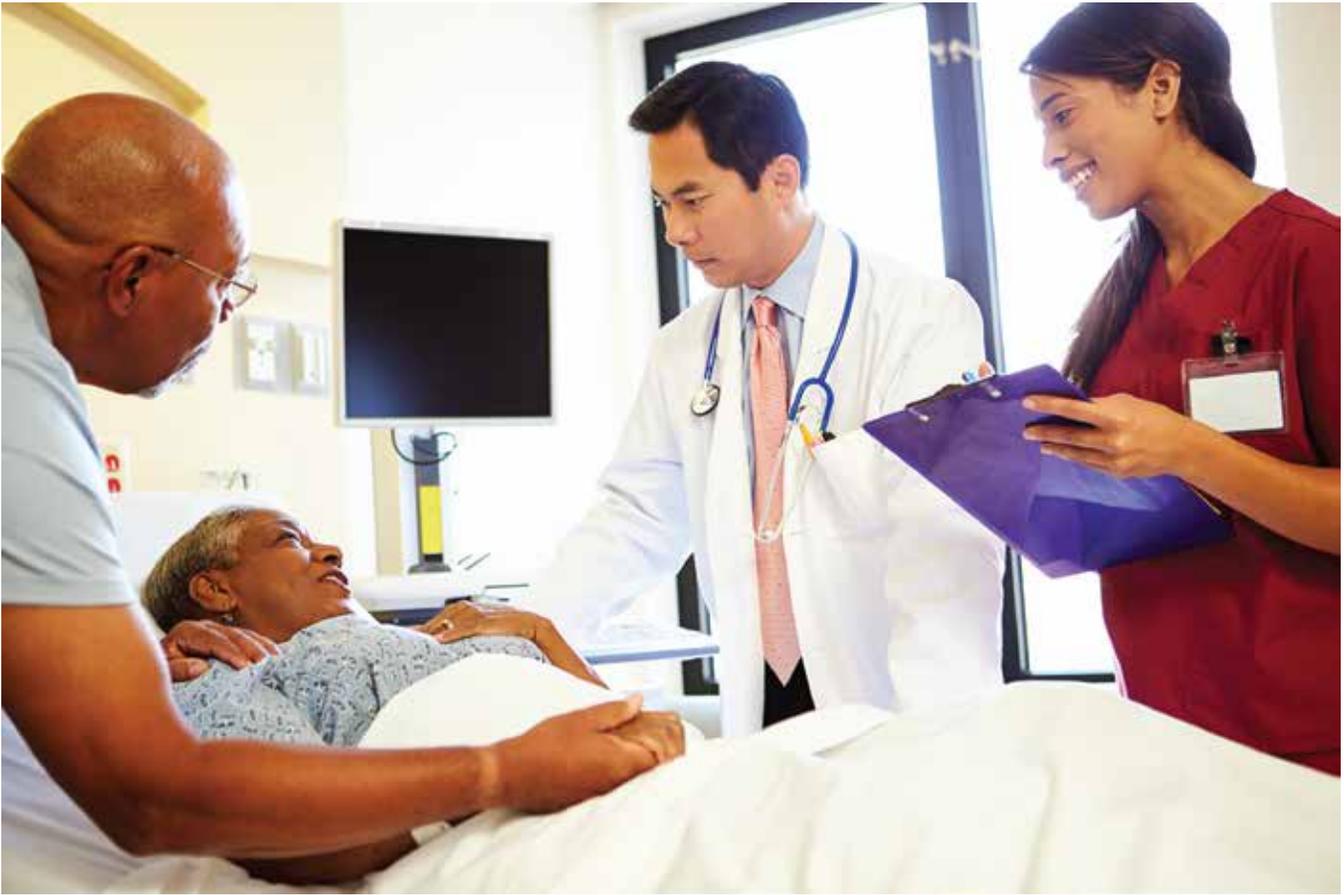
The Washington State Coalition for Language Access (WASCLA) offers an example of the intersection of access, quality of care, and equity:

A woman who was an ELL was staying in a local shelter. The staff quickly deemed her uncooperative because she did not follow the rules. Without translation and interpretation, many of the shelter services remained out of her reach. When her purse was stolen, rather than helping her file a police report, the shelter staff instructed her to do it on her own. Even though the shelter provided food for clients in the common area, the woman did not eat any of it simply because she did not know she was allowed (Washington State Coalition for Language Access, 2017).



All three elements listed above must be met to achieve health equity. In this example, the woman entered the shelter for needed services. But she could not communicate with her providers, so how could she trust them? While other English-speaking clients interacted with staff to access needed services, this woman could not.

Language barriers affect patients and providers in a variety of ways. Without access to language services, quality of care may be compromised and may lead to secondary issues such as poor patient satisfaction, higher healthcare costs, and frustration for both patients and providers (The Colorado Trust, 2013). Simple tasks such as making appointments, providing a medical history, and explaining symptoms are difficult and can lead to unfortunate health outcomes. A 2007 study revealed that over half of adverse events occurring to hospital patients who spoke a language other than English was a result of communication errors (The Colorado Trust, 2013).



Health equity means “all people have full and equal access to opportunities that allow them to lead healthy lives” (Health Equity Institute, n.d.). Achieving health equity requires identifying health disparities for different groups and populations and then identifying steps to address and, ideally, eliminate these disparities. Speakers of languages other than English are at risk of racial, ethnic, and socioeconomic disparities and of experiencing language barriers in health services (Fiscella, et al., 2002). **The provision of language access services is a major step forward in achieving health equity for a population at risk on multiple levels.**

Legal Issues Can Affect Bottom Line and Health Consequences

As discussed in the introduction to this guide, the 1964 Civil Rights Act and the 2010 Plain Writing Act created a legal mandate for health services organizations to provide language services to people who speak languages other than English.

Liability

When adverse health outcomes occur as a result of communication issues, providers and organizations are at risk for legal liability, defined as “legal responsibility for one’s acts or omissions” (Showalter, 2015). The type of liability depends on the specific situation, but a few examples are breach of contract, negligence, and intentional tort. Negligence is defined as “the failure to comply with established standards for the protection

(Showalter, 2015). Failure to provide adequate interpretation and translation services has served as the claim of medical negligence in many legal battles between patients or their families and providers. Even in cases where the court rules in favor of the provider, legal fees add up quickly, and high-profile cases may be damaging to a provider's reputation.

Informed Consent

Another legal issue around inadequate language services is informed consent. Failure to obtain informed consent, whether intentional or due to inadequate language services, can result in liability for negligence. When services are provided from a provider to a patient, legally sufficient informed consent must be obtained from the patient. Consent can either be expressed - spoken or written - or implied - action that demonstrates the patient agrees to treatment (Showalter, 2015). However, consent cannot be given without the following conditions being met. The patient must possess:

- (1) Legal competence; and
- (2) A reasonable amount of knowledge or understanding about the proposed treatment or service.

While informed consent should be obtained by using a language the patient understands, this is not always the case. A 2007 study found that fully documented informed consent was provided to speakers of languages other than English at far lower rates than English-speaking patients (Schenker, et.al. 2007). If patients do not fully understand the language in which information is provided, they cannot possess a reasonable amount of knowledge about their care.





Patient Privacy

A third legal issue that may occur for speakers of languages other than English is a violation of patient privacy. A study found that hospitals randomly used people such as taxi drivers, restaurant employees, and people in hospital waiting rooms to provide translation and interpretation services (Wilson, 2013). While these ad hoc interpreters may serve a useful immediate purpose, they almost always lack the necessary confidentiality training needed to deal with health issues (Lo, 2011). Interpreting requires proper training, and untrained interpreters are more likely to be unfamiliar with medical terminology or procedures and may not speak the same dialect as the patient. Finally, strangers become privy to a patient's sensitive medical information without the patient's informed consent.

Economic, Social & Human Factors

Language access not only has legal effects; language barriers impact the insurance market rate, the economy, and society as a whole. Barriers to receiving high-quality healthcare services include the inability to navigate the complex healthcare delivery system, to communicate with healthcare providers, and to understand providers' instructions. Poor hospital visit experiences can result in patients becoming disengaged, discontinuing their care, and canceling their insurance coverage or using it less for preventive care.

In addition, the jobs available to people who lack proficiency in English are unlikely to provide health insurance as a benefit of employment. Recent immigrants and non-citizens may receive fewer benefits from public health insurance programs than earlier immigrants did and that citizens do. Researchers found that limited proficiency in English affects Hispanics' ability to seek and obtain health care. It also reduces access to health information in the media (Ruiz, Marks, and Richardson, 1992). Communication is central to healthcare delivery and has profound effects on patient-provider relationships and the health care people receive. Studies by David and Rhee (1998); Morales, Cunningham, Brown, Liu, and Hays (1999); and Timmins (2002) have found that language barriers between providers and patients may result in:

- Excessive medical tests;
- Lack of understanding of medication side effects and provider instructions;
- Decreased use of primary care;
- Increased use of the emergency department; and
- Inadequate follow-up



Two key barriers to healthcare access are lack of health insurance coverage and lack of a usual source of care. Language barriers can have harmful effects. Patients who face such barriers are less likely than others to have a usual source of medical care, and they have an increased risk of non-adherence to medication.

Among patients with psychiatric conditions, those who encounter language barriers are more likely to receive a diagnosis of severe psychopathology and are more likely to leave the hospital against medical advice. Among children with asthma, those who confront language barriers have an increased risk of intubation (putting a flexible plastic tube into the windpipe to maintain an open airway). Such patients are less likely to return for follow-up appointments after visits to the emergency room, and they have higher rates of hospitalization and drug complications. Greater resources are used in their care, but they have lower levels of patient satisfaction (Flores, 2006).

Health insurance reduces out-of-pocket costs and is the most important predictor of use of health care. Without health insurance coverage, many people find health care unaffordable and forgo care even when they think they need it.

Having a usual source of care reduces non-financial barriers to obtaining care, facilitates access to healthcare services, and increases the frequency of contacts with healthcare providers. Having a usual source of care provides a point of entry into the complex healthcare delivery system (Lewin-Epstein, 1991). People with a usual care source are less likely to have difficulty obtaining care or to go without needed care. People with limited insurance coverage face multiple preventable hospitalizations. A lack of health insurance makes the costs of services prohibitive for many people and is the most important barrier to adequate healthcare access.

The lower rates of insured among people who speak languages other than English may result in higher insurance cost for the rest of people insured and delay the extension of affordable health care for all (National Research Council [US] Panel on Hispanics in the United States, 2006).

Communication inadequacy and failures can have tragic consequences. Consider the story noted earlier in this chapter of how misinterpretation of a single word led to a patient's delayed care and preventable quadriplegia (loss of use of all four limbs) (Flores, 2006). A Spanish-speaking 18-year-old friend said he was "intoxicado". Then, he collapsed. The non-Spanish-speaking paramedics took it to mean "intoxicated", but the intended meaning was "nauseated." After more than 36 hours in the hospital being worked up for a drug overdose, the comatose patient was re-evaluated and diagnosed with bleeding in the brain. The patient became a quadriplegic, and the hospital ended up paying a \$71 million malpractice settlement



Call to Action

Title VI has supported progress towards providing meaningful language access to the growing number of linguistically diverse people.

Offering meaningful language services to ELLs is a key component for achieving health equity. As we celebrate the passage of Title VI, we must remain steadfast in our commitment to provide effective language services to those seeking access to care. Given the reality of the increasing number of people who speak languages other than English and who continue to face language discrimination, we must go beyond “compliance” to achieving language equity.

As members of Pacific Northwest Health Equity Council, we call on our colleagues to join us in making a new case about why this work remains critical to the communities we all serve. As public health advocates, we know that health equity exists when people have equitable opportunities to be healthy. A key to achieving health equity is meaningful and effective language access.

References

- The Colorado Trust (2013). Health Equity and Language Access: How Language Access Affects Patients, Policymakers, and Health Care Providers. Retrieved from http://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf.
- David, R. A., Rhee, M. (1998). The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mt. Sinai Journal of Medicine* 65(5-6) 393-397
- Fiscella, K., Franks, P., Doescher, M. P., & Saver, B. G. (2002). Disparities in health care by race, ethnicity, and language among the insured: Findings from a national sample. *Medical Care*, 40(1), 52-59.
- Flores, Glenn (2006). Language barriers to health care in the United States. *New England Journal of Medicine*, 355:3 229-231 Retrieved from <http://www.nejm.org/doi/pdf/10.1056/NEJMp058316>
- Health Equity Institute. (n.d.). Defining Health Equity. Retrieved from <https://healthequity.sfsu.edu/content/defining-health-equity>.
- Lewin-Epstein, N. (1991). Determinants of Regular Source of Health Care in Black, Mexican, Puerto Rican, and Non-Hispanic White Populations. *Medical Care* 29:6
- Lo, L. (2011). The right to understand your doctor: Protecting language access rights in healthcare, 31 *Boston College Third World Law Journal*, 31:2 pp. 377-403. Retrieved from <http://lawdigitalcommons.bc.edu/twlj/vol31/iss2/6>
- Morales, L. S., Cunningham, W. E., Brown, J. A., Liu, H., & Hays, R.D. (1999). Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine* 14(7) pp. 409-417.

- Office of Disease Prevention and Health Promotion. (2017), Access to Health Services. U.S. Department of Health and Human Services, Healthy People 2020. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.
- Ruiz, M., Marks, G., Richardson, J. L. (1992) Language Acculturation and Screening Practices of Elderly Hispanic Women: The role of exposure to health-related information from the media. *Journal of Aging and Health* 4:2. pp. 68-281.
- Schenker, Y., Wang, F., Selig, S. J., Ng, R., & Fernandez, A. (2007). The Impact of Language Barriers on Documentation of Informed Consent at a Hospital with On-Site Interpreter Services. *Journal of General Internal Medicine*, 22 (Suppl 2), 294–299. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2078548/>
- Showalter, J. (2015) *The Law of Healthcare Administration*, 7th ed. Health Administration Press: Chicago.
- Washington State Coalition for Language Access. (2017). Welcome to the Washington State Coalition for Language Access. Retrieved from <https://www.wascla.org/>
- Wilson, C. C. (2013) Patient safety and healthcare quality: The case for language access. *International Journal of Health Policy and Management* 1(4), pp. 251-253 Retrieved from http://ijhpm.com/article_2796.html



Chapter 5: A Framework for Interpretation and Translation and Promoting a New National Standard

Framework for Interpretation and Translation

To address disparities and promote health equity in interpreting and translating, we propose new regional and national standards that go beyond what has been proposed in our nation to date.

Interpreting and translating are essential services in health care and other services for English Language Learners (ELL). Yet, straight interpreting and translating can result in inaccuracies, which, in turn, contribute to health disparities. Effective interpretation and translation go beyond putting words into another language, and they contribute to health literacy. Health literacy means the ability to access, understand, and use health information to make health-related decisions.

Health literacy is considered a social determinant of health (SDoH). Social determinants of health are the “conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (Office of Disease Prevention and Health Promotion, 2016). They include housing, access to services, religion, employment, education, sexual orientation and gender identity, age, language, transportation, and national origin.



Interpreters and translators need to be able to work collaboratively with health and social services providers and to account for important factors such as health literacy and social determinants of health in their work. Therefore, it is essential that training programs incorporate these topic areas into curricula and assessments. In addition to content area, researchers in the sign language interpreter field have suggested that traditional interpreter training programs focus largely on “technical skills of source-to-target language translation to exclusion of other factors, especially contextual factors, equally pertinent to effective interpreting practice” (Dean and Pollard, 2011). Interpreters who use this approach might miss significant elements of the client’s communication or background. This could negatively impact interaction or information conveyed.

Dean and Pollard argue that interpreting should be considered a practice field, such as nursing or social work, as opposed to a technical profession, like engineering or accounting. The difference is that practice professions always require the application of technical skills “in a dynamic, interactive social context...” (2011). Dean and Pollard have developed the Demand Control Schema conceptual framework as a way for interpreters to navigate communication barriers, including ethical dilemmas, using critical thinking. It is essential for interpreter and translator training programs to incorporate this and other paradigms to ensure future language assistance professionals have the best knowledge and tools to execute their practice.

Definition of Interpretation and Translation

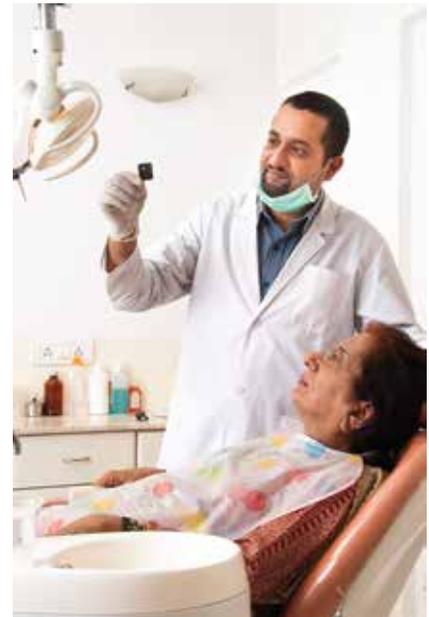
According to The Merriam-Webster Dictionary, translation means “to change words from one language into another language”.

Translators write.

Interpretation is verbal translation. Interpreters speak. There are three styles of interpreting:

- (1) Consecutive
- (2) Simultaneous
- (3) Sight reading

Consecutive interpreting is when the speaker says a sentence or two and pauses, and the interpreter then interprets that sentence or two. Simultaneous interpreting is often done with headsets, and the interpreter interprets at the same time the speaker is speaking. Sight reading means interpreting something written.

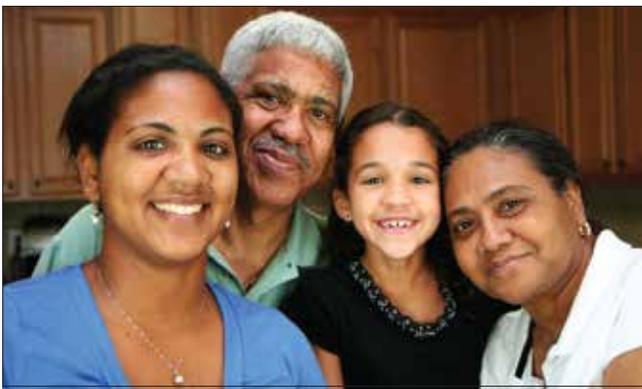


Who are appropriate interpreters and translators?

Let’s start with who should not interpret and translate. Anyone who is not formally trained as an interpreter or translator should not interpret or translate.

Many assume that if people are bilingual they can interpret and translate in those two languages. That is a dangerous assumption. While they may be bilingual conversant, they may not be bilingual literate. They may not understand medical terminology or nuance. Staff, family members, and friends may not be trained interpreters and translators. These are professional skill sets that require formal training and adherence to ethical standards, protocols, and procedures.

Why Are Interpretation and Translation Essential in Health Care and Other Services?



There is a high number of people in the US who are speakers of languages other than English and are ELLs. According to 2014 US Census Bureau data, 61.8 million people speak a language other than English at home; this represents one in five Americans, a number that has increased by 2.2 million since 2010. The largest increases have been in Spanish, Chinese, and Arabic.

Of those who speak a language other than English at home, 41 percent reported they speak English less than “very well”. This means that more than 23 million

people speak English less than “very well” and are ELLs. These 23 million include 10.5 million native-born and naturalized citizens, and up to 4.2 million documented immigrants.

There is also significant “linguistic isolation” among these. To be linguistically isolated, all adults in a household must speak a language other than English and none of them can speak English “very well”. In Region X, more than one-fourth of households in which Spanish or an Asian or Pacific Islander language is spoken experience linguistic isolation (United States Census, 2001).

Language Barriers May Compound or Worsen Other Barriers to Care

Language and cultural barriers hinder certain groups’ ability to attain or restore health (NPA, 2015). This is the case even when healthcare resources are locally available.

ELL populations already face a number of disparities when it comes to health care. These include being uninsured or residing in areas that are medically underserved. Many populations work in low-wage jobs and industries that do not offer health insurance coverage. The percentage of those born outside of the US who are without health insurance is more than double that of the native-born population. These groups are at much higher risk of experiencing linguistic isolation (NPA, 2015).

The following section offers a brief overview of populations with ELL using US Census Bureau data.

Census Data

The 2010 US Census states 25.3 million people with LEP are living in the US. This represents one 10th of the entire population five years of age or older. Since the country has seen a growing immigrant population over the past 30 years, the number of people with LEP has increased by 81%. Also, the language and dialect groups have diversified with each resettled population.

The data below on the Pacific Northwest come from 2013-2017 American Community Survey 5-Year Estimates.

Location	Total # of people (5+ years)	Speak English less than “Very Well”
United States	301,150,892	25,654,421
Alaska	684,298	34,359
Idaho	1,543,263	61,745
Oregon	3,793,273	222,428
Washington	6,721,822	510,111

It's the Law

Executive Order 13166, Title VI of the Civil Rights Act of 1964 requires federal agencies and organizations that receive federal funds to:

- Examine the services they provide;
- Identify any need for services to those with LEP; and
- Develop and implement a system to provide those services so people with LEP can have meaningful access to them (Limited English Proficiency Federal Interagency, 2015).

For more information and discussion about to this topic, please refer to Chapter 3: Beyond Compliance.

Affordable Care and Patient Protection Act Section 1557 states that people cannot be subject to discrimination based on their race, color, national origin, sex, age, or disability. An implementation requirement of 1557 requires covered entities to post notices of nondiscrimination and taglines that alert ELLs that language assistance services are available to them. These notices must be made available in at least the top 15 languages spoken by ELLs in the relevant state or states, as estimated by the Office of Civil Rights. There are fact sheets and training materials for this requirement on the HHS website (Office of Civil Rights, 2016).

The Association of Asian Pacific Community Health Organizations (AAPCHO) has commended the new federal rule for language assistance. It has also issued a statement of support. Here is a brief overview of the statement:

Support for this new federal rule for language assistance would:

- Establish a stronger definition of who is a “qualified interpreter” within health services (This does not include using automated computer-based translation services.);
- Require written translation services in states or service areas that have 5 percent or 1,000 ELLs who speak any one language; and
- Ensure proper patient data collection, subject to enforcement in cases in which Section 4302 of the Affordable Care Act is not followed.

For AAPCHO’s complete statement of support, please visit <http://www.aapcho.org/wp/wp-content/uploads/2016/05/AAPCHO-Section-1557-Final-Rule-Statement-FINAL.pdf>.

Serious Liability Risk of Not Providing Professional Interpretation and Translation

Non-English speakers must have access to language services in health care. Trained, qualified, and certified professionals need to be the ones to offer these services.

Example 1

An 18-year-old man ended up in the ER at a Florida hospital in 1980. An untrained bilingual staff person was called to interpret. Due to inaccurate interpretation, the patient was misdiagnosed and treated incorrectly. This resulted in the patient becoming quadriplegic. He filed a \$71 million lawsuit against the hospital (Kelly and Zetsche, 2012).



Example 2

A clinician communicated in French to a Haitian patient who spoke only Creole. Haitian interpreters later noted a mix-up in terminology. In French, “estomac” means stomach; in Creole, “lestomak” can refer to the chest. Such an error could result in a costly and potentially life-threatening procedure for the patient (Rice, 2014).

Example 3

A 2012 study at two large pediatric emergency departments found thousands of interpretation mistakes among nonprofessional and professional interpreters. Such mistakes included “omitting, adding, or substituting words; adding the interpreter’s own perspectives; or using idioms, words, or phrases that didn’t exist in the patient’s language” (Rice, 2014). About 18 percent of these interpreter mistakes had potential clinical consequences. The study showed that professional interpreters with more than 100 hours of training made mistakes less often.

Costs Associated with Not Having Trained Interpreters and Translators

According to Kelly and Zetzsche (2012) in *Found in Translation: How Language Shapes our Live and Transforms our World*, “... the costs to the entire healthcare system are higher when qualified interpreters are not used. When language barriers are present, medical errors are more common. There are countless reported incidents of doctors ordering unnecessary – and expensive – diagnostic tests instead of simply paying for interpreting services. When patients cannot understand instructions, they can easily overdose by accident or take medications incorrectly. It is risky and costly to forego language services.” (p. 5).



Culturally Competent Care and Closing the Disparities Gap in Health Care

The Office of Minority Health (OMH) (2016) defines cultural and linguistic competency as “appropriate services [that] are respectful of and responsive to the health beliefs, practices, and needs of diverse patients”. Cultural health beliefs can have a profound effect in health care. This is why understanding someone’s cultural background helps in providing the best care for the patient (Legacy Health, 2016).

OMH has developed a series of initiatives and tools to aid in this effort, including the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). Other agencies, federal and otherwise, have developed similar plans. For instance, the Cross Cultural Health Care Program (CCHCP) offers Closing the Gap: Cultural Competency, a course for medical agencies to fulfill CLAS standards. The Centers for Medicare and Medicaid Services (CMS) produced the Toolkit for Making Written Material Clear and Effective; Part 11 covers “Toolkit Guidelines for Culturally Appropriate Translation”.



The following section provides examples of the need for cultural and linguistic competency in health care.

Know Your Audience when Interpreting and Translating

When interpreting or translating, know your intended audience. Language services should be specific to the unique language of the intended audience.

- Imagine that the health department where you work is starting an interpreter program. To help meet the needs of linguistic competency:
 - Find out the primary non-English languages spoken in your service area and by whom.
 - Identify or train professional medical interpreters from those nations of origin or ancestry represented in your community.
- Imagine that you need to translate a health document from English to Spanish. To meet the needs of linguistic competency:
 - Identify the origin of your Spanish-speaking audience: Mexico, Puerto Rico, Dominican Republic, or Central or South American countries. This applies to people from Asian or African countries as well.
 - Seek out trained translators from that nation or ancestry of origin if possible.

One of the greatest challenges when interpreting and translating is having the appropriate terms. In some languages, there may not be an equivalent English word in the native language. In that case, the interpreter or translator must convey the source word by using an equivalent message in the language to which it is being interpreted or translated. For instance, the word “epilepsy” in English would be conveyed in traditional Hmong as “when the spirit catches you and then you fall down”. In indigenous languages, such as Yup’ik (spoken in Western Alaska), language experts and elders would gather together to determine the meaning and context of the word in English. Then they would come up with an equivalent word or words in Yup’ik for that same context.

The examples below reveal the complex nuances that arise for culturally and linguistically diverse audiences. They come from academic and popular sources.

Examples of Nuances that Arise for Culturally and Linguistically Diverse Audiences

Example 1: Oregon’s Slavic Community

There are issues that go beyond terminology. The context of history and culture are embedded within language itself. The Slavic community in Oregon is one such example. Nearly one third of Oregon’s Slavic population likely arrived as refugees. Often, they escaped from violent and traumatic situations in their home countries. This history is still felt after resettlement and even among those born in the US. Many Slavic parents choose not to enroll their children in Oregon’s Healthy Kids initiative, even though it is free. Why? They do not trust the government telling them the program is free. Based on past experiences, the government is not an entity that can be trusted (Curry-Stevens et al., 2014).

¹ The 13 countries considered to be official Slavic states include the Czech Republic, Bosnia, Serbia, Poland, Slovakia, Belarus, Russia, Ukraine, Bulgaria, Macedonia, Croatia, Slovenia, and Montenegro.

Russian-speaking workers who are members of the community itself are able to interpret and translate. Yet, they can take this a step further, because they are aware of the historical injustices the Slavic community has faced. These workers can help debunk myths and create trust with Slavic community members who have viewed healthcare services with little, if any, confidence.



Example 2: Oregon’s Somali Community

We cannot assume that interpreters and translators who speak a language will be able to meet the specific cultural needs of a language group. This is the case no matter how fluently an interpreter or translator speaks a language. Gender norms in Oregon’s Somali community, for instance, create an added health barrier that needs to be addressed beyond providing basic interpreting and translating services (Curry-Stevens, et al., 2014; Kafoury, 2015).



African family structures are male led in most cases. Yet, African families in the US often disrupt this structure, as women are more likely than men to be employed outside the home and develop English skills. As a result, men can feel further weakened if the only interpretation and translation services are offered by Somali- speaking women. One community member expressed that he would rather avoid such services completely than engage in such an interaction. Likewise, Somali women may not feel comfortable disclosing personal,

health- related information to male interpreters and translators. This especially is the case if the information is related to sexual health (Kafoury, 2015).

Example 3: Alaska’s Filipino Community

Filipinos are one of the largest and fastest growing immigrant groups in Alaska (US Census Bureau, 2010). Within the Filipino community, there is linguistic diversity: While the Philippine national language is Filipino, which is mainly Tagalog based, there are more than 130 languages in the country (McFarland, 1993; Komisyon sa Wikang Filipino, n.d.). In addition to Tagalog, other common languages Filipinos speak include Ilokano, Bikolano, Pampango, and Sebwano. Healthcare providers cannot assume that all Filipinos are able to speak Tagalog. And, although the Philippine educational system generally teaches the English language, not all Filipinos will have an appropriate level of English proficiency to discuss their health concerns.

English proficiency often is tied to one's educational status and acculturation level. The more educated and acculturated Filipinos are to the US mainstream culture, the better their English proficiency. With the US colonization of the Philippines for several decades in the early 1900s, the use of the English language has colonial mentality implications. Colonial mentality is the perception that the colonizer's language are viewed positively. As a result, there may be *hiya*, or shame, involved when Filipinos admit they cannot understand and speak English well. Some even may be hesitant to ask for an interpreter when talking with their healthcare provider. Letting Filipino patients know that the clinic or hospital provides interpreting services to all of its patients, regardless of their level of English proficiency and background, may help lessen their *hiya* in asking for an interpreter.

Besides the complexity of the meaning of language among Filipinos, there are certain Filipino words or concepts not easily translatable to English (and vice versa). Having a trained Filipino medical interpreter is important. Filipino health-related concepts such as *asma* have no literal English translation. *Asma* is a folk illness believed to be caused by a sudden exposure of warm bodies or muscles to cold water, causing feelings of neurological dysfunction (Jocano, 1973).



A Special Note about Spanish Language Interpreting and Translating

Sixty-five percent of ELLs in the US are Spanish speaking (Migration Policy Institute, 2011). Spanish is the most spoken language other than English in the nation (Gonzalez-Barrera & Lopez, 2013), and most Latinos or Hispanics in the US use the Spanish language. A recent study conducted by the Instituto Cervantes states that the US is now the world's second largest Spanish-speaking country, second only to Mexico (The Guardian, 2015).

The terms "Latino" and "Hispanic" were created by the U.S. government for classification in the census (Migration Policy Institute, 2011). However, Latino or Hispanic people tend to identify themselves through their country of origin or ancestry. They do not naturally use the terms "Latino" or "Hispanic" (Pew Research Center, 2012). People identify as "Puerto Rican," "Colombian", or "Mexican American", as examples.



Suggestion 1: Produce Spanish language materials that take into account the country of origin or ancestry of the intended audience

Spanish language is not the same across countries, just as English language is not. For instance, English language in the US differs from English in Great Britain or Australia.

When translating into Spanish, first recognize the country of origin or ancestry of the intended audience. Seek out trained translators. When possible, use professional translators from the intended audience. Have people from that country of origin or ancestry review the material. Edit and improve the material based on their feedback.

Suggestion 2: Use standard Spanish when preparing Spanish language materials at the national level

The majority (64 percent) of Latinos or Hispanics in the US are from Mexico or of Mexican descent. All other groups make up less than 10 percent of the Latino or Hispanic population in the nation (Pew Research Center, 2017). According to the 2013 US Census Bureau American Community Survey (2013), “People of Mexican origin are the largest Spanish-speaking population in the United States. It is crucial to provide culturally and linguistically appropriate materials for this audience.”

For a national Spanish-speaking audience, offer information in standard Spanish. This also is referred to as Neutral Spanish, Universal Spanish or Global Spanish. Standard Spanish allows the greatest number of Spanish speakers to understand the message without the use of local terminology and certain verb tenses (Trusted Translations, 2017).

Field-test national level materials before you finalize the material. This is also referred to as user testing. Conduct interviews or hold focus groups with Spanish speakers per ratio of Latinos’ country of origin or ancestry. For instance, if you were going to have 100 Spanish speakers review the material across the country, you would want to interview 64 people of Mexican origin or descent, nine Puerto Ricans, four Cubans or Cuban Americans, four Salvadorans, three Dominicans, two Guatemalans, etc. This honors and reflects the ratio of country of origin or ancestry of Spanish speakers at the national level.

Suggestion 3: Be aware of and sensitive to Latinos in the US whose first language is an indigenous one

In some cases, Spanish is a second language and not a primary one. Indigenous language speakers may not speak Spanish. We cannot assume that people are Spanish speaking if they come from a country where Spanish is the primary language. In some cases, indigenous people do not identify as Hispanic or Latino. They may identify themselves through their tribal group. “Indigenous migrants from Mexico are a subset of the ELL population.

A vast majority originate from the Mexican state of Oaxaca which is made up of more than 16 distinct ethnic groups, of which Mixtecs and Zapotecs are the largest. They may speak an indigenous language and may not speak Spanish. The indigenous do not have a written language and are culturally different than the general Mexican-born population.” (Prue, 2013).

The National Standards for Culturally and Linguistically Appropriate Services (CLAS)

The National CLAS Standards, first released in 2001, “are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.” (Think Cultural Health, 2017) These standards are essential standards for which to commit.

THINK CULTURAL HEALTH



OMH recently explored the ways in which some health and healthcare organizations have applied, used, and, when needed, altered the National CLAS Standards (Office of Minority Health, 2016).

How did they do it? By:

- Providing comprehensive language assistance services
- Offering specialized training to the workforce
- Completing organizational self- assessments to inform needs and gaps
- Providing compensation to staff to complete CLAS-related training

What helped?

- Support from leadership for implementation
- Creating an organizational culture that supports implementation
- Identifying CLAS champions inside and outside of the organization

What changes are needed?

- Better communication with populations served
- Improved ability to address and consider the cultural and linguistic characteristics of populations served
- Increased cultural and linguistic competency of staff
- Better organizational capacity to provide care and services to more people
- Better patient experience

The principal CLAS Standard is to “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.” (OMH, 2016).

Of the 15 CLAS Standards, numbers 5 through 8 relate to interpreting and translating.

Communication and Language Assistance:
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

To promote equity, it is important that we meet the CLAS Standards related to communication and language assistance in our health services and other services. The Pacific Northwest Health Equity Council urges that health and services programs meet the CLAS standards.

To address health disparities and promote health equity, we support and encourage the adoption of new national standards, as follows.

Going Beyond the CLAS Standards with Interpretation

There are factors in interpreting that influence effective two-way communication. These factors sometimes require going beyond interpretation of words from one language to another. For instance, CCHCP in Seattle, WA has been offering training for medical interpreters since 1992. Called Bridging the Gap: A Basic Training for



THE CROSS CULTURAL HEALTH CARE PROGRAM

Medical Interpreters©, the training goes beyond the CLAS Standards of language services.

The 40- to 64-hour trainings include information on interpreter roles and ethics, interpreting skills, medical terminology, the impact of culture, an overview of the health system, and the numerous practical details of interpreting successfully in the healthcare encounter.

The trainings emphasize four very distinct roles for the interpreter working in the medical encounter: Conduit, Clarifier, Culture Broker, and Advocate. Each role is essential to addressing cultural, linguistic, and systemic barriers to effective communication between the patient and the provider. The trainings clearly define each role, limits, and applications:



Language differences are not the only barrier separating an English-speaking provider from a non-English-speaking patient. Imagine a provider and a patient with different views on how the world works, what is important in life, and what causes an illness or how to treat the illness. These different views are heavily influenced by each person's culture. Differences can potentially lead to misunderstanding between patient and the provider.

An action or message in one context may have a completely different meaning in another. In a medical setting, the clarification of these cultural norms may be crucial to understanding. This clarification of cultural norms is the job of the interpreter when acting as the culture broker (Cross Cultural Health Care Program, 2014).

The trainings provide practice in the Five Steps of Culture Brokering. This maintains the patient and provider autonomy and minimizes the involvement of the interpreter in that relationship.

The interpreter in medical and social service settings also has a role as an advocate with clear limits. Advocacy is the most controversial of the four interpreter roles. Despite this controversy, it is possible for an interpreter to advocate effectively without undermining the patient's autonomy or the patient-provider relationship. CCHCP's Bridging the Gap training teaches the skills and provides clear guidelines on the steps to effective advocacy.

An interpreter with experience, knowledge of institutional policies related to advocacy, good interpersonal skills, and a clear understanding of when and how to advocate appropriately can be an effective and positive advocate.

CCHCP has also developed a national training for Patient Guides®. In this program, interpreters train to be patient navigators for ELLs and also for people born in the US who have low literacy and low health literacy.

Going Beyond the CLAS Standards with Translation

Sprager and Martinez introduced the new national standards in health materials translated from English in September 2015 in a commentary published by the National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM). Their commentary is entitled “Beyond Translation: Promoting a New National Standard for Equity in Health Materials Translated from English” (Sprager, 2015). Sprager elaborates on the proposed national standard first published by NAM. Please note that programs throughout the nation conduct or promote different aspects of the proposed national standards. Below are the seven new national standards we are promoting:

1. Translation, which includes a translation check by a second translator and coming to agreement on the final translated document
2. Plain language adaptation
3. Cultural adaptation
4. Back translation
5. Field test with members of the intended audience
6. Modify and finalize the material based on field test feedback
7. Include the intended audience in distributing and applying the material

Seven New National Standards for Equity in Health Materials Translated from English

STEP 1: Translation

When translating health materials from English, ensure that certified translators do the work. Professional translation includes translation by a trained professional and review and check by a second professional. Both translators discuss any discrepancy and come to agreement on accurate translation to arrive at the final version. This ensures the highest quality translation, as any apparent mistakes or concerns can be jointly addressed and corrected by the two professionals. It also is crucial that translators be able to contact the client to clarify any questions about the document they are translating.

Translation is not an exact science. Translators strive to produce a translation as close in meaning as the source document. The source document is the original document being translated.

Translating often increases reading level and complexity by 1 to 3 grade levels (Sprager & Martinez, 2015). The result can be a disparity between the English language information and the translated information. The disparity is more significant because people in the US who speak languages other than English are predominantly immigrants (Migration Policy Institute, 2011). And immigrants tend to have lower literacy levels than the general population in the US (Center for Global Assessment, 2004). Some immigrants face challenges because they did not have the opportunity to learn to read and write in their first language. A plain language adaptation helps to address these disparities. Also, confident readers welcome materials in plain language.

STEP 2: Plain Language Adaptation

Plain language adaptation means making materials “...easy to read and understand, clear, concise, and well-organized information. It is also an approach for communicating in a way that fits the needs, interests, and abilities of the intended audience. Plain language can be used in all forms of communication—oral, print, web, multimedia, and social media. It is not ‘dumbing down’ information, nor is it ‘word-smithing.’” (Plain Language, see www.clearlanguagegroup.com) The recommended reading grade level for health materials for the general public in the US is 6th grade (Doak, Doak, & Root, 1996).

Plain Language Adaptation Examples

Plain language adaptation can include the following:

- Using a conversational tone
- Avoiding jargon, technical terms and bureaucratic language
- Keeping information to key points
- Using language that is more familiar to the intended audience and used in everyday language

Examples of using more familiar language:

FROM:	TO:
Outcomes	Results
Utilize	Use
Insufficient	Lack of - or - Not enough
Increase the effectiveness of programs...	Make programs more effective...

Example of breaking long sentences into shorter ones:

FROM:	TO:
Our mission is to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action.	Our mission is to increase the effectiveness of programs that target the elimination of health disparities. This is done through the coordination of partners, leaders, and stakeholders committed to action.

Example of breaking long sentences with many points to a shorter sentence with listed points:

FROM:	TO:
Eliminating health disparities will necessitate behavioral, environmental, and social-level approaches to address issues such as insufficient education, inadequate housing, exposure to violence, and limited opportunities to earn a livable wage.	Eliminating health disparities will require behavioral, environmental, and social-level approaches to address issues such as these: <ul style="list-style-type: none">• Insufficient education• Inadequate housing• Exposure to violence• Limited opportunities to earn a livable wage

Example of using consistency in terms:

FROM:	TO:
Using both “individuals” and “people” alternating through text.	Using “people” consistently.

Example of using the active voice instead of the passive voice:

FROM:	TO:
This plan will be used by HHS agencies to assess...	HHS agencies will use this plan to assess...

STEP 3: Cultural Adaptation

Language does not live in isolation. It is directly linked to the cultures of the people that speak it. All of us naturally view the world through our own cultural lens.

Writers of original English-language health materials apply their own cultural lens. Because of this, review for any needed cultural changes after a professional translation and plain language adaptation. This adapts the information for the intended audience.

Cultural adaptation means modifying the material for appropriate cultural messages for the intended audience. CHW/Promotores de Salud programs representing the intended audience may be able to make recommendations for cultural adaptation. Faith and other community leaders of the intended audience may also be able to make cultural adaptation recommendations. In some cases, healthcare or translation professionals from the intended audience may be able to make recommendations.

Cultural Adaptation Examples

Cultural adaptations can include these:

- Adapt for cultural motivators:
The source document may use a cultural motivator for smoking cessation as “smoking could give you lung cancer or emphysema” (focus on the individual). A cultural adaptation may be, “in addition to hurting your breathing, your smoking could harm your kids and other family members” (focus on the family).

In some cases, it may be appropriate to add a cultural motivator where there is none in the source document. For instance, in a video for advance directives, it may be appropriate to add the motivator of “Do this for your loved ones so they are clear about your wishes.”

- Modify for appropriate cultural perspectives or terms.
For instance, changing “birth control” to “family planning”.
- Modify any cultural concepts or terms that could be considered offensive.
For instance, change a reference to “death” to “passing away”.
- Modify for the reality of the intended audience.
For instance, when sharing information on healthy foods, highlight the preferred foods of the intended audience.

When sharing information on healthcare access with an immigrant population, avoid assuming all qualify for health insurance. Recognize that some do not. Include healthcare access information that does not require insurance, such as Federally Qualified Health Centers and health departments with sliding fee scales.

When sharing information on how to be physically active, be aware of and sensitive to income differences. Imagine information that promotes riding bikes in the parks while wearing helmets. Not everyone has easy access to safe parks. Also, bikes and helmets can be costly. Choose options that are inclusive across incomes if addressing a broad audience. Consider changing text to go walking in a safe place or turn on some music at home and dance.

- Modify for appropriateness of visual content.
Do images of people look like people in the intended audience? Does other visual content and graphic design speak to the intended audience in the intended way? Are there colors that have positive or negative meanings that need to be modified?

STEP 4: Back Translation

If the client does not speak the language in which the material has been translated, once you have a draft of the translated and adapted material, “back translate” it into English. A back translation means you translate a document back to the source language of the original document. This lets the client get the flavor of the translation as well as plain language and cultural adaptations. For longer translations, it can be helpful to back translate a few sections of text.

STEP 5: Field test of the material

Test the material with members of the intended audience. This can be done through focus groups or one-on-one interviews.

STEP 6. Modification and finalization

Take the feedback from the field test with the intended audience to modify and finalize the material.

STEP 7: Distribution and application

Include the intended audience in distributing and applying the material.

- Share the material with CHWs/Promotores de Salud and their programs. They are trusted and respected members of their communities and can help distribute the health material. They can also work with fellow community members to apply the information to together improve the health of their communities.
- Work with faith communities and share materials of the intended audience and their leaders.
- Share the material with and work with other trusted and respected members from the community of the intended audience.
- Work with community radio stations to share with and encourage communities to use the information in the material to improve health.

References

- Bridging the Gap: A Basic Training for Medical Interpreters. (2014). Communications Skills (Lesson 9, page 125).
- Seattle, WA: Cross Cultural Health Care Program
- Curry-Stevens, A. & Coalition of Communities of Color. (2014). The Slavic Community in Multnomah County: An Unsettling Profile. Portland, OR: Portland State University.
- Curry-Stevens, A. & Coalition of Communities of Color. (2014). The African Immigrant and Refugee Community in Multnomah County: An Unsettling Profile. Portland, OR: Portland State University.
- David, E. J. R. (2013). *Brown Skin, White Minds: Filipino-American Post-colonial Psychology* (with commentaries).
- Charlotte, NC: Information Age Publishing.
- Doak, Doak, & Root. (1996). *Teaching Patients with Low Literacy Skills, Second Edition*. Philadelphia, PA: J.B. Lippincott Company.
- Dean, R. K. and Pollard, R. Q. (2001). Context-based Ethical Reasoning in Interpreting: A Demand Control Schema Perspective. *The Interpreter and Translator*.
- Flores, A. (2017) Facts on U.S. Latinos, 2015: Statistical portrait of Hispanics in the United States. Retrieved from <http://www.pewhispanic.org/2014/04/29/statistical-portrait-of-hispanics-in-the-united-states-2012/>
- Gonzalez-Barrera, A., & Lopez, M. H. (2013). Spanish is the most spoken non-English language in U.S. homes, even among non-Hispanics. Retrieved from <http://www.pewresearch.org/fact-tank/2013/08/13/spanish-is-the-most-spoken-non-english-language-in-u-s-homes-even-among-non-hispanics/>
- Jocano, F. L. (1973). *Folk Medicine in a Philippine Community*. Quezon City, Philippines: Punlad Research House, Inc.
- Kafoury, D. (2015). Chair: We will improve health outreach to Somali-speaking residents. Retrieved from <https://multco.us/global/news/chair-we-will-improve-health-outreach-somali-speaking-residents>
- Kelly, N. & Zetzsche, J. (2012). *Found in Translation: How Language Shapes our Lives and Transforms the World*. New York, NY: Penguin Group.
- Komisyon sa Wikang Filipino. (n.d.). Mapa ng mga Wika. Retrieved from <http://kwf.gov.ph/mapa-ng-mga-wika-ng-filipinas/>.
- Legacy Health. (2016). Culturally competent care. Retrieved from <http://www.legacyhealth.org/our-legacy/legacy-values/diversity/deliver-culturally-competent-care.aspx>
- Limited English Proficiency (LEP) Federal Interagency. (2015). Retrieved from www.lep.gov
- McFarland, C. D. (1993). *Subgrouping and number of Philippine languages*. Manila: Prepared for the Secretary of Education, Culture and Sports, Republic of the Philippines, Pasig, Metro Manila.

- Migration Policy Institute. (2011). Limited English Proficient Individuals in the United States: Number, Share, Growth, and Linguistic Diversity. Retrieved from <http://www.migrationpolicy.org/research/limited-english-proficient-individuals-united-states-number-share-growth-and-linguistic>
- Migration Policy Institute. (2011). Pigments of Our Imagination: The Racialization of the Hispanic-Latino Category. Retrieved from <http://www.migrationpolicy.org/article/pigments-our-imagination-racialization-hispanic-latino-category/>
- National Partnership for Action to End Health Disparities. (2015). Region X Health Equity Council Blueprint for Action. Retrieved from <http://region10.npa-rhec.org/in-the-spotlight/blueprint>
- National Partnership for Action to End Health Disparities (2017). Learn About the NPA. Retrieved from <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=11>
- Office of Disease Prevention and Health Promotion. (2016). Social Determinants of Health. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
- Office of Minority Health. (2016). Understanding How Organizations Use the National CLAS Standards. Retrieved from <https://www.healthplanalliance.org/NewsBot.asp?MODE=VIEW&ID=236&TITLE=Understanding-how-organizations-use-the-national-CLAS-standards>
- Oregon Judicial Department. (2010). OJD Court Interpreter Services 2009 Annual Report. Retrieved from <http://www.courts.oregon.gov/programs/interpreters/news/Annual%20Reports/2009%20CLAS%20Annual%20Report.pdf>
- Rice, S. (2014). Hospitals often ignore policies on using qualified medical interpreters. Modern Healthcare Retrieved from <http://www.modernhealthcare.com/article/20140830/MAGAZINE/308309945>
- Rudd, R., Kirsch, I., & Yamamoto, K. (2004). Literacy and Health in America. Educational Testing Service Center for Global Assessment. Retrieved from <http://files.eric.ed.gov/fulltext/ED486416.pdf>
- Shaw, A. (2013). Evaluation of Adapted Health Education Materials for Limited English-Proficient Spanish-Speaking and Mexican Indigenous Populations. Power Point Presentation. National Conference on Health Communication, Marketing, and Media. Atlanta, GA.
- Sprager, L., & Martinez, O. (2015). Beyond Translation: Promoting a New National Standard for Equity in Health Materials Translated from English. National Academy of Medicine: Washington, DC.
- Sprager, L., & Shaw, A. (2015). Achieving Cultural Competency and Health Literacy through Developing Original Materials for and with Spanish-Speaking Mexican Immigrants. Familias en Accion 2015 Latino Health Equity Conference Equity in the Era of Healthcare Reform. Page 29. Retrieved from <http://familiasenaccion.org/images/2015%20LHEC%20Program.pdf>
- The Guardian. (2015). US now has more Spanish speakers than Spain – only Mexico has more. Retrieved from <http://www.theguardian.com/us-news/2015/jun/29/us-second-biggest-spanish-speaking-country>

- Think Cultural Health website (2017). U.S. Department of Health & Human Services. Retrieved from <https://www.thinkculturalhealth.hhs.gov>
- Trusted Translations. (2017). Retrieved from <http://www.trustedtranslations.com/spanish-language/translation/neutral-spanish.asp>
- U.S. Census Bureau. (2001). Language Use and Linguistic Isolation: Historical Data and Methodological Issues. Retrieved from <http://www.census.gov/population/socdemo/language/li-final.pdf>
- U.S. Census Bureau. (2010). 2010 American Fact Finder. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1
- U.S. Census Bureau. (2017). American Community Survey (ACS). Retrieved from <https://www.census.gov/programs-surveys/acs/>
- U.S. Department of Health & Human Services. (2017). Affordable Care and Patient Protection Act, Section 1557. Retrieved from <https://www.hhs.gov/civil-rights/for-individuals/section-1557>
- Shaw, A. (2013). Power Point "Evaluation of Adapted Health Education Materials for Limited English-Proficient Spanish-Speaking and Mexican Indigenous Populations". National Conference on Health Communication, Marketing, and Media, Atlanta, GA.



Chapter 6: Certification, Contracting, and Procurement

Volunteers versus Professional Language Services

Some organizations have a volunteer language bank of bilingual staff who are asked to provide translation and interpretation services. While it is cost effective to use in-house volunteers compared to a paid vendor service, it may be harder to ensure the quality of the language services provided. Volunteers may lack training and certification. They may have only an elementary understanding of the language and be unable to translate or interpret terms specific to health care or other services. Volunteers pose the problem of accuracy of translated and interpreted information.

Organizations should decide when to use a volunteer from the language bank versus a paid vendor service. A standard option is to use a professional vendor to provide the majority of language services and the volunteer language bank only to supplement and enhance these services. When using volunteer services, keep in mind privacy regulations and concerns. Never ask volunteers to translate a medical or legal document. When the language professional knows the person receiving interpretation services, recognize potential conflicts of interest and confidentiality concerns. Discuss these concerns with the interpreter prior to providing services.

Specifications

Specifications for translation and interpretation services in a request for proposal (RFP) will depend on type of service needed. Consult with someone in your organization who works with contracts to help you.

Key elements to consider in an RFP and contract are:

- Scope of Work, including languages and dialects needed for interpretation and translation services
- Time frames
- If the service is interpretation, then determine the type of interpretation needed; On-Site or Remote Video Interpretation
- Cost
- General Management
- Human Resources Capacity
- Technology
- Damages
- Quality Control
- Evaluation Criteria

Translation Services Guide/Checklist

Specifications for translation services in a request for proposal (RFP) will depend on type of service needed. This checklist can help guide your RFP proposal and service monitoring.

1. IDENTIFY LANGUAGES

Before creating an RFP, do a needs assessment to determine what languages and dialects clients of your organization speak. Look at government-provided demographics. Reliable sources of information include the US Census, American Community Survey, and local school district data on languages spoken in the homes of the students.

Also, indicate the kind and amount of technical language your organization uses. This allows contract bidders to provide detail on their capacity to meet such needs. For example, if your organization works in the healthcare sector, signal to bidders they need the capacity to work with medical terminology.

- Language needs assessment conducted
- Languages identified
- Type of technical language identified

2. TIME FRAMES

Lay out the length of the contract award and delivery expectations. Include how often and when language services will be requested as well as penalties for not meeting deadlines. Time frames will vary depending on the type of service your organization is requesting.

- How often will translation services be requested?
- What penalties are expected for not meeting deadlines?
- How long will bidders need to provide translated materials?
- Will delivery time frames differ based on the type of translation (i.e. a form versus a publication)?

3. COST

Detail how you will decide on payment. Consider different rates depending on the language. If you cannot determine a basis for pay rates, ask bidders to provide their going rate for translation. Rates will vary depending on the type of service you are requesting.

- Will your organization pay per word, use an all-inclusive rate, or separate rates by first translation and third-party review (a qualified person who examines the translated information for accuracy)?
- Will your organization pay extra for rushed translation requests?
- Will your organization pay different rates for different languages?

4. GENERAL MANAGEMENT

Clearly identify the division of responsibilities between your organization and the bidder. Consider the roles of insurance, complaint resolution, and contract monitoring in the contract. Lay out a process for tracking use of language services, which party will be responsible for this, and how these data will be provided.

- Describe your organization's confidentiality and safety needs and procedures.

The major goal of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to assure that a person's health information is properly protected while allowing the flow of health information needed to provide and promote high-quality health care and to protect the public's health and well-being. Effective April 14, 2003, the Privacy Rule limits the ways in which protected health information about people can be used or disclosed. Where use of disclosure is permitted, a written agreement that contains the required privacy language detailing the limits of the use or disclosure is required. Each agency will decide if there shall be a formal agreement between vendor and agency and will execute such an agreement within 30 days of award of contract.
- In addition to the Privacy Rule of HIPAA, bidders are not allowed to disclose contents of any records, files, papers, software, or other communications connected with the administration of its programs for reasons not connected with official business. Official business shall include purposes connected with the administration of purchasers and other agency programs.

5. HUMAN RESOURCES CAPACITY

Ask bidders to indicate the number of translators on staff and their availability. This is very important for high-volume languages, where translators may be working across several contracts. Also, ask for specific information on uncommon languages or dialects.

- Is translation provided by a person or by machine (electronically)?
- Do proofreaders verify the quality of the original translation?
- Is there some other standardization process or final quality control check such as a review for cultural relevance and appropriate dialect?
- What is the bidder's records retention policy?
- Will the translator(s) use glossaries you provide for organization-specific terms? (Note: If your organization does not have a glossary of common terms this would be an opportunity to develop one. A glossary of common terms ensures consistency among translated documents.)

6. TECHNOLOGY

Understand whether technology is used to assist in translation.

- Is translation provided by a person or by machine (electronically)?
- If translation is provided by machine, what type of software is used? (i.e. translation memory vs. machine-based translation)
- What are the limitations of the software used?

7. DAMAGES

Include a section on how to recover damages when translation errors occur, particularly for documents that are professionally printed or produced in mass quantities.

8. QUALITY CONTROL

Ask the bidder to highlight their process for certifying or assessing the quality of translators or outline your expectations. Ask for references, resumes, performance evaluation and monitoring forms, and professional codes of ethics. You can also ask about a process for continuation of language services in the event of a disaster or emergency.

- Are translations proofread by an independent certified linguist prior to submission?
- Ensure that a single translator completes each document to ensure continuity and consistency in terminology, syntax, and style. The dictionary of key words and writing standards will help.
- Translate documents at the same reading level as the source material.

- ❑ Review each translation prior to delivery to ensure that the translated document is linguistically accurate and consistent with the formatting and technical specifications of the original document. The project will not be considered complete if any inaccuracy or inconsistency is found. The additional time used for corrective translation of file(s) will become a part of the total time used to complete the project.

9. EVALUATION CRITERIA

Decide and outline how you will weigh the importance of different parts of the proposals you will receive. For example, costs, quality control and management are important to consider. You can create a point or percent scoring system to make your RFP evaluation process easier and more consistent.

10. QUALITY ASSURANCE BEGINS DURING THE REQUEST FOR PROPOSAL (RFP) PROCESS

- ❑ Require potential bidders to commit to an adequate quality-control process for all deliverables. Specifically, this should include a process in which multiple linguists review all translations before delivery.
- ❑ Contractors should detail their (and their independent contractors') skills with translation memory software. Translation memory software helps ensure quality through consistency. Bidders should include the discounted prices in their final proposal results from using the translation memory software.
- ❑ If dealing with multiple contractors, consider evaluating the contractors' performance to produce a ranking order. This will help for future service requests.

11. INTERNAL STRATEGIES

Internal strategies can help the contractor provide a translation that best fits the needs of both your agency and the people you serve.

- ❑ Establish a bilingual glossary of key terms for each language. Include a set of writing and design standards. This may be done with bilingual staff familiar with the organization's jargon. In some cases, contractors may create these tools. Alternatively, they can be developed through a combination of both contractors and internal staff to reach agreement. A glossary will help ensure consistency, regardless of who translates the document, and will minimize criticism of the translations.
- ❑ Provide the text in plain language when possible. Translation often increases complexity. This will help prevent any misinterpretations of words used or intent of the information.
- ❑ Consider the reading level of the text provided.
- ❑ Ensure that the internal reviewer focuses only on true errors and omissions. Be prepared to provide contractors with appropriate guidance and direction, instead of simply criticism. Contractors need to hear what they are doing wrong – and right – so that they learn your preferences and apply them on future jobs.
- ❑ Use Translation Correction Guidelines, if your agency has them, when reviewing and responding to comments that are the result of translation accuracy reviews conducted.

Interpretation Services Guide/Checklist

Specifications for interpretation services in a request for proposal (RFP) will depend on type of service needed. This checklist can help guide your RFP proposal and service monitoring.

1. IDENTIFY LANGUAGES

Before creating an RFP, do a needs assessment to determine what languages and dialects clients of your organization speak. Look at government-provided demographics. Reliable sources of information include the US Census, American Community Survey, and local school district data on languages spoken in the homes of the students.

Also, indicate the kind and amount of technical language your organization uses. This allows contract bidders to provide detail on their capacity to meet such needs. For example, if your organization works in the healthcare sector, signal to bidders they need the capacity to work with medical terminology.

- Language needs assessment conducted
- Languages identified
- Type of technical language identified

2. TIME FRAMES

Lay out the length of the contract award and delivery expectations. Include how often and when language services will be requested as well as penalties for not meeting deadlines. Time frames will vary depending on the type of service your organization is requesting.

- How often will interpretation services be requested?
- What is the typical length of time with clients and customers?
- On-Site Interpretation: How long in advance must your organization give notice for an on-site interpreter? Can last-minute requests be met? Are interpreters available during specific hours?
- Telephone or remote video interpretation: How long will a client or customer wait to be connected with an interpreter? Are interpreters available during specific hours?

3. COST

Detail how you will decide on payment. Consider different rates depending on the language. If you cannot determine a basis for pay rates, ask bidders to provide their going rate for interpretation. Rates will vary depending on the type of service **you are requesting**.

- On-Site Interpretation: How will you pay — per hour, per half hour? Will you pay for interpreters' travel time or mileage? Will pay rates differ based on time of day and day of week? Sometimes you need to pay a service or contractor to be on call, even if you end up not using its services. Will you pay a minimum advance fee to ensure services are available on a day even if you end up not needing the service?
- Telephone Interpretation: What will be the time measurement for pay rates — per minute, per 30 seconds? Will pay rates differ based on time of day and day of week?
- Will your organization pay different rates for different languages?

4. GENERAL MANAGEMENT

Clearly identify the division of responsibilities between your organization and the bidder. Consider the roles of insurance, complaint resolution, and contract monitoring in the contract. Lay out a process for tracking use of language services, which party will be responsible for this, and how these data will be provided.

- Describe your organization's confidentiality and safety needs and procedures. The major goal of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to assure that an individual's health information is properly protected while allowing the flow of health information needed to provide and promote high-quality health care and to protect the public's health and well-being. Effective April 14, 2003, the Privacy Rule limits the ways in which protected health information about individuals can be used or disclosed. Where use of disclosure is permitted, a written agreement that contains the required privacy language detailing the limits of the use or disclosure is required. Each agency will decide if there shall be a formal agreement between vendor and agency and will execute such an agreement within 30 days of award of contract.
- In addition to the Privacy Rule of HIPAA, bidders are not allowed to disclose contents of any records, files, papers, software, or other communications connected with the administration of its programs for reasons not connected with official business. Official business shall include purposes connected with the administration of purchasers and other agency programs.

5. HUMAN RESOURCES CAPACITY

Ask bidders to indicate the number of interpreters on staff and their availability. This is very important for high volume languages, where interpreters may be working across several contracts. Also, ask for specific information on uncommon languages or dialects.

- Does the interpreter have glossaries or other guides to assist in interpretation? Will the interpreter use glossaries you provide for organization-specific terms?

6. TECHNOLOGY

Lay out expectations for the use of technology to assist in interpretation. At a minimum, clearly establish whether your organization will provide technology, whether the bidder will provide the technology, and what technology the bidder uses. These considerations will vary depending on the type of service your organization is requesting

- Telephone/Video Interpretation: What software is used? What are the limitations of the software? What processes are in place in the event the software fails?
- On-Site Interpretation: What types of software or technical tools are used, if any?

7. QUALITY CONTROL

Ask the bidder to highlight their process for certifying or assessing the quality of interpreters or outline your expectations. Ask for certification, qualification, references, resumes, performance evaluation and monitoring forms, and professional codes of ethics. You can also ask about a process for continuation of language services in the event of a disaster or emergency.

- Are translations proofread by an independent certified linguist prior to submission?
- Ensure that a single translator completes each document to ensure continuity and consistency in terminology, syntax, and style. The dictionary of key words and writing standards will help.
- Translate documents at the same reading level as the source material.
- Review each translation prior to delivery to ensure that the translated document is linguistically accurate and consistent with the formatting and technical specifications of the original document. The project will not be considered complete if any inaccuracy or inconsistency is found. The additional time used for corrective translation of file(s) will become a part of the total time used to complete the project.

8. EVALUATION CRITERIA

Decide and outline how you will weigh the importance of different parts of the proposals you will receive. For example, costs, quality control and management are important to consider. You can create a point or percent scoring system to make your RFP evaluation process easier and more consistent.

9. QUALITY ASSURANCE BEGINS DURING THE REQUEST FOR PROPOSAL (RFP) PROCESS

Require potential bidders to commit to an adequate quality-control process for all deliverables.

10. INTERNAL STRATEGIES

Internal strategies can help the contractor provide interpretation services that best fits the needs of the people you serve.

- Establish a bilingual glossary of key terms used by your agency for each language. In some cases, contractors may create these tools. Alternatively, they can be developed through a combination of both contractors and internal staff to reach agreement. A glossary will help ensure consistency.
- All interpreters providing services under this contract must undergo an interpreter skills assessment by the organization and/or the American Translator's Association (ATA). Prior to any interpreter performing services for this contract, the contractor, or an authorized alternate qualified contractor, must perform an assessment and endorse the interpreter as approved and qualified.

Chapter 7: Resources

Laws & Regulations

- [Plain Writing Act of 2010](#)
- [CDC Action Plan to Improve Health Literacy](#)
- [Executive Order 13166, Title VI of the Civil Rights Act of 1964 \(Title VI\)](#)
The Executive Order requires federal agencies to examine services they provide, identify any need for services to those with limited English proficiency, and develop and implement a system to provide those services, ensuring meaningful access to them.

Websites with Resources

- [Think Cultural Health](#): The National Standards for Culturally and Linguistically Appropriate Services (CLAS) provide the framework for all health organizations to best serve the nation's diverse communities.
- [EthnoMed](#): Integrating Cultural Information into Clinical Practice
- [Limited English Proficiency \(LEP\) Federal Interagency website](#)
- [Diversity Rx](#): Promotes language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities

Toolkits & Resources

- [Tools for Cross-Cultural Communication and Language Access Can Help Organizations Address Health Literacy and Improve Communication Effectiveness](#). Centers for Disease Control and Prevention (CDC)
- [Learn About Health Literacy Centers for Disease Control and Prevention \(CDC\)](#)
- [University of Washington Medical Center - Patient Health Literacy \(https://depts.washington.edu/pfes/PDFs/Patient%20Health%20Literacy.pdf\)](https://depts.washington.edu/pfes/PDFs/Patient%20Health%20Literacy.pdf)
- [Outreach in an Anti-Immigrant Climate Health Outreach Partners](#)
- [Toolkit Guidelines for Culturally Appropriate Translation](#) The Centers for Medicare and Medicaid Services
- [Early Childhood Education and Assistance Programs](#) and qualifying community clinics to improve health literacy
- [Cultural Diversity - A Guide for Health Professionals](#)
- [Refugee Health – Vancouver: Cultural Profiles](#): Cultural profiles provide an overview of the countries from which Canada receives refugees.
- [Maya Health Toolkit for Medical Providers](#): This toolkit identifies the major healthcare barriers between Maya and medical professionals, and provides resources to bridge gaps in communication.

- [EthnoMed - Ethnic Specific Geriatric Care in the United States](#): Stanford School of Medicine has developed an ethnogeriatric curriculum for 13 ethnicities (African American, Alaska Native, American Indian, Asian Indian American, Chinese American, Filipino American, Hawaiian and Pacific Islander, Hispanic/Latino American, Hmong American, Japanese American, Korean American, Pakistani American, and Vietnamese American) to better prepare health professionals in providing culturally-competent care.
- [Cultural Diversity - A Guide for Health Professionals](#)
- [“ISpeak” Cards](#): The “ISpeak” cards are for consumers to bring with them when seeking care which identifies the language they speak. The cards, available in more than 30 languages, are produced by the Washington State Coalition for Language Access.
- [Clinical Pearl: End of Life Care](#) A short clinical pearl about the additional complexities of communicating about end-of-life care with non-English speakers.
- [Phrases of Courtesy in Nine Languages: A Tool for Medical Providers](#)
- [Translation Getting it Right](#): A guide to buying translation published by the American Translators Association
- [Guidelines for Interpreted Visits](#)
- [Cross-Cultural Medicine & Working With Interpreters](#): A teaching module designed and narrated by Dr. Margaret Isaac, Foundations of Clinical Medicine at the University of Washington
- [Communicating through an Interpreter](#): This is an on-line training course authored by Cynthia Roat, MPH and Elizabeth Jacobs, MD, both nationally recognized experts in language access in health care.
- [Tools for Assessing Cultural Competence Training](#): Association of American Medical Colleges
- [A Physician’s Guide to Culturally Competent Care](#): A course for health practitioners from the US Department of Health and Human Services Office of Minority Health
- [Immunization Action Coalition](#): Vaccine information available in many languages through the Immunization Action Coalition
- [Health Information Translators](#): Provides education resources in multiple languages for healthcare professionals and others to use in their communities
- [USCRI Healthy Living Toolkit](#) is designed to educate refugees and immigrants to become proactive health consumers and promoters in their communities.
- [Selected Patient Information Resources in Asian Languages \(SPIRAL\)](#): A compilation of health materials available in Cambodian, Chinese, Hmong, Korean, Laotian, Thai, and Vietnamese languages. A joint initiative between Tufts University Health Sciences Library and the South Cove Community Health Center.
- [Provider’s Guide to Quality and Culture](#): Information and resources for clinicians working with immigrant, refugee, and racial/ethnic minority populations. This guide is web based with interactive components.

Organizations

National Organizations

- [American Civil Liberties Union](#): Advocates for rights through legal action, legislation, and public education, and provides updates on key issues and campaigns.

- National Immigration Law Center: Offers the latest immigration news and resources.
- National Network for Immigrant and Refugee Rights: Educates communities and the public to develop and coordinate plans of action on immigrant and refugee issues.
- The US Department of State: Consulates are important resources that may be able to provide recommendations or support around immigration-related issues. Many consulates have a protection department that helps address issues of immigration, detention, and deportation.
- CDC Refugee Health Profiles: These refugee health profiles provide key health and cultural information for specific refugee groups resettling in the United States.
- Cultural Orientation Resource Center (CORC): The Cultural Orientation Resource Center has produced numerous publications providing key information about various refugee populations.
- National Council on Interpreting in Health Care:
- The Cross Cultural Health Care Program (CCHCP): CCHCP's primary goal is to improve the health care of communities that face linguistic and cultural barriers to receiving health services.
- Spring Institute for Intercultural Learning: Provides language training, direct services, and technical assistance with a focus on language and culture. They have a number of resources around English- language teaching available for downloading.

Pacific Northwest-Specific Organizations

- State Hispanic, Asian, or Other Ethnic Minority Commissioners: Alaska, Idaho, Oregon, and Washington have variations of this type of state organization that may focus respectfully on disparities relating to a specific common population. They can be great partners, offer other resources, and influence policy.
- The Oregon Primary Care Association featured the Read Out and Read Program at its Spring Symposium in April 2013. The organization hopes to “weave health literacy into the Patient-Centered Medical Home fully, along with motivational interviewing and other core skills”.
- The Puget Sound Health Alliance launched a health literacy initiative.
- The Cross Cultural Health Care Program (CCHCP) has recently completed an analysis of existing patient navigator programs.
- The Anchorage Health Literacy Collaborative
- Idaho Community Health Worker Alliance
- Harborview Interpreter Services Department
- Collaborative Strategies For Language Access In Health Care in Seattle & King County

Programs

- The Cross Cultural Health Care Program (CCHCP) in Seattle, WA has been offering training for medical interpreters since 1992. CCHCP courses include Bridging the Gap: A Basic Training for Medical Interpreters and Equity and Inclusion: Cultural Competency.
- The State Board for Community and Technical Colleges (SBCTC) funds and supports literacy services at community and technical colleges and community-based organizations.