

6 Access to Care

INTRODUCTION

Latinos face many challenges in accessing needed health services. New immigrants often have different health care beliefs, and may not understand how the US health system works or how to access services (see Chapter 3). Many Latinos face significant financial barriers, with a disproportionate number of Latinos lacking health insurance coverage, and many afraid to seek services from governmental agencies (see Chapter 7). Like other low-income populations, many Latinos work and have difficulty taking off work to go to the doctor; others have transportation barriers. Latinos, especially recent immigrants, also face significant language barriers. These problems are compounded for migrant farmworkers who travel with the growing season, staying in each individual community for short periods of time. Because of the transitory nature of their work, migrant farmworkers may have little understanding of the local health care systems. Migrants are often isolated, live in rural areas, lack telephones, and may lack transportation.

This chapter focuses on language and cultural barriers faced by the population. Language, in particular, is one of the biggest challenges North Carolina faces with the influx of Latino immigrants. According to the US Census, approximately half of North Carolina Latinos have limited English proficiency (LEP) or are unable to speak English very well.¹ These language barriers can impair a Latino's ability to access needed programs and services. Further, almost 30% of North Carolina Latinos immigrated to the United States recently (since 1995), and may not be knowledgeable about how the US health care system works.²

Federal regulations, interpreting Title VI of the Civil Rights Act of 1964, have provisions to ensure that language does not prevent people from accessing federally-funded programs. Title VI prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal

assistance.³ This includes both public agencies receiving federal funds (such as state or local health departments, area mental health programs, or departments of social services) and private individuals and institutions that receive federal funds, including Medicaid or Medicare payments. Title VI regulations prohibit both intentional and unintentional discrimination resulting from policies that may appear to be neutral, but, in fact, have a discriminatory effect. Thus, the failure to make services and programs linguistically accessible to LEP individuals has been interpreted to have a discriminatory effect on the basis of a person's national origin. As North Carolina has experienced one of the fastest growing rates of Latino immigration in the country, complying with Title VI has become a critical issue.

In October and November of 2001, the Office of Civil Rights (OCR) within the US Department of Health and Human Services conducted a review of the NC DHHS to determine their compliance with Title VI. Each of North Carolina's one hundred counties filled out a survey as part of this review. OCR selected specific counties for on-site reviews of local public health and DSS agencies, including Chatham, Randolph, Johnston, Wake and Forsyth. Based on these surveys and site visits, the OCR sent a letter at the request of the NC DHHS outlining their "preliminary assessment" of the situation. The letter described several instances of poor compliance and concluded:

"...The evidence gathered by OCR during the course of the ... review indicates that overall, the NC DHHS fails to provide adequate language assistance to Hispanic/Latino, Hmong and other national origin groups who speak a primary language other than English. This failure makes it more difficult for members of these population groups to access the various services, programs, and benefits provided by NC DHHS and/or outright be denied access to the same. In addition, a lack of adequate language assistance also causes some national origin minorities who are also the agency's LEP clients or prospective clients to be subjected to differential treatment. Accordingly, OCR's preliminary findings reflect that NC DHHS conduct, in the context of the specific circumstances uncovered during the course of this review, constitutes a violation of the Title VI regulatory provisions... Based on the deficiencies briefly summarized [in this letter], OCR's preliminary analysis indicates that the NC DHHS would likely be found out of compliance with Title VI." (*Letter from Roosevelt Freeman, Regional Manager, Office of Civil Rights, Region IV to Secretary Carmen Hooker Buell, dated May 24, 2002, hereinafter referred to as "OCR letter."*)

The failure to comply fully with Title VI could threaten the federal financial assistance received by state or local agencies or private providers. Even absent the threat of loss of federal funds, the Task Force recognized the underlying need to address linguistic and cultural barriers that prevent Latinos from seeking health care services. Thus, the Task Force placed a high priority on ensuring that the NC Department of Health and Human Services, local agencies, and private providers comply with the requirements of Title VI.

Compliance with Title VI involves the provision of linguistically and culturally appropriate services. This seemingly simple statement requires effort and

action on many levels. To the extent possible, care should be compatible with the individual's cultural health beliefs and practices. Further, Title VI requires federal-fund recipients to make services linguistically accessible, by providing free language assistance through translated materials, interpreters, or bilingual staff. Task Force members recognized that the goals of ensuring linguistically accessible and culturally appropriate services could best be met through the use of bilingual providers. This is especially critical when dealing with sensitive health issues or areas, such as counseling, where direct communication between provider and patient is critical. However, there are currently insufficient numbers of bilingual, culturally proficient providers. In the interim, interpreters coupled with skilled professionals who are able to recognize and respond to the health-related beliefs and different cultural understandings of Latinos are needed. To accomplish the provision of culturally and linguistically appropriate services, collaboration is needed between state and local agencies, and between public and private organizations.

The Task Force thoroughly reviewed Title VI guidelines and recommendations issued by several agencies at the national level. OCR issued guidelines on how federal-fund recipients can comply with Title VI (hereinafter referred to as "OCR guidelines").⁴ Similar guidelines were published more recently by the US Department of Justice (hereinafter referred to as the "DOJ guidelines").⁵ The DOJ guidelines, in particular, try to balance the competing needs of people with limited English proficiency in accessing services or programs against the additional costs that could be incurred.

While the guidance is designed to be a flexible and fact-dependent standard, the starting point is an individualized assessment that balances the following four factors: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. As indicated above, the intent of this guidance is to suggest a balance that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits.⁶

Using both the DOJ and OCR guidelines as a base, the North Carolina Department of Health and Human Services has developed a Title VI compliance plan that it submitted to OCR. This plan was reviewed by the Task Force, and when appropriate, endorsed as part of its overall recommendations. However, other recommendations were also made to ensure compliance on the part of public and private organizations.

The following sections, including the recommendations, are divided into eight areas that are essential to compliance. These are: *Assessment; Provision of Culturally and Linguistically Appropriate Services; Translation of Written Materials; Training Staff; Monitoring and Reporting; Complaints; and Community Partnerships, Publicity, and Education.*

ASSESSMENT

OCR found that the NC DHHS has "failed to conduct an assessment regarding the language needs of (LEP) population groups... As a result, program administrators do not have sufficient understanding regarding the variety and/or overall size of the LEP populations in their respective service areas." (OCR letter) Further, OCR found that the NC DHHS also failed to gather information about the frequency with which members of different LEP categories attempted to access services and programs. Assessment is an important first step in adequately providing language services to LEP groups.

OCR and DOJ guidelines require Title VI recipients, including the NC Department of Health and Human Services, to identify the language needs of LEP persons that are eligible for services or likely to be affected by the program. Federal fund recipients can use census data, client utilization data from program files, and data from school systems and community agencies and organizations to try to ascertain the language needs of LEP individuals. This needs to be done at both the state and local level. In addition, all federal fund recipients are required to collect utilization data by race and ethnicity.

The NC Department of Health and Human Services can help analyze state-level data sources to determine the number of potential LEP individuals in a community. For example, the state can analyze Census data, school enrollment data, or Medicaid/NC Health Choice eligibility information files to identify the number of Latinos or other immigrants in a county. While Census numbers and other state-level utilization data may help identify the number of immigrants in particular areas of the state, these sources are not as helpful in identifying the language skills and cultural background of community members who might seek assistance from a federally-funded agency or health provider. Local monitoring and assessment are needed to adequately identify the language skills and cultural background of community members who might be seeking services.

The OCR guidelines state that federal fund recipients should identify the language needs of each applicant, and document this in the client file. In addition, local agencies must make available language identification cards that allow LEP individuals to identify their language needs. Recognizing that each local agency will not have the capacity to meet the language needs of every individual who seeks services, the OCR guidelines require agencies to identify community resources to help address these needs, and to establish mechanisms to access these services in a timely manner. In addition, the Task Force recognized the importance of understanding the cultural background of the clients, so as to provide culturally appropriate services.

Recommendations

After reviewing the OCR and DOJ guidelines and the draft of the NC Department of Health and Human Services compliance plan, the Task Force recommended that:

- 11. The NC Department of Health and Human Services analyze existing data to identify the potential number of individuals with limited English proficiency. These data should be shared with local agencies and health care**

organizations. Local agencies and other federal fund recipients should use this information, along with their own client data, in their assessments to determine the language needs and cultural background of their client population. In addition, federal fund recipients should ask their clients (or program applicants) of their language needs. If an individual self identifies as having limited English proficiency, this information must be recorded in the client's file so that interpreters and/or written translated materials can be provided.

Specifically, the Task Force suggested the following:

- The NC State Center for Health Statistics should collaborate with other NC DHHS Division staff to analyze census and program utilization data at the county level. The Census data will show the numbers of Latinos and other immigrant populations in the county and some income information to help determine potentially eligible individuals for means-tested programs. DHHS and local data systems can examine the Health Services Information System (HSIS) and other state data systems to identify the number of Latinos who use services. NC DHHS should identify any population group where the potential number of LEP persons exceeds five percent of the population or 1,000 people.⁷
- NC DHHS should help local agencies access appropriate language identification cards. Language identification cards help identify individuals with limited English proficiency and also help identify the language needs of individuals. These cards are available from the US Department of Health and Human Services, and are also available through the Internet.⁸ The NC Department of Health and Human Services can help local agencies access these resources by developing a Title VI web page for the Department, linking to the US DHHS website that includes the language identification cards. This Web site could also contain all LEP materials the state develops, such as translations of notices, application forms, instructions, and outreach materials.
- The NC General Assembly should require DHHS to work with other groups (e.g., AHEC, state licensure boards, Carolina Association of Translators and Interpreters, Community Colleges) to develop a registry of health professionals who are proficient in other languages (or sign language). The Board of Nursing and the Board of Pharmacy already collect these data, or are in the process of doing so. Other licensure boards should be contacted and encouraged to include similar questions as part of their periodic licensure renewals. By linking LEP persons in need of health care with providers proficient in their language, DHHS will provide persons with a higher quality of care and avoid the cost of providing interpreter services.
- DHHS should make available an assessment tool to enable health and social services programs to evaluate their agency-specific assessment plans and their capacity to meet OCR guidelines (i.e., technical assistance for organizations desiring to improve compliance). An assessment tool is available from the US Department of Health and Human Services.⁹ This assessment tool

should be evaluated to determine whether it meets the needs of the state, local agencies, and private sector care providers. If so, links to this assessment tool can be included in the NC DHHS Title VI web page.

- Local agencies and health care providers and institutions should determine the language needs of each applicant/recipient at the first point of contact. Information about language needs should be collected on the program applications or on patient records. Individuals with limited English proficiency must be informed of their right to have an interpreter at no cost.
- State and local agencies and health care providers should develop a written plan that outlines policies and mechanisms to ensure they provide culturally and linguistically accessible services. The plan should be tied to the organization's mission, should include the personnel or departments responsible for implementing the plan, and should include a mechanism for ongoing self-assessments to determine the extent to which the organization is meeting its goals of providing culturally and linguistically accessible care.

PROVISION OF CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES¹⁰

OCR in its evaluation of the linguistic accessibility of local health departments and social services agencies in North Carolina, found that individuals with limited English proficiency were, in some instances, "effectively denied the services" because no interpreter was available.

"The record also shows that national origin minorities who are LEP have been subjected to unjustified, differential treatment as prohibited under Title VI. There are specific instances in the record where LEP clients were not provided interpreters as needed. In many of these situations, LEP clients did not receive the services sought at the time.... there is also evidence that in a number of situations, after being turned away because no interpreters were available, several LEP clients were never provided the programs or services being sought. In other words, they were effectively denied the services being requested." (OCR letter)

In other instances, local agencies were requiring LEP clients to bring their own interpreters, a policy that violates Title VI.

"...in many instances the agency implements a policy of requiring LEP clients to use their family members, including minor children, and friends as interpreters. The record documents several situations involving LEP clients being turned away because they did not bring their own interpreters with them. In such cases, they were denied assistance altogether or delayed because they were asked to return later with an interpreter. This practice compromises the confidentiality and accuracy of the communication between agency personnel and the clients/patients/beneficiaries." (OCR letter)

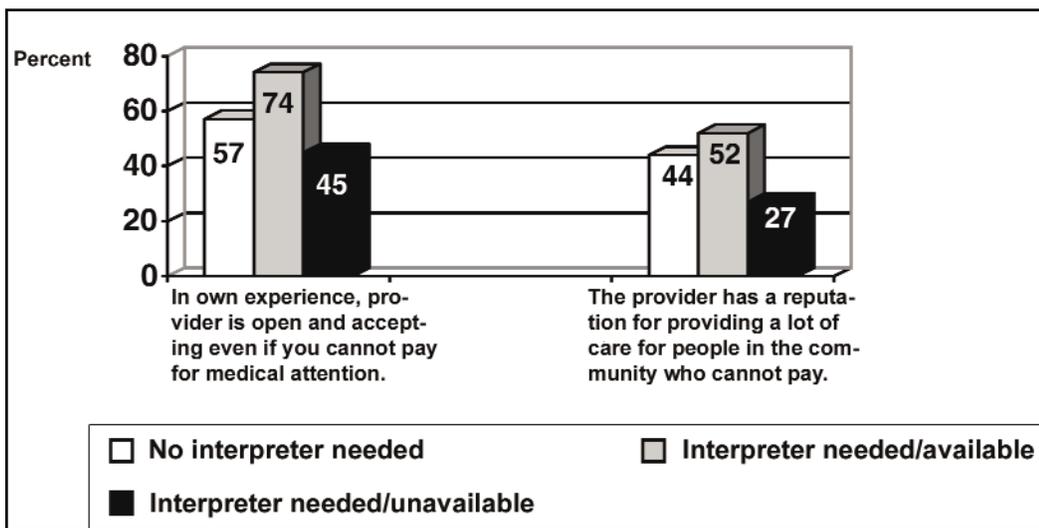
Agencies need to understand that this practice is inappropriate, as it compromises confidentiality and the accuracy of communication.¹¹ Family members may also be unfamiliar with medical terminology and appropriate methods of

interpreting.

When there are no Spanish-speaking providers or interpreters available, clients are not adequately served. National studies of patients with language barriers show that this population is generally less satisfied with their care, less willing to return to the specific facility where they received care, and less likely to be given a follow-up appointment compared to those without language barriers (Chart 6:1).^{12, 13} Needing an interpreter and not receiving one also results in more confusion about how to take prescribed drugs and led to negative attitudes about future use of the facility.

Chart 6:1

Respondents with Positive Perceptions of Provider's Openness to Uninsured and Reputation in Community¹⁴



Having access to an interpreter may lessen the likelihood that uninsured LEP patients will avoid or delay needed health care.

In North Carolina, interpreters are available at many state and local public and private organizations. For example, almost all health departments have mechanisms to provide translation and interpretation for certain services. Ninety-four DSS offices offer some interpreter services, either through paid interpreters, volunteers, contracts or language lines.¹⁵ Some mental health agencies also have interpreters or bilingual staff. The actual number of interpreters or bilingual staff in local agencies is unknown. Determining the actual number of people who serve in this capacity would be difficult as few agencies have large numbers of dedicated staff interpreter positions. Many bilingual staff members serve in other positions in the agency and their interpreter duties are in addition to their primary responsibilities. These individuals are not listed as interpreters, but as bilingual staff or volunteers. The larger the budget, the greater chance there is a professional interpreter or a high-level bilingual staff member. In smaller counties it is more common to find volunteers or staff that serve multiple roles.

Exemplary Practices

Duke's Organization of Interpreter Services

Duke University's International Patient Services (IPS) office provides interpreter services to Duke Hospital and 17 outlying clinics. During business hours, medical interpreters (including Spanish, Arabic, French, German, and Mandarin) are dispatched from the IPS office. Providers call a central number to request interpretation services immediately or to schedule services for a later time. Interpreter services can also be provided over the phone, which is useful when patient-provider interactions are brief, patients need help making appointments or asking questions, or when assistance is needed with the billing process. After business hours, interpreters are dispatched from the hospital's Service Response Center. One interpreter remains on duty after hours and on the weekends, and a backup interpreter works from home. Overnight and during the weekends, the hospital uses a local contract service that dispatches Spanish medical interpreters to a number of hospitals and agencies.

Training is a central part of the interpreter services provided at Duke. IPS provides extensive training to all new interpreters before they are allowed to interpret in difficult medical situations. In addition, IPS staff members have been certified to give a "Bridging the Gap" course each year that teaches interpreter skills, cultural competency, communication skills, advocacy skills, and professional development to Duke interpreters. IPS hopes to extend the training program so that other local hospitals can participate.

Similarly, private providers, especially those likely to serve the Latino community, also try to have interpreters or bilingual staff available. Community and Migrant Health Centers routinely offer interpreter services, and many have bilingual staff. Eight of the 19 state-funded rural health organizations have at least one bilingual medical provider.¹⁶ However, having one or more people on staff who speak Spanish may not be sufficient to meet the needs of all the Spanish-speaking people in the service area that have limited English proficiency and are eligible for services.

Each of North Carolina's 140 hospitals has a senior level manager in charge of ensuring that interpreters are available when needed.¹⁷ Since hospitals provide services twenty-four hours a day, these managers are faced with the challenge of providing interpreter services at all times of the day and night. Additionally, maintaining interpreter programs involves the availability of appropriately trained staff, verification of skills and competence among interpreters, costs of recruiting bilingual providers, translating patient-education materials, and establishing back-up services.

While many agencies have started to hire interpreters or bilingual providers, the capacity of these agencies and local providers to meet the language needs of the state's rapidly growing Latino population is still limited. The NC Center for Public Policy Research study in 1995, along with the recent OCR review, showed that the lack of interpreter services and bilingual staff is one of the overriding concerns in meeting the health needs of the Latino population.¹⁸

Although there are many people in this state who speak Spanish, particularly with the growing Latino population, identifying individuals who are competent to serve as interpreters is not a simple matter. The OCR and DOJ noted that federal-fund recipients must offer competent interpreters free of charge to the LEP individuals. This can be accomplished by either hiring bilingual staff, hiring staff interpreters, contracting with outside interpreter services, arranging for voluntary community services, or arranging/contracting for the use of telephone interpreter services. The DOJ guidelines allow the LEP person to use a family member or friend, if appropriate and the person is competent.¹⁹ However, it is difficult to ensure competency of individuals not specifically trained to be interpreters. Because of the concern over potential breaches of confidentiality as well as the need to ensure trained interpretation, OCR specifically notes that agencies may not suggest or encourage LEP individuals to use friends, minor children or family members as interpreters. If a person chooses to reject the agency's offer of a trained interpreter, or chooses to bring his or her own interpreter, this must be recorded in the file. The NC Department of Health and Human Services, in its proposed compliance plan, requires agencies to inform LEP individuals of their right to free interpreter services.

An important part of providing linguistically and culturally appropriate services is publicizing these services so that consumers will use them. In its evaluation of the NC DHHS, the OCR found that "throughout the State, the agency fails to provide notice to program participants that interpreter services are available to them at no cost." (OCR letter) All health care organizations need to publicize, in English and Spanish, the fact that they provide interpretation services

Exemplary Practices

Union County DSS

Union County's Department of Social Services is at the forefront of developing culturally appropriate and linguistically accessible services. The agency has hired a Spanish-speaking receptionist and five caseworkers to help determine eligibility for public assistance programs. They also contract for the services of interpreters/translators for other programs provided to families. Before these employees were hired, they had only 50 Spanish-speaking cases. Their Latino caseload has grown to more than 1,000 Medicaid cases and 350 Food Stamp cases. In addition, Union County DSS developed a training video and other materials, including basic information on Latino culture, demographics, public assistance eligibility issues, and child welfare services for Latino families for use by its staff. This video has been used by several other county social services agencies, both inside and outside of Union County. The video's production costs were all donated.

to those who need them. Further, the NC DHHS Office of Citizens Services' toll-free hotline (CARELINE) should be publicized so that individuals who need information about the availability of publicly-funded services and/or interpreter services can obtain information. The Office of Citizens Services has bilingual staff who can answer questions and refer individuals with limited English proficiency to appropriate state and community resources.

Covering the costs of interpreter services is more complicated, especially for private providers. Some of these costs can be reimbursed through Medicaid, for example, interpreters used during the DSS eligibility process can be reimbursed as an administrative cost at a 50% federal match rate. However, only 67 of the 100 DSS offices claim the 50% administrative match for interpreter services.²⁰ Interpreters used by health professionals during the provision of medical services may be included as part of the cost-based reimbursement paid to public providers, community and migrant health centers, and rural health clinics. Some private providers may be able to build some or all of the interpreter's costs into their reimbursement system; but this may not always be possible, particularly when the state pays based on a fixed payment scale (for example, physicians are reimbursed as a percentage of Medicare's physician payment system. There is no mechanism in the state's current payment system to enhance payments to physicians who hire interpreters to serve the Latino population).

Information from the National Health Law Program showed that a number of states have obtained federal funding to help offset part of the costs of interpreter services.²¹ Idaho, Hawaii, Maine and Utah receive reimbursement for interpreter services as a covered service, thus obtaining reimbursement at a higher match than the traditional 50% administrative match rate. Hawaii, Washington and Utah contract with agencies to provide interpretation services. The state pays for these services directly. Washington plans on moving to a contract broker system for all interpreter services, which is expected to result in reduced rates. In New Hampshire, interpreters contract with the state as participating providers. Idaho, Maine and Minnesota require providers to pay for interpreter services, but then the state reimburses the providers for these costs.

While training and finding payment sources for interpreters is critically important, it does not replace the need for hiring bilingual staff or providers who can work directly with the Latino population. Under the state personnel system, state agencies can increase salaries for bilingual staff by 5%.²² While this option is available, it is not always used. Similar systems are not always available at the local level. Further, special recruitment efforts are needed to recruit bilingual and bicultural providers and agency staff, and to encourage Latino youth to seek health care professions.

Recommendations

To address these needs, the Task Force recommended that:

- 12. The North Carolina General Assembly appropriate funds to AHEC and the NC Department of Public Instruction to develop specific career development strategies targeted to middle and high school LEP and Latino students to promote educational success and to foster interest in higher edu-**

cation (including associate, college and post-graduate education) to enter health and human services professions. Community Colleges and Universities should help facilitate the entry of Latinos and other bilingual individuals into health and human services professions.

Ultimately, the best way to address the language barriers of the Latino population is to train native-Spanish speaking individuals in the health professions. Not only will training native-Spanish speaking individuals in health professions help address the language barriers that currently exist, but it can also help ensure that more patients receive culturally appropriate care. Identifying Latino youth who may be interested in a health care or human services profession, and encouraging them to obtain the needed training may be the best way to address the health care needs of the growing Latino population. One promising way to identify these youth is to collaborate with Latino organizations that have youth leadership programs, such as El Pueblo, El Centro Hispano of Durham and the NC Society of Hispanic Professionals.

One of the major barriers to this approach is the current policy of the NC Community College System, which restricts undocumented immigrants from enrolling in college level or other post-secondary courses for academic credit. According to the state's interpretation of federal immigration law,²³ Community Colleges can only enroll undocumented immigrants in GED preparation, Adult Basic Education, Adult High School, English as a Second Language (ESL) or other continuing education courses, and not in post-secondary institution (whether or not the student is willing to pay the full costs of their education). Other states, including New York, California and Texas, have developed systems to enable undocumented immigrants to enroll in their post-secondary institutions for college level courses.

The Task Force also recommended that:

13. The Department of Health and Human Services help local communities in their efforts to recruit and retain bilingual and bicultural providers and to hire and train interpreters. The Department will take responsibility for identifying possible grant sources for these efforts, and will assist local communities in seeking these funds. In addition, the Department should develop systems to maximize federal funds to reimburse providers and agencies for interpreter services. The NC General Assembly should appropriate funding to the Department of Health and Human Services to assist in recruiting bilingual and, if available, bicultural health professionals and pay for interpreter services.

The Department of Health and Human Services should coordinate the state's efforts to recruit and retain culturally appropriate bilingual staff and interpreters. The state should also monitor possible federal grant sources, and help local agencies apply for these funds for culturally appropriate interpreters or bilingual providers when available.

Funding from the General Assembly should be provided to the Office of Research, Demonstrations, and Rural Health Development (ORDRHD) to recruit additional bilingual and bicultural providers. Recruitment should be broadened to include all types of health professionals (including dentists, mental health providers, substance abuse counselors, doctors, nurses, certified nurse midwives, and physician assistants). In addition, ORDRHD should develop materials to assist local agencies in recruiting bilingual and bicultural providers.

The NC Department of Health and Human Services should also work with the Office of State Personnel to determine whether there is an existing classification for interpreters, and whether staff that serve in dual capacities (both as interpreters and as another job function), could qualify for differential pay based on a differential job classification. This could affect interpreter pay at both the state and local level. Counties use the state's classification system in establishing an employee's classification, although the amount of pay for each job classification is determined at the county level. Thus, an upgraded classification could yield higher pay, which could assist in recruitment efforts. Durham County DSS, for example, currently pays a differential salary for bilingual staff members.

In addition, the Department should develop methods to use Medicaid and NC Health Choice funds to reimburse private providers who use interpreters when providing services to Medicaid-eligible individuals or children covered by NC Health Choice. The Department should consider the experiences of other states to determine whether there are less costly methods of paying for the costs of interpreter services through Medicaid and NC Health Choice.

Additionally, the Department may have some ability to negotiate lower rates for telephonic interpretation services. Using the purchasing power of the state, the NC Department of Health and Human Services should explore the possibility of negotiating lower rates for telephone interpretation services for all state and local agencies. If possible, these lower rates should be made available to other local health providers and organizations providing health and human services to LEP individuals. Alternatively, the Department may want to consider Washington's approach of entering into a contract with a broker, who can provide interpreter services to public agencies and private providers. The Division of Public Health has a contract with Tri-County Community Health Center to provide interpreter services to health professionals; however, the availability of these services is limited. The state may want to explore whether this contract can be expanded or another contract entered into, so that telephonic interpretation is available 24 hours/day, 7 days/week.

To address the issues around certification and credentialing of foreign health professionals, the Task Force recommended that:

14. The Governor's Office and NC Department of Health and Human Services explore the issues around certification, credentialing and licensing of foreign graduates and research what other states are doing to develop systems to enhance recruitment of bilingual and bicultural health, behavioral health, dental, and human services providers.

- **Because of the immediate need for bilingual and bicultural mental health**

and substance abuse counselors, the NC Department of Health and Human Services should work with the NC Social Work licensure board and the NC Certification Board for Substance Abuse Counselors and Office of State Personnel to facilitate the certification, credentialing, licensure and employment of bilingual, bicultural social workers and substance abuse counselors.

- **The General Assembly should appropriate funds to the University and Community College systems to provide course work tailored to foreign graduates to assist them in preparing for certification, credentialing and licensure in social work, substance abuse, nursing and other allied health and human services professions to increase the recruitment of bilingual, bicultural providers.**

Some health, behavioral health and other human services professionals that have been trained in a Spanish-speaking country have moved to North Carolina, but it is currently difficult for them to practice in North Carolina because of state licensure and certification requirements. The Task Force did not study this issue in great detail, but recognized that some of these professionals may be competent to practice in North Carolina, and can address the gap in the availability of bicultural, bilingual health, behavioral health and social services providers. Several North Carolina organizations have investigated this issue over the past two years and are collaborating with national associations that are also interested in the issue. The Task Force recognized that a more extensive review of this issue is generally necessary; however, wanted more immediate attention focused on removing barriers for foreign-trained social workers and substance abuse counselors in order to address the dire lack of bilingual and bicultural behavioral health professionals.

The Task Force also recommended that:

- 15. Staff at health, behavioral health and social services organizations, including the leadership and governing boards be diverse and representative of the community that they serve.**

In order to help promote cultural awareness and understanding, staff should be ethnically and racially diverse, and should reflect the population the organization serves. This will improve the organizations' ability to provide culturally appropriate services.

TRANSLATION OF WRITTEN MATERIALS

OCR requires that certain vital documents be translated into other languages for each LEP group of people who are likely to be affected or served by the agency. These vital documents include: applications; consent forms; letters containing important information regarding program participation; notices pertaining to the reduction, denial or termination of services or benefits, and the right to appeal; notices advising individuals with limited English proficiency of the availability of free language assistance; and other outreach materials. Generally, this rule applies to languages of groups that constitute five percent or 1,000 persons in a given population (whichever is less). The 5%/1,000 people threshold is a "safe harbor," which means that if the state translates written materials for

population groups that meet the 5%/1,000 person threshold, that such translation will constitute strong evidence that the state is complying with these requirements. In addition to Latinos, there are several other population groups that potentially may meet the 5%/1,000 person threshold. These include the Hmong and other population groups that comprise more than 1,000 people who could be eligible for services and who may need language assistance.

The NC DHHS compliance plan ensures that vital documents will be translated into Spanish and made available to local entities. If local information needs to be included, it must be provided in the individual's primary language. Local agencies are responsible for the translation of programs specific to their community.

The Task Force found that there is no standard practice on how to translate materials into other languages. Public agencies need more resources and guidance so that all vital documents can be translated into Spanish. With the assistance of Latino leaders and organizations around the state, the NC DHHS developed a guide for translating documents into Spanish that has been available on the Internet since 2000 (*Developing, Translating and Reviewing Materials in Spanish*).²⁴ However, it is not clear whether this document is well-utilized.

The Task Force also wanted to encourage the coordination and sharing of information among agencies. There have been past efforts, led by the now-defunct Bilingual Resources Group within the NC Department of Health and Human Services, to centralize documents that had been translated into Spanish by local public health departments, but the effort to develop a centralized database of translated materials was abandoned for lack of funding. The effort to maintain a library of health care resources available in Spanish has been more successful through the AHEC system's Spanish Language and Cultural Training Initiative's web page (a project funded by The Duke Endowment).²⁵ Similarly, the North Carolina Primary Health Care Association houses the NC Farmworker Health Alliance Resource Library, intended to support individuals or organizations who are helping to improve the health of farmworkers and their families. Efforts are underway to catalog the resources and make the inventory available to others on the Internet. Similar efforts to share resources are needed among public agencies, including local health departments, departments of social services, and area mental health programs.

Even when materials are available in Spanish they are often underutilized. For example, public benefit program forms in English are being sent from the state agency headquarters to Spanish-speaking people. This represents a lack of coordination between the state agency and county administrative agencies and it has caused some LEP persons to be dropped from the rolls of public benefit programs forcing them to reapply for benefits. Coordination between state and local agencies needs improvement so that translated materials are well-utilized.

Innovative Practices

The Spanish Language and Cultural Training Initiative

The Spanish Language and Cultural Training Initiative is an effort supported by The Duke Endowment and coordinated by the North Carolina AHEC (Area Health Education Centers) Program. The five components of the initiative are language training for providers and students, interpreter training, instructor training in basic medical Spanish, mental health and substance abuse, and immigrant health information resources. The NC AHEC partners with the Area L AHEC, the Duke University AHEC Office, the UNC Chapel Hill School of Public Health and Health Sciences Library, and the NC DHHS Office of Minority Health and Health Disparities (OMHDD). Each of the partner organizations has taken the lead in one of the initiatives. For example:

OMHDD offers interpreter training several times a year in various AHEC locations across the state. In total, since 1998, 54 Interpreter Trainings have been offered to over 1,068 participants. In 2002 alone, 19 trainings were offered to over 329 participants.

The UNC School of Public Health has developed a video, a handbook, sequenced workshops, and the Language Across the Curriculum Program (LAC) as part of the language-training component.

The Mountain AHEC offers a two-day seminar to train instructors on how to teach the basic Spanish course.

The Duke AHEC Office provides basic Spanish for mental health and substance abuse providers and training on Latino cultural issues in mental health.

The Area L AHEC has helped develop a Spanish-language materials website with a wealth of information for use by providers and students.

Recommendations

To address these issues, the Task Force recommended that:

- 16. The NC Department of Health and Human Services take the lead in translating vital documents into languages needed by groups of individuals with limited English proficiency. Local agencies have an independent responsibility to translate written materials (such as notices, applications, outreach materials) if the forms or services are unique to the local communities and the LEP populations that meet the OCR prevalence thresholds.**

Specifically, the NC Department of Health and Human Services should, whenever possible, standardize social services, health department, and mental health, developmental disabilities and substance abuse area program applications, forms and notices. Materials that are necessary for all clients must be translated into principal languages other than English, and should be made available to all public programs serving LEP persons. In addition, the state should develop standardized notices informing LEP persons of their right to receive an oral translation of written materials. These forms should be developed in the principal languages of individuals served by the state and at reading levels appropriate for the groups to be served.

As noted earlier, Title VI applies not just to public agencies, but to any provider who receives federal funds. Thus, to ensure that other vital records are translated, the Task Force recommended that:

- 17. The NC Hospital Association, NC Medical Society, Administrative Office of the Courts, and Health Lawyers Section of the NC Bar Association work collaboratively to identify standardized legal forms that affect health care (such as health care power of attorney, guardianship forms, and living wills). These forms should be translated into Spanish and other needed languages and made available to Latino organizations, individuals in need of the forms, and through the Internet.**

TRAINING STAFF

The OCR guidelines state that staff who are likely to have contact with LEP persons must be trained to ensure they are knowledgeable about LEP policies and procedures, work effectively with in-person and telephone interpreters, and understand the dynamics of interpretation between clients, providers and interpreters. The NC Department of Health and Human Services proposed compliance plan models this guideline. For example, North Carolina's proposed Title VI access policy requires appropriate training at new employee orientation and continuing training programs. The training should include language assistance policies and procedures, resources available to support such procedures, how to effectively use interpreters, and familiarization with the discrimination complaint process. Each local agency must also develop cultural awareness training programs for appropriate employees. Agencies should maintain records of the training provided to each staff member. In addition, local agencies have a responsibility to ensure that grantees, contractors, and other entities that receive state or federal dollars are trained in these requirements.

The NC DHHS compliance plan includes a provision that appropriate training is provided to bilingual staff and interpreters employed by or utilized by local entities. This training should include confidentiality, the ethical responsibility of interpreters, how to accurately and impartially interpret, and specialized terminology needed to interpret. Interpreter training must ensure that the person learning to be an interpreter has effective communication skills in English and in the primary language of the LEP individual, and has demonstrated cultural proficiencies.

Since 1994, the NC Interpreter Task Force, an interagency group consisting of the NC Primary Health Care Association, Department of Health and Human Services, El Pueblo, AHEC and others has worked to develop a training curriculum for interpreters as well as helping to set state-level policy on the issue. In 1998, as part of the AHEC Spanish Language and Cultural Training Initiative, the Interpreter Task Force was able to hire a full-time coordinator (who was housed at the Office of Minority Health and Health Disparities) and develop a Level II and III training. These are currently offered through AHECs.

Currently, many interpreters lack this type of training. The OCR found that the NC DHHS "fails to have sufficient measures to evaluate the competency of those serving as interpreters." (OCR letter) In North Carolina, no formal test exists to certify interpreters. Many times the persons hiring interpreters are not bilingual and have no way of assessing applicants' language skills. A standardized test of interpreter competence is needed.

Providers also need training about the use of interpreters. Even when qualified interpreters are available, the NC DHHS has no clear procedures informing staff on how and when to access interpreters. The policies that do exist are unfamiliar to many staff members. More education needs to occur so that providers use existing interpreters effectively. The Interpreter Task Force has also developed a training "How to Effectively Work with an Interpreter." This should be more widely available.

The NC Area Health Education Centers (AHEC) Program has taken the lead, working with other statewide partners, in developing interpreter training courses, and implementing language skills among health care professionals (see sidebar). Private educational institutions, such as Duke University and Wake Forest University, have developed their own curricula to increase their health career students' capacity to serve Latinos. Further, the University of North Carolina at Chapel Hill currently offers a 10-session non-credit course that covers speaking and listening comprehension; but is in the process of developing a one- or two-semester intermediate Spanish course to be offered to health professions students. The goal is to eventually make this training available statewide through DVD and the Internet.

The community colleges also offer Spanish-language classes as well as interpreter classes. The Z. Smith Reynolds Foundation recently awarded the Community College system a \$200,000 grant over a two-year period to establish a liaison from the System Office to work with community colleges to enhance the services provided to Latino learners, increase the number of classes where

interpreter training is offered, and collaborate with other agencies that offer similar training.

The Task Force recognized a need for two types of trainings: training for agency staff in both public and private agencies about Title VI requirements and how to provide assistance to individuals with limited English proficiency; and training to ensure that interpreters have certain core competencies.

Recommendations

To address these issues, the Task Force recommended that:

- 18. The NC Department of Health and Human Services develop a model training curriculum that can be shared with local agencies, and if appropriate, private providers, to inform staff about Title VI policies and how to make services more accessible.**
- 19. The OMHHD expand the availability of cultural diversity training to staff at local health departments, DSS, mental health and other health, dental, behavioral health, and human services agencies.**

All agency staff that interact with clients should be provided language and cultural diversity training. The training should be geared to different types of staff who work in health, mental health, dental, and social services organizations, including but not limited to receptionists, eligibility workers, social workers, health, dental, and mental health professionals. The training should include many topics, including but not limited to: the effects of culture on workplace encounters, effective communication, the organizations written policies and procedures, information regarding Title VI, strategies for conflict resolution, and the impact of culture on health, diagnoses and treatment, and health outcomes. Training should be tailored to the specific organization.

While a number of efforts have been undertaken to ensure that there are sufficient numbers of trained interpreters, many of these efforts are operating under time-limited grant funding. To address the ongoing need for interpreters, the Task Force recommended that:

- 20. The NC General Assembly appropriate funding to maintain and expand the AHEC Spanish Language and Cultural Training Initiative and the Office of Minority Health and Health Disparities interpreter training and cultural diversity training courses.**

The AHEC/OMHHD program has received national recognition. However, the foundation funding for this initiative is limited, and scheduled to end by December 2003. The General Assembly should give a high priority to continue funding this initiative, to ensure that the state has sufficient numbers of trained interpreters. Further, the state, working with the Community College system, should develop a registry of students who successfully completed the training, and this registry should be made available to public agencies and private providers who are seeking trained interpreters.

21. The University of North Carolina and Community College systems review all program offerings and should offer language/cultural competency courses for health professional students and place a priority on offering such courses. In addition, the Community College system should expand the availability of interpreter training courses offered throughout the system.

Some initial work has started on this issue. A few community colleges currently offer and/or have offered Associate Degrees in interpreting. The NC DHHS, Office of Minority Health and Health Disparity Hispanic Health Task Force, AHEC and the Community Colleges should collaborate to develop such offerings.

MONITORING AND REPORTING

Absent a mechanism to monitor the provision of services and program operation, there is no way to ensure that services are culturally and linguistically accessible. The OCR guidelines require that federal fund recipients monitor the programs and services provided to ensure linguistic accessibility and cultural appropriateness at least annually. As part of its annual monitoring, the federal fund recipients must:

- Assess the current LEP makeup of its service area and communication needs of LEP applicants and clients.
- Determine whether the agency's existing language assistance is meeting the needs of such persons.
- Determine whether staff is knowledgeable about policies and procedures and how to implement them.
- Assess whether sources of and arrangements for assistance are still current and viable.

The Department's compliance plan requires local agencies to conduct an annual compliance report. Self-monitoring must be conducted on a quarterly basis by state and local agencies. A standard reporting system will be developed by the state, and should be used by local agencies. In addition, the Department and local agencies must ensure that other subcontractors that receive federal funding also conduct self-assessments and provide additional training or modify services if necessary.

Because the state has not yet implemented its compliance plan, there is no ongoing monitoring system. The Task Force recognized that individual agencies and local providers have primary responsibility for monitoring service delivery to ensure that services are linguistically and culturally appropriate. Nonetheless, the NC Department of Health and Human Services has ultimate responsibility for ensuring that Title VI requirements are met. This means that the state has an independent responsibility to monitor and oversee the provision of services by local agencies.

Exemplary Practice

El Centro Hispano of Durham

El Centro Hispano is a grassroots community-based organization dedicated to strengthening the Latino community and improving the quality of life of Latino residents in North Carolina and the surrounding area by developing programs in the areas of education, leadership development, community organizing, community support, and economic development. Some of their programs include: English as a Second Language, GED, parenting classes for adults, counseling, summer camps for children and youth, women's and youth leadership groups, problem solving community forums, referrals, interpretation, advocacy, consultation with agencies in the county that are trying to better serve the Spanish speaking community, and providing micro-enterprise development training. Project LIFE - a project that provides health education and prevention in the area of HIV / AIDS, diabetes and/or sexually transmitted diseases (STD).

Recommendations

To address this issue, the Task Force recommended that:

- 22. The NC DHHS establish a standardized OCR compliance reporting system for use by state and local programs and agencies; and ensure that local agencies coordinate their Title VI compliance activities with that of the Department. The local monitoring will include a standardized consumer/client assessment instrument to assess the extent to which the programs and services are linguistically accessible. In addition, NC DHHS should conduct periodic site visits to determine the extent of Title VI compliance by local agencies.**

COMPLAINTS

Individuals who have been harmed by a federal-fund recipient's failure to follow Title VI requirements can file a complaint to OCR and NC DHHS. Under federal law, individuals have 180 days from the date of the alleged discrimination to file a complaint to OCR. To implement this provision, the NC DHHS compliance plan instituted a proposed process to investigate and address complaints. Under the DHHS policy, individuals who have complaints must file them within 180 days of the date of the alleged discrimination. Individuals who do not speak or write English must be given assistance in their primary language in filing the complaint. The state agency or Division shall investigate the complaint, generally within 30 days of when the complaint is issued. All interested parties have a right to submit evidence. The goal is to be able to resolve the issue informally if the investigation shows a violation occurred. However, if the state Division or Agency cannot resolve the complaint informally within 60 days, then the matter will be referred to the Secretary's Office with a recommendation that appropriate proceedings be brought under applicable state or federal law.

Recommendations

To ensure that this provision is implemented, the Task Force recommended that:

- 23. The NC DHHS require each state or local agency or Division within NC DHHS to notify the NC DHHS Office of General Counsel every time a complaint is filed, so that the Department can maintain a database of complaints to discern if there is a pattern of the types of complaints raised, and if any additional action is needed at the state level to address these issues. Language accessibility issues raised with the Office of Citizen Services should also be reported to the NC DHHS Office of General Counsel.**

COMMUNITY PARTNERSHIP PUBLICITY AND EDUCATION

Community-based Latino organizations in certain counties have established collaborative relationships with their local public health and social service agencies. These community collaborations have involved community outreach, organizing health fairs, recruiting staff, and many other efforts. Examples of this include Hispanic Action Office in Winston-Salem and *El Centro Hispano* in Durham. El Pueblo, as a statewide Latino organization, actively participates in several NC DHHS committees and Task Forces, as well as provides input in program planning and evaluation of local and state health-efforts aimed at Latinos.

It is important and necessary for the state to build its own capacity in serving the needs of LEP clients. This responsibility cannot be transferred to non-profit organizations operating in the community, as most community-based organizations are not funded by the state and have limited resources. However, the Task Force recognized that collaborations among and between these agencies are of benefit to the community and should be encouraged.

Recommendations

One way to enhance the capacity of local communities to address the health needs of the growing Latino population is to train more Latino community leaders around health issues. To address this need, the Task Force recommended that:

24. El Pueblo, in collaboration with AHEC and other organizations, create a Latino Health Institute dedicated to improving the health of North Carolina Latinos.

The Task Force recognized a need for leadership in Latino health. Many agencies throughout the state, both public and private, require assistance in their efforts to address Latino health issues and reach out to the Latino community. Over the past few years, El Pueblo, as a statewide organization, has served in this capacity. Different Latino organizations and individuals have also worked to meet the health needs of Latinos across the state. Discussions have begun about the creation of a Latino Health Institute specifically devoted to Latino health. This entity would dedicate itself to improving the health of Latinos in North Carolina from a Latino perspective and would undertake projects in the following areas:

- Leadership development
- Health policy and advocacy
- Direct services
- Training
- Coalition work
- Research and evaluation
- Technical assistance

NOTES

1. US Census, 2000. Supplementary Survey Summary File 3. PCT006, PCT020.
2. US Census 2000. Supplementary Survey Summary File 3. PCT64H.
3. 42 USC § 2000d and implementing regulations found at 45 C.F.R. Part 80.
4. OCR policy guidance, December 5, 2001. Available on the Internet at: www.hhs.gov/ocr/lep/guide.html (accessed November 10, 2002). Note: since the publication of this policy guidance, the US Department of Justice has issued guidelines. In general, the two guidelines are similar, however there are some differences-particularly as it relates to written translation of materials. The US Department of Health and Human Services is in the process of updating their policy guidance, to reflect the changes from the DOJ guidelines. When the two guidelines vary, reference is given to the DOJ guidelines.
5. US Department of Justice. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. Available on the Internet at: www.usdoj.gov/crt/cor/lep/DOJFinLEPFRJun182002.htm. Accessed November 14, 2002.
6. 67 Fed. Reg. 41455 at p. 41459. June 18, 2002.
7. *Ibid.*
8. Available on the Internet at: <http://www.usdoj.gov/crt/cor/Pubs/ISpeakCards.pdf>
9. Available on the Internet at: www.lep.gov
10. Julie Dombrowski, Lipi Vaidya and Ellen Wilson contributed to the research of this section of the report.
11. OCR policy guidance, December 5, 2001. Available on the Internet at: www.hhs.gov/ocr/lep/guide.html, (accessed November 10, 2002).
12. Carrasquillo O, Orav J, Brennan T, Burstin. Impact of Language Barriers on Patient Satisfaction in an Emergency Department. *Journal of General Internal Medicine*, Volume 14, pgs. 82-87, 1999.
13. Sarver J, Baker DW. Effect of Language Barriers on Follow-Up Appointments After an Emergency Department Visit. *Journal of General Internal Medicine*, Volume 15, pgs. 256-264, 2000.
14. What a Difference and Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency. April 2002. Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University. http://www.accessproject.org/downloads/c_LEPreportENG.pdf [Accessed November 2002].
15. DSS Interpreter Survey. Compiled by the Division of Medical Assistance. December 2002.
16. Price J. Office of Research, Demonstrations and Rural Health Development. Presentation to NC IOM Latino Health Task Force. May 7, 2002.
17. Spade J. Vice President, NC Hospital Association. Presentation to NC IOM Latino Health Task Force. May 7, 2002.
18. In 1995, the NC Center for Public Policy Research conducted a study that included a literature review, interviews and field visits, and a survey of all local health departments, community and migrant health centers, rural health centers, and rural hospitals across North Carolina. When asked to indicate the most significant barriers to Latinos obtaining adequate health care, the language barrier was cited most frequently. Scharer, J.; "Hispanic and Latino Health in North Carolina: Failure to Communicate?" *Insight*. August 1999; 18 (2-3):2.
19. The Department of Justice guidelines define interpreter competency. When using interpreters, the federal fund recipient must ensure that they:

"Demonstrate proficiency in and ability to communicate information accurately in both English and in the other language and identify and employ the appropriate mode of interpreting (e.g., consecutive, simultaneous, summarization, or sight translation); Have knowledge in both languages of any specialized terms or concepts peculiar to the entity's program or activity and of any particularized vocabulary and phraseology used by the LEP person; and understand and follow confidentiality and impartiality rules to the same extent the recipient employee for

whom they are interpreting and/or to the extent their position requires."

67 Fed. Reg. 41455 at p. 41461. June 18, 2002.

20. DSS Interpreter Survey. Compiled by the Division of Medical Assistance. December 2002.
21. Perkins J. Personal Communication. November 14, 2002. Information to be published in a Kaiser Family Foundation Issue Brief.
- 22.. Hodges MT, DHHS Compliance Attorney. Presentation to NC IOM Latino Health Task Force. May 7, 2002.
23. 8 USC § 1621. The NC Community College system policy can be read at:
http://www.ncccs.cc.nc.us/Numbered_Memos/Memos_for_2001/cc01-271.pdf
24. Available on the Internet at: <http://www.dhhs.state.nc.us/dph/DEVSPAN-web.pdf>
25. Available on the Internet at: www.hhcc.areasheh.dst.nc.us/hhcrindexf.html