The California Endowment

Language Access Needs in Alameda County:

New and Emerging Immigrant and Refugee Communities

May 2008

TABLE OF CONTENTS

Introduction……..…….………………………………………………………………...1

Executive Summary………...……………………………………………………...……...3

Survey Findings……………………………………………………..…….………...……7

I. Background of Organizations and Services Provided…………….…………9

II. Health Organizations………………………………………………………13

III. Barriers to Health Care Access and Language Assistance Services…………17

IV. Solutions……………………………………………………………………..23

A Summary of Recommendations…………………………………………………29

Attachment A - Language Access Legislation and Guidelines…….……..………..33

Attachment B – Use of Traditional Treatments…………...……………………………34

One of the key goals of The California Endowment is to increase the cultural and linguistic competency of health providers and health systems to effectively serve California's diverse communities. In Alameda County, one of the most diverse counties in the state, there are innovative efforts under way to address the language needs of residents and to develop and train the healthcare interpreting workforce. To identify opportunities to strengthen the health care workforce to meet diverse language needs, The Endowment has been interested in identifying existing and emerging needs and gaps in language assistance services, current and new language access efforts, and key players related to the language access workforce.

As part of this larger effort, during the summer of 2007 The Endowment commissioned a survey of community-based organizations serving immigrant and refugees in Alameda County. Community-based organizations are key access points connecting immigrants and refugees to health and behavioral health services, and many provide culturally and linguistically tailored support services such as informal healthcare navigation, interpretation, translation, case management, transportation and enrollment in public assistance programs. The purpose of this survey was to increase The Endowment's knowledge of existing and emerging language assistance needs, the current capacity of community-based organizations to meet these needs, and to gather community recommendations for improving language access. While health systems and providers are working to find staffing and technological solutions to meet "high volume" languages, there are less visible populations and communities who speak languages that are "less common." While this survey focused on language assistance services, language access is one of many issues confronting immigrants and refugees who struggle to access the health care system and receive quality care. The findings therefore address broader concerns and issues about health care and health. After the survey findings were compiled, the Endowment convened the majority of the respondents and additional community members in March 2008 to solicit feedback on the report and provide input on recommendations.

The Endowment has compiled the following report – consisting of the survey findings and recommendations based on input from the March convening – to be shared back to the community and with health systems, policy makers, direct service providers and community and patient advocates. The California Endowment would like to extend our appreciation to the survey interviewer and author of the findings section of this report, Jill Tregor, for her commitment to reaching a broad range of community voices and perspectives. We would also like to express our appreciation for our convening facilitator and author of the recommendations section, Laurin Mayeno, who skillfully engaged a diverse audience in a constructive discussion on improving language assistance services and health care more broadly for underserved immigrants and refugees.

Justine Choy, Program Officer
The California Endowment
May 2008

EXECUTIVE SUMMARY

Community-based Organizations Serving Immigrant and Refugee Communities

Community based organizations provide a critical bridge to health services for their immigrant and refugee clients. Most of the surveyed organizations do not provide health services directly, but help their communities gain access to these services. At nearly every surveyed organization, all staff provide interpretation services – regardless of job title or other responsibilities – yet few organizations have staff that provide these services exclusively. Many organizations, though ethnic-specific, are actually providing services to a broad range of people and in many languages. Organizations are clearly overwhelmed by the task of responding to so many different communities, as well as with their attempts to respond to the entire spectrum of needs that immigrant and refugee families have.

Underserved and Emerging Populations

The following populations are identified as either newly emerging, or as populations that are underserved by language assistance services in Alameda County.

- Afghani
- Arab
- Eritrean
- Ethiopian
- Liberian
- Iraqi and other Middle Eastern
- Somali
- Filipino
- Pacific Islander
- Samoan
- Tongan
- Burmese, including Karen and Chin
- Cambodian
- Korean
- Lao
- Mien
- Mongolian
- Nepali
- South Asian
- Southeast Asian

Immigrant and Refugee Experiences with Health Systems in Alameda County

Organizations describe mixed experiences with referring clients to hospitals and clinics. Some feel that clinics are making efforts to increase the availability of language services and some provide excellent services. Yet barriers exist, including a lack of regular availability of interpretation, requiring patients to come back "another day," a lack of specific language services, and a lack of availability of medical specialty services in clinic settings with language capacity. Organizations refer clients to a community health center or clinic specifically because it has interpreters and/or language services their clients need. Community-based service providers report that health care providers seek help with translation and interpretation services from community organizations and these organizations have limited capacity to respond regularly to those requests. Due to lack of health insurance and lack of language accessibility, people who need language interpretation services postpone seeking care and many rely on emergency rooms for primary care. Organizations' clients have mixed perceptions about the best place to go for linguistically competent care. Some believe a big facility like a hospital has

better services and more language access while others believe that clinics are a better option, for both language access and obtaining primary care for their whole family. Many organizations report that their clients are using a mix of Traditional and Western medicine.

Institutional and Individual Barriers to Health Care and Language Assistance Services

Lack of interpreters - There is a need for many more health interpreters, both in additional languages not currently provided and also over the continuum of care. The common practice of relying on children or family members for interpretation is particularly problematic because many adults and elderly people will not admit to certain health problems in the presence of their children, and family members may not understand medical terminology.

Technology barriers - Telephone and video interpretation, voice mail, and other electronic technologies are confusing or alienating for some immigrants and refugees, particularly the elderly.

Lack of continuity of care
Interruptions in care occur when there is no continuity with providers at clinics, or there are changes to the scope of services among public health plans based on age eligibility and residency status.

Health care coverage - Although refugees, children, and seniors are eligible for Medi-Cal, many immigrants and refugees cannot afford to pay for it. Since many do not know what public health services they are eligible for or have a right to, many do not attempt to access services. In addition, oral and dental health services are unavailable, unaffordable, or without language access.

Language, cultural and literacy barriers - Many organizations report that their clients are ashamed they do not understand English or the complicated U.S. health system, which prevents them from accessing care. Sometimes, cultural conflicts impede effective communication between clients and interpreters due to inappropriate matching with regard to age, gender, ethnicity, or country of origin. Immigrants and refugees are not always familiar with the concept of mental health services, or if they are, are often reluctant to access such services due to stigma. Many immigrants and refugees are not literate in their own languages, or are from oral cultures; it can be difficult for clients to read signs at health sites, even when translated in their own languages.

Immigration status - Many community organizations are concerned that undocumented clients are too afraid to attempt to access health care. These clients avoid contact with “officials” who might turn them in to immigration authorities.

Recommendations

Patient rights and enforcement of language access laws

1. Provide education about patient rights, language rights and eligibility for health coverage.
2. Enforce federal and state language access laws and local ordinances.
3. Use multiple strategies to increase language access.

Language assistance services in health systems

1. Strengthen coordination and communication between health facilities and CBOs.
2. Provide information in different formats for people who cannot access written materials.
3. Consider both the <u>cultural</u> and linguistic needs of patients when matching patients with interpreters.
4. Increase health system awareness about less common languages and health provider responsiveness to smaller and linguistically isolated communities.
5. Increase language access and cultural competency over the continuum of care.

Health care interpreter workforce development

1. Increase awareness of healthcare interpreter training and certification programs.
2. Provide CBOs resources to train their staff as Certified Health Interpreters.
3. Include community input in the content of health interpreter trainings for less common languages.

The role of community-based organizations (CBOs) in the continuum of culturally and linguistically competent services in Alameda County

1. Recognize immigrant and refugee-serving CBOs as integral partners in the provision of culturally and linguistically competent services to the community.
2. Support and replicate culturally tailored programs and services that support community health and health promotion.
3. Create a funding source or mechanism (public sources, grants or fee-for-service programming) that provides compensation and resources for the interpretation and translation services currently being provided by CBOs at no charge.
4. Enhance the capacity of CBOs to conduct language access advocacy.

Cross-sector (health, housing, legal and social services) system coordination to meet the linguistic and cultural needs of immigrant and refugee communities

1. Develop a pool of interpreters that can be shared between service providers and sectors and can be managed through a centralized, coordinated system.
2. Strengthen and coordinate case management for families.
3. Improve individual and community health education for immigrants and refugees.

Institutional and Public Awareness of Language Access Issues

1. Increase provider awareness and sensitivity to the stresses and challenges created by a patient's immigration and refugee status.
2. Improve demographic data collection systems to capture racial/ethnic nuances and true linguistic and cultural diversity of communities.
3. Strengthen awareness of and value of multilingual and multicultural communities.

SURVEY FINDINGS

During the summer of 2007, The California Endowment contracted Jill Tregor to conduct a community health assessment to identify the language access needs and gaps in health services throughout Alameda County. The following findings are a result of that survey.

According to the 2000 U.S. Census**,** Alameda County, California is home to nearly 1.5 million residents, of whom 392,656, or 27% are foreign born.[1] Of those, 237,864 are considered persons with Limited English Proficiency (LEP).[2]

During July and August 2007, The California Endowment conducted a community health assessment to identify the language access needs and gaps in health and behavioral health services for emerging immigrant and refugee communities throughout Alameda County. Specifically, the assessment was intended to determine the concerns of less visible populations and communities who speak languages that are less common in the Bay Area. The assessment is based on the experience and perceptions of people working in community-based organizations serving these communities.

This report was primarily intended to inform The California Endowment. The findings and recommendations are also relevant to health systems, policy makers, direct service providers and community and patient advocates.

Purpose of the Assessment
The goals and objectives for the assessment were:

1. To increase knowledge of immigrant and refugee community needs for language access compared with existing language access capacity as provided by community-based organizations, health providers, public agencies, and educational institutions serving Alameda County, CA.
2. To identify current and new language access efforts in Alameda County, CA.
3. To identify key players related to the language access workforce.
4. To determine emerging immigrant and refugee community leaders' interest in becoming involved in language access efforts in Alameda County.

Methods
In-depth interviews were conducted using a list of community organizations that are funded by The California Endowment or are organizations that The California Endowment staff identified as likely to have an interest in the topic. Additionally, using snowball sampling, the consultant

[1] The California Endowment (2006). California county profiles: Limited English proficient population. 6/2006, p.3
[2] Ibid, p.3

asked each organization interviewed for referrals to other individuals and organizations that might be appropriate for participation.

The following organizations participated in the assessment:

- Afghan Coalition
- African Immigrant & Refugee Resource Center
- Arab Cultural Center
- Asian Community Mental Health Services
- Asian Pacific Psychological Services
- Cambodian Community Development, Inc.
- Catholic Charities of the Diocese of Oakland, Inc.
- Eastern European Service Agency, Inc.
- Filipinos for Affirmative Action, Inc.
- International Rescue Committee
- International Institute of the East Bay
- Jewish Family & Children's Services of the East Bay
- Korean Community Center of the East Bay
- Lao Family Community Development, Inc.
- Law Center for Families
- Mongolian Health Access Project

The majority of interviews were conducted by telephone, and lasted between 45 minutes and one hour. One organization answered all questions by email. Three interviews were conducted in person, and lasted between 1.5 and 2 hours. These interviews were with ethnic-specific agencies. In each case, the interviewee's first language was not English, and the interviewee wanted to ensure that the interviewer had a full understanding of the scope of the organization's work. When initially scheduling interview appointments the interviewer reassured people that they did not have to meet with her in person. When she recognized that some people wanted the opportunity for a face-to-face interview, the interviewer began to give people the choice to be interviewed in person or by phone. It may be helpful for future work with similar organizations to recognize that the telephone may be a barrier to full communication and understanding.

The methods utilized may not have identified all the new and emerging communities of Alameda County. Despite numerous attempts, the interviewer was unsuccessful in contacting representatives from the growing Alameda County Punjabi community. In addition, because the majority of the organizations contacted receive funding from The California Endowment, there is the possibility that interviewees were reluctant to discuss certain issues out of a desire to protect their funding. No interviewee indicated that concern, but the possibility that responses were in some way influenced by the funder/recipient relationship cannot be completely eliminated.

On March 19, 2008, The California Endowment convened the survey participants to review the draft report, solicit feedback on the recommendations and to share ideas for using and disseminating the report to have an impact. Feedback from this convening was incorporated into this final report.

I. Background of Organizations and Services Provided

Interviews were conducted with representatives of organizations providing services to a broad range of immigrants and refugees in Alameda County. Table 1 outlines the organizations, languages, communities, and services as discerned during interviews. Many organizations provide training for their staff and volunteers in cultural competency or health care interpretation; having staff that are certified as interpreters is a priority for only one organization. At nearly every organization, all staff provide interpretation services, regardless of job title or other responsibilities. Few organizations have staff that provide those services exclusively.

Table 1: Organizations and Language Services

Organization	Languages Spoken by Clients	Clients' Country of Origin	Language Services	Who Provides Language Services	Approximate # of Clients Served per Year
Afghan Coalition	Farsi/Dadi (70%) Pashto (30%)	Afghanistan India Iran Iraq Pakistan Palestine Other Arab Countries	Translation Interpretation Navigation Advocacy	Staff—some training, but not certified. Volunteers Has staff that work exclusively as health interpreters	Not stated
African Immigrant & Refugee Resource Center	Amharic Arabic Bassa Eritrean Ethiopian Ethnic/tribal languages French Kpelle Portuguese Swahili Tigrinya	Entire African Continent	Translation Interpretation Navigation	Staff Volunteers Other clients Is currently sending some staff and volunteers for interpreter training	Not stated
Arab Cultural Center Arabic	English North Africa	Palestine (30%) Yemen (40%) Other Arab Countries Other African Countries	Translation Interpretation Navigation	Interpretation Navigation	Primarily staff 400 per year for social services
Asian Community Mental Health Services	Chinese (Mandarin, Cantonese, other dialects) (24%) Japanese (2%) Khmer (6%) Korean (3%) Lao (<1%)	China (ethnic Chinese, may be from other countries) Japan Cambodia Korea Laos	Translation Interpretation Navigation Advocacy Promotor/a	All staff provides interpreter services in addition to other roles	

Organization	Languages Spoken by Clients	Clients' Country of Origin	Language Services	Who Provides Language Services	Approximate # of Clients Served per Year
	Mien (12%) Tagalog (5%) Thai (<1%) Vietnamese (15%) English (20%)	Philippines Thailand Vietnam Non-Asian countries			
Asian Pacific Psychological Services	Burmese Cambodian Cantonese Hindi Lao Korean Khmai Mandarin Mien Mongolian Thai Tongan Vietnamese	Cambodia Hawaii (U.S.) Hong Kong Korea Laos Mainland China Samoa Mongolia Vietnam	Navigation Interpretation Translation Advocacy	Staff--trained but not certified	30-60 clients per day; 100 students per day
Cambodian Community Development, Inc.	Cambodian (98%) Spanish	Cambodia	Accompaniment Interpretation Navigation Translation	All staff provides interpretation assistance, none have special training	800+ per year
Catholic Charities	Amharic Cambodian Farsi Hindi Portuguese Spanish (40%) Thai Vietnamese (8%)	Mexico Latin America Vietnam Thailand Cambodia Africa	Interpretation Navigation Translation	All Staff Volunteers Peer Companions All receive extensive training, but not certified	16,000-18,000 per year
Eastern European Service Agency, Inc.	Bosnian (80%) Croatian/Serbian/ Russian (20%)	Bosnia Russia Former Soviet Republics	Advocacy Navigation Interpretation Translation	Staff	400-500 per year
Filipinos for Affirmative Action, Inc.	English Ilokano Tagalog Visayan/Bisayan	Philippines	Navigation Community Advocacy	No interpretation services	Not stated
International Rescue Committee	Amharic Arabic Aromo Burmese Chin Dari Farsi French	Afghanistan Bosnia Burmese Central/South America Congo Ethiopia Eritrea	Translation Interpretation Navigation	All staff may act as interpreters Volunteers No health interpreter training	Not stated

Organization	Languages Spoken by Clients	Clients' Country of Origin	Language Services	Who Provides Language Services	Approximate # of Clients Served per Year
	Greibo Karen Krahn Mam (Mayan dialect) Mongolian Russian Serbian Croatian Somali Spanish Swahili Tibetan Tigrinya Turkish Vietnamese Uzbek	Iraq Liberia Mongolia Nepal Russia Somalia Sudan Tibet Turkey Uzbekistan Vietnam			
International Institute of the East Bay	English Japanese Spanish	Mexico Central/South America	Interpretation Translation	Staff	Not stated
Jewish Family & Children's Services of the East Bay	Bosnian Farsi Russian Spanish Cambodian (mostly referred out)	Afghanistan Bosnia Cambodia Iran Former Soviet Republics	Navigation Interpretation Translation	Staff-trained but not certified	200-300 immigrants/refugees per year
Korean Community Center of the East Bay	English Korean Other Asian Languages	Korea	Advocacy Interpretation Navigation Promotor/a Translation	Staff Volunteers	Not stated

Organization	Languages Spoken by Clients	Clients' Country of Origin	Language Services	Who Provides Language Services	Approximate # of Clients Served per Year
Lao Family Community Development, Inc.	Arabic Burmese Cambodian Cantonese Chow Chinese Hmong Farsi Japanese Haitian Kario Kmien Lao/Khammouan Mandarin Mien Pashto Russian Spanish Thai Urdu Ukranian Vietnamese Yemeni	Arab Countries African Countries Cambodia Cameroon Central/South America China Haiti Iran Japan Myanmar/Burma Russia Sierra Leone Southeast Asia Thailand Ukraine Vietnam Yemen	Accompaniment Advocacy Interpretation Navigation Translation	Staff-no special training	10,600 per year in Alameda, Contra Costa, Sacramento
Law Center for Families	African Languages API Languages (6-13%) Cantonese Farsi Spanish (20%) Vietnamese	Vietnam Afghanistan Mainland China Hong Kong Africa	Community Advocacy	No interpretation provided	Not Stated
Mongolian Health Access Project	Mongolian Russian	Mongolia	Interpretation Translation Navigation	Org. has no staff Volunteers are trained but not certified	200 per year

The community organizations that are identified with a specific immigrant community generally play the role of primary translator/interpreter for their clients, accompanying clients to appointments, providing help with navigation of the health system, advocacy when necessary, as well as virtually any other services (not necessarily health related) that a family might require, such as reading bills and solving family problems of all types.

Many of these organizations, though ethnic specific, are actually providing services to a much broader range of people than might be expected. The representative of one organization states that "all are our family, they are all refugees like us," and reports providing services in many languages, including: Arabic, Burmese, Cambodian, Cantonese, Chinese, Farsi, French,

Japanese, Kamu, Lao, Mien, Pashto, Russian, Spanish, Urdu, Vietnamese, and Yemeni. Staff at another center affirm that they can count on Asian and Southeast Asian service providers, who are "sensitive and really helpful" to people from diverse ethnic groups. These organizations are clearly overwhelmed by the task of responding to so many different communities, as well as with their attempts to respond to the entire spectrum of needs that immigrant and refugee families have.

Some of the organizations' representatives identify the following as newly emerging communities or as populations that are not presently being served by language access services in Alameda County.

- Afghani
- Arab
- Eritrean
- Ethiopian
- Liberian
- Iraqi and other Middle Eastern
- Somali
- Filipino
- Pacific Islander
- Samoan
- Tongan
- Burmese, including Karen and Chin
- Cambodian
- Korean
- Lao
- Mien
- Mongolian
- Nepali
- South Asian
- Southeast Asian

II. Health Organizations

The health facilities shown in Tables 2 and 3 were identified as those commonly utilized by organizations in this study and by their clients. The community organizations send clients to these facilities because even limited language access is better than none.

Table 2: Hospitals and Clinics

Facility	Clients Utilize Facility	Clients Referred to Facility
Alameda County Ambulatory Care	• Jewish Family & Children's Services.	
Alameda County Refugee Health Program	• International Rescue Committee	• International Rescue Committee
Alta Bates Hospital	• Lao Family Community Development	• Lao Family Community Development
Central Clinic	• Asian Pacific. Psychological Services	
Children's Hospital	• International Rescue Committee	• International Rescue Committee
Eastmont Clinic	• Asian Pacific Psychological Services • African Immigrant & Refugee Res. Center • Cambodian Community Dev. Inc. • Asian Community Mental Health Board	

Facility	Clients Utilize Facility	Clients Referred to Facility
Hayward, Union City, Newark, Tri-City and other County Health Clinics	• Asian Pacific. Psychological Services Filipinos for Affirmative Action • Law Center for Families • Arab Cultural Center • Jewish Family & Children's Services • Lao Family Community Development	• Afghan Coalition • Jewish Family & Children's Svcs. • Lao Family Community Development
Fairmont Hospital	• International Rescue Committee	• International Rescue Committee
Alameda County Medical Center (Highland Hospital)	• Korean Community Center • Asian Pacific Psychological Services • Asian Community Mental Health Board • Law Center for Families • Eastern European Service Agency • Arab Cultural Center • African Immigrant & Refugee Res. Center • International Rescue Committee • Cambodian Community Dev. Inc. • Lao Family Community Development • Catholic Charities	• Korean Community Center • International Rescue Committee • Jewish Family & Children's Services • Lao Family Community Development
Hume Center	• Asian Pacific Psychological Services Afghan Coalition	
Kaiser	• Filipinos for Affirmative Action • Jewish Family & Children's Services • Lao Family Community Development	• Lao Family Community Development
Summit Hospital	• Eastern European Service Agency • Arab Cultural Center • Lao Family Community Development	• Korean Community Center • Eastern European Service Agency • Lao Family Community Development
Tiburcio Vasquez Health Center		• Filipinos for Affirmative Action
West Oakland Health Center		• African Immigrant & Refugee Center

Specific Comments on Hospitals and Clinics

Organizations interviewed describe mixed experiences with clinics. Some feel that clinics are making efforts to increase the availability of language access services and some provide excellent services. Specific barriers mentioned include lack of regular availability of interpretation, requiring patients to come back "another day," lack of specific language services, such as Liberian, and lack of availability of medical specialty services in clinic settings.

Several organizations were critical of the language capacity at one county hospital. One reports that this hospital has eliminated their Tagalog interpreters. Another states that there are no Mongolian interpreters on staff. Although some older Mongolian immigrants speak Russian, a language for which interpretation is available, salient cultural issues may be missed if a Mongolian patient has to communicate through a Russian-language interpreter. A third organization states that although there are "many" Liberian immigrants in Alameda County there are no Liberian interpreters on staff at this hospital. There is only one interpreter who speaks

Amharic and Tigrinya, which is inadequate given the numbers of Ethiopian people in the county. Their Ethiopian clients are frustrated with this hospital and do not believe they receive "good" health care there. Another reports that after September 11, 2001 it seemed that services for refugees were cut in half.

Table 3: Community-Based Health Organizations and Other Providers

Facility	Clients Utilize Facility	Clients Referred to Facility
A Safe Place		• Arab Cultural Center
Asian Community Mental Health Board	• Asian Pacific Psychological Services • Cambodian Community Dev. Inc.	• Law Center for Families
Asian Health Services	• Korean Community Center • Asian Pacific Psychological Services • Asian Community Mental Health Board	• Korean Community Center • Asian Pacific Psychological Services • Filipinos for Affirm. Action • Law Center for Families • Asian Community Mental Health Board
Asian Pacific Islander Wellness Center	• International Rescue Committee	• Asian Pacific Psychological Services • International Rescue Committee
Asian Pacific Psychological Services	• Cambodian Community Dev. Inc.	• Law Center for Families • Cambodian Community Dev. Inc.
Cambodian Community Development	• Asian Pacific Psychological Services	
Center for Empowering Refugees	• Asian Pacific Psychological Services	
La Clinica de la Raza	• Lao Family Community Development	• Filipinos for Affirm. Action • Law Center for Families • Lao Family Community Development
San Antonio Neighborhood Clinic	Asian Community Mental Health Board	
Shimtuh		• Arab Cultural Center
Thunder Road		• Asian Pacific Psychological Services
Private Doctors	• Korean Community Center • Afghan Coalition • Asian Community Mental Health Board	• Korean Community Center
Survivors International	• International Rescue Committee	• International Rescue Committee

Specific Comments on Community-Based Health Organizations and Other Providers

Several organizations report that they refer clients to a community health center or clinic specifically because it has interpreters and/or language services their clients need. Some refer clients to a health center or health clinic because they know that they will accept clients who do not have health insurance. Organizations note that health centers/clinics cannot be used in emergencies, as it takes as long as two months to get appointments.

One organization had referred mental health clients to a community development organization until the specific staff person they were working with left. One organization refers clients to an ethnic-specific domestic violence program. Another organization refers clients who have insurance to private doctors who speak their clients' language.

Many of the community-based service providers report that health care providers seek help with translation and interpretation services from community organizations. However, none of these organizations have the capacity to respond regularly to those requests, and some refuse to provide such assistance on principal, believing that the health organizations should provide it themselves. Organizations report receiving requests for language assistance from several hospitals and County community clinics.

Reliance on Emergency Rooms

Due to lack of health insurance and lack of language accessibility, people who need language interpretation services postpone seeking care for as long as possible, often "waiting until the last minute." As a result, all the community organizations report that their clients use emergency rooms for their primary care. One organization explained that for their Ethiopian clients there is a perception that a big facility like a hospital is the best place to go for health care. These clients think hospitals have better services and more language access. By contrast, another organization believes that clinics are a better option for their clients, both in terms of language access and in terms of obtaining primary care for their whole family.

One community organization points out that, given the expense of emergency room care instead of considerably less expensive preventive care, it is ironic that "the easiest access [to health care] is the thing we least want them to use." The representative of another organization continues, "if you walk in [to emergency services] bleeding, screaming, or crying, you'll get the attention you need" regardless of the language you speak. A third provider says that often his clients do not know that they can access primary health care and prevention services, so they only utilize emergency care. He also says that his clients often get frustrated with long waits for appointments and the amount of paper work required, and give up before accessing preventive care.

As the main emergency site for Alameda County, and because it accepts people who have no health insurance, Highland Hospital is utilized more by immigrants and refugees than any other health facility. However, Highland Hospital is not perceived by many community organizations as providing the best language access; both Children's Hospital and Kaiser are identified by community organizations as having better language accessibility than Highland. However, neither of these facilities is available to the majority of those needing services, as so many of these individuals do not have health insurance.

Uses of Traditional Treatments

Many organizations report that their clients are using a mix of traditional and Western medicine. Two organizations raise concerns about the possible repercussions of this. For some immigrants and refugees, continued use of traditional medicines reflects an ongoing mistrust of Western

medicine. The representative of a third organization suggests that clients may use traditional forms of treatment first, at least in part because it is more affordable than Western medicine. The data gathered from interviewees on this topic is summarized in Attachment B.

III. Barriers to Health Care Access and Language Assistance Services

Any discussion of barriers to health care access must acknowledge that Emergency Rooms provide the only health care that many immigrants and refugees attempt to utilize, as mentioned above, even though language access is often quite limited.

Lack of Interpretation Services

Every community representative interviewed for this study reports that language-accessible health services are either entirely unavailable or available only on a very limited basis. Several service providers describe clients who go to a clinic for services, only to be told by clinic staff to come back again the next day when an interpreter will be available. Others report that some health care providers "demand" that patients bring their own interpreters with them to appointments. Overall, language services provided by health care services are described as "very spotty" and "not really what we need."

One organization representative describes a client's experience:

> "She was a victim of a street crime. It happened while she was bringing her grandchild home. Some kids knocked her into the street and no one helped her. She managed to get home on her own, but didn't know to call the police. She lay on the floor in tremendous pain, but she didn't want to call her children and interrupt them at work. The next day her family took her to a [county] clinic, but there was no one there to help her in her language, so only her children could help with interpretation. She required multiple surgeries, but is still suffering from the pain today. She had side effects from the medication they gave her, but she wasn't able to describe the symptoms to the doctors, so even her medicine didn't help her."

Many providers complain they have no way to know when particular language interpretation will be available, which wastes staff and clients' time and effort. Often patients are sent away from clinics and hospitals with instructions to come back at a different time when an interpreter will be available. Community organization staff members, already stretched thin, have difficulty finding time to return to a clinic repeatedly with a client when so many others need their services.

Even when health services do have interpreters available, many organizations reported that their clients prefer to have their own staff provide interpretation rather than the interpreter at the health facility. This is seen as due to both the clients' difficulty in understanding how the United States health care system works, as well as a desire to ensure competent translation/interpretation. Clients need help with system navigation and understand that a health care interpreter employed by a health care facility may not be able to provide such assistance.

Health Insurance Eligibility and Affordability

The community organizations were asked about health insurance and their clients. None of the organizations interviewed are aware of clients who have private health insurance, and most of their adult immigrant clients have no insurance unless they are refugees or have full-time jobs that provide health insurance as a benefit. All report that their elderly clients qre covered by either Medi-Cal or Medicare insurance. Refugees are eligible for Medi-Cal, and several organizations interviewed provide assistance to their refugee clients in applying for this insurance and in understanding the myriad complexities of that system. One organization statew that getting Medi-Cal insurance in place for their clients is their "biggest issue."

One problem with Medi-Cal is that coverage for refugees is short-term, and organizations raise concerns about the complicated paperwork and problems with the system that leave people without coverage even when they think they have it. Medi-Cal coverage does not start until two months after the date of qualification, and membership cards take as much as five months to arrive. Few health care providers are willing to provide services and bill clients later. Pharmacies are often a significant source of problems, as they are often unwilling to check state computer databases that show whether clients are qualified for coverage even though they do not yet have their membership cards. A community mental health organization is concerned that the Medi-Cal system determines how services are structured, forcing a dependency on medical services as the centerpiece of health care rather than on prevention or wellness. Many organizations raise concerns about the lack of dental health care available for their clients. This lack of access to dental health services appears to be a matter of both affordability and language access. This is consistent with recent research demonstrating significant health disparities in dental health based on socioeconomic status, race, language, and ethnicity

The organizations that provide services to children are generally aware of children's eligibility for health insurance and they provide assistance with applying for coverage. For some organizations, a significant number of their clients are undocumented, and most of these clients have no insurance. It is important to note that undocumented individuals are reluctant to access health services even in emergency circumstances, and are therefore particularly vulnerable. The finding that refugees, children, and the elderly have health insurance coverage while other family members do not is consistent with studies previously conducted by The California Endowment.

Cultural and Language Barriers to Mental Health

One organization emphasizes that health care access is both a matter of language and culture, and explains that even clients who have been in the United States for as many as ten years do not fully understand how the health care system works. Mental health services are often not part of the culture from which many immigrants and refugees have come, although there are myriad reasons why they need such services once they are in the United States.

This representative reports that when their clients arrive here they experience problems with alcoholism, domestic violence, sexual harassment by employers, and other issues. Although some of these problems are not specifically mental-health related, they would be more likely to receive the attention and intervention required if patients were connected to mental health care.

One specific example is Mongolian immigrants, who experience extreme isolation once they are in the United States, not only due to language and cultural barriers, but also as a result of their own cultural practices. They do not tend to reach out to each other, perhaps because of their history as nomadic people who live in small family groupings and rely only on immediate family for help. As a result, newcomers are unable to get help from other Mongolian immigrants who have been in the United States for longer periods of time.

One organization reports that convincing some clients to seek mental health care is difficult due to cultural and language barriers. Two organizations report that Muslim clients deny a need for therapy, believing that their problems are given by God. For others, the belief that they "should be" fine gets in the way of seeking the care they require. A third organization states that many of their clients came to the United States in the early 1990's, and as the representative describes it, the process of immersion in a new culture was overwhelming at first, and all their clients' attention was directed to the process of adjustment. Several years later, however, mental health problems emerge, ranging from post-traumatic stress disorder to deep depression, and these problems largely go unaddressed. Unfortunately, even if mental health services are available for immigrants and refugees, the nuances of language make it difficult for a provider and a patient to understand each other.

A fourth organization is concerned that many of their elderly clients are self-medicating with alcohol or prescription drugs prescribed for other purposes in their attempts to cope with mental health problems.

A fifth organization states that their clients need service providers who speak the clients' languages, because building trust between the provider and the client is the most difficult aspect of getting help. Interpretation alone would not solve the barriers to mental health care that their clients experience. This representative reports that stigma is one significant barrier that prevents many from even attempting to seek mental health services.

Generational Issues—Elderly and Youth

Many organizations identify their clients' need to rely on their children or grandchildren as interpreters/translators as a significant problem. Although this issue is well documented elsewhere, it must be noted here due to the number of times it was raised during interviews. Adults and elderly people do not admit to certain types of problems in front of their child(ren), so health practitioners do not have all the information they require to make a reliable diagnosis. Further, children are unfamiliar with specific health terminology, so terms used by health practitioners are unlikely to be understood or interpreted accurately for patients. One organization uses the matter of signing a consent form as an example, pointing out that neither the child nor the adult patient are likely to understand what was being signed.

Staff at another organization describes a situation with a client who suffers from extreme post-traumatic stress disorder. This man brought his daughter with him to a health care appointment, but was then unable to talk about what had happened to him in the concentration camp where he had been imprisoned. A third organization mentions a client who brought one of his children to

interpret for him at a health care appointment, but was then unable to tell his health care provider about a problem with sexual dysfunction because he did not want his child to know about it.

Pride, Shame, and Fear

The representative of one organization mentions that for immigrants who have been in the United States for some length of time, the fact that they still do not understand how the health system or public health insurance such as Medi-Cal work is a source of embarrassment. This particularly affects immigrants and refugees who are elderly. Their feelings that they "should" already understand the system, combined with traditional beliefs that one should trust authority, make it enormously difficult for them to ask for help or let it be known when they are confused about the information and instructions they have been given. In addition, for some of these people it is considered a sign of weakness to admit they do not understand something.

Ironically, immigrants and refugees who have a rudimentary understanding of English may be more at risk than those who know no English at all. Neither they nor their health care providers always recognize that they have not understood medical concepts and terminology. In these instances, health practitioners do not bring in an interpreter because there does not appear to be a language barrier. One organization describes clients who are asked, "Do you understand?" and despite their clear lack of understanding from the perspective of the organization's staff person, the clients answer "Yes."

Due to clients' fear and discomfort, as well as unfamiliarity with navigating health systems, a number of organizations note that their clients' first contacts with health systems are the most difficult. As stated above, most immigrants and refugees experiencing language barriers postpone their attempts to access health care until they are at the crisis stage, in their desire to avoid engaging with the health care system.

Cultural Conflicts Between Patients and Interpreters

Two organizations mention female clients' need for female interpreters, due to shyness and modesty. Staff from another organization describe potential problems due to ethnic conflicts between communities in clients' home countries. For example, a Serbian immigrant may speak Croatian (or vice versa), but a Croatian client may not be willing to work with a Serbian interpreter.

Electronic Technology

A number of organizations identify elderly immigrants and refugees, particularly people from rural areas, as uncomfortable with the electronic technology commonly utilized in the United States to provide language assistance. Recorded messages, voice mail, and telephone and video interpretation are perceived as "too daunting" and also too impersonal, so clients give up their attempts to access health care when faced with unfamiliar technology. One organization reports that although some of their clients have experienced video interpretation, the technology is not useful because clients do not think the person appearing on the screen is real and therefore do not trust the process. For those clients, trust can only be built through direct personal contact.

Numerous organizations point out that such technology does not address the need to draw out information from patients in order to make correct diagnoses and identify appropriate treatments. Several raise the concern that telephonic interpretation could be dangerous in a health care context because of the possibility of misunderstanding or misinterpreting information given by the client, and because phone interpretation may entirely miss salient cultural issues. One community organization describes telephone interpretation as useful only for non-emergency and non-critical care.

Low or No Literacy

Many immigrants and refugees are not literate in their own language, or are from oral cultures. Many organizations described the difficulty their clients have reading signage at health facilities, even when it is in their own language. Although every organization welcomes health organizations providing brochures and other written information in their clients' languages, many of them note that such information will only help a fraction of their clients.

Confusion Regarding Instructions for Taking Prescription Drugs

The issue of prescriptions is one with potentially lethal consequences, which is raised by the majority of those interviewed. There are a number of reasons why prescriptions present a problem in terms of language access:

- Pharmacists who speak the patient's language are not available to provide verbal instructions for taking prescribed medications correctly.
- Prescription labels are not provided in the patient's language.
- Patients have no information about the effects (and possible negative side-effects) of medication. The staff member at one organization points out that such communication could prevent "overdose, misdiagnosis, and death."

Community organizations are aware of additional problems regarding medications. For example, their clients may stop taking prescription drugs as soon as their symptoms disappear, and many share prescribed drugs with others. One organization's representative describes clients who attempt to obtain prescriptions in order to send the drugs back home because access to drugs is so difficult there. The desired drugs are based on the family's diagnosis of their relatives' health problems. Another organization reports that their clients rely on what the pills look like, in the absence of other information. Some organizations are concerned about their clients combining Western medications with traditional treatments from their home countries. One representative raises a concern that their Southeast Asian clients were combining medications from Laos and Thailand with Chinese and herbal remedies, with potentially harmful consequences.

Lack of Continuity of Care

Community organizations report that language access is usually not available over the continuum of care, such that, although an interpreter might be provided during an intake session, once a client is checked into a hospital there is no language assistance available. Further, patients often have a different person acting as their interpreter at every appointment, which also interrupts

continuity. Perhaps a less well recognized problem is that health care offered beyond an initial phone call or appointment also suffers because of lack of language access. Reminder phone calls and postcards are in English, pharmacy clerks primarily speak English, and prescription instructions are only in English. Even when an interpreter is provided during the actual visit with a primary care doctor, generally the process of checking in for the appointment, being weighed, having blood pressure taken, lab tests, visits to specialists, and other interactions are all conducted in English.

Lack of health insurance is another critical factor that works to interrupt the possibility of continuity in care. Because of how the county's public health system works, patients rarely see a particular health provider more than once. This means that there is no opportunity to build trust and rapport between the health care provider and the patient.

One organization's representative describes how Alameda County practices disrupt continuity of care due to the way services are contracted out and funded. For example, when a young person reaches a certain age, they "age out" of the community mental health services that are provided through a contract with the county, and are then required to go to Alameda County Mental Health Services for any further care. It would be better for the patients if this organization received funding for what they described as both Level One and Level Two services, in order to be able to follow a client over time.

This same organization also raises a concern about the need for language-accessible psychological services to be available in schools. Currently, due to limited funding, this agency is forced to choose only a few schools in which to provide services, again creating a barrier to continuity in care, despite the agency having chosen the schools at which they work based on their relevance to their client families.

Immigration Status

Many community organizations are concerned that undocumented clients are afraid to attempt to access health care. These clients avoid contact with all "officials," who might turn them in to immigration authorities.

In addition, employers are said to take advantage of immigrant employees' lack of knowledge about health and employment rights, and their fears about their immigration status. Staff at one organization report that many employers refuse to allow their immigrant employees to attend health care appointments during work hours, or penalize employees for taking time for appointments by withholding pay. This representative describes one situation in which an employer had refused to pay the employee's salary for one month as a penalty for arriving late to work after an early morning health care appointment. As a result, immigrants and refugees often keep working, even if they are suffering great pain.

Another important factor concerns the risk that bringing certain problems to the attention of authorities might jeopardize someone's immigration status. For a woman experiencing domestic violence, for example, the perpetrator may threaten to turn her in to the authorities if she reveals the violence to anyone. This problem has been well documented elsewhere.

Lack of Knowledge about Patient Rights

Organizations report that they do not have time or capacity to share information with clients about patient and language rights. Yet it is imperative that this information is given to those lacking language access, as it is an important tool for them in their efforts to gain access to care.

Lack of Oral Health Services

Many organizations raise concerns about the lack of dental health care available for their clients. This lack of access to dental health services appears to be a matter of both affordability and language access. This is consistent with recent research demonstrating significant health disparities in dental health based on socioeconomic status, race, language, and ethnicity.

IV. Solutions

Enforce Language Access Laws

One organization makes a very simple point: enforcement of current laws regarding language access would immediately and dramatically improve the lives of their clients.

Communicate with the Public about Interpreter Availability

Many organizations express a desire for information about when specific language interpreters are available at each health facility, so that agencies can steer their clients to certain days/times for health care visits. A survey of health care providers and a regularly updated directory that lists language availability at each health facility, as well as specific information about days and times those languages are available, would benefit all the community organizations. The representative of one organization says that this information would allow community-based organizations to decide which facilities they could partner with effectively.

The California Endowment might play a convening role, bringing together community-based organizations with hospital and clinic staff, to identify other areas where improved communication would eliminate, or at least reduce, some present challenges.

Create Better Access for First Contacts with Health Facilities

To address the fact that many immigrants and refugees do not read, health facilities must consider other methods for communication about services. One organization suggests that it might be more useful to offer video directions and information in the lobby of hospitals and clinics, though other organizations note that such technology could create new barriers for immigrants and refugees, particularly for elderly people who are uncomfortable or unfamiliar with electronic technology.

The same representative also suggests distributing cards to their clients that state, for example, "I speak Mien, and I need someone who speaks my language," which patients could present upon arrival at clinics and hospitals.

Provide Resources for Agencies to Train Employees as Certified Health Interpreters

Most community-based organizations are not aware that health-care interpretation training programs are available. It would appear that nearly all community agency staff providing interpretation services are uncertified, yet clearly expert at what they are doing. Most say they cannot afford to send staff for certification training. The organizations lack both the money to pay for such training and also the capacity to release staff from regular work responsibilities, as this would impact their overall ability to provide services to the many thousands of individuals they work with.

In addition, there is a need to promote the availability of such training programs among communities who speak the languages. Numerous organizations report that they are unaware of the existence of any resources for health-care interpretation training or of any local resources for training.

One provider suggests that her staff could benefit from the kind of training that could best be described as "health navigation" training. She wants her staff to learn about such issues as patients' rights, community resources, how to fill out various forms and applications, and information about basic medications so that they can advise their clients better. It appears that her staff members are learning such information as they can glean on their own, rather than in a systematic way.

One organization wants staff to be allowed to provide interpretation in health care settings as clients' advocates. Currently, they report, if no certified interpreter is available, the client is turned away. In order to prevent this problem, hospitals should recognize community organization's staff or volunteers as qualified to provide interpretation.

Provide Education to Patients about Their Rights

One organization's representative states that demands for language access must come from those directly affected by lack of services, and not just from service agencies that attempt to intervene on their behalf. The first step in organizing those experiencing language barriers must be educating them about their right to access.

Another organization raises the issue that many of their clients are not aware of their eligibility for public health insurance through Medi-Cal or Medicare. Even those who have been granted asylum may not know they have the right to health care. This representative tells the story of such a client with a major health crisis who went to the hospital for care. It was not until he received a bill for over $300,000 that he sought help. A medical social worker helped him prove his eligibility for the care and the bill was waived. The client, who had been granted asylum in the United States, had no idea that he was eligible for free care.

Many organizations want to be able to inform their clients about these rights, while some also wish for larger, public education campaigns to provide that information whether by radio, ethnic media, or other methods.

Acknowledge Community Organizations' Roles in the Lives of Immigrant Families

Some organizations are attempting to do *everything* for their clients. From basic phone calls to bill paying, writing résumés and accompanying them to appointments, the agencies are involved in every aspect of an immigrant or refugee family's life. These organizations seem to be in danger of sinking under the huge array of their clients' needs. Such organizations could benefit from increased training and support to develop their own infrastructure, as well as assistance in developing new generations of leadership.

It appears that in response to current changes in federal immigration law, many Alameda County organizations—in particular those providing services within Asian communities—have an influx of Spanish-speaking clients seeking immigration assistance. It is not clear if this is because the organizations that might be in a better position to provide such services are overwhelmed and these clients are the overflow, or if they are simply availing themselves of services located close to where they live. None of the organizations providing assistance to Latino immigrants raise any concerns or complaints about the situation, but it clearly impacts their ability to provide services to their primary community or communities.

Explore Alternative Models of Support

One organization has developed a Senior Peer Companion model, which merits exploration as to its application in other communities. The peer companions receive a stipend and extensive on-going training, which includes interpretation skill building. The organization has found the model to be cost-effective, and notes that having a cadre of people who have received health-focused training is invaluable. This organization's representative questions whether their model would work in all immigrant and refugee communities because of the challenge involved in providing such training in many different languages. They are more confident that communities who speak what they consider "core languages" such as Spanish, Cantonese, and Mandarin, would benefit.

Though not health focused, another organization has an intergenerational program that brings youth and elders together. Given that elderly immigrants and refugees appear to be the most linguistically isolated, it would be useful to find ways to incorporate increased health support for elders into such a program. Although it is important not to increase the reliance on children and grandchildren being utilized inappropriately as interpreters in medical settings, there may be appropriate times, within the family, that youth could help their elders communicate information about pain, for example. This is in keeping with a suggestion made by the representative of a second organization who points out that the children and grandchildren of immigrant and refugee families are already bicultural, bridging the traditional culture of their elders and mainstream U.S. culture. They suggest exploring ways to build on that reality by developing training for young people to strengthen their capacity as interpreters.

A third organization has also developed a program that brings together youth and elders, with the goal of helping the elderly to feel as though they are still needed and are an important part of the community through connecting with youth. While the program does not presently have a health focus, it could be expanded in this direction.

Access Must Address Barriers Beyond Language

Several community organizations point out that lack of transportation acts as a barrier for many of their clients. Some of those staff members actually drive patients to appointments when possible, but the organizations do not have the capacity to do this on the scale required by their clients. One volunteer at a community agency reports driving his own car 20,000 miles in a six month period, simply driving clients to their appointments. Many elderly people have regularly scheduled appointments, yet using public transportation is difficult due to their physical health and language barriers.

The fear that undocumented persons experience about any contact with "authorities" must also be addressed. Public health facilities should provide the public with information about their practices in regard to working with law enforcement and/or immigration agencies. Those facilities that are committed to providing services regardless of immigration status must explore methods for reassuring undocumented people that they can receive health services without concern about arrest and deportation.

Prescriptions

Drug labels should either be provided in the language of the person who will be taking the drug, or an internationally understood set of symbols should be developed and utilized for labeling. Health providers must check with their patients about their use of traditional treatments, to ensure safety in combining herbal remedies and prescription drugs. More time must be spent with patients to ensure that they understand the doctor's directions for taking medications.

Cultural Matching between Patient and Interpreter

Representatives of two organizations point out the "need to make appropriate cultural matches between translator/interpreter and client." Health providers must be familiar enough with cultural practices to be aware of when it is necessary to match a male client with a male interpreter, a female client with a female interpreter, and adults with adults. One of these organizations emphasizes that it is critically important that health care providers have enough awareness of international conflicts that they match interpreters and patients who do not have a history of conflict in their countries of origin.

Case Management for Families

Case management for newly arrived immigrant and refugee families would resolve many problems. One organization reports that their capacity to follow families and provide the ongoing navigation assistance they need is extremely limited. They propose that Alameda County provide caseworkers to keep track of families and make sure they have not fallen through

gaps in the system. By building trust with their clients over time, these caseworkers would be able to answer client's questions, provide the link between health care and psycho/social support, and solve myriad non-health related problems as well -- all services that the community-based organization is not able to provide. Another organization reports that they are often asked to provide case management services because their clients trust them more than they trust their doctors, and because no such case management is provided by the health care facilities.

Health Education

Although some of the community organizations in this study provide limited health education services to their clients, this appears to be fairly basic in nature and it is clear that many communities would benefit from more options. One organization's representative suggests their clients would benefit from education in nutrition, for example. The organization is concerned that clients experienced enormous lifestyle changes when they arrived in the United States, particularly those who have spent time in refugee camps. The abundance of food here after near starvation, the comparative lack of exercise, and the availability and affordability of junk food have all contributed to a rampant increase in obesity for such people. Nutritional counseling, as well as reminders of the healthiness of their traditional foods would benefit this community. This representative references a study conducted in Chicago that combined nutritional counseling with classes in English as a Second Language.

Enhance the Capacity of Organizations to Conduct Advocacy

Many organizations report that they are too overwhelmed to be able to engage in advocacy for systems change, yet would like to be able to work with other community organizations on such issues. The California Endowment may be able to play an important facilitating role in increasing organizational capacity to engage in systems-change activities.

Author's Acknowledgements

Special thanks are due to the many community-based organizations whose staff members made time in their extremely busy schedules to speak with the interviewer. With limited resources, these organizations often provide the only support many immigrant and refugee families and individuals have as they attempt to understand their new environment. Nearly all of them help their clients access health services by offering interpretation, translation, navigation, advocacy, and accompaniment, in addition to the assistance they provide in their primary service area. All have my respect and gratitude.

Finally, thank you to The California Endowment for its passion and commitment to eliminating systemic and institutional barriers that so many Californians face when they attempt to access culturally appropriate health care. In particular, thank you to both Justine Choy and Sandra Davis for their support, insight, and patience in the production of this report.

Jill R. Tregor, Consultant
December 2007

A SUMMARY OF RECOMMENDATIONS

In March 2007, The California Endowment convened the respondents to the original survey and additional community members to solicit feedback on the report. The following are recommendations that resulted from the March convening.

Patient rights and enforcement of language access laws (see Attachment A)

1. *Provide education about patient rights, language rights and eligibility for health coverage.*
   Increase awareness of individuals directly affected by lack of services and educate the public at-large. Explore alternative models to communicate and transfer this knowledge into the community; refugee resettlement programs, for example, could play a larger role in educating newly-arrived families about their rights.

2. *Enforce federal and state language access laws and local ordinances.*
   Currently, enforcement is reactive rather than proactive. Allocate resources to finance enforcement, and create an "ombudsman" for language access in health care settings to address the lack of enforcement.

3. *Use multiple strategies to increase language access.*
   Language law compliance alone is not enough to address the diverse needs of underserved communities. Employ a multi-strategy approach that includes legal and patient advocacy, services, community organizing, and litigation to address enforcement issues.

Language assistance services in health systems

1. *Strengthen coordination and communication between health facilities and community-based organizations (CBOs).*
   Survey health care providers and produce a regularly updated directory that lists language availability at each health facility, including specific days and times of interpreter availability, to help CBOs bridge services to their clients/members more efficiently. Convene CBOs and hospital and clinic staff to improve communication about language assistance service availability and language needs.

2. *Provide information in different formats for people who cannot access written materials.*
   Many immigrants and refugees do not read, and others speak languages that have no written form. Health facilities must consider other methods and media for communication about services, such as audio, video and information cards.

3. *Consider both the <u>cultural</u> and linguistic needs of patients when matching patients with interpreters.*
   It is important to make appropriate cultural matches between translator/interpreter and client. Health providers must be familiar enough with cultural practices to consider gender, age, country of origin, and historic religious and political conflicts when making these matches.

4. *Increase health system awareness about less common languages and health provider responsiveness to smaller and linguistically isolated communities.*
   Ensure that the needs of smaller immigrant and refugee communities that do not meet a 5% population threshold (the threshold used for some language assistance services) are met. Include community input in the development of language services for less common languages.

5. *Increase language access and cultural competency over the continuum of care.*
   Provide language assistance from intake through discharge, including diagnostic, specialists and follow-up appointments. Provide prescription information in appropriate languages or use an internationally understood set of symbols. Check with patients about their use of traditional treatments to ensure safety in combining herbal remedies and prescription drugs.

Health care interpreter workforce development

1. *Increase awareness of healthcare interpreter training and certification programs.*
   Target immigrants and refugees from emerging communities, CBO staff, and culturally and linguistically competent community members.

2. *Provide CBOs resources to train their staff as Certified Health Interpreters.*
   Provide incentives and release time to complete interpreter training and provide mentoring and other supports to retain staff with language interpretation skills. Provide health navigation training that includes information about patients' rights, community resources, and application processes so that staff can better advise their clients.

3. *Include community input in the content of health interpreter training programs for less common languages.*
   Gather community input on how to better address communication barriers due to differences in education, class, and gender within communities that speak the same languages, as well as language differences among people from the same country.

The role of community-based organizations (CBOs) in the continuum of culturally and linguistically competent services in Alameda County

1. *Recognize immigrant and refugee-serving CBOs as integral partners in the provision of culturally and linguistically competent services to the community.*
   Many organizations try to meet the range of their clients' health and social service needs and are responsive to the changing demographics in their communities and neighborhoods.

Provide resources to strengthen the sustainability of CBOs to meet multiple and emerging needs in their communities.

2. *Support and replicate culturally tailored programs and services that support community health and health promotion.*
   Sustain the culturally appropriate and relevant models of care developed by CBOs, such as peer-to-peer and intergenerational programs, and if applicable, replicate these programs in other communities.

3. *Create a funding source or mechanism (public sources, grants or fee-for-service programming) that provides compensation and resources for the interpretation and translation services currently being provided by CBOs at no charge.*
   Support a dedicated interpreter staff position at CBOs and/or enhance the roles for current staff case managers to include compensation for interpretation.

4. *Enhance the capacity of CBOs to conduct language access advocacy.*
   Facilitate a collective effort among CBOs to increase organizational capacity to engage in systems-change activities.

Cross-sector (health, housing, legal and social services) system coordination to meet the linguistic and cultural needs of immigrant and refugee communities

1. *Develop a pool of interpreters that can be shared between service providers and sectors and can be managed through a centralized, coordinated system.*
   Disseminate the activities and outcomes of the effort underway by the Alameda County Coalition on Language Access in Healthcare (ACCLAH) to explore coordinated or pooled efforts to increase language access.

2. *Strengthen and coordinate case management for families.*
   CBOs, which have the trust of their clients, provide some case management but have limited capacity to do so. Provide more public resources for case management for newly arrived immigrant and refugee families to help them navigate the multiple service systems and link them to appropriate services.

3. *Improve individual and community health education for immigrants and refugees.*
   Provide nutritional counseling and reminders of the healthiness of their traditional foods to new arrivals. Offer services like these along with classes in English as a Second Language.

Institutional and public awareness of language access issues

1. *Increase provider awareness and sensitivity to the stresses and challenges created by a patient's immigration and refugee status.*
   Explore ways to communicate and reassure undocumented people that they can receive services at facilities that are committed to providing services regardless of immigration status, without fear of arrest and deportation.

2. *Improve demographic data collection systems to capture racial/ethnic nuances and true linguistic and cultural diversity of communities.*
   Use anecdotal information in combination with census data to get at nuances in race and ethnicity classifications. Use the work that CBOs are doing with emerging communities to build a knowledge base about these communities and address their language needs. For example, although the Cambodian community in Alameda County is relatively small, their linguistic isolation is great. A CBO successfully advocate for Social Services to include Cambodian as a threshold language and provide language assistance services due to this linguistic isolation, as documented through anecdotal evidence.

3. *Strengthen awareness and value of multilingual and multicultural communities.*
   An overarching value or respect for multilingual and multicultural communities is missing, which speaks to a lack of respect for and recognition of language access needs. Initiate a national campaign about diversity awareness.

ATTACHMENT A – Federal, State and Local Language Access Legislation and Guidelines

	Legislation/ Guidelines	Covers	Key Elements	Enforcement	Links/Additional Information
Federal	Title VI of the Civil Rights Act (1064)	Any program or activity that receives federal funding or assistance, including payment for services provided to Medicare, Medicaid and SCHIP enrollees.	Recipients of federal funds must take reasonable steps to ensure meaningful access to their programs and activities by persons with limited-English proficiency (LEP). Effective language assistance plans include: 1) identifying LEP individuals who need language assistance; 2) providing language assistance measures; 3) training staff; 4) providing notice to LEP persons; and 5) monitoring and updating the language assistance plan.	US HHS Office for Civil Rights	http://www.lep.gov
	Culturally and Linguistically Appropriate Standards (CLAS) (2000)	Health care organizations and systems.	The first national standards for culturally and linguistic appropriate services (CLAS) in health care. OMH designed CLAS standards to help organizations provide culturally and linguistically accessible services for all. OMH also published a practical guide implementing language assistance services in healthcare organizations.	The Office of Minority Health (OMH)	CLAS Standards: http://omhrc.gov/templates/browse.aspx?lvl=2&lvlid=15
	Joint Commission Data Requirements (2006)	Ambulatory care, behavorial health care, critical access hospital, home care, hospital, and long term care instiutions.	Effective January 2006, The Joint Commission requires a patient, client, or resident's language and their communication needs to be in their medical records. The Joint Commission has cross-referenced its existing standards to CLAS standards, focusing on the individual's right to quality care.	The Joint Commission on the Accreditation of Hospitals	http://www.jointcommission.org/patientsafety/hlc/
California	Kpp Act (1983)	Any general acute care hospital in California.	Covered hospitals must conduct a variety of language assistance activities, including: provide language assistance services 24 hours a day for language groups that comprise 5% or more of the facility's geographic service area or actual patient population; post multilingual notices about the availability of interpreters, how to obtain an interpreter, and how to make complaints to state authorities about interpreter services; and identify and record patients' primary languages in hospital records.	California Department of Health Services	http://futurehealth.ucsf.edu/pdf_files/CA_US_langasst_reqs1.pdf
	California Senate Bill 853 (2003)	All health insurance products and health plans regulated and licensed by the Department of Managed Health Care or the Department of Insurance.	Senate Bill 853, sponsored by Senator Escutia, requires all health plans to have language access – including specific requirements around interpreting, translation, data collection and reporting.	Department of Managed Health Care, Department of Insurance	DMHC regulations: http://wpso.dmhc.ca.gov/regulations/docs/regs/12/1169760040301.pdf
	Medi-Cal Language Access Services Taskforce (2006)	Medi-Cal providers.	The Medi-Cal Language Access Taskforce, convened by the Department of Health Services (CDHS) is charged with forming recommendations to the CDHS Administration on a model for the economical and effective delivery and reimbursement of language services in Medi-Cal.	California Department of Health Services	http://www.dhcs.ca.gov/services/multicultural/Pages/LangAccessTaskforce.aspx
Alameda County	Oakland Equal Access Ordinance (2001)	City of Oakland departments and City Agencies.	City of Oakland departments and city agencies are required to hire a sufficient number of Bilingual Employees in Public Contact Positions (PCP) so as to adequately serve members of the Limited English Speaking Persons Groups in the City of Oakland. A language is automatically covered by the law whenever the 10,000-person threshold is met.	Equal Access Office	http://www.oaklandnet.com/government/Equalaccess/English/

ATTACHMENT B - Use of Traditional Treatments vs. Western Medicine

Organization	Use of Traditional Remedies and Medicines in Addition to Western Treatments
Afghan Coalition	Clients use a mix of Western medicine and herbal remedies they have made themselves or have brought with them, such as using garlic for high cholesterol. There is some fear of Western drugs due to side effects. Those who are more religious use prayer as well as Western resources.
African Immigrant & Refugee Resource Center	The Center has not done a full health assessment but suspects that the use of traditional medicines is particularly high among immigrants originally from rural areas. Their clients are in the process of deciding how much to trust Western medicine. For people from Ethiopia, for example, this means that they only turn to Western resources at the last minute.
Arab Cultural Center	Clients from Yemen, North Africa, and Afghanistan prefer a mixture of Western and traditional treatments. Palestinians and Jordanians prefer Western medicine exclusively. For mental health, people from Yemen do not believe that Western approaches are necessary. They read the Qu'ran or do not get treatment.
Asian Community Mental Health Board	Clients combine traditional and Western treatments.
Asian Pacific Psychological Services	Clients use a combination of Western and traditional medicine. Some Southeast Asian adults are "self-medicating" with herbs and alcohol. Some Chinese clients use herbal remedies in addition to Western medicine. Many clients are using prescription drugs that were not prescribed to them and may not know what they are taking.
Cambodian Community Development, Inc.	Not reported.
Catholic Charities	Not reported.
Eastern European Service Agency, Inc.	Clients use a mix of traditional/cultural treatments and Western medicine, including herbal and "self-cures." Currently, many clients are using bio-energy because one client had success using it to treat her cancer.
Filipinos for Affirmative Action, Inc.	Clients use traditional healers in addition to Western medicine. Often people rely on traditional ways as a first response, and then access the Western system. Possibly this is due not just to traditional beliefs but also because traditional approaches are less expensive.
International Rescue Committee	Not reported.
International Institute of the East Bay	Not reported.
Jewish Family & Children's Services of the East Bay	Not reported.
Korean Community Center of the East Bay	Korean clients use Western medicine primarily, and also use acupuncture, acupressure, and herbal medicines. Elderly Koreans in their 70's and 80's use traditional treatments - if available - in addition to Western medicine.
Lao Family Community Development, Inc.	Clients combine traditional remedies, including herbal medicines and acupuncture, with Western medicine. Staff members are concerned that combinations may be very dangerous. For some clients, spiritual beliefs are also important; others simply go to the hospital.
Law Center for Families	Not reported.
Mongolian Health Access Project	Not reported.