CONNECTING
Across Cultures

IMPROVING ACCESS TO HEALTH AND HUMAN SERVICES FOR THE FOREIGN BORN IN HOWARD COUNTY, MARYLAND

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Project Definitions

Access (to health services)

The ability to obtain health care to achieve the best possible health outcome. An individual's ability to obtain health services may be influenced by many factors, including insurance status, the linguistic and cultural competence of providers, the availability of services, cost, and the complexity of U.S. health care.

Barrier (to health services)

An obstacle that prevents or limits access. Barriers to health care are complex. They may be monetary (for example, the high cost of care or lack of insurance), geographic (a lack of private transportation, inadequate public transportation, the location of providers), or social/institutional (the linguistic and cultural competence of providers, immigration status of consumers, discrimination, the availability of interpreters, and the complexity of the health care system, among other factors).

Culture

The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. (Office of Minority Health.)

Cultural and linguistic competence

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. (Office of Minority Health.)

Equal access (to services)

*To be informed of, participate in, and benefit from services at a level equal to English-proficient persons. (*Adapted from Maryland Senate Bill 542, 2001 General Assembly.)

Foreign born

Born in a country other than the United States. Note, however, that in the definition of the U.S. Census Bureau *foreign born* refers to those residents of the U.S. who were not U.S. citizens at birth, whether or not they were born abroad.

Health

A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. (World Health Organization.)

Health and human services

Services that support complete physical, mental and social well being. From the perspective of this report, such services cover a broad spectrum ranging from traditional health and human services (including alternative medicine, mental health services and preventive health programs) to human and social services.

PROJECT DEFINITIONS, CONTINUED.

Immigrant

A foreign-born resident who is not a United States citizen, defined by U.S. immigration law as a person lawfully admitted for permanent residence in the United States. This is the legal definition of "immigrant" used by the Immigration and Naturalization Service. In this report, however, for ease of reading and to avoid a tedious repetition of "foreign born," the word "immigrant" may sometimes approximate its colloquial usage and refer loosely to any foreign-born person living in the U.S.

Interpretation

The oral conversion of speech from one language to another.

Limited English Proficient (LEP)

LEP individuals are those persons who cannot speak, read, write or understand English well enough to interact effectively with service agencies.

Political Asylee (legally "Asylee")

A foreign-born resident who is not a United States citizen and cannot return to his or her country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Asylee status is generally given after arrival in the U.S. (Immigration and Naturalization Service.)

Refugee

A foreign-born resident who is not a United States citizen and cannot return to his or her country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Refugee status is generally given prior to entering the U.S. (Immigration and Naturalization Service.)

Translation

The written conversion of text from one language to another.

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While FIRN staff members contributed to the content of the surveys of foreign-born residents and administered most of them, FIRN volunteers were also instrumental in translating and assisting with these surveys. Our heartfelt thanks to all our volunteers.

Betty H. Myers, President
FIRN Board of Directors

Authors' Note: In addition to providing critical board leadership support for this project, Betty H. Myers also contributed to the design of the focus groups, constructed questions for focus group discussions, and served as a reader of the final draft. The Authors are indebted to her for her leadership and expertise.

Organizations working with the foreign born and other interested parties are welcome to reproduce this report, in its entirety or in part, provided that full acknowledgment and attribution is provided.

A number of copies of this report have been printed with a detailed appendix that includes the complete reports on focus groups, survey forms and findings, and community forums. Readers interested in obtaining the full report may contact FIRN at 410-992-1923 to request a copy.

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Executive Summary

Even with the abundance of doctors and services, not everyone can access them because of lack of insurance, lack of English, and no money to pay for treatment.
Latino Forum Participant

If you don't speak English, it's scary. As the saying goes, "Don't think that because I speak poorly, I think poorly."
Focus Group participant

The Project

In 2001 and 2002, the Foreign-born Information and Referral Network (FIRN) of Howard County, Maryland, led a project to investigate language and cultural barriers to health and human services in Howard County. The goals were:

1) To investigate national concerns in these areas and report on them.
2) To capture and record the voices of local foreign-born residents on their experiences in accessing health and human services.
3) To ask the foreign born for their own solutions to these challenges.
4) To issue a set of recommendations.

To this end, FIRN collected information and research on language and cultural barriers, language access laws and best practices; held 9 focus groups for various foreign-born communities (Central American, Mexican, South American and Caribbean, African, Korean, Haitian, Vietnamese, Pakistani, and Chinese); held a Latino forum; and conducted written surveys of foreign-born residents of the County and of County health and human service providers. In addition, FIRN worked closely with the Association of Community Services of Howard County (ACS), a local umbrella organization with over 100 member health and human service agencies, to hold a forum for service providers.

The results of all these investigations converged. There was a clear consensus on the problems encountered by immigrants that matched the national research and also the experience of other cities and counties across the nation.

Barriers to Health and Wellness

The barriers that emerged repeatedly as the most significant and troubling for access of foreign-born residents to health and human services in Howard County were:

- Lack of language assistance (bilingual staff or interpreters).
- Lack of cultural understanding by providers.
- Lack of cultural sensitivity.
- Cost of services.
- Discrimination.
- Lack of information on the health care system.
- Lack of insurance.
- Limited transportation options.

In addition, foreign-born residents of the County appear in general unaware of the existence of

The Health Alliance, a local free clinic in Howard County for people with chronic health problems who are uninsured or underinsured.

Even more troubling, during focus groups and the Latino forum, participants displayed an apparent lack of awareness of their legal rights to interpreters. These rights are conveyed under Title VI of the Civil Rights Act of 1964 and other language access laws governing agencies that receive federal or state funding. (See Section Three, "Language Access Laws, Regulations and Guidelines".) Title VI prohibits discrimination in the provision of federally-funded services, including discrimination based on national origin. Such discrimination is against the law. In addition, foreign-born residents did not seem aware that in cases of discrimination they could file a complaint with the Howard County Office of Human Rights.

Service providers mirrored many of the same concerns as immigrants regarding the limited access of the foreign born to local services. They also offered their own perception of the barriers, which included, in addition to those listed above, the foreign-born consumer's:

- Lack of money/lack of insurance.
- Illiteracy.
- Cultural differences.
- Fear/mistrust of authority.
- Fear of stigma.
- Fear of jeopardizing immigration status.
- Difficulties caused by family members.

Recommendations

On the basis of the findings of this project, including suggestions and recommendations of the foreign born and of health and human service providers, FIRN recommends that area health and human service providers, with the support of Howard County government, ethnic organizations, faith-based organizations and key stakeholders, including the foreign born:

1) Create a broad-based County coalition to address language and cultural barriers to health and human services.

2) Provide interpreters as needed at all health and human service encounters in Howard County.

3) Offer cultural competence and diversity training to all staff at area health and human service organizations.

4) Publish and maintain a database of bilingual health providers in the Howard County area.

5) Organize broad outreach efforts to inform foreign-born residents in the Howard County area about:
    a. Available resources, including the Maryland Children's Health Insurance Program (MCHIP), The Health Alliance free clinic, and other free or low-cost health and human services.
    b. The U.S. health system and how to navigate it.
    c. The legal rights of the foreign born

Section One
Introduction

What can a newly arrived person do when they first come here? What institutions can they go to for help?

Focus Group Participant

The National Scene

Today, one U.S. resident in ten is foreign born. One child in five is an immigrant or an immigrant's child. Since 1970 the foreign-born population of the U.S. has more than tripled, going from 9.6 million to 31.1 million.[1] These numbers represent the largest wave of immigration in the history of the United States.

Foreign-born residents who seek health and human services in the U.S. face many challenges. In addition to language differences, immigrants may have their own cultural concepts of health, illness and doctors that are at odds with western medicine. Language and cultural barriers to health and human services are among the most painful barriers faced by immigrants in their daily lives.

It is not only the foreign born themselves who feel the pain of these barriers. Providers are often frustrated and baffled in their attempts to serve the foreign born. In particular, language barriers have emerged as a national and local crisis in health and human services. According to federal civil rights laws, agencies that receive federal funding (for even a single program or service) are required to provide interpreters for all their limited English proficiency (LEP) clients, at no cost to the clients. Yet most health and human service providers across the nation lack adequate bilingual staff or interpreters to assist them.[2]

In addition, most providers do not know where to find qualified interpreters or how to work with them. It is especially difficult for them to find affordable interpreters who specialize in health and human services. Typically, there are few funds in agency budgets for interpreters and no person on staff with the expertise—or time—to address the issue.

Cultural barriers also complicate access. Few providers in Maryland engage interpreters or cultural brokers who are trained to assess and remediate cultural barriers. Many providers are not aware that a cultural broker or trained interpreter can provide valuable information to service providers and clients on how they may overcome such barriers to improve health outcomes.

Immigrants in the U.S. are an especially vulnerable population. Those who want to promote their own health and wellness face many challenges, for example:

- Over 40 percent of non-citizens lack health insurance.[3]
- Over half of foreign-born Hispanics are uninsured.[4]
- Almost 18 percent of immigrants speak a language other than English at home.[5]
- The poverty rate for the foreign born is over 50 percent higher than for the native born.[6]

- Low-income immigrants are no longer eligible for Medicaid.[7]
- Children in immigrant families are three times less likely than children in U.S.-born families to be insured.[8]

Educational levels of the foreign born complicate this picture. Recent studies findings by the U.S. Census Bureau find that only 67 percent of the foreign born hold high school diplomas compared to 87 percent of the native born.[9] Lower levels of education affect not only immigrants' future earnings but their ability to obtain health insurance and to navigate the complex U.S. health care system.

In addition, recent research suggests that the rate of food insecurity among the foreign born is almost three times as high as for native-born families. Among the foreign born, food insecurity was reported twice as often among limited English proficient families as those that speak English well.[10]

In short, many members of this vulnerable population appear to greatly need the very health and human services they find so difficult to access.

The Local Scene: Howard County, Maryland

Howard County faces all these challenges. The County's foreign-born population more than doubled in the last decade. Between 1990 and 2000, the percentage of foreign-born residents of the County rose from 6.1 percent to 11.3 percent of the population.[11] Located between Washington, D.C., and Baltimore, Maryland, Howard has seen neighboring counties also struggling to provide adequate health and human services to the foreign born.

In the experience of FIRN staff, the majority of health and human service providers in Central Maryland that receive federal funding are not aware that it is considered a violation of federal law to ask—far less require—clients to bring an interpreter to appointments. In addition to federal requirements, recent changes in Maryland state law that are currently being phased in mandate that all agencies and programs that receive state funding must provide interpreters as needed for limited English clients, at no cost to the clients. It remains to be seen if this legislation will be effective in assisting foreign-born Marylanders as they attempt to access health and human services. (See Section Three, "Language Access Laws, Regulations and Guidelines.")

The Health Access Project

Anecdotal reports in Howard County have long suggested that foreign-born residents face significant challenges as they try to access health and human services. This project was designed to investigate and evaluate those barriers and devise strategies to overcome them.

Recognizing that the immigrant population is a vulnerable group, the Horizon Foundation and FIRN worked closely together to plan a project that would evaluate as objectively as possible the current access of local immigrants to health and human services.

The intent of this project was therefore to focus on local immigrants themselves. Their voices have not been heard; their needs and aspirations have not been recorded. This project set out to gather the data and record those voices in order to develop a prioritized plan to overcome language and cultural barriers to health and human services in Howard County.

Scope of the Project

This Health Access Project offers a snapshot of the foreign-born population of a small mid-Atlantic county within the context of the national and state scene. It corroborates and puts a human face on current research.

The project collected and assessed demographic information about the foreign-born population in the United States and in Howard County. It also gathered data on language and cultural barriers by looking at the following areas:

- Current research on language and cultural barriers to health access.
- Best practices found in programs around the country.
- The words of foreign-born people and health and human service providers themselves.

The Health Access Project adds considerably to current research by bringing these voices into the public arena. The voices were heard through:

- A written survey completed by 104 foreign-born residents of Howard County.
- A written survey completed by 15 County health and human service organizations and agencies.
- Nine focus groups of foreign-born County residents with an average of 10 participants.
- A forum of 31 Latino immigrants in the County.
- A forum of 50 Howard County health and human service providers.

This is a report of those findings, provided in detail in each section and accompanied by conclusions and recommendations.

A Word about FIRN

FIRN has over 20 years' experience serving foreign-born individuals and families and interacting with area businesses, nonprofit health and human service organizations and government agencies on their behalf.

Founded in 1981 and incorporated as a 501(c)(3) in 1984, FIRN is the only nonprofit organization in Maryland that offers comprehensive services to foreign-born individuals and families regardless of their country of origin or native language. Each year FIRN assists foreign-born residents from about 100 different countries who speak more than 50 different languages and dialects. Serving the counties of Central Maryland, including suburbs of Washington, D.C. and Baltimore, MD, FIRN with a staff of 10 provides direct services, information and referral in the areas of employment, housing, health, crisis intervention, language services (interpreters and translators), English language skills, immigration counseling, U.S. citizenship, legal referrals, and consumer issues.

In addition to its other services, FIRN directly addresses language and cultural barriers through a program that provides culturally sensitive interpreters to Howard and other counties in Maryland. Through Language Connections, established in 2000, FIRN offers the only community interpreter service in the state.

A corps of professional interpreters trained in medical, social services and legal interpretation,

Language Connections offers low-cost quality services for health and human service appointments. (Court-certified interpreters are also available through this program.) The interpreters are specially trained to address undisclosed cultural concerns and to clarify confusion about the "system." The goal is to help service providers and their foreign-born clients overcome cultural as well as language barriers. (For a more complete description of the program see “Language Connections: A Model Interpreter Service in Maryland” in Section Five.)

Section Two
The Demographic Context

The Nation, Maryland and Howard County

The United States saw a dramatic increase in the foreign-born population between 1970 and 2000. The U.S. Census Bureau reports an increase from 9.6 million in 1970 to over 31 million in 2000, and statistics from Census 2000 show the following figures for the foreign-born population:[12]

Geographic Area	Percentage of Foreign Born	Number of Foreign Born
United States	11.1 percent	31,107,573
Maryland	9.8 percent	518,315
Howard County	11.3 percent	28,113

These figures represent substantial increase from Census 1990 statistics for this same population:

Geographic Area	Percentage of Foreign Born	Number of Foreign Born
United States	9.7 percent	19,767,316
Maryland	6.6 percent	313,494
Howard County	6.1 percent	11,365

Clearly, during the decade between 1990 and 2000 the foreign-born population in the United States and Maryland increased considerably. But in Howard County those numbers more than doubled. The percentage of the foreign born in the total population of Howard County also nearly doubled during that decade, and the foreign-born population in Howard County grew at a faster rate than the general population. By comparison, the U.S. population as a whole increased 13.2 percent during that decade, and the native-born population increased by only 9.3 percent.

In 2000, over half (51.7 percent) of the U.S. foreign-born population came from Latin America, about a quarter (26.4 percent) from Asia, and 15.8 percent from Europe. However in Maryland generally and in Howard County in particular, immigrants' origins differ from national statistics. According to the 2000 census, for example, Howard County has a higher percentage of African immigrants (7.9 percent of the foreign-born population) and Asians (54.5 percent) than the national average, but a lower number of residents from Latin America (18.7 percent).

In Howard County, the foreign born are concentrated in Columbia and Ellicott City, two areas where more than 13 percent of the population is foreign born.

These statistics show large increases in the foreign-born population, but it is widely recognized by demographic experts[13] that statistics on immigrant population may also be significantly underreported. The U.S. Census Bureau has made great strides in adjusting data to correct such errors, and there is a general consensus that it remains the most reliable source of data on the demographics of the foreign born currently available in the U.S. It therefore remains, for the time being, the official count. Nonetheless, it should be noted that many community-based organizations serving ethnic groups across the country remain skeptical about the accuracy of Census data—and in private communications, they are often vehement on the subject. Local

organizations in Howard County that work with the Hispanic population, for example, anecdotally report that the Hispanic population is actually double the size reported in official Census Bureau statistics. While such organizations cannot provide scientific evidence to bolster their arguments, several reasons are often presented as the cause of underreporting of immigrants by Census data. The reasons are cited so consistently that they should be carefully noted:

- Language barriers.
- Cultural barriers.
- The fears that many immigrants share—for example fear of authority figures, of government, of deportation, of going to prison, of repercussions if too many occupants are living in a single dwelling, among others.
- Lack of trust.
- Lack of understanding, particularly among low-income, less-educated immigrants, concerning the importance of surveys in general and of the Census in particular.

The Big Picture

Above are the bare statistics: the facts. What do they mean?

Washington, D.C. was reported by the Immigration and Naturalization Service (INS)[14] as one of the top five "magnets" for legal immigrants in 1998, after New York, Los Angeles, Chicago and Miami. Overall, it has the 6th largest metropolitan area population of immigrants in the U.S.[15] According to a Brookings Institute report in 2001[16], one resident in six in the D.C. region is foreign born; residents of the area come from 193 countries, and no one country dominates the mix. In addition, 87 percent of recent immigrants have chosen to live in the surrounding suburbs.

What has happened to this population in Central Maryland (and northern Virginia) is similar to the concentric rings from a pebble cast in water. Immigrants migrating to the urban hub of Washington, D.C. tend to settle further and further out—in areas as far away as Baltimore, the eastern shore of Maryland and Richmond, Virginia. Thus, many counties in Maryland and Virginia are seeing surges in their immigrant population. Montgomery County, for example, closer to Washington, D.C. than Howard County, currently has a foreign-born population of over 25 percent.

Languages Spoken at Home

According to Census 2000 data, almost 47 million in the United States, or 17.9 percent of the U.S. population age five or older, spoke a language other than English at home. In Maryland 622,714 spoke other languages at home (12.6 percent of the total State population) and in Howard County over 32,000 spoke other languages at home (14.0 percent of the total County population).

Of Howard County residents speaking another language at home, close to one quarter of them spoke Spanish, while over a third spoke an Asian/Pacific Island language such as Korean or Chinese. About a third of those who spoke another language than English at home reported speaking English "less than well."

These are dramatic statistics for a small county.

English for Speakers of Other Languages (ESOL) classes

One often-neglected source of data on the burgeoning population of immigrants and limited English speakers is the public schools. While not all students who are foreign born attend ESOL classes, and a number of native-born children with limited English do attend them (due to having spent five years with parents who speak little to no English in the home), ESOL statistics remain meaningful. They portray a trend.

A Brookings study[17] reported in March 2002 that the number of LEP students enrolled in public schools in the Washington, D.C. area has soared. Public Schools in D.C., Maryland and Virginia collectively reported a 16.2 percent increase in 2001 alone for a total of 53,990 students enrolled in ESOL classes in these three jurisdictions. The average annual growth from 1993 to 2000 was 9.6 percent.

In Howard County Public Schools, the increases are also striking. In the 2001-2002 school year, Howard County schools served over 1,551 LEP students. They came from 88 countries and spoke 64 languages. In all, the schools' ESOL population has increased by 77.5 percent in the last six years. At the high school level, the increase in just two years was 98 percent.

The top languages spoken by Howard County ESOL students in 2001 were Korean (spoken by 27 percent of the ESOL population), Spanish (25 percent), Chinese (9 percent) and Urdu (6 percent), followed by Vietnamese, Russian, French, Hindi, Portuguese, Arabic, Japanese, Farsi, French Creole, Twi and Thai.

Unfortunately, Howard County schools report data that should concern both local and state authorities: over the last three years, the number of LEP students arriving with interrupted education or *no* formal education has more than doubled. The number of students illiterate in their native language has also risen by 60%. Despite a strong and supportive ESOL program and other resources in schools for LEP families (such as parent-teacher liaisons, interpreters and after-school programs), the retention rate of LEP students during the same three years has quadrupled and the number of drop-outs almost doubled. Such problems may affect the ability of these students in the long term to obtain employment with health care benefits and to gain enough education to successfully navigate the U.S. health care system.

Who's Here?

According to the Center for Immigration Studies, which analyzed Immigration and Naturalization Service (INS) admissions data between 1991 and 1998, the "top ten" countries represented by legal immigrants in Howard County are the following:

Howard County Immigrant Admissions FY'91-'98: Top Ten Countries

Rank	Country	No. of Immigrants
1	India	631
2	China *	599
3	Korea	556
4	Soviet Union	356
5	Pakistan	198
6	Iran	173
7	United Kingdom	163

8	Philippines	147
9	Nigeria	132
10	Vietnam	129

* Includes Hong Kong and Taiwan

However, these data include only officially stated "first" destinations of legal immigrants. Immigrants are a highly mobile population. Other minorities besides those listed above who are widely observed and (in the case of Hispanics) well documented in Howard County include residents from:

- Mexico.
- Africa (several countries, perhaps especially Liberia).
- Central America (especially El Salvador, Guatemala and Honduras).
- Middle East (Iran in particular).

Refugee populations have also increased in Howard County, including Bosnians and Serbs. For example, in 2000 the top five languages used by Howard County General Hospital during telephonic interpreter encounters were Spanish (72.5 percent), Mandarin Chinese, Russian, Korean and Vietnamese. However, in 2001, the "top five" list included Albanian, a refugee language.[18]

The Immigrant Admissions data in the table above refer to legal immigrants. Yet some of the most vulnerable residents of the county lack legal documentation. There are no reliable data on local undocumented residents. However, anecdotal information and subjective indicators such as high visibility at local clinics and human service settings suggest that residents from Mexico, El Salvador, Guatemala, Honduras and some southeast Asian countries may account for a significant portion of the undocumented population of Howard County.

When community service providers in Howard County were asked in the survey administered by FIRN "What are the most common languages [in Howard County] spoken by those who speak little or no English?" the answers included Russian, Bosnian, Serbocroatian and East Indian dialects. Anecdotally, FIRN reports that the vast majority of vital documents and information brochures translated by local community service provider agencies are translated into Spanish and Korean.

STRATEGY

The statistics above can be used by local health and human service agencies to justify inserting into the budgets of federal, state, county and foundation grant proposals line items intended to cover:

- Interpreter services.
- Cultural competence trainings.
- Outreach to the foreign born.
- Interpreter trainings for bilingual staff.
- Translation of vital documents.
- Creating coalitions, focus groups, and ties with ethnic community-based organizations.
- Other services intended to overcome language and cultural barriers in service delivery.

One health department director outside Howard County strongly recommends writing costs for such services "into every single grant" proposal.

Section Three
Language Access Laws, Regulations and Guidelines

All of us who come here from other countries are intelligent, but we don't know how to claim our rights.

Focus group participant

"No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, or be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Title VI of the Civil Rights Act of 1964

FEDERAL AND STATE INITIATIVES TO REDUCE LANGUAGE BARRIERS

Title VI of the Civil Rights Act offered the first broad protection for limited English speakers in the United States seeking access to health and human services.

In practical terms, any agency that receives federal funding is required by Title VI to provide interpreters for persons of limited English proficiency (LEP). The agency must do so at its own expense. That is the consistent interpretation of Title VI that has been applied by the Department of Health and Human Services (HHS) Office for Civil Rights (OCR). Failure to provide interpreters for LEP clients seeking health and human services from a federally-funded agency or program would constitute discrimination on the basis of national origin.

In addition, such agencies must provide translations of vital documents and ensure equal access of LEP clients to all their services. Even if the agency receives federal funding for only one program, it must ensure equal access to all its other programs too, regardless of their funding source.

The vast majority of health organizations in the United States receive funding from HHS, whether they receive the money directly or filtered down through a state or local agency. As a result, Title VI covers most health care organizations in the U.S. In addition, the law covers a very large number of public and nonprofit human and social service agencies.

Title VI may apply to private practitioners who accept Medicaid funding as well as to government and nonprofit providers. However, interpretation of the law as it applies to private practitioners is currently a delicate area of dispute, and the Office for Civil Rights for Region III (which includes Maryland) currently is not certain how courts will ultimately rule on this issue, since no final ruling has yet been made. In any case, interpretation of the law by OCR allows private practitioners and small agencies more latitude than hospitals and large organizations. However, no business, organization or agency receiving federal funds is exempt from the law. Justice officials, boards of education, housing authorities and other agencies that receive federal funding are also expected to provide interpreters for LEP clients of their services.

It is important to note, however, that Title VI is an unfunded mandate. Currently, no federal agency provides comprehensive funding for interpreters or translators in support of Title VI. The federal government will offer "matching funds" to those states that help pay for interpreters in

support of Title VI requirements. To date, only five states have taken advantage of this funding: Hawaii, Maine, Minnesota, Utah, and Washington, which is a leader in this area.

In some cases, interpreter agencies are paid directly by the State. This arrangement greatly alleviates the financial and logistic burden placed on health and human service agencies, who simply request and schedule the interpreters as needed and then document the visit.

What Should Happen?

It is the obligation of any agency that receives federal funding to inform all LEP clients of their right to a free interpreter and to provide the interpreters. If the individual then insists on bringing in his or her own interpreter, the agency should note that information in the individual's file. Above all, minor children should not be used to interpret.

The Office for Civil Rights (OCR) states that agencies, businesses, private practitioners and health and human service organizations that receive federal funding are expected to hire and train bilingual staff as interpreters where possible. Where it is not feasible to use bilingual staff, such agencies should contract with community-based language banks of trained interpreters, or build their own language bank of trained interpreters. They should also secure other interpreter resources to call upon in times of need. Agencies should not rely on a single language resource (such as telephonic interpretation).

HHS and the U.S. government expect publicly funded agencies to develop a plan to cover all contingencies. This plan should address what happens from the moment of first contact with an LEP client until the client is discharged.

The Reality

Despite Title VI and clear guidance on these issues from OCR, the harsh reality in Maryland and in Howard County is that friends and family members (including minor children) are still routinely used as interpreters. In many cases, clients are asked or required to bring their own interpreters.

In fact, few organizations across the country are aware of Title VI. Most small health and human service agencies would be astonished to learn that they should provide interpreters at their own expense. They are unaware that they may not ask (far less require) clients to bring in their own interpreters. Many health and human service organizations routinely request that clients come in with their own interpreters, typically family members or friends—even minor children. They are unaware that in doing so they may be in violation of the law. Often such agencies are also unaware that they may be in violation of the law when they fail to provide translations of vital documents, including consent forms.

Conversely, many doctors across the nation—and the American Medical Association (AMA)—*are* aware of Title VI. Such doctors know that if they participate in a federally-funded program, such as Medicaid, they may be required to provide interpreters. However, the AMA and individual doctors have taken a strong position that it is unfair to impose the burden of paying for interpreters on the shoulders of private practitioners. They point out that Title VI enforcement may ultimately lead many doctors to refuse all Medicaid or Medicare patients. The issue is currently working its way through the court system and at the time of writing it is uncertain what the final outcome of such cases will be.

Recent research as well as anecdotal evidence and many news stories about hospitals and clinics have shown that untrained interpreters, or the absence of interpreters, can lead to gross errors that sometimes result in death, misdiagnoses, perpetuation of abuse (for example, when an abusive spouse acts as interpreter, which is a frequent problem), and other distressing or dangerous situations.

Federal Orders and Policies in Support of Title VI: Executive Order 13166 and the Policy Guidance Statement of OCR and HSS

Title VI was not successful in undermining discrimination against the foreign born. As a result, in August 2000 President Clinton strengthened legislative remedies by issuing Executive Order 13166. In essence, EO 13166 reaffirms Title VI and requires all agencies that provide federal assistance to prepare a guidance policy and create a plan to improve access to federally funded programs for LEP individuals.

EO 13166 put "teeth" into Title VI. The Executive Order came as a wake-up call to many large health and human services providers across the country. However, at the local level, most smaller agencies are still unaware of Title VI or the Executive Order. Most of these organizations do not provide interpreters. Many do not translate even their most vital documents. Such documents might include:

- Consent and complaint forms.
- Intake forms, especially for emergency services.
- Financial eligibility forms.
- Written notices of rights, denial of service, etc.
- Notices advising LEP persons of free language assistance.

On the heels of the Executive Order 13166, on August 30, 2000, the Federal Office for Civil Rights with the U.S. Department of Health and Human Services issued a policy guidance statement: Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency. This document (the current version can be accessed at <www.hhs.gov/ocr/lep/guide.html>) provides clear guidance for implementation of Title VI.

With this action, together with EO 13166, the Federal government has made clear that it expects all federally funded agencies to respect their legal obligations under Title VI.

Other Federal Laws

Title VI is not the only federal protection for LEP clients seeking health services. Other laws include:[19]

The Hill-Burton Act: Dating back to 1946, this act requires all public and nonprofit community hospitals and health centers to comply with a "community service obligation" that includes (in the OCR interpretation) caring for the needs of LEP patients.

Medicaid: First enacted in 1965 as an amendment to the Social Security Act of 1935, Medicaid is a medical assistance program administered by the Centers for Medicare &

Medicaid Services (CMS) and jointly financed by state and federal governments for low-income individuals. (Prior to July 1, 2001, CMS was the Health Care Financing Administration.)

CMS requires states to communicate with Medicaid beneficiaries, including residents of long-term care facilities, through interpreters and written translations.

Medicare: Also enacted in 1965 and administered by CMS, Medicare is a federally funded system of health and hospital insurance for U.S. citizens age sixty-five or older, for younger people receiving Social Security benefits, and for persons needing dialysis or kidney transplants for the treatment of end-stage renal disease.

Medicare stands alone in providing reimbursement to Medicare-participating hospitals for bilingual services to inpatients.

Federal Categorical Grant Programs: Categorical grant programs are programs for which funding is restricted to specific purposes governed by a unique set of statutes and controlled by provisional language found in the budget item governing the program.

Under these programs, federally funded community health centers and migrant health centers are required to provide linguistically and culturally appropriate services.

Emergency Medical Treatment and Active Labor Act: Enacted in 1996. Hospitals that participate in Medicaid and have an emergency room are required to treat patients in an emergency under a set of diagnosis and treatment parameters that would be impossible to meet without overcoming language barriers.

Culturally and Linguistically Appropriate Services (CLAS): In 2001, the U.S. Department of Health and Human Services Office of Minority Health (OMH) issued a set of standards for the delivery of health services in a culturally and linguistically appropriate manner, commonly referred to as the CLAS standards. CLAS means "Culturally and Linguistically Appropriate Services" in the delivery of health care services to the foreign born, the deaf and other minorities with limited English proficiency. CLAS Standards are the first comprehensive, nationally recognized standards of cultural and linguistic competence in health care service delivery.

While not obligatory, CLAS was the first set of national standards ever developed. In the process of creating them, OMH collected extensive feedback from consumers, community-based organizations, health organizations (large and small), specialists in language and cultural barriers to health, and ethnic leaders across the nation. This effort began in 1997, a draft report was issued in 2000, and the final standards were published in March 2001.[20]

It is notoriously difficult to define how anyone can deliver quality health care to the foreign born. It is even harder to assess the outcomes of such care. CLAS standards go to the heart of those challenges. They put on paper *what* constitutes such care and *how* to assess it. This is the first broad-based attempt by the U.S. government to standardize both the research literature and views "from the trenches," including hospitals, nonprofits, large and small health centers, government agencies and the foreign born across the country.

The CLAS standards are a remarkable development, and should ideally be read in detail. For the convenience of readers of this report, a summary of the standards is provided at the

end of this Section. For the complete set of standards go to the Federal Register: December 22, 2000 (Volume 65, Number 247). The standards, the public comments from the regional meetings, and a complete report on the project may also be accessed online at <www.omhrc.gov/CLAS>.

State Laws

Across the nation, a number of states have enacted language access laws to protect LEP individuals. Some laws have focused on health services. Others have strict and explicit requirements for mental health and long-term care. Some laws—including laws passed in California, Massachusetts and New York—offer guidance to providers on improving access of LEP clients to health services.

Recently, Maryland enacted its own language access laws. In 2001 and 2002, Senate Bills 542 and 265 were passed into law. Taken together, they show that the General Assembly considers it the policy of the State to provide equal access to public services provided by State departments, agencies, and programs in Maryland to persons with limited English proficiency.

Under these laws, it is the responsibility of organizations providing state-funded programs to provide interpreters to LEP clients. In essence, the requirements are similar to those of Title VI except that they address state rather than federal funding. These laws are currently being phased in over several years.

- Senate Bill 542, passed by the General Assembly and signed by the Governor May 15, 2001 (Chapter 396), stated the intent of the General Assembly that State agencies are authorized to provide services to persons with limited English proficiency. It requires that State agencies survey the need for interpretation and translation services and provide the Department of Human Resources with a description of the current measures taken to provide the services.

- Senate Bill 265, passed by the General Assembly and signed by the Governor April 25, 2002 (Chapter 141), stated the intent of the General Assembly that State departments, agencies, and programs shall provide equal access to public services for individuals with limited English proficiency. This law makes Maryland one of the state leaders across the nation in language access laws.

  The law requires State agencies to take reasonable steps to provide equal access to public services for individuals with limited English proficiency. The Department of Human Resources, in consultation with the Office of the Attorney General, must provide central coordination and technical assistance to programs.

  SB 265 also states that state-funded programs must provide translations of forms and documents ordinarily provided to the public into any language spoken by 3% or more of the population within that geographic jurisdiction. Finally, the law states that any additional methods or means necessary to ensure equal access to services funded by the state should be used.

  On or before July 1, 2003, SB 265 should be fully implemented by the Department of Human Resources (DHR), the Department of Health and Mental Hygiene (DHMH) and the Department of Juvenile Justice, among other agencies.

As with federal language access laws, Maryland state laws will most likely (in practice) allow private practitioners and small agencies more latitude than hospitals and other large organizations. Nevertheless, no business, organization or agency in Maryland that receives federal or state funds is exempt from the law.

Current Strategies in Maryland

A key survey mandated by Maryland Senate Bill 542 was performed by the National Foreign Language Center to assess the current access of LEP clients in Maryland to State agencies, programs and services. The report, issued in 2001,[21] revealed the following:

- Every county in Maryland has LEP clients.
- The use of minor children as interpreters persists.
- Spanish is the language most commonly encountered by the State government service providers, after English.
- Korean, Russian, Chinese, Vietnamese and other Asian languages were also commonly encountered.
- Less than one fourth of responding agencies, departments or programs track LEP impact or track training in policies and procedures to overcome language barriers.

The report also identified the strategies most widely used in Maryland State agencies, departments and programs to overcome language barriers. In order of frequency, they were as follows:

- Bilingual staff (untrained).
- Family members brought by client.
- Friends brought by client.
- Contract interpreters (telephonic).
- Contract interpreters (in person).
- Community advocate brought by client.
- Trained/certified staff.
- Community-based organizations (such as FIRN).
- Other volunteers.

It is unfortunate, given the vast array of problems associated with using family members or friends as interpreters, to see those two strategies among the top three that have been adopted in delivering State-funded services in Maryland.

From a telephone survey of State employees, however, the distribution was different:

- Call on fellow employees (27 percent).
- No response (22 percent).
- Handle it themselves (15 percent).
- Call on contractor (14 percent).
- Rely on clients themselves (12 percent).
- Rely on clients' friend or a community member (8 percent).
- Other (2%).

This second set of responses is also discouraging. Neither set of responses matches federal guidelines or the research in the field concerning models and best practices (see the next Section of this report).

Creating a Plan to Cover All Contingencies

Both OCR and Maryland state laws are quite clear. Agencies should not rely on a single language resource (such as telephonic interpretation) to provide equal access to their services. Instead, health and human service agencies in Maryland that receive federal and/or state dollars must develop a plan to cover all contingencies. This plan should ideally address what happens from the moment of first contact with an LEP client until the client is discharged.

Any plan or set of policies and procedures regarding services to LEP clients should include an appropriate combination of interpreter and translation resources. The goal is to cover any contingencies and provide effective service delivery.

Standards for Culturally and Linguistically Appropriate Services (CLAS)

Definitions

THE OMH CLAS Standards define cultural and linguistic competence in the following terms. Definitions and other quotations are taken from the CLAS Standards report.

Culture: "The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given."

Cultural and Linguistic Competence: "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. `Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."

Culturally and Linguistically Appropriate Services: "Health care services that are respectful of and responsive to cultural and linguistic needs."

In a Nutshell: "Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter."

The Standards

The 14 national, federal standards are provided below in italics, followed by comments by report author Marjory Bancroft, based on the discussion of each standard in the complete report. It should be noted that while these federal standards were developed to address barriers in the delivery of health services, they apply to human services as well.

1. ***Health Care Organizations Should Ensure That Patients/Consumers Receive From All Staff Members Effective, Understandable, and Respectful Care That Is Provided in a Manner Compatible With Their Cultural Health Beliefs and Practices and Preferred Language.***

Comment: Standard 1 is the "baseline" standard. All the other CLAS standards are intended to (a) clarify this standard in more detail and (b) show how the standards can be met by all health organizations delivering services to anyone of limited English proficiency (LEP).

2. ***Health Care Organizations Should Implement Strategies To Recruit, Retain, and Promote at All Levels of the Organization a Diverse Staff and Leadership That Are Representative of the Demographic Characteristics of the Service Area.***

   Comment: Hiring diverse, bilingual staff does not guarantee culturally and linguistically appropriate health care services. However, it helps enormously.

3. ***Health Care Organizations Should Ensure That Staff at All Levels and Across All Disciplines Receive Ongoing Education and Training in Culturally and Linguistically Appropriate Service Delivery.***

   Comment: Staff education and training are critical factors in ensuring competence. As this report illustrates, many immigrants in Howard County strongly recommend that health and human service providers receive such training. Specialists, however, often stress that *all* members of the organization, including administrators, board members and front-line staff, should receive training in cultural competence. .

4. ***Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation.***

   Comment: Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI). For complete details on compliance with these requirements, see the HHS guidance on Title VI with respect to services for LEP individuals (65 FR 52762-52774, August 30, 2000) at <www.hhs.gov/ocr/lep>.

   Note that Standard 4 includes all individuals with limited English proficiency, whether or not they come from a commonly spoken language group in the area. This standard also specifies (in the discussion that follows it in the report) that bilingual staff members are preferred; face-to-face interpretation is the next step if bilingual staff are not available; finally, telephone interpreter systems are a supplemental system and should not be used as a primary means of establishing communication with patients.

5. ***Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services.***

   Comment: LEP individuals should be informed—in a language they can understand—that they have the right to free language services and that such services are readily available. Health care organizations should also post translated signs at all points where LEP patients enter health care centers and should distribute written materials to notify these patients about their rights.

6. ***Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/Consumer).***

   Comment: This standard means that a patient/consumer may choose to use a family member or friend as an interpreter unless the effectiveness of services is compromised by that choice or

the LEP person's confidentiality would be violated. However, *minor children should never be used as interpreters, nor be allowed to interpret for their parents*.

7. ***Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area.***

Comment: Applications, consent forms, medical or treatment instructions and other vital health documents should be translated. If the language is not a widely spoken language in the area, patients should still be notified of their right to receive an oral translation of all vital written documents. (For more information on what the OMH considers "vital" documents, consult 65 FR 52762-52774, August 30, 2000 at <www.hhs.gov/ocr/lep>.

8. ***Health Care Organizations Should Develop, Implement, and Promote a Written Strategic Plan That Outlines Clear Goals, Policies, Operational Plans, and Management Accountability/Oversight Mechanisms To Provide Culturally and Linguistically Appropriate Services.***

Comment: It is not enough to develop a written plan: staff members need to know of the plan and be prepared to act on it. The DHHS Office for Civil Rights, Region III (the office that covers Maryland), has found that it is not rare for organizations with a written plan for providing services to LEP clients to have front-line staff who are unaware that such a plan exists.[22]

9. ***Health Care Organizations Should Conduct Initial and Ongoing Organizational Self-Assessments of CLAS-Related Activities and Are Encouraged To Integrate Cultural and Linguistic Competence-Related Measures Into Their Internal Audits, Performance Improvement Programs, Patient Satisfaction Assessments, and Outcomes-Based Evaluations.***

Comment: Unless agencies make an effort to monitor their own compliance with CLAS Standards, how well will they implement those standards? This is a hard effort.

In smaller organizations, bilingual staff and interpreters can contribute in direct ways by informing administrators about the language and cultural barriers they perceive in day-to-day service delivery. In larger organizations, bilingual staff and interpreters may have to make a conscious effort to inform higher levels of management about such barriers and offer viable strategies for overcoming them. Administrators, in turn, could make clear that they seek and welcome such feedback as they devise performance measures and conduct staff evaluations.

Ultimately, however, without close collaboration between health organizations and community-based organizations serving the foreign born, the likelihood of obtaining accurate feedback from immigrant consumers is very low.

10. ***Health Care Organizations Should Ensure That Data on the Individual Patient's/Consumer's Race, Ethnicity, and Spoken and Written Language Are Collected in Health Records, Integrated Into the Organization's Management Information Systems, and Periodically Updated.***

Comment: Many smaller organizations are reluctant to collect information on race, ethnicity, and language. But it is necessary to do so in order to identify population groups within a service area, monitor patient/consumer needs and quality of care, and study outcome patterns. The

data will also help to improve service planning and delivery. It is important to realize, however, that this is a delicate and sensitive issue, especially for many minority staff members. In some organizations (especially grassroots nonprofit agencies), in order to obtain "buy-in" from service providers it may be necessary to discuss these issues openly in staff meetings. Cultural competence includes displaying sensitivity to minority and foreign-born staff members and their concerns.

11. ***Health Care Organizations Should Maintain a Current Demographic, Cultural, and Epidemiological Profile of the Community as Well as a Needs Assessment to Accurately Plan for and Implement Services That Respond to the Cultural and Linguistic Characteristics of the Service Area.***

    Comment: The need for baseline data on health outcomes of the foreign born is overwhelming. To date, there are almost no such data. The only way to learn what is working and how it is working in health care delivery is to document the need, the services delivered and the outcomes. If health care organizations obtain baseline data and update it regularly health care providers will be able to plan and implement services of higher quality.

12. ***Health Care Organizations Should Develop Participatory, Collaborative Partnerships With Communities and Utilize a Variety of Formal and Informal Mechanisms to Facilitate Community and Patient/Consumer Involvement in Designing and Implementing CLAS-Related Activities.***

    Comment: This is an extremely important standard. There is an urgent need for greater collaboration between ethnic communities, the leaders and organizations that represent them, and health and human service agencies.

13. ***Health Care Organizations Should Ensure That Conflict and Grievance Resolution Processes Are Culturally and Linguistically Sensitive and Capable of Identifying, Preventing, and Resolving Cross-Cultural Conflicts or Complaints by Patients/Consumers.***

    Comment: Interpreting . . . Translating . . . Overcoming cultural barriers . . . What a complex task! No organization can carry out CLAS Standards perfectly. Rather, it is crucial to have a mechanism in place to allow feedback from LEP patients who perceive problems with service delivery in order to improve those services.

14. ***Health Care Organizations Are Encouraged to Regularly Make Available to the Public Information About Their Progress and Successful Innovations in Implementing the CLAS Standards and To Provide Public Notice in Their Communities About the Availability of This Information.***

    Comment: Different organizations will handle this recommendation in the ways that make most sense, including notices in ethnic media (multilingual newspapers, magazines, radio and television), as well as reports, newsletters, conferences, press releases, articles, broadcast media and web sites.

The complete report on CLAS Standards, along with supporting material, is available online at <www.OMHRC.gov/CLAS>.

Section Four
Cultural and Language Barriers: A Look at the Literature

> *I had stomach pains, so I went to the hospital, without any reference. They did tests, but there was no interpreter, no diagnosis. They asked me for my Social Security number, but I don't have one. They were reluctant to care for me and told me to go to a gynecologist, although I don't know any. At the gynecologist they asked me for my medical insurance, which I don't have. One month has passed, and I still don't have a diagnosis.*
>
> Focus group participant

> *Even in the little aspects of life, what you look like will determine how you will be treated. It's even worse if you have an accent.*
>
> Focus group participant

The Need

Across the nation, news stories are multiplying about immigrants who cannot obtain health care due to language barriers. Sometimes the consequences are minor, such as failure to get treatment for a sore throat or viral infection. Sometimes they are severe, resulting in death, suicide or permanent injuries.

- "When she arrived by ambulance at Woodhull Medical and Mental Health Center, Juana Alvarez was bleeding profusely, but no one could understand her when she said - in Spanish - that she was in labor. By the time a hospital employee who understood Spanish was located two hours later, it was too late. The baby died."[23]

- "In extreme cases, such as that of a 13-year-old girl who died two years ago of a ruptured appendix after doctors at Mesa Lutheran Hospital [in Arizona] sent her home, the lack of trained, dedicated Spanish interpreters can be the difference between life and death."[24]

- "In Fairfax County, Humaira Ali, a volunteer doctor at the American Muslim Foundation Health Services clinic in Herndon, remembers treating a diabetic who had been turned away from an overburdened county clinic. 'He walked in with blood sugar levels of 520 mg [the normal blood sugar range in people without diabetes is 70 to 120 mg/dl]. He had gone to a county clinic, and they told him to come back after one month,' Ali said. 'I treated him, and he said, "Wherever you go, Dr. Ali, I'll follow you." ' "[25]

A growing body of research is beginning to documents such barriers. Despite Title VI and other language laws and regulations described in the previous chapter, a number of studies show that LEP patients fail to receive appropriate language assistance at publicly funded institutions.[26] One study suggested that 52 percent of Spanish-speaking patients did not receive an interpreter, even though they considered one was necessary.[27]

At times the barriers are cultural as well as linguistic. They too can result in severe injuries, death—or even imprisonment.

- One Hmong man in Minnesota was jailed because doctors and the police thought he had beaten his daughter. "In actuality, he had used a traditional Hmong treatment, "coining", to try to reduce her fever. When the fever persisted, he took her to the hospital, where doctors had him arrested after seeing bruises on her body. 'He committed suicide in Jail,' [Dr. Phua] Xiong said, 'because he did not understand the system'."[28]

"Coining" or "spooning" is a traditional treatment in several Asian cultures that involves rubbing warm gels or oils over a person's skin using a coin or a spoon. While it is believed to break a fever, it can leave bruises or red marks on the skin. In Howard County, service providers at FIRN have found that accusations of child abuse stemming from "coining" or other traditional healing treatments have led to investigations for child abuse. The parents are innocent in such cases. While it does not appear that any Howard County parent has committed suicide over the issue, Bonny Knight of FIRN reports that the legal and psychological toll such investigations have taken on several Asian parents is deeply painful and intense.

Anecdotal evidence of language and cultural barriers abounds. Media stories include a patient who believed she had been kidnapped when she was simply transported to another hospital, a teenage interpreter informing his mother (who needed X-rays) that she was going to be micro-waved, a young child interpreter announcing to his mother that she had cancer, and another child telling her mother she had AIDS. It is clearly important to address the consequences of ignoring language and cultural barriers in health care and human services.

Impact of Language Barriers

Although research has been slow to assess the impact of language barriers on health, the last decade has witnessed a sudden increase in the number of studies addressing the issue. One recent review of the literature[29] cites evidence that, compared to native speakers, patients speaking limited English:

- Receive less than optimal health care.
- Receive less preventive care.
- Have less timely eye, dental and physical examinations.
- Are at increased risk of experiencing medical errors.
- Have fewer physician visits.
- Are less likely to return for follow-up visits after trips to the emergency room (ER).
- Are less satisfied with their health care.

In addition, the evidence reported that Spanish-speaking Latinos are:

- Less satisfied with their communication with health providers.
- Less satisfied with the care they receive.
- More likely to report overall problems with care.

Research is also demonstrating the negative effects of using untrained interpreters such as family members (including minor children) or friends of clients in health care. The review of the literature cited above goes on to address the following consequences of using such interpreters:

- Inaccurate communication.

- Misdiagnoses.
- Inadequate/inaccurate treatment.
- Reduced quality of care.
- Breach of patient confidentiality.
- Reduced trust in physicians.

Not surprisingly, the research is also beginning to demonstrate how improving language access also improves outcomes, by increasing patients':

- Compliance with requests and instructions.
- Understanding of their disease.
- Self-reported well being and function.
- Access to primary care and preventive services.

Finally, quality of interpretation appears to correlate with patient understanding and satisfaction with the encounter.[30]

Language barriers also appear to result in greater health care costs, specifically, an increase in diagnostic tests and time spent with physicians.[31]

A large survey released by the Robert Wood Johnson Foundation (RWJF) in 2001[32] offers a snapshot of the language barriers that face the foreign born. Although the survey focused on Spanish-speaking Latinos and their service providers, other evidence suggests that the results would hold true for other language groups.

- Sixty-eight percent of providers surveyed said they found it a top or important priority to help primarily Spanish-speaking health care consumers better use and benefit from the health care system.
- Due to a language barrier, 19 percent of Spanish-speaking respondents have not sought care when needed.
- Sixty-five percent of Spanish-speaking respondents have concerns about using an interpreter.

Altogether, this body of research clearly shows the dangers of failure to use professionally trained bilingual staff or interpreters and the need to overcome language barriers to ensure health and well being. The consequences of failure to address language barriers can be devastating and even fatal.

Impact of Cultural Barriers

Unfortunately, very little academic research currently exists documenting the impact of cultural barriers on health and well-being. Nonetheless, community-based organizations serving immigrants and refugees across the nation do perceive the impact of such barriers, particularly in health encounters, and report their concerns regularly in meetings and coalitions.

In recent years, quite a number of reports on individual cultures intended to assist health providers have emerged, many available on the Internet.[33] While not strictly research based, they illustrate a number of cultural barriers common to various cultures:

- Discomfort with/refusal to see health providers of the opposite gender.

- Failure to understand or seek preventive care.
- Failure to take prescribed medicine correctly—or at all.
- Reliance on one family member who makes medical decisions for the family.
- Respect for authority leading to docility.
- Respect for authority leading to nodding or saying yes without comprehension.
- Lack of information on dental care, contraception, vaccinations and sexually transmitted diseases (STDs), among other basic health issues.
- Lifelong lack of dental care in the home countries of many immigrants.
- Isolation of some women.
- Reliance on folk remedies (some of which may assist healing, promote a placebo effect, reassure the patient or have a neutral effect, while some may actively interfere with western medical treatment).
- Lack of understanding of the U.S. health care system.
- Inability to navigate that system due to a variety of cultural barriers.
- Lack of refrigeration in the home (which affects some medications).

Such barriers can be tragic. One of the most famous (and highly readable) books on the subject, *The Spirit Catches You and You Fall Down*,[34] documents the disastrous collision of Hmong culture and U.S. medicine in the case of a refugee family from Laos over the care of a Hmong child diagnosed with severe epilepsy.

Some specialists, including those at the Cross-Cultural Health Care Program (a nonprofit organization in Seattle, Washington that has emerged as a national leader in overcoming language and cultural barriers to health care), recommend that health providers exhibit great sensitivity in the area of traditional remedies. It may even be advisable to support patients who seek these remedies, where appropriate, since folk healers may provide great psychological comfort. In itself, such comfort may promote the patient's healing.

Prejudice and Discrimination

While research on the impact of prejudice and discrimination against foreign-born clients in health and human services is poorly documented, it remains a bitter fact to many immigrants. A survey in 2002 conducted by the Pew Hispanic Center and Kaiser Family Foundation found that Latinos "overwhelmingly" reported that discrimination against Latinos was a problem both in general and specific settings: 82 percent found that such discrimination prevented Latinos from succeeding in the U.S., while 31 percent reported that they or someone that they know has suffered from discrimination in the past five years due to racial or ethnic background.[35] About one in seven reported employment-related discrimination. Latinos in the survey were most likely to report that such discrimination against Latinos was due to the language that they speak (35 percent).[36]

Discrimination against the foreign born has emerged as a major concern of immigrants in the focus groups of this project. In fact, discrimination on the basis of national origin may have a significant impact on the health and overall well being of foreign-born residents, including their access to services. Certainly it was considered so serious by the Clinton administration that then-President Clinton issued Executive Order 13166 in August 2000 to support and reinforce Title VI of the Civil Rights Act of 1964.

Insurance

Complicating the issue of language and cultural barriers is health insurance. In 2000, according to the U.S. Census Bureau, the percentage of non-citizens without health insurance (41.3 percent) was more than triple that of the native population (11.9 percent).[37] But the most troubling statistics concern foreign-born Hispanics: in 2000, *over half (51 percent) of this group had no health insurance,* while of those foreign-born Hispanics residing in the U.S. fewer than 10 years*, 60.5 percent lacked health insurance.*[38]

In addition, even the poorest immigrants may lack health insurance. Undocumented residents do not qualify for Medicaid, including their foreign-born children. Due to welfare reform legislation passed in 1996, even legal immigrants who arrived after August 22nd of that year are not eligible for Medicaid and many other "safety-net" benefits. The exception, in Maryland, would be children of low-income parents who are permanent legal residents: these children are eligible for the Maryland Children's Health Insurance Program (MCHIP). Unfortunately, due to lack of awareness of the program, language and cultural barriers, fear of authority, and/or a fear that applying for such benefits could jeopardize the family's legal papers or chances of citizenship (among other factors), many foreign-born parents still do not insure their children under MCHIP. In addition, the children of many immigrants with legal status in this country—including those with work permits, Temporary Protected Status (TPS), certain types of visa, and political asylees waiting for final adjudication—do not qualify for MCHIP.

The consequences of lacking health insurance are well known. According to the Kaiser Family Foundation, which tracks research on the issue closely, nearly 40 percent of the uninsured have no source of regular care. According to a report issued in 2000,[39] the uninsured delay seeking care when needed: 20 percent in 2000 reported having needed such care and failed to received it due to lacking insurance. Uninsured children are at least 70 percent less likely to have received medical care for common health problems (such as ear infections) and 30 percent less likely to have received care for injuries. The uninsured are also more likely to end up in hospital emergency rooms for pneumonia, diabetic emergencies and other conditions that could have been controlled with preventive care or timely treatment. They are more likely to be diagnosed with late, rather than early, stages of cancer. In short, poor health outcomes are a direct result of lacking health insurance.[40]

Poverty

In 1999, 36.3 percent of foreign-born workers (full time/year-round) earned less than $20,000, compared to 21.3 percent of native workers.[41] Central Americans, including Mexicans (many of whom live in Howard County), fared much worse: *57.1 percent earned less than $20,000.*[42]

According to the U.S. Census Bureau, the official poverty rate of the foreign born in 1999 was 17 percent, as compared to 11 percent for the native born.[43] In addition, only 67 percent of the foreign born held high school diplomas, compared to 87 percent of the native born,[44] a factor that greatly influences their future earnings and their ability to obtain employment with health insurance benefits.

Poverty affects access to health services in a variety of ways, including transportation, opportunities for education, skill in navigating the complex health system, ability to understand patient directives, compliance, access to medication and a lack of willingness to seek needed services due to cost.

Fear

For decades, immigrants in the United States have been confused by Immigration and Naturalization Service (INS) guidelines regarding health services. Will receiving subsidized health care in any form jeopardize their chances of obtaining legal status in this country, such as a green card and citizenship?

Their fears are well founded: historically great uncertainty has existed. INS was so unclear on these issues that health and human service providers and immigration specialists across the country were for a long time uncertain how to advise immigrants. Fortunately, guidance on these issues now exists. For practical purposes, in most cases, receiving such services will not jeopardize the legal status of immigrants, and that is a message that foreign-born residents seeking health and human services need to hear clearly. For more information, or to reassure immigrant clients who have concerns, it may be helpful for providers to consult the INS site <www.ins.doj.gov/graphics/publicaffairs/summaries/Public.htm>.

An extensive survey of immigrants in Los Angeles and New York City conducted in 2002 (in five languages) by the U.S. Department of Social Services[45] showed that almost 40 percent of survey respondents (and 50 percent of low-income respondents) failed to correctly answer at least two out of three questions on public benefits. The questions addressed program eligibility for health and other safety-net services funded by federal and state governments and the impact that receiving such benefits would have on immigrants' ability to “legalize or naturalize.” The survey had other disturbing news:

- Poverty rates of immigrant families were twice as high as rates for native citizen families.
- About 75 percent of immigrants surveyed had limited English proficiency skills.
- About one third of immigrant families surveyed were food insecure and over 10 percent experienced moderate hunger, as compared to about 12 percent food insecurity for native-born citizen families. Food insecurity was twice as high among LEP families as those speaking English well.

Health Outcomes of Language, Cultural and Insurance Barriers

It is difficult to tease out the impact that language, cultural and insurance barriers have on the health and well-being of the foreign born. Given that the U.S. leads the world in medical research and technology, it is astonishing that we know almost nothing about the health status (far less the general well being) of our foreign-born residents or how to improve it. In contrast to some countries such as Australia[46], the U.S. does not clearly identify health trends, outcomes and statistics by country of origin. At best, a few general health trends have been noted. For example, the risk of diabetes for Mexican Americans is almost twice the risk for non-Hispanic whites.[47]

Another challenge is that remarkably little research addresses the question of what specifically improves (or harms) health outcomes for the foreign born. For example, how is an LEP patient's health and well-being affected when an interpreter is not provided in the emergency room? Does using "cultural brokers" (representatives from ethnic groups with cultural expertise) at health encounters influence the health of foreign-born patients? What is the difference in health outcomes if a housekeeper or cook is called in to interpret when compared to a similar

health encounter with a trained, professional medical interpreter? Many studies are in the planning stages nationally that should help to fill in these gaps.

One recent trend in U.S. health statistics is to track the health outcomes of Hispanic and Asian/Pacific Island residents. (For example, for reasons still unknown, there are more pregnancy-related deaths among Hispanic than non-Hispanic women.[48]) However, these two large groups comprise residents from dozens of countries who speak diverse languages and have quite distinct cultures and health practices. Many are second- and third-generation American citizens whose work, diet and exercise patterns often mirror those of native-born Americans, in contrast to the lifestyles of their foreign-born parents or ancestors. Thus, while statistics on Hispanic and Asian health are not meaningless, they are often too broad-based to be definitive . At best they document (sometimes eloquently) the degree to which ethnic background may correlate with widely divergent mortality and health outcome statistics when compared to those of white residents. For example:

- *"One in every six American children is Hispanic, but it's hard to find them in the research on child health. According to the Journal of the American Medical Association, Latino children suffer from a disproportionate number of health problems that have been poorly studied. Diabetes is on the rise, and Latino boys have the highest rates of obesity among young people, but researchers don't know why. They also don't know why Puerto Rican children have rates of asthma higher than those in any other region."*[49]

- *"Many of the statistics pose mysteries that go beyond the fact that Hispanic children are less likely to be covered by health insurance than are children in other ethnic groups. For instance, Latino children who are hospitalized with limb fractures receive less pain medication than do white or African-American youths. No one seems to know why, and data is hard to collect because Hispanic children are often included in the categories of white, black or 'other' in medical research. Many researchers also ignore these children and their parents by excluding non-English-speakers from their studies."*[50]

Such problems show the urgent need to reduce health disparities between ethnic groups. At least two bibliographies exist that showcase some of the current research on these issues. [51] Ultimately, however, the available facts highlight an urgent need to track health outcomes by country of origin.

There is even less information on the impact of human services on the well being of the foreign born. And as painful as this dearth of statistics may appear at the national and state level—the local scene is more distressing. Information is fragmented and piecemeal, where it exists at all. In Howard County, virtually no information is available.

There is some good news, however. Immigrants on the whole are healthier than U.S. citizens. (This advantage fades with the second generation and is largely missing by the third.)[52] The reasons for their better health are not firmly documented. However, it seems that such immigrants arrive with healthier nutritional habits and that they also engage in fewer sedentary hours than native-born Americans. Unfortunately, this is not so true of their children.

Health problems affecting immigrants as a group tend to be quite specific. The most commonly noted are the following:

- Tuberculosis.

- Hepatitis B.
- Vaccine-preventable diseases.
- Parasites.
- Tropical diseases (such as malaria).[53]

There are many other health concerns that relate to immigrants. For example, for reasons still unclear, foreign-born women tend to die more often of heart disease than native-born females.[54] Mexican women seem more prone to gallbladder disease than native-born Americans (with the exception of native Americans).[55] Sexual assault can cause even more trauma, secrecy, shame and depression for many foreign-born residents (and their children) than for native-born residents, due to complicating cultural factors. And refugees suffer intolerably high rates of post-traumatic stress disorder, depression and histories of sexual assault (particularly during periods spent in war zones and refugee camps). Refugees also have particular health problems caused by torture and starvation or the traumatic history of refugees' persecution and flight from nations ripped apart by war and other disasters.[56]

Like their parents, immigrant children overall are healthier than native-born citizens. However, they appear to be at higher risk than U.S. citizen children for malaria, congenital syphilis, Hepatitis B, helminthic infections and drug-resistant tuberculosis.[57] In addition, children of migrant farm workers may suffer from exposure to toxins, while children of Mexicans in the U.S. have elevated blood lead levels and appear to suffer from a number of health and dental problems.[58]

In the end, however healthy the foreign born may be, when they fall sick they face complex barriers to improving and maintaining health. What is true across the nation is also true in Howard County.

Section Five
Models and Best Practices

> *There needs to be more education for the doctors and their staff on culture sensitivity and also on how to obtain interpreters for their clients. And the staff needs to learn how to explain things to clients in a way that they will understand.*
>
> FIRN Survey Respondent

What works? What doesn't? How can providers overcome language and cultural barriers in health and human services?

These are simple questions and fair ones: we know now that there are answers. However, some of those answers are difficult to implement, and several come at a cost. Fortunately, a variety of models and strategies can be phased in using simple approaches shown to be effective.

Based on the research and the experiences of model programs, the benefits of incorporating best practices in serving the foreign born are incalculable—and may save lives.

The first part of this section, "Beyond the Barriers", lists approaches that research and experience have shown to be the most effective in facilitating immigrants' access to health and human services. The second part, "Model Programs", looks at programs that work. The third section, "Practical Strategies for Overcoming Language and Cultural Barriers," offers practical suggestions for implementing such models. The fourth section, "Language Connections: A Model Interpreter Service in Maryland", describes a successful model in Howard County.

Beyond the Barriers

Despite the lack of research on overcoming language and cultural barriers, a few clear trends have emerged. Federal (and many state) officials, specialists in cross-cultural communications and advocates for the foreign born are approaching a national consensus on how to overcome these barriers. In general, they agree that:

- Bilingual staff should be recruited wherever possible.
- Ideally, interpreters should be provided where bilingual staff are not available.
- Both interpreters and bilingual staff should receive a minimum of 40 hours of training in professional medical and/or social services interpretation.
- Cultural expertise is also necessary.
- Vital forms, patient education materials and discharge instructions (among other documents) should be translated or sight-translated.[59]

Bilingual/Bicultural Staff

As our population grows increasingly diverse, opportunities to recruit and hire qualified bilingual and bicultural staff increase. The advantages are clear. Bilingual, bicultural providers need no interpreters. Where bilingual providers are not available, other bilingual staff members can

come in to interpret for them. Clients, including some members of the focus groups in this project, often report feeling more comfortable with a provider of their own language and culture. Not only are language barriers overcome in such encounters: the bilingual staff member has valuable cultural expertise to offer to providers and clients.

Interpreters

Where bilingual providers and staff interpreters are not available, there are many types of interpreters that an agency may engage in health and human services. The costs vary. Here are a few examples:

1) ***Commercial interpreters*** work at for-profit language services and specialize primarily in corporate and higher-level government or conference interpreting. Many also work as freelancer interpreters (see below). Their costs vary, depending in part whether they are self-employed or work for commercial language services. In the Washington, D.C./Baltimore area, for example, commercial interpreters generally cost $60 to $100 per hour or more with a two-hour minimum charge. Most are not trained in medical or social services interpretation.

2) ***Community language banks*** are the most common, affordable interpreter resource in the U.S. for health and human services. When a grassroots organization, typically a nonprofit agency, assembles a group of bilingual individuals to assist those who speak little or no English, that group of interpreters is often called a language bank. Such "banks" are composed primarily of volunteers. Some include low-cost interpreters (paid anywhere from $8 to $20 an hour according to anecdotal reports from across the nation). While interpreters in language banks sometimes receive training, the vast majority do not. Some may receive a brief orientation or workshop.

3) ***Community interpreter services*** are a relatively new phenomenon in the U.S. Across the U.S., an increasing number of organizations are creating nonprofit services that provide trained, professional interpreters at a reasonable hourly cost to health and human service agencies. Such interpreters are typically specialized in health services. Some have also received training in social services and/or court interpretation. A number of interpreter services are available only to a particular hospital or group of health care providers. Others serve the community at large. Most are run by nonprofit organizations. Currently, the only community interpreter service serving several counties in Maryland is Language Connections at FIRN (see below). The cost of such services may range from $35 to $50 per hour, depending on the geographic area served.

4) ***Community interpreters*** (mostly untrained are typically volunteers. They often volunteer for language banks, community-based organizations and nonprofit organizations. A community interpreter may serve a whole county or a particular organization such as the Red Cross, or several hospitals and clinics. A number of community interpreters work for school systems either as volunteers or for a low cost. "Community interpreters is also a term applied to professional interpreters who work for nonprofit community interpreter services.

5) ***Conference interpreters*** are commercial interpreters specialized in the techniques of interpreting at conferences, including simultaneous interpreting in soundproof booths and whispered interpretation. Their rates are typically not affordable for health and human service agencies.

6) ***Freelance interpreters*** are self-employed individuals who work for hospitals, courts, motor vehicle administrations, lawyers, community interpreter services and/or commercial or government agencies. Most work on an hourly basis. Some charge a two-hour minimum. While some have hourly rates of $60 or more, many charge less than $15. Some have extensive experience working for health and human services; others have none. A number have no credentials. When using the services of freelancers, it is particularly important to verify qualifications and prior experience, and to check references.

What kind of interpreters should health and human service agencies use?

The research is categorical. Whether an agency engages bilingual staff members or interpreters-for-hire, ideally they should use *trained* interpreters. The length of training now widely considered to be a national minimum standard is 40 hours or more. Such training should focus on medical and/or human or social services interpretation, which is a highly specialized area of interpretation. The errors caused by using untrained (or under-trained) interpreters, or interpreters trained only in another field (such as court interpretation) may prejudice the health and well being of clients and cause them to avoid seeking needed health and human services—a problem that is reported anecdotally and may be widespread. Such errors have also led to lawsuits.

Why do untrained interpreters create such risk? There are many reasons. Untrained interpreters may lack adequate knowledge of both languages. They are not skilled in interpreting with cultural and medical accuracy. They usually summarize what is said rather than interpret it, leading to errors and crucial omissions. Many also add information or insert their own opinions. They may suppress patient reports about their cultural remedies or beliefs as irrelevant or embarrassing when in fact the provider needs this information. Unfortunately, even when interpreters are of the same ethnic background as the clients, they may also engage in discriminatory attitudes and behavior. (Such discrimination has been anecdotally reported both locally and nationally. It appears to stem from class differences and/or differences in national origin.)

Untrained interpreters (whether bilingual staff members, paid interpreters or volunteers) also typically fail to understand the importance of strict confidentiality. Confidentiality is critical both for legal reasons and because many foreign-born patients are alarmed at the idea of interpreters "leaking" information about their health conditions or financial woes to their own ethnic community.

In addition, untrained interpreters often fail to use their background knowledge of both cultures to act as "cultural interpreters" or "cultural brokers" and thus neglect to inform the client or service provider of issues crucial to the client's well being.

Above all, impartiality is at risk: consistent reports from service providers, ethnic organizations that serve immigrants, cultural experts and others suggest that an interpreter who is a spouse, child or friend of the client is likely not to communicate important information. In some cases, according to these anecdotal reports, family interpreters and friends fail to interpret accurately out of embarrassment, ignorance or even ill will. Unfortunately, it is a common occurrence that abusers interpret for victims of domestic violence, even to police, hospitals and community workers, thus helping to prolong the abuse. (One of the authors of this report has heard of several such cases in Howard County.)

Interpreters who are not impartial often interfere and insist on adding their own ideas or advice. They may fail to follow up on important details, such as checking for a clear understanding of medication instructions, exploring illiteracy issues when a client is given written follow-up instructions, and other common problems or cultural misunderstandings. In a number of cases, the untrained, unscreened interpreter simply cannot understand English or the other language adequately enough to interpret.

Finally, untrained interpreters lack the experience and knowledge needed to communicate meaningful cultural information:

> *I asked one of the interpreters, who was a Vietnamese interpreter, some cultural question, and the interpreter seemed somewhat hesitant to answer the question. "In Vietnamese, how do people feel and how do they like to be supervised, and what is a good thing and what is a bad thing?" The Vietnamese interpreter could not or would not say. I didn't know if they understood the question.*[60]

A professionally trained interpreter will watch carefully for any concerns affecting the health and well being of the client and will also know and respect a professional code of ethics. He or she will make sure that the provider understands everything that takes place during the encounter. The trained interpreter will not engage in "side conversations" with the patient and will notify the provider and patient of everything that is said.

Model Programs

Language is the significant barrier that everyone grasps, the tip of the iceberg. Culture is the vast expanse of barrier that lies underneath the surface, the part that can cause damage as serious as the more visible iceberg of language. What are the most effective programs in the field that have evolved to overcome both these barriers in health and human services?

What follows below is a progression of models, from "ideal" down to "least ideal." All are used in the field. However, the only viable model is a mixed model, where agencies adapt and combine the models listed below to find the flexibility they need to match their resources with their needs.

For more detailed information on model programs in the field, an excellent report issued in 2002 by the National Health Law Program is available online at <http://www.cmwf.org/programs/minority/youdelman_languageinterp_541.pdf>. Readers may also consult a draft of an important report on the same subject by the National Council on Interpretation in Health Care at <http://www.ncihc.org/Language_Access_Models.pdf>. For a survey of 23 interpreting programs across the country conducted by the Cross Cultural Health Care Program in Seattle, go to <www.xculture.org/training/overview/interpreter/downloads/survey.pdf>.

MODEL ONE: Bilingual/bicultural providers

A growing chorus of voices from government, researchers, clinicians and health organizations states the obvious: the ideal situation is a bilingual, bicultural service provider. This would not, however, imply a nurse or social worker with two years of college-level Spanish. Culture is complex. In fact, one clinic director found that a Puerto Rican employee had cultural difficulties serving a largely Mexican population.

Among the advantages of using bilingual/bicultural service providers are:

- The absence of a language barrier.
- Removal of most cultural barriers.
- Increased comfort level of client.
- Greater trust of client in provider.
- In many cases, a more open and forthcoming client.
- Reduced cost (no interpreters).
- Saved time (no back-and-forth interpreting).
- Easier scheduling (no third-party interpreter to schedule).
- Greater compliance.
- Improved outcomes.

However, bilingual providers may be hard to recruit in certain settings (especially rural settings), and will be unavailable for certain languages. They take time and effort to recruit.

Recommendation:	Health and human service agencies should receive training on strategies for recruiting, hiring and working with bilingual providers.

MODEL TWO: Other Bilingual/bicultural staff members

In the absence of a bilingual provider, a bilingual, bicultural staff member can step in as an interpreter. Ideally, such staff members are dedicated interpreters. In reality, many (perhaps most) are pulled from other work. Thus, the bilingual staff member could be a receptionist, a technician, a clerical worker—or in many cases a janitor, a cook or a housekeeper.

In the field, staff interpreters face many challenges. These include:

1) Lack of training

Most bilingual employees do not receive training in interpretation. Others are offered a half-day workshop, an orientation which most specialists in the field consider inadequate. The errors of untrained staff members, like those of other untrained interpreters, include:

- Inaccurate/incomplete interpretation.
- Answering for the patient.
- Engaging in side conversations with the patient.
- A negative attitude.
- Violations of interpreter ethics.
- Use of third person.[61]
- Offering advice or opinions.
- Unethical or inappropriate behavior (e.g., taking gifts).
- Failure to establish boundaries (e.g., giving a home phone number to client).
- Failure to contribute cultural expertise.

Recommendation:	Bilingual staff should receive a 40-hour training program in medical and/or human services interpretation.

Other challenges that face bilingual staff include the following:

2) Stress and burnout

Bilingual staff often have no official interpreting assignments: interpretation is simply added to their regular workload. They may be pulled from deadline-related projects and other urgent work to interpret; they may irritate or upset colleagues who must take over their duties; they may not be paid overtime to complete their regular duties. Other stresses ensue. Most bilingual employees are not paid for their interpreting, and many do not feel valued for their bilingual/bicultural skills. As a result, a number of bilingual employees burn out or become stressed and frazzled.

Recommendations:	Bilingual staff should receive compensation for their skills. Bilingual staff should receive compensation for interpreting. Bilingual staff should be offered training on how to set boundaries.

3) Lack of qualifications

Quality interpretation requires a certain level of literacy and education. Fluency in colloquial English and another language is not adequate, particularly in health settings. While completion of high school and a high level of literacy is a minimal requirement, a college education is preferable. Pulling in an unqualified staff member (e.g. clerical staff, cooks, housekeepers), while a common practice in clinical and especially hospital settings, is inappropriate and in some cases dangerous. One Executive Director of a health center in Anchorage cites the case of a diabetic patient whose blood sugar levels were sky-rocketing because the interpreter could not read the English labels on the patient's medication accurately.[62]

In addition, while an increasing number of providers and staff members are trying to learn Spanish, the consensus among specialists is that a year or two of Spanish is insufficient for providers to treat patients or for "bilingual" staff to act as interpreters. In addition, employees who have simply taken classes in another language lack vital cultural expertise.

Recommendation:	Bilingual staff should be screened and assessed for fluency, literacy and skill level in both languages before being allowed to interpret.
Recommendation:	Training in cultural competence for area agencies should include educating providers on the importance of screening bilingual providers, bilingual staff members and other interpreters for true language proficiency and cultural knowledge.

MODEL THREE: Trained, professional interpreters

After bilingual providers and staff interpreters, the "next-best" resource in the field is widely considered to be trained, professional interpreters.

Most commercial agencies charge rates that are too high for health and human services agencies. In addition, the vast majority of commercial interpreters are not trained in health and human services. They are typically inappropriate for such settings.

It is therefore generally preferable to locate, where possible, a nonprofit organization that provides a community interpreter service—that is, a corps of trained, professional interpreters provided at affordable rates to health and human service providers. Such interpreters are specialized in health care and sometimes social services. Most have received at least 40 hours of training, are highly skilled and respect a professional code of ethics. Often, they will educate both provider and patient on relevant cultural issues that can affect health outcomes. In the words of one Health Department employee in Howard County: "They're worth every penny that you pay them."[63]

Professional interpreters sometimes appear expensive to service providers. Yet in fact, they are highly cost effective. They prevent misdiagnoses, clarify confusion, verify that medication instructions have been understood and discuss cultural alternative remedies taken by the patient. In many cases, they provide background information to clear up misunderstandings between the health provider and patient that could affect outcomes. Nevertheless, there are some disadvantages too:

- Interpreters must usually be scheduled in advance.
- Regular interpreting can drain budgets.
- The encounter requires coordinating three parties (provider/client/interpreter).
- The encounter is often two to three times longer than for a client fluent in English.
- The client often grows attached to one interpreter.
- Out-referral for other services (e.g., radiology/labwork, specialists, etc) may require that the referring agency send the interpreter with the client.

Recommendation:	Health and human service agencies should seek funding to pay for interpreters (staff or agency interpreters).

MODEL FOUR: Language banks and volunteer interpreters

Model Four is the classic language bank: a collection of volunteer interpreters. (Some include low-cost paid interpreters.) Typically a language bank is organized by a nonprofit or government agency, school, hospital, church or other concerned group. In many cases, language banks are created by a coalition of groups who pool their resources. Most language bank interpreters are untrained.

Community-based organizations, alone or working together with local government and health agencies, can almost always find immigrants who speak fluent English and wish to become interpreters. Ideally, the organization or group should then raise funds to hire a part-time or full-time staff member to recruit and coordinate interpreters and to procure training for them.

In Montgomery County, Maryland, the county government created a volunteer language bank with a list of interpreters available to local government or nonprofit organizations willing to sign a memorandum of understanding. Annapolis and Frederick County have also set up language banks, and other parts of Maryland may be following suit. Each language bank has its own rules and requirements suited to the needs of area providers.

MODEL FIVE: Telephonic interpretation

Increasingly, across the nation, health and human service agencies are picking up the phone to speak to an interpreter. Many companies now offer "24/7" interpreters in a wide variety of languages, some of them specialized in medical, legal or corporate interpretation. Some of these interpreters are trained; many are not.

There is no question among specialists that when it comes to a crisis or emergency on the doorstep, or when an appointment needs to be scheduled for when a live interpreter can attend, telephonic interpretation lines are convenient and valuable.

They are, however, expensive. Charges at the low end run from about $1.75 to $2.00 per minute.[64] For more "exotic" and difficult-to-find languages, off hours or more expensive services in general, the rate can climb to $7.00 per minute.

In addition, in telephonic interpretation, the client and service provider are speaking to the phone—not each other. Body language is missing, and a relationship of trust between the client and provider is more difficult to establish. The encounter is less personal. Cultural barriers are often more difficult to address. By contrast, with either a bilingual provider or a trained, professional interpreter, the client and provider speak directly to each other. (A trained interpreter will position himself or herself away and/or to one side to facilitate this sense of direct communication and connection.) More contextual information is available, and clients may find a warmer, more personal atmosphere. They often develop a bond with the on-site interpreter due to the shared culture and language.

For all these reasons, telephonic interpretation should be considered an additional resource, and not a primary approach, to overcoming language or cultural barriers.

Conclusion on Use of Models

Each agency is the expert on itself. Administration and staff know their organization best, and each agency inhabits a unique community with its own resources and needs. Thus, there are no one-size-fits-all approaches. In the end, almost every organization needs a mix-and-match of models to meet their needs and maximize their assets. Discussions with staff and volunteers, clients and board members, community-based organizations and interpreters will help guide each agency to the decisions that make sense.

Practical Strategies for Overcoming Language and Cultural Barriers

There are a number of practical ways to overcome language and cultural barriers. Here are a few collected from across the country that are widely known and used by organizations that specialize in serving immigrants and refugees.

1) Develop a plan

There is no substitute for a written plan addressing how language and cultural barriers will be addressed from the moment a client calls or walks in the door to the final stage where the presenting issue, concern or problem is resolved. Such a plan is, in fact, a requirement for agencies that receive federal funding and for many others that receive funding from states such as Maryland with language access laws.

To develop a plan it is wise to work with ethnic community-based organizations, community leaders, professional interpreters, specialized consultants and/or others with expertise in the area of language and cultural barriers.

2) Recruit bilingual staff

If the priority is to hire bilingual service providers, they are not always easy to find. Some clinics and service providers across the country recommend hiring bilingual, bicultural individuals without the qualifications desired and then training them in interpretation while providing educational opportunities for their advancement or certification.

Suggestions for recruiting both providers and bilingual employees in general include:

- Contact ethnic community-based organizations.
- Send speakers and fliers to ethnic churches, mosques and other faith-based organizations.
- Specify "bilingual preferred" (and specific languages, if desired) in newspaper ads.
- Place ads in ethnic newspapers: editors will often translate them from English into their own language.
- Place radio spots/PSAs on ethnic radio and TV stations.
- Hold appearances/talks on ethnic radio and TV stations.
- Distribute fliers and/or posters in ethnic grocery and other stores or services (hairdressers, drycleaners, etc.).
- Contact university language departments.
- Try to obtain feature articles/news coverage in local media, using the statistics of increased demographics of immigrants in the area to entice media interest.
- Try web recruitment.
- Go to the minority community to find out how to reach the minority community.
- Attend ethnic gatherings and festivals, International Days, etc.—with a booth or kiosk if possible.

3) Recruit interpreters

Many of the strategies above apply to recruiting volunteer interpreters. However, other strategies more suited to recruiting interpreters include the following:

- Hold "Interpreter parties" (parties to celebrate current interpreters, with prospects/friends invited too).
- Hire bilingual staff: often inquiries about such positions can lead to volunteer interpreters.
- Contact organizations dealing with international issues (some can refer you to volunteer sources).
- Contact your local volunteer office.
- Contact the Peace Corps: their volunteers often speak a variety of languages fluently.
- Ask clients if they know anyone who would be interested. (They, or their friends, or their family members may be interested in giving back to the community by volunteering and training to be interpreters.)
- Contact community college staff and foreign-born students.

- Some universities may have a service learning program that encourages community service.

In general, word of mouth remains a powerful recruitment tool for volunteers.

4) Train interpreters

If bilingual staff members and interpreters should be trained in professional interpretation, how is that done, and what does it cost?

If an agency engages a community interpreter service to provide interpreters, typically the interpreters have received at least 40 hours training in health or general interpreting. But some agencies cannot afford to do so. One option is to create a language bank of volunteers and then to provide training. This need not be done by a particular agency.

It should be kept in mind, however, that 40-hour interpreter trainings typically cost $500 to $700 per student. That figure covers training costs and materials. It does not include lost staff time for bilingual staff members who attend the trainings. Nor does it usually cover the cost of food, room rentals—not to mention staff time spent recruiting, screening and even testing prospective interpreters.

Increasingly, as a result, agencies with staff or volunteer interpreters are turning to shorter trainings. Most of them last from half a day to a full day. The trainers vary in the quality of their background and competence. However, the typical cost is much lower and thus more affordable to agencies than 40-hour trainings.

A great deal of debate is raging across the country on the viability of short trainings. Many specialists and agencies feel that nothing less than a 40-hour training is safe, and that interpreters with less training should not interpret. However, many directors of health and human service agencies feel that there is no other answer but short trainings: interpreters must interpret, and not all can receive 40 hours of training.

In particular, the constraints imposed by volunteer interpreters make 40-hour trainings impractical. Many in the field therefore argue that at least the shorter trainings emphasize basic skills, ethics and interpreter roles. Interpreters learn valuable skills in even a short training and become aware of how much they need to learn. This awareness in turn may motivate them to take advantage of opportunities for longer trainings. Indeed, one argument against an overemphasis on longer trainings is that it prevents information about the importance of interpreter skills from spreading throughout the community of volunteer interpreters and bilingual staff. In the wry comment of one clinic director on this issue: "Sometimes 'best' is the enemy of the good."

There are no easy answers. In the end, each agency must make this decision for itself.

5) Welcome the foreign-born client

Overcoming language and cultural barriers also means addressing what happens the moment a client walks in the door or calls an agency. The foreign born have many problems learning to trust providers. They may come from countries where providers are associated with repressive government regimes. They may fear that receiving assistance will jeopardize their immigration status in this country. They may come from backgrounds of

torture, war trauma, natural disasters and severe poverty, especially if they are refugees. They may lack secondary education and have no history of even the most basic health care and social services. Their cultural beliefs may have little to do with western medicine or western education.

Thus, establishing a relationship of trust is critical. There are many ways an agency can show that it welcome immigrants:

- Post a multilingual welcome poster.
- Have a “language poster” (where clients can point to the name of their own language, which is also translated into English) by the reception desk.
- Display pictures that show clients of diverse races and ethnic backgrounds.
- Offer multilingual brochures and fliers on community resources.
- Display reading materials (e.g. magazines or newspapers) in other languages.

If the agency is federally funded, it is required to post information stating the right of the client to a free interpreter. Such signage should be multilingual, reflecting dominant languages in the area or the agency’s clientele.

Practical Service Delivery Strategies

How do staff members greet clients? For a number of cultures, a business-like approach in clinical settings seems rude. Shaking hands may be unacceptable between men and women from some cultures. Some clients may avoid your eyes to show respect for authority. So it is important to establish a warm relationship yet remain sensitive to the cultural meaning of physical gestures and behavior. Below are a few examples of service delivery strategies that have been found effective in the field.

Take time
For many cultures in the world, a first meeting in a service delivery setting should begin with a pleasant conversation. It can include questions about neutral subjects, putting the client at ease. The goal is to establish a relationship of warmth and trust. Only then is it helpful to proceed to some of the personal questions that often arise in health and human services.

Use interpreters as a cultural resource
A trained interpreter has a wealth of cultural knowledge. How do they recommend a service provider should greet clients from a particular ethnic group? Providers can also consult local ethnic community-based organizations. Acquiring cultural information can help put your clients at ease.

Use simple language
Whether in speech or brochures, the language used should be simple and direct. Both colloquial and formal speech are often confusing to the foreign born. This is particularly important in directions and instructions.

Check for understanding
Foreign-born clients often nod or murmur, “Yes,” when in fact they may understand little or nothing. The only practical way to verify understanding is to ask the client to repeat back, in his or her own words, the information the provider wishes the client to understand.

Verify contact information.
The foreign born are such a mobile population that it is important to verify address and phone number at every encounter, to ensure follow-up.

Situate services close to the population.
Transportation is a consistent and troubling barrier for many low-income immigrant clients in health and human services.

Understand literacy issues
In particular, many immigrants from Mexico/Central America, some countries in Africa and several countries in Southeast Asia (particularly for women) have problems of literacy in their own language.

Carefully choose patient/client education materials
Due to low levels of education among a number of immigrants, it is preferable to choose materials written in clear, simple language with many illustrations, where possible.

Find the right interpreter
Women of certain cultures may require female interpreters and providers. One language may have several dialects that must be considered when engaging an interpreter. In addition, ethnic, tribal and religious affiliations of the interpreter can cause difficulties if there are violent conflicts between these groups in the home country. (This is often particularly important with refugee clients.)

Research body language
Does the client fail to meet the provider's eyes? This may be a sign of respect among Hispanic, Korean and other clients. Does a woman refuse to shake a provider's hand? Does a man nod, meaning "No?" Body language is not international. Many ethnic profiles can be downloaded easily from the web and books and other resources can be purchased that permit providers to recognize or "interpret" body language.

The examples above are not intended to be comprehensive. They do however illustrate an emerging body of knowledge in the field of cross-cultural encounters. They also highlight the importance of educating and training providers about practical strategies for enhancing service delivery to the foreign born.

Language Connections: A Model Interpreter Service In Maryland

> *If you can't communicate with someone, you're just lost.*
> Service provider in Child Protective Services
>
> *Now I know how to introduce myself. I learned how to interpret—I mean quality interpreting. I learned how to be a cultural broker, I learned how to solve those cultural difficulties. That's most important.*
> Trained interpreter at Language Connections

Language Connections is the only community interpreter service in Maryland. A model for communities without established interpreter resources, it is also an illustration of how such

resources evolve and adapt themselves to the needs of a local community. The history of Language Connections reflects the history of many language banks across the nation.

Located in Central Maryland, near Baltimore and the suburbs of Washington, D.C. Language Connections is managed by FIRN. When FIRN was established in 1981 in Howard County, Maryland,[65] its founder, Pat Hatch, saw a need for interpreters and soon established an interpreter list. Over time, that list evolved into a community language bank of over 200 volunteer interpreters and translators. To meet the needs of FIRN's clients and to assist the community at large, FIRN staff members called in interpreters from the list by phone. Most were volunteers. However, as the need for professional interpreters grew urgent, a number of these volunteers became paid interpreters sent by FIRN to the Howard County Health Department and other agencies in the area. For several years even paid interpreters were untrained.

A number of problems developed. The time spent maintaining the list (interpreters, like the foreign born in general, are a highly mobile population) grew unmanageable. The time required to find an interpreter was also overwhelming, often requiring a dozen calls or more. In some cases, in response to an emergency, a FIRN staff member dropped all other duties for half a day. No funds reimbursed FIRN for this lost staff time. Regretfully, FIRN could no longer procure interpreters at no cost for other agencies.

In 2000, FIRN began the transition from community language bank to community interpreter service. In 2001, under the auspices of a contract with the Maryland Office of New Americans (MONA), FIRN engaged a dedicated coordinator and a half-time assistant who recruited and interviewed 175 interpreters. About 86 were screened for proficiency. Subsequently 45 interpreters were trained in medical interpretation for 40 hours using experienced trainers from Northern Virginia Area Health Education Center using the respected *Bridging the Gap* curriculum. A number of interpreters were later trained in social services (12) and legal interpretation (35). FIRN has since expanded its list of trained interpreters to include court-certified interpreters, commercial and freelance interpreters, and others. Currently, no other interpreter service in Maryland but Language Connections has the following:

- Affordable, trained interpreters for nonprofit and government agencies.
- A corps of dedicated interpreters specialized in health, social services and legal interpretation and highly sensitized to the needs and concerns of local providers.
- Supervision by a parent nonprofit agency that offers comprehensive services to immigrants.
- An program with monthly in-services for interpreters.
- Trainings for health and human service providers on how to work with interpreters.

(To date, Language Connections has trained 250 providers in 5 counties.)

A recent telephone survey of the trained FIRN interpreters showed that all had at least some years of college; 30 percent had a B.A. or B.S.; 26 percent also had a master's degree; and 7 percent had an M.D. or Ph.D. Overwhelmingly, service providers who used these interpreters valued the interpreter services offered by FIRN, rating them as excellent or very good. Several providers spontaneously emphasized the crucial need for the interpreters:

- *We couldn't have done the function we had to do without the interpreters.*
- *When we have to have an interpreter, we have to have an interpreter. It's not like a frill!*

Every provider surveyed felt that FIRN interpreters made it easier to communicate with the client. One said forcefully: *What I deal with is communicable illness—tuberculosis. I deal with people with active illness. [...] Without the interpreter I can't do it at all. It's a key component. Seven out of 8 cases that I'm treating currently in the county are foreign born.*

Other comments included:

- *Clients do not relate to the staff well but they relate to someone who speaks and is of their culture. That's important.*

- *I cannot think of a single one of them [the interpreters] that I would not want to have here. And the clients love them.*

- *The [Language Connections interpreters] that I've worked with have been very warm, friendly sensitive people and very caring, and I should add that the two that I'm most familiar with were very bright people with a medical background.*

Language Connections is an excellent illustration of how a community-based organization begins with an informal language bank and slowly develops into a community interpreter service. It was also the result of a conscious effort to model best practices in the field.

Section Six
Voices of the Foreign Born: Focus Groups

Overview

As part of its investigation into language and cultural barriers to health and human services, FIRN conducted 9 focus groups with Howard County residents from several countries and regions. The groups, held between July and October 2001, focused on positive and negative experiences of the foreign born in their attempts to access health and human services in Howard County. A particular emphasis was placed on barriers to services and possible solutions to overcome these barriers.[66]

Findings from the 9 focus groups revealed:

- Local immigrants' distress over language barriers, lack of insurance and cost of services.
- Perceived discrimination against the foreign born in health and human service delivery.
- A desire for clear, simple explanations of processes and procedures.
- A number of positive experiences with particular institutions or programs.

These responses in turn showed the urgent need for:

- Interpreters in health and human services.
- Cultural competence trainings across Howard County.
- Recruitment of foreign-born health and human service providers and bilingual staff.
- Access to free or affordable health services for low-income immigrants.

In general, the findings highlighted human suffering but also the courage and success of many immigrants faced with daunting challenges and meager resources.

The Participants

Participants were foreign-born residents of Howard County. Each group targeted a particular country or region selected on the basis of 1990 Census data for Howard County[67] and anecdotal information from FIRN staff and local service providers. The intent was to capture the opinions of vulnerable residents from immigrant communities with high populations in the county and/or a visible presence at area health and human service agencies.

The Latino/Hispanic community was of particular concern, as these foreign-born residents constitute about 40 percent of FIRN clientele and are most often mentioned by local health and human service agencies in discussions about their foreign-born clients. Residents from Central America are among the most vulnerable in the U.S. due to low income, low education[68] and (in many cases) lack of legal documentation. Thus, 3 of the 9 focus groups targeted Latino residents from Mexico, Central America, and South America and the Caribbean.

Sessions averaged 10 participants. Most participants were recruited from FIRN's client base (FIRN sees between 1,500 and 2,000 unduplicated clients per year from more than 100 countries). Others came from local churches and schools. A few of FIRN's interpreters, their

spouses and bilingual service providers joined the groups.

According to moderators, the participants who attended varied widely in age, gender, socio-economic background, and occupation. However, most were low income and without college education, reflecting FIRN's low to very-low income client base.[69] Since many participants spoke limited English, interpreters or bilingual moderators attended. A group for each of the following ethnic groups was held:

Country of Origin	# of participants
Central America	11
Mexico	10
South America and the Caribbean	11
African	12
Korea	5
Haiti	17
Vietnam[70]	5
Pakistan	8
China	10
Total	89

The Questions

Four questions were asked at each focus group. The questions were formulated in order to capture the following information:

- How foreign-born residents of Howard County interpret "health and wellness services."
- What participants saw as the primary language and cultural barriers to health and wellness.
- How they believed such barriers could be overcome.

The four questions asked by the moderators at each focus group were as follows:

1) Participants were asked to brainstorm examples of health and wellness services in Howard County (after two or three prompts from the moderator). They were then asked:

2) "Of the health and wellness services you have received in Howard County, what has worked particularly well for you, and what do you think should be continued in the future?"

3) "What are some of the difficulties you or other members of your community have encountered when trying to get health or wellness services in Howard County and what would you have done differently to eliminate those difficulties?"

4) "Name one thing you would do to improve health and wellness services in Howard County by finishing the sentence, 'If I were President of the United States, I would…'"

Results

We as immigrants find ourselves in this country, and often feel like we are lost in space.

Focus group participant

Overall, the findings of focus groups confirmed many of the trends captured in the research emerging in this field. Regardless of their country of origin, participants expressed high levels of distress caused by language barriers, cultural insensitivity, discrimination, the high cost of health services, lack of insurance and difficulties accessing services.

It was striking, in fact, that ethnic and national origin did not appear to influence the comments. By covering up the name of a particular focus group (see Appendix E), issues, concerns and even the emotional coloring of comments appeared intensely similar.

While distress over cultural insensitivity surfaced in comments, cultural barriers did not often emerge explicitly. Their absence may reflect the difficulty of capturing such information in words. Culture is complex and amorphous; language and insurance barriers are obvious and clear. Implicitly and repeatedly, however, the comments of participants revealed cultural barriers caused by a lack of mutual understanding and providers' lack of sensitivity to cultural differences.

The three most intense concerns were discrimination, language barriers and high cost. Discrimination and language problems were felt in many different areas of service, whereas participants spoke of financial distress chiefly with respect to health services. The financial problems included lack of insurance, major medical bills, the high cost of dental services, paying for elderly relatives without insurance and failing to qualify (under 1996 changes in immigration law) for medical assistance. The participants' pain was palpable.

Question 1

AWARENESS OF HEALTH AND WELLNESS SERVICES AMONG THE FOREIGN BORN OF HOWARD COUNTY

What do foreign-born residents of Howard County consider to be a health or wellness service? In general, their view of health services appeared broad: it included domestic violence programs, for example, health care legislation and Howard County's food bank. In contrast to a common view of a wellness service as a health promotion activity (e.g., weight loss or smoking cessation programs), for moderators "wellness service" was equated with community services, while for participants, the term appeared to refer to any service promoting the overall well-being of local residents, including churches, the fire department and the Immigration and Naturalization Service.[71]

Question 2

POSITIVE EXPERIENCES WITH HEALTH AND WELLNESS SERVICES

I found better services than in other counties, especially in the food stamp and healthcare programs.

Focus group participant

The second question focused on positive experiences with health and wellness services in Howard County. Answers to this question offered a consistent finding: ***agencies that offered interpreters received the highest praise and were mentioned most often for the positive experiences of participants.***

The Howard County Health Department and some of its services (including family planning and prenatal services) received particular praise: the Health Department was mentioned in 19 separate instances for this question. For several years, the Health Department has had a full-time bilingual staff member (a Spanish speaker) and has also run interpreter-staffed clinics. In addition, staff members call interpreters from FIRN to attend individual health appointments in Spanish, Korean, Chinese, Vietnamese, Gujurati, Hindi and other languages. For emergencies and walk-ins, the Health Department uses Language Line, a telephonic interpreter service.

Next, FIRN itself received the second highest number of positive comments (14). This is not surprising, since FIRN is the only nonprofit organization in Maryland offering comprehensive services to foreign-born residents from around the world. Staff members speak 11 languages, and FIRN also runs Language Connections, the only professional nonprofit interpreter service in Maryland for health and human services. Needless to say, FIRN also organized the focus groups.

Howard County General Hospital (HCGH) received a very high number of positive comments: 11 altogether. Given what a frightening experience it can be for a foreign-born person to go to a U.S. hospital, this was an impressive finding. HCGH uses bilingual staff members and telephonic interpreter services to serve LEP patients.

Other programs were mentioned several times: Project Literacy (which many native-born residents might not consider a wellness service) is an adult literacy service run through the Howard County Library that has served high numbers of foreign-born residents and helped many immigrants to pass their citizenship exam. The Health Alliance, Howard County's only free clinic, has many foreign-born clients and offers volunteer interpreters to patients. The English for Speakers of Other Languages (ESOL) classes of Howard Community College (HCC) also received positive comments. These classes are perhaps the most accessible for local foreign-born residents who wish to learn English at an affordable cost. Participants also mentioned the Women, Infants and Children program (WIC) and Howard County Recreation and Parks, among others. Readers seeking more detailed information may request from FIRN a full copy of this report, which includes the appendices that offer detailed reports on each focus group.

Question 3

BARRIERS THAT FOREIGN-BORN RESIDENTS OF HOWARD COUNTY FACE WHEN ACCESSING HEALTH AND HUMAN SERVICES

Question 3 focused on barriers to health and wellness services and proposed solutions. Most of the barriers discussed at these sessions reflect the complaints heard in the offices of FIRN counselors almost every day. In general, health issues were voiced far more often than complaints about human services. In addition, there seemed to be a lack of knowledge about health services available to low-income residents with language barriers. Several participants complained they could not get a diagnosis. Some have avoided going to the emergency room (ER) due to language barriers or high cost.

Discrimination

Discrimination on the basis of national origin is perceived and deeply felt by many of the foreign born in Howard County as they try to access health and human services. Sadly, many participants' comments illustrated this view. Here are only a few:

- *When I went to my children's pediatrician's office I was disrespected by the assistant and then ignored because I did not speak English. But when I went with my American husband, we were treated well.*
- *I hurt my back at my job. My boss told me that this is men's work; nobody comes here to cry.*
- *Doctors discriminate against immigrants.*
- *I brought my son to the doctor. He had insurance, but nobody there spoke Spanish. I said it in English but the receptionist treated me rudely and said, "I don't understand." She gave me the wrong information and waited on me last. They tried to close without seeing us. …. When I went with my American husband, they treated me better.*

Language Barriers

Language barriers caused a great deal of pain and distress. Language issues came up in many contexts. Yet focus group participants seemed unaware they had a right to free interpreters at federally-funded health and human service agencies. Some LEP clients felt the need for more interpreters in clinics. Many expressed their belief that it is easier for native English speakers to access services than for immigrants.

- [*I need] a permanent interpreter; you feel bad asking friends to come with you to appointments all the time.*
- *[The state government needs] bilingual employees and interpreters. Also, employees who deal with the public should be kinder and more sensitive.*

Health Insurance

Health insurance is perceived as too expensive. Yet the lack of it created tremendous health and social difficulties for participants.

- *You have to wait 90 days at a job for the insurance to kick in. When you buy a car, you get insurance right away.*
- *I am a high school student and I want to play on the basketball, but I can't because I don't have insurance.*
- *It is especially difficult [for Koreans] to get insurance because a lot of Koreans are self-employed.*
- *Everybody should have health insurance. If you work part time you cannot get insurance. You are still paying taxes if you are working part time.*

Hospitals

Of all the barriers, problems at area hospitals seemed to arouse a very intense response: they were mentioned in 19 instances. Perhaps a crisis is especially frightening if it involves health, money and language barriers. Among the problems encountered at local hospitals were discrimination, language barriers, cultural insensitivity, lack of insurance and unexplained major

medical bills (a frequent problem, especially at ER).

- *Children have to be dying of fever to be seen at the hospital. The hospital should accept everyone.*
- *A friend's wife had stomach pains and went to the doctor [in a hospital]….No one wanted to help her; she was seen in the hallway. At least she spoke a little English -- what if she hadn't spoken any English? Here, hospitals continue to send bills although a patient remains sick.*
- *When my daughter hurt her arm at the pool, I knew I could not take her to the ER because it is too expensive and we do not have insurance.*
- *I had an emergency and they brought me to the hospital without an interpreter—with nothing.*
- *Sometimes they will charge you more or not see you if you are from another county.*
- *On the second floor of the hospital, my daughter-in-law was in labor and the attending nurse was making derogatory comments to the effect of 'you are better off here than in your rural Pakistani home.'*

Many participants found the long-term financial consequences of hospital bills a financial burden. Such bills were mentioned repeatedly and the burden was voiced with pain. A number of participants had no idea where to find help with major medical bills.

- *I went to the Emergency Room and I got a poor diagnosis and a poor solution. The service was not fair. I am paying $86 every two weeks for bad service.*
- *Last year I was billed seven times the amount and calling the hospital took 2 or 3 hours.*

Lack of Information on rights, resources and the health care system

A great deal of frustration was caused by lack of information. The health care system in this country is complex even for the native born. Immigrants often had no idea how health insurance worked, how to find help in their own language or what their rights were.

- *All of us who come here from other countries are intelligent, but we don't know how to claim our rights.*
- *Communication is a problem. FIRN helps, but without them, we wouldn't know what services are available, or free (like the prenatal clinic). My son got very sick and I didn't know that there were free services available.*
- *You have to get permission from your insurance company to see another doctor. And I don't know anything about insurance. We don't have the information.*
- *I was having my first baby and I did not have papers or insurance. When I got to the hospital I had no doctor's supervision. I did not know English and I did not know my rights. I did not feel respected at the hospital.*
- *I was not informed about these services when I first came into the country.*
- *Koreans … think free services are less quality than paid services.*

Confidentiality

Many foreign-born residents (particularly those in communities that shun public exposure of private problems) fear going to local health and human services. They are not certain that their confidentiality will be protected.

Medical Assistance

Changes in immigration law in 1996 that bar most immigrants from receiving social services, including medical assistance, until they become citizens, also caused distress.

- *My parents just came with a green card and I can't get any medical coverage for them.*
- *Five years is a long time to wait. It's a big concern for immigrants. What do I do in case of an emergency?*

Transportation

Transportation appeared to be a significant barrier for the foreign born in need of services.

Solutions Proposed by Foreign-Born Residents to Improve Access to Health and Human Services

> *Speak up for your rights. If the employee is rude, ask for the manager or boss to make your complaint. Fill out survey forms to make your opinion count. Lose the fear to stand up for yourself even if you have a thick accent or need to use an interpreter.*
>
> Focus group participant

Solutions proposed by focus group participants to improve access to health and human services can be loosely grouped under the following categories.

Language Barriers

- Patients would feel more comfortable with medical professionals of their own language/culture.
- The foreign born should learn English as soon as possible.
- Health and social services should provide bilingual staff and interpreters for health.
- Health insurance companies should hire more bilingual customer service representatives.

Cultural Competence Training

- It was suggested several times that workers in health and human services should receive training in cultural sensitivity and other cultural issues.

Social Services

- Participants recommended a quicker response and greater availability of caseworkers.
- Better training for Department of Social Services workers was also recommended.

Health Insurance

More affordable insurance or universal health coverage was mentioned repeatedly by participants. Other insurance suggestions included:

- Government insurance for part-time workers.
- Using MCHIP to offer cheaper insurance for the rest of the family.
- High school insurance.
- Lobbying for a change in insurance laws.
- No co-pays for those on disability or those with low-income.
- Immediate coverage at work. (One participant reports: *Why should we wait 3 months before receiving insurance at a new job? I knew a lady that had to wait 6 months because her employer forgot to give her the papers to fill out.*)
- Lower rates for the uninsured.

Hospitals

A number of solutions were proposed:

- Higher funding at hospitals to support low-income patients
- A Spanish-speaking patients rights representative at hospital.
- A health care center for low-income residents.
- Special billing procedures for the foreign born/limited English speakers.
- Cultural sensitivity training for hospital staff.
- A government office for health billing complaints and a benefits manager to clear up problems.
- Priority for small children at hospitals.
- Pro bono pediatricians in emergency rooms (ER).

One participant recommended: *There should be less of a wait. The hospital should hire more doctors who are competent. The hospital should tell you how much they are going to charge you, instead of just sending the really high bill.*

Immigration

- Provide legal documentation for all immigrants.
- Provide immigration assistance.
- Set up a 24-hour hotline to assist the undocumented.
- Offer health benefits to asylees.

Lack of Information

- Give clear explanations when services are denied.
- Inform new residents about available services.
- Teach immigrants about their patient rights and the "system."

Overcoming Discrimination

- Make institutional efforts to eliminate racism.
- Engage immigrants in community building.

Outreach to the Foreign Born

- Give information on available services to new residents.
- Educate the foreign born on their rights and resources.
- Have FIRN perform more outreach.

- Show immigrants the value of free services, as some suspect pro bono means low quality.

As one participant so clearly stated: *People will be able to claim their rights if they have the knowledge that enables them to do so.*

Transportation

- Offer sliding-scale transportation charges (including free transportation for low-income families).

Question 4

IF I WERE PRESIDENT . . .

What is the vision of foreign-born residents for a community where health and human services are easily accessible to even those with limited English? Question 4 of the focus groups explores that vision. It also brought one of the saddest commentaries to emerge from a focus group: two Haitian participants refused to answer the question, saying that due to their skin color they would never be President, so they saw no point in responding.

In general, however, participants willingly answered. The most frequent reply was the provision of universally affordable, accessible health care, mentioned 13 times. The “runner-up” was public support for education (8 instances). Affordable housing was the third priority, mentioned 7 times. Other responses included respecting the rights and equality of the foreign born; supporting equal opportunity for all; better pay/living wages; universal legal papers or citizenship; freedom from discrimination; universal employment (nationally, the foreign born experience higher rates of unemployment than the native born); and reduced taxes.

Section Seven
Voices of the Foreign Born: The Latino Forum

Introduction to the Latino Forum

As part of this project, a forum was held to collect the opinions of a variety of foreign-born Latinos in the County and to build on information obtained through focus groups.[72] A two-hour forum conducted entirely in Spanish was held at the Wellness Center near Howard County General Hospital on October 24, 2001: 31 participants attended. Most were recruited from a local Hispanic church, Howard Community College classes for English as a Second Language and FIRN's clients, and so they may not have represented the local Hispanic community as a whole. There was little overlap with the project's focus groups: organizers of the forum estimate that only about 4 participants had previously attended focus groups.

As the demographics of the County and information in this report suggest, Latinos constitute a significant local foreign-born minority. The goal of the Latino forum was to ascertain what health and human services local foreign-born Hispanic residents find most or least accessible. Another goal was to find out how well services in Howard County meet their needs.

This was a delicate mission. It is well known that many Latinos are wary of authority. However, FIRN was uniquely positioned in the county to hold such a forum, as it is widely considered the only local organization to have earned the trust of the foreign-born community. In addition, four of its 10 staff members hail from Mexico, Uruguay, Ecuador and Bolivia, while other staff members speak Spanish. In a typical year, between 35 and 40 percent of FIRN clients are Latino.

Best and Worst Services

Participants were presented with a list of health and wellness services compiled from the 9 focus groups. (They were asked to suggest others, but no suggestions were offered.) Each participant was given two blue and two red dots and asked to prioritize the services by putting their blue dots next to the two "best" services and red dots next to the two "worst" services.

The group was then divided into four break-out groups to discuss positive and negative aspects of the services and offer recommendations to improve access.

Best and Worst Experiences with Health and Wellness Services

In another activity, each participant was given a green dot and asked to place it on a "wall spectrum" of 1 to 10, where 1 represented "worst" and 10 represented "best." They were asked to use the spectrum to rate their experience with health and wellness services in Howard County. Of 31 participants, four placed their dots between 1 and 5; 25 between 6 and 7, and two dots between 8 and 10.

Finally, each group was asked to rate their experiences with health and wellness services in Howard County, on a scale of 1 to 10.

Results

Best Services

- Church (12 dots)
- FIRN (12)
- Public library (8)
- Firefighters (7)
- HCC English classes (4)
- INS (4)
- MVA (4)
- WIC (3)
- HCHD mammogram screenings (1)
- Housing (1)

Worst Services

- INS (22 Dots)
- IRS (8)
- Private dentists (8)
- Private doctors (7)
- MVA (7)
- NSA security (3)
- SSI (2)
- Transportation (2)
- Healthy Families program (1)
- Courts (1)
- Health insurance (1)

Positive experiences

Churches were valued as "a place of refuge and peace" offering "all kinds of help" that also promoted "family unity" and a "sense of security." They offered a "source of information in my own language."

Public libraries were praised for being "very accessible" with "good hours of operation" and "good service." Free access to computers and the Internet was also valued.

The only positive comments concerning health services at the forum focused on:

- Hospital Emergency Room services.
- The number of specialists.
- The diversity of available health services.

No human services (except FIRN) were mentioned.

Problems and Concerns

Some of the problems and barriers to health and wellness that emerged for participants during breakout group discussions included:

- Transportation.
- Lack of preventive health services.
- Language barriers.
- Cost barriers.
- Lack of awareness (e.g., of family planning services).
- Lack of outreach.
- Cultural insensitivity.
- Troubled youth.
- Long waits for processing of immigration documents.
- Lack of equitable tax treatment of women.

Recommendations for Improvement

Participants recommended the following changes to facilitate their access to health and wellness services:

- Provide more interpreters in private dentists' and doctors' office.
- Create a health clinic for low-income residents without insurance.
- Include dental services (for low-income clients).
- Improve public transportation.
- Publish a list of bilingual doctors in area.
- Hold more programs for teens/young adults.
- Hire more bilingual staff.
- Provide opportunities for long-time immigrants to legalize their status.
- Speed up processing of immigration documents.
- Purchase Spanish newspapers like *El Heraldo* and more books and materials in Spanish for public libraries.

Discussion

In contrast to the focus groups, there was no discussion about public or private nonprofit health and human services at the Latino forum. In itself, this was a striking difference.

While it is possible to attribute the positive focus on churches to the participants of this forum (about half of whom were from a Hispanic congregation), it is not so easy to dismiss the consensus reached on problems concerning private doctors and private dentists. The intense reactions of participants appear to indicate troubling barriers in the private health care system, at least for local Latinos. In an echo from focus groups, one participant said to justify why physicians on a list of bilingual doctors should be checked out: *Many times doctors are in it just for the money and don't provide a good service.*

In addition, the dissatisfaction with immigration and IRS was quite strong. There appears to be a great deal of "heat" generated by these two issues. The distress of participants may reflect their very strong sense that resolving immigration status and having fair taxes is central to their health and wellness. That is a message. To the best knowledge of the authors, no comparable focus groups or forums focused on health and human services have witnessed an intense reaction to the two government agencies that govern immigration and taxes (INS and IRS).

It also became clear, both in focus groups and this forum, that many foreign-born residents are unaware that a free clinic exists in Howard County.

Finally, despite worries and concerns, on a scale of 1 to 10 (with 1 as the worst and 10 as the best), 81 percent of participants rated their experiences with local health and wellness services between 6 and 7. That is encouraging news.

Section Eight
Voices of the Foreign Born: Survey of Individuals

Health insurance should be made to everyone at an affordable rate
FIRN Survey participant

FIRN Health Care Access Survey

Between April and July 2002, FIRN conducted a written survey of foreign-born residents of Howard County, including many of its own clients, regarding their access to health services.[73]

In all, 104 surveys were completed. 67 of them (64.4%) were taken by an interviewer in the respondent's primary language; taken by an interviewer in English as the respondent's second language; or completed by the respondent in English without the assistance of an interpreter. 36 surveys (34.6%) were completed by respondents in Spanish. One survey (1.0%) was completed by a respondent in Korean. Most of those taken by an interviewer were conducted by staff members of FIRN, Inc. at the FIRN offices or at Howard Community College.

This survey of foreign-born residents of the County reached a broad cross section of the population:

Age. The survey reached all adult age groups, with the largest group being the 30 through 39 year olds. The next largest group of respondents was 18 through 29 year olds. 16 respondents (15.4%) were between the ages of 40 and 49; 16 respondents were between the ages of 50 and 64; and three respondents (2.9%) were age 65 or over.

Gender. Two-thirds of the respondents were female.

Country of Origin. Respondents came from 34 different countries in continents of North America, Central America, South America, Europe, Asia and Africa. More than one third of the respondents (35.6%) were from Mexico.

Native Language.
Out of twenty-two native languages listed, more than half of the respondents (55.8%) identified Spanish as their native language.

Education Level. Roughly one third of the respondents (38) completed university and one third (33) completed secondary school. Only 27 of the respondents (27.9%) did not receive a secondary education or higher.

English Proficiency. Respondents were asked to give their own perceptions of how well they speak English. Half 50.6 percent answered that they spoke English "a little"; 34.9 percent felt they spoke English well and 14.5 percent marked that they spoke no English. Out of 22 native languages listed, half the respondents (49.4 percent) identified Spanish as their native language.

Findings

The survey found that foreign-born residents of Howard County face language and cultural barriers to health and human services regardless of age, gender, country of origin, native language, length of residency in the United States, educational level, or English proficiency.

Language Barriers

Over half of respondents (56.7 percent) reported experiencing language barriers when trying to make appointments or get directions to health providers. Over half (51.9 percent) reported language barriers with their doctor of provider. A large number felt that the doctor or health care provider either did not understand their culture (43.3 percent) or their traditional healing methods (34.6 percent). A third (32.7 percent) did not understand how to get a prescription filled, while more than one quarter (27.4 percent) did not know how take a prescribed medicine. In fact, 46.1 percent of respondents reported feeling so overwhelmed in health situations that they only pretended to understand.

The high levels of education reported by respondents, though not unusual in Howard County, are not typical of the foreign-born population as a whole[74]. They do not appear to reflect the less-educated population that area service providers anecdotally report seeing in area clinics and public or nonprofit health services. If, therefore, respondents with these higher levels of education are reporting language barriers of this magnitude—it is somewhat staggering to consider how less-educated patients can manage to procure culturally and linguistically appropriate services.

Cultural barriers

Differences of gender relations in some cultures can affect the health encounter. For example, 27.9 percent of respondents did not feel comfortable with a doctor of the other gender.

It is not uncommon to see, in certain cultures, a particular family member who may control or direct treatment and make medical decisions for the entire family. This may pose certain problems, and in fact, in this survey, 30.8 percent of respondents reported that a family member did not approve of the doctor or treatment received.

A third of respondents (30.8 percent) have needed health care in the past and were unable to obtain it because they knew they might not be accepted. About half (51.9 percent) did not experience this problem, while others (17.3 percent) did not respond to the question.

Employment conditions appear to be a particular barrier: 48.1 percent said they could not get a weekend or evening appointment when needed because of their work schedule, while over half (55.8 percent) had problems taking time off work to go to a health care provider.

Fear Barriers

Anecdotally, providers commonly report that immigrants are often afraid to receive health services in case it later causes them trouble with their legal status. In fact, 32.4 percent of respondents were afraid that receiving health services might prevent them from getting a green card or becoming a citizen.

One respondent with limited English proficiency wrote: *I don't no if I take some help from health care I'll have problems to a probe [approve] to my residence*. This is a valid concern for obtaining some but by no means most health services. However, due to lack of available information, many immigrants share this respondent's fears. The comment reflects some of the problems of understanding about their rights that are experienced with particular poignancy by our undocumented residents—who are primarily from Central America, speak little English and have among the lowest levels of education in the nation.[75]

The Special Case of Community Healers

While most respondents had seen private doctors and dentists, clinics and/or hospital emergency rooms, it is of particular note that 8 respondents (3.5 percent) had visited community healers. Community healers are a concern among specialists on language barriers (see section 5 and 6) because treatments that patients receive from such healers potentially do interfere or interact with medical treatment. Conversely, some health organizations (including the Cross-Cultural Health Care Program in Seattle) maintain that such healers could be turned into assets for healing and have remained largely untapped by providers as valuable resources in the community.

Knowledge Barriers

It is no surprise that local foreign-born residents have difficulty negotiating the complex health system in the United States. The vast majority of survey respondents, 82.7 percent, reported needing health services in the last year. However, when asked if they would know where to turn when they needed health care, only 36.2 percent reported "most of the time." The majority (63.8 percent) reported either "some of the time" (40.0 percent), "hardly ever" (13.3 percent) or "never" (10.5 percent).

A majority (60.6 percent) of respondents felt they needed more information on how to find a doctor. Over half (56.7 percent) needed more information on billing or paperwork. Another 41.4 percent had difficulty arranging for transportation to a health care provider.

Cost Barriers

Cost emerged as another barrier. Respondents reported difficulty paying for medicine (51.9 percent), finding out how much health care would cost without insurance (62.5 percent) and understanding how to obtain payment through insurance (51.9 percent).

Only half (48.1 percent) of respondents reported having health insurance.

Recommendations from the Foreign Born

Respondents proposed the following when asked what would make it easier for them to obtain health care:

- affordable health care/reduced cost/free clinics (15.6 percent)
- interpreters (4.8 percent)
- more/"closer" clinics (4.8 percent)
- more information (on services, insurance) (2.4 percent)
- improve English of respondents (2.4 percent)

Other suggestions included improving public transportation and providing more dental services, "faster" services, walk-in and outpatient services. When asked if they had additional comments, respondents added: cheaper medicine (4.8 percent).

Some individual comments or requests included:

- *There needs to be more education for the doctors and their staff on culture sensitivity and also on how to obtain interpreters for their clients and the staff needs to learn how to explain things to clients in a way that they will understand.*
- *That all doctors attend to Hispanics without discrimination. Equal to American citizens.*
- *That they continue helping those persons who don't have documents and are pregnant*
- *That they would offer more information regarding specialists, such as optometrists, psychologists, etc.*
- *More information how to obtain [health care].*
- *What organizations (a list) help immigrants find out about their benefits for health insurance.*
- *List what kind of health care services are available in the phone book and on the web.*
- *Medicine is too expensive.*
- *Create more community clinics for all ages and low incomes*

Section Nine
Survey of Health and Human Service Providers

Fifteen surveys were returned from health and human service providers. The surveys were distributed at the Health and Human Services Forum on Health Access held March 20, 2002 at the Owen Brown Interfaith Center in Columbia, Maryland.

Findings

This small sampling of health and human service providers lends insight into several issues faced by providers as they interface with foreign-born clients.

- First, of the fifteen respondents, only two were themselves foreign born, and those from primarily English-settled, English-speaking countries: Canada and Australia.

- Second, the health and human service community represented even in this small sample is very diverse—not in the nationality and ethnicity of its staff but in the variety of its services and the breadth of its coverage.

- Third, even though every one of the provider organizations served foreign-born people, their operational practices were ill equipped to work with this population. Only one-third of these organizations, for example, recorded in the client file whether the foreign-born person speaks or writes English.

Multi-Cultural Inexperience of Providers

This last point may suggest the relative inexperience of providers in recruiting, serving, and maintaining a database on the foreign-born people who are their clients. For example, only seven responses out of 24 listed “Requested on intake, medical history, or other official record” in response to the question, “How do you identify a person as foreign born?” Two responses said that this identification was made by the name of the individual, two responses said it was by sight and visual cues, eight responses said that identification was made by the person’s speech or language.

Service Strategies

Responses to the question, “What special services do you offer to foreign-born residents?” supports the indication that health and human service providers are relatively inexperienced in serving the foreign born and have not developed specific service strategies for this population.
Only one of the organizations reported that their telephone answering machine messages were in languages other than English, only six provided interpreters or had bilingual staff, and only eight organizations had brochures or written material in a language other than English. One organization, however, had outreach workers specifically for Korean and Latino populations, and another had bilingual beginning classes in Korean and Spanish.

Outreach Strategies

The organizations' reports of strategies they use for attracting foreign-born clients and patients is encouraging. Six of the organizations build partnerships with churches, community organizations, and others who are tied to or represent foreign-born people. Six engage in outreach through fairs, community events, and other activities that are well attended by foreign-born people. Four organizations do outreach in communities of foreign-born residents.

Yet there is much to do. Only two organizations reported that they place foreign-born organizations on their mailing lists, only two reported using diversity in advertising, and only one organization reported that they advertise in foreign-language newspapers or on foreign-language radio stations.

Recommendations from Providers

When asked, "What would be most helpful to you as you provide services to foreign-born residents?" several very practical suggestions surfaced. One was to develop standard intake in other languages to gather demographics. Another was to develop materials, forms, signs, etc. in various languages. A third suggested ongoing staff training in cultural competency. Another suggested outreach offices in communities with high foreign-born populations. Several of the ideas emphasized interpreter and translation services aw well as more bilingual, fully trained staff. Collaborative values surfaced in the suggestion to share references and resources among agencies.

Conclusions

Based on the cultural sensitivity, concern, and insights expressed by these same respondents during discussions at the Health and Human Service Provider Forum, these levels of organizational inexperience and the lack of institutionalized practices regarding the foreign born is more an organizational stasis than personal disregard.

Health and human service professionals need more materials and more knowledge about how to serve the population. And perhaps most importantly, they need more funds for acquiring these materials and implementing these practices.

Section Ten
Health and Human Service Provider Forum

Introduction

FIRN, in partnership with the Association of Community Services of Howard County (ACS), convened a forum of health and human service providers in March 2002 to explore the issue of barriers from the provider's point of view. Forum participants received preliminary data on the foreign-born population in the County, engaged in a discussion of barriers and remedies, and were asked to complete a written survey. The forum was held during an ACS general membership meeting and was open to all health, wellness, and human service professionals who serve Howard County residents.

Identification of Barriers

The providers identified barriers that are similar to those identified elsewhere, including the focus groups and surveys of foreign-born residents: lack of money and lack of insurance to pay for care, transportation barriers, language barriers, and cultural differences such as communication styles and practices. These cultural differences included differences in how people who are foreign born view government entities such as the police. They also encompassed cultural taboos, values, and practices that impact on the individual's perceptions of what is appropriate when receiving services, particularly in health care. Reference was made to the issue of "cultural malpractice" in the provision of services. (Though the term was not defined by participants, it refers to negative health outcomes caused by a provider's inability to provide culturally appropriate services.)

Providers identified the limited availability of public transportation in Howard County as a significant barrier for the foreign born, as well as the lack of familiarity with the public transportation system. Providers also cited cultural literacy as a barrier: many foreign-born residents lack familiarity with signs, symbols, schedules, and other means of communication in U.S. culture. In an interesting aside, providers noted the common practice of walking or using bicycles to get around in some cultures and commented that in the United States this practice made them more vulnerable to crime.

Literacy proved to be a significant concern: these providers reported that a client's language difficulty was often complicated by illiteracy in his or her native language in addition to their difficulty with English. The lack of education the individual received in his or her native country places them at a disadvantage in the United States where education is so highly valued and necessary to navigate the culture.

According to service providers, in many cases their clients feared losing their children or jeopardizing their immigration status by seeking services. They also noted that these fears were intensified when the diagnosis was a serious illness. They felt their clients had a fear of the stigma that is attached to seeking service in general and to services for mental illness in particular. Providers noted the clients' fear of repercussions for seeking services. Such fears concerned not only repercussions from outside the family circle but also from within it—particularly for victims of rape. Sadly, in many cases that perception is also a reality.[76]

Proposed Solutions

Client-centered solutions offered by service providers for removing barriers to health care access focused on education and language assistance. Providers believed that more information for foreign-born clients on how to "know" the system would help the foreign-born individual to access services. This same information might encourage immigrants to seek services that they need.

Several providers use interpreters when available (the Howard County Health Department has a contract with FIRN to provide interpreters on an on-going basis) and some use a commercial telephonic interpreter service in crisis intervention situations where interpreter services could not be arranged.

One solution highlighted by providers was staff training. Such training might use material from around the country on best practices; be provided by community groups, particularly by foreign-born groups; and/or use a model employed by the Howard County Department of Social Services for frequent training sessions on serving the foreign born.

Finally, some providers considered enrolling in Spanish classes at Howard Community College, particularly its "Command Spanish" program that teaches basic conversational Spanish for people who need to learn Spanish quickly for immediate application on the job. Such a plan might well promote cultural sensitivity as well as interest in other cultures among area providers. However, it is important to bear in mind the concerns of specialists in the field that a year or two of Spanish is no substitute for a bilingual, bicultural and culturally competent service provider.

Section Eleven
Conclusions and Recommendations

> *We need more community building. We need to teach each other what we know. We need to keep in touch with each other. There should be classes and workshops about topics such as domestic violence and overcoming the fear of standing up for rights with or without documentation. If we know what services we have in our community, then we will use them more.*
>
> Focus group participant

Conclusions

Barriers to Health and Well-being

During the course of this project, certain key barriers emerged repeatedly as the most significant and troubling for access of foreign-born residents to health and human services in Howard County. In their own perception and statements, often voiced with feeling, the obstacles for the foreign born included:

- Lack of language assistance (bilingual staff or interpreters)
- Lack of cultural understanding by providers
- Cultural insensitivity
- Cost of services
- Discrimination
- Lack of information on the health care system
- Lack of insurance
- Transportation

Other significant obstacles appear to include a lack of awareness about the existence of Howard County's free clinic (The Health Alliance); and a lack of knowledge about where to find bilingual providers or providers willing and able to use interpreters.

In addition, during focus groups and the Latino forum, participants displayed an apparent lack of awareness of their legal rights to interpreters under Title VI of the Civil Rights Act of 1964 and other language access laws, or the recourse available to them in cases of discrimination, such as filing a complaint with the Office of Human Rights.

Service providers mirrored many of these concerns regarding access of the foreign born to services and offered their own perception of the barriers, which included:

- Lack of money/lack of insurance.
- Illiteracy.
- Transportation.
- Cultural differences.
- Fear/mistrust of authority.
- Fear of stigma.

- Fear of jeopardizing immigration status.
- Difficulties caused by family members.

Improving Access: Recommendations from the Foreign Born

The major recommendations about how to improve their access to health and human services to come from local immigrants include the following:

- Provide interpreters.
- Hire more bilingual staff.
- Hold cultural competence trainings.
- "Eliminate" discrimination.
- Reduce cost of services.
- Conduct outreach.
- Provide insurance or free services for low-income residents.

As this report shows, the concerns of Howard County immigrants mirror those of national research, other focus groups and the statements of ethnic organizations, health organizations and nonprofits that serve immigrants across the country.

Improving Access: Recommendations from Service Providers

Area health and human service providers suggest the following:

- Improve cultural literacy skills (of the foreign born).
- Enhance system navigation skills (foreign born).
- Telephonic interpretation.
- Hold staff trainings (using available resources and community groups).
- Improve tracking of foreign-born clients.

One innovative suggestion was to develop a standard, multilingual intake form to be shared among community service agencies in the county.

Recommendations

On the basis of the findings of this project, FIRN recommends that area health and human service providers, with the support of Howard County government, ethnic organizations, faith-based organizations and key stakeholders, including the foreign born:

1) Create a broad-based county coalition to address language and cultural barriers to health and human services.

2) Provide interpreters as needed at all health and human service encounters in Howard County.

3) Offer cultural competence and diversity training to all staff at area health and human service organizations

4) Publish and maintain a database of bilingual health providers in the Howard County area.

5) Organize broad outreach efforts.

Recommendation #1: THE COALITION

The proposed coalition would ideally include:

- Ethnic leaders in the community.
- Ethnic community-based organizations.
- Law enforcement and justice officials.
- Local government agencies (including the Office of Human Rights).
- Nonprofit agencies.
- Faith-based organizations.

Recommendation #2: INTERPRETERS

Ways to facilitate the provision of interpreters to area providers include:

- Educate providers on the impact of interpreters on health and well being.
- Collaboratively support service providers who seek funding for interpreters.
- Offer providers more information about FIRN Language Connections interpreters.
- Inform providers about OMH CLAS Standards.
- Inform providers about their legal obligations to provide interpreters.
- Reach out to the foreign born.
- Cooperate with the Maryland Department of Human Resources to ensure compliance with federal and state language access laws.
- Train service providers how to work with interpreters.

In addition, the proposed coalition, once established, could approach the Maryland legislature about the possibility of obtaining federal matching funds to pay for interpreters in health and human services.

Recommendation #3: TRAINING

Cultural competence/diversity trainings to area providers should focus on practical strategies to reach out to immigrant clients and overcome language and cultural barriers. Such training should also include, at a minimum, the following areas:

- The need to develop a plan to serve foreign-born/LEP clients.
- Definitions of cultural competence.
- National and local demographic changes.
- Federal and state language access laws.
- OMH CLAS Standards.
- Relationship between language/cultural barriers and health.
- How to recruit and work with bilingual/bicultural staff.

- How to work with interpreters.
- Differences between trained/untrained interpreters.
- How to diversify interpretation/translation resources.
- Information on local cultural groups and languages.
- Simple strategies for enhancing cultural competence.

It would also be helpful to have both consumers and ethnic community leaders/organizations come to speak on the skills, strengths and assets of foreign-born residents, areas in which providers can build strategies to improve services and enhance access. In addition, during such trainings it would be in valuable to have consumers, bilingual service providers and trained interpreters share their experiences in the field or their daily lives.

Ideally, a local government or nonprofit agency would be charged with leading such trainings in a coordinated manner across the county.

Recommendation #4: DATABASE OF BILINGUAL PROVIDERS

While FIRN maintains a small database of bilingual health providers and specialists, the list is informal and relies chiefly on word of mouth from clients. Other partial efforts include the Mental Health Authority's director of mental health services, which specifies languages spoken by local providers. However, no systematic effort has been made in the County to interview research providers to determine the languages spoken in their offices, whether by providers or bilingual staff.

Recommendation #5: OUTREACH

Outreach to the foreign born should prioritize multilingual outreach to ethnic communities in Howard County, using ethnic media and working with ethnic organizations where possible. Looking at Census data, its own clients, reports from service providers and the need demonstrated in this report, FIRN recommends that the following languages be emphasized in the first outreach efforts:

- Spanish
- Korean
- Chinese
- Vietnamese
- Russian
- Urdu
- Farsi
- French (for African and Haitian immigrants)

A LAST WORD

Ultimately, there is no substitute for a strong relationship with ethnic communities themselves. County and local providers will ideally forge and maintain strong ties with ethnic community- and faith-based organizations. These organizations, more than any others, allow the voices of immigrants to speak for themselves about their needs, assets, goals and aspirations.

Until we hear those voices, the foreign born among us will not experience the full acceptance or integration into our society that promotes their health, happiness and well being. In the closing words of a Mexican survey respondent who lives in a household of 14:

Thank you for realizing that we exist.

Guide to the Appendix

Appendix A. Survey Instrument, Foreign-Born Residents

Appendix B. Responses, Foreign-Born Residents

Appendix C. Survey Instrument, Providers of Health and Human Services

Appendix D. Responses, Providers of Health and Human Services

Appendix E. Focus Group Reports

General Format and Summary Overview

Focus Group Reports
- **#1—Central America**
- **#2— Mexico**
- **#3—South America and Caribbean**
- **#4—Africa**
- **#5—Korea**
- **#6—Haiti**
- **#7—Pakistan/India**
- **#8—China/Taiwan**
- **#9—Vietnam**

Appendix F. Latino Forum (Design)

Appendix G. Latino Forum (Responses)

Appendix H. Health and Human Service Provider Forum

Appendix Endnotes

For a copy of the full report, including these appendices,

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Endnotes

[1] Between 1970 and 2000. *C.f.* U.S. Census Bureau, Census 2000, Table DP-2, Profile of Selected Social Characteristics, 2000: United States, and Lisa Lollock, *The Foreign Born Population in the United States: March 2000*, Current Population Reports, P20-534, U.S. Census Bureau, Washington, D.C.
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[3] U.S. Census Bureau , *Health Insurance Coverage: 2000*, based on data from the Bureau's March 2001 Current Population Survey (CPS).
[4] *Ibid.*
[5] U.S. Bureau of the Census, Census 2000, Table DP-2: Profile of Selected Social Characteristics: 2000.
[6] *Population Profile of the United States: 2000,* Chapter 17, "Adding Diversity from Abroad: The Foreign-Born Population, 2000," pp. 17-2*f.* Washington, D.C.: U.S. Census Bureau, 2000
[7] Due to welfare reform legislation passed in 1996, legal immigrants arriving since then are ineligible for most Medicaid and welfare benefits, including food stamps. As always, undocumented residents are ineligible for Medicaid, Medicare and food stamp programs
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Harborview Medical Center, Seattle Washington has many valuable resources, in addition to the cultural profiles, at <http://ethnomed.org>; Cross Cultural Health Care Program (CCHCP), which has many excellent resources in addition to the culture profiles available at <http://www.xculture.org/resource/library/index.cfm#downloads>.; and the University of Washington Medical Center series of Culture Clues™ at <http://depts.washington.edu/pfes/cultureclues.html>.
For a broader overview containing a greater number of different cultures, see Elaine Marie Geissler, *Pocket Guide to Cultural Assessment.* St. Louis, Missouri: Mosby, 1998, 2nd edition.
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[48] Reported following a 14-year study by the Centers for Disease Control and Prevention (CDC). *Cf.* the CDC “Fact Sheet: Increased Risk of Dying from Pregnancy Among Hispanic Women in the United States.” Available at < www.cdc.gov/nccdphp/drh/surv_hispwus.htm>.
[49] Editorial, “Health Problems of Latino Children.” *New York Times*, July 26, 2002.
[50] *Ibid.*
[51] They can be accessed on the web at < http://www.ncihc.org/NCIHC_Bibliography.pdf> <http://ethnomed.org/ethnomed/clin_topics/biblio/2001_chrisman_biblio.html>, August 30, 2002.
[52] California Policy Research Center, *Children in Immigrant Families: Issues for California’s Future.* Berkley, CA: UCLA Center for Health Policy Research/California Policy Research Center, 2002.
[53] See e.g. Minnesota Department of Health, *Eliminating Health Disparities in Foreign-Born Persons: Minnesota Department of Health Fact Sheet.* 2001. Available at <http://www.health.state.mn.us/facts/disparitiesforeign.pdf>, February 5, 2002.
[54] Reuters, "U.S. Immigrant Women Face Higher Heart Death Risk." January 1, 2002 and Peter Muennig *et al,* **Increased risk of heart disease and stroke among foreign-born females residing in the United States**. *American Journal of Preventive Medicine*, 2002: 22(1), pp. 30-35.
[55] National Institute of Diabetes &Digestive & Kidney Diseases, Gallstones factsheet available at < http://www.niddk.nih.gov/health/digest/pubs/gallstns/gallstns.htm >, August 30, 2002.
[56] For a bibliography of articles on refugee health compiled by the CDC, go to <http://www.cdc.gov/nceh/ierh/pub/Pub.htm>.
[57] Donald J. Hernandez and Evan Charney (Eds.), *From Generation to Generation: The Health and Well-Being of Children in Immigrant Families*. Washington, DC: National Academy Press, 1998, p. 5.
[58] *Ibid.*

[59] "Sight translation" is a process whereby a professional interpreter orally translates a written text, such as a consent form, a prescription, patient directives, or a financial disclosure form.

[60] This comment was noted by one of the authors on June 10, 2002, when she was conducting an evaluation of FIRN's interpreter training program , a program funded by the Maryland Office of New Americans

[61] Most trained, professional interpreters use first person. That is, if the patient says, "My stomach hurts," instead of saying, "She says her stomach hurts," the interpreter says in the other language, "My stomach hurts."

[62] Private communication, Joan Fisher, Executive Director of Anchorage Neighborhood Health Center, August 26, 2002.

[63] This was another comment noted by one of the authors on June 14, 2002, when she was conducting an evaluation of FIRN's interpreter training program.

[64] For Maryland agencies that have state-funded programs, CTS Language Link offers a rate of $1.65 per minute that has been negotiated through the state.

[65] FIRN incorporated as a 501(c)(3) in 1984.

[66] For a detailed summary of focus group findings and the reports on each focus group, see Appendix C. Appendices are not included in most copies of this report. To obtain a complete report, call 410-992-1923.

[67] Census 2000 county data on the foreign born was not then available

[68] U.S. Census Bureau, *Coming From the Americas: A Profile of the Nation's Latin American Foreign Born.* Washington, D.C.: U.S. Census Bureau Census Brief, 2000, pp. 2*f*.

[69] Low- to low-moderate income residents are those most often seen by area nonprofit or government health and human services. See Section 8 of this report.

[70] Unfortunately, during a time of internal reorganization at FIRN, most of the data for the Vietnamese focus group was lost. Only the list of health and wellness services offered by Vietnamese participants and their comments about the issue of confidentiality are therefore included in this report.

[71] For this reason, most of this report refers not to health and wellness but to health and human services, even though the questions to focus groups addressed wellness.

[72] The complete report may be found in Appendix D. For a copy of the report that includes Appendices, please call FIRN at 410-992-1923, Ext. 12.

[73] The survey form is included in Appendix A. Survey responses are summarized in Appendix B.

[74] Lisa Lollock, *The Foreign Born Population in the United States: March 2000*, Current Population Reports, P20-534. Washington, D.C.: U.S. Census Bureau, 2001.

[75] *Ibid.*

[76] Reliable national and international statistics on this subject are difficult to find. The World March of Women 2000 website estimates that 5,000 women are victims of honor crimes every year (see <http://www.ffq.qc.ca/marche2000/en/cahier/sexisme.html>, August 30, 2002.)