
Language and Access to Health Care: Easing Barriers in New Hampshire

**New Hampshire Advisory Committee to
the U.S. Commission on Civil Rights**

June 2005

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Letter of Transmittal

New Hampshire Advisory Committee to
the U.S. Commission on Civil Rights

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The New Hampshire Advisory Committee submits this report, *Language and Access to Health Care: Easing Barriers in New Hampshire*, as part of its responsibility to advise the Commission on civil rights issues within the state. The report was adopted by the Advisory Committee by a 10 to 1 vote (non-response). Agency regulations require that if a SAC member fails to respond to a request for a vote, that person's vote is counted as a "no."

The Committee identified access to health care by limited-English-proficient, deaf, and hard-of-hearing persons as an important civil rights issue in New Hampshire and held a community forum in Manchester on December 4, 2003 to gather pertinent information and to hear testimony. Presentations were made to the Committee from 12 persons in three panels, which were designed to offer background information, health care provider perspectives, and client advocate perspectives related to language and communications issues affecting access to health care.

This report is based on the panelists' statements and additional research. Federal law requires that health care providers accommodate limited-English-proficient, deaf and hard-of-hearing persons. This report looks at how some health care providers in New Hampshire have responded to this requirement and offers recommendations for improvements. The Advisory Committee trusts the Commission and the public will find the material in this report informative.

Sincerely,

Andrew T. Stewart
Chairperson
New Hampshire Advisory Committee

New Hampshire Advisory Committee to the U.S. Commission on Civil Rights

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Chapter 1: Introduction

Health care providers in New Hampshire, like their counterparts across the United States, increasingly serve clients who communicate best in a language other than English. In New Hampshire, the challenges these clients face in getting linguistically appropriate services and the challenges health care providers face in delivering such services mirror those elsewhere in the country.

Open communication between the health care provider and the client helps ensure that the client receives appropriate medical attention and treatment. Shared language and an understanding of cultural differences facilitate such communication. However, many people seeking health care in New Hampshire, as well as in the nation as a whole, do not communicate well or at all in English and have cultural backgrounds with which many health care providers are unfamiliar. These people include growing numbers of immigrants of increasingly diverse national origins, as well as deaf and hard-of-hearing persons. When English-speaking health care providers and limited-English-proficient (LEP),¹ deaf, or hard-of-hearing clients meet, professional medical interpretation services are often the best suited to bridge communication gaps rather than untrained family members, bilingual staff persons, and others.

Nevertheless, the use of professional interpretation services in health care settings is far from universal. In a number of studies, the language barrier between health care providers and non-English-speaking² clients is a frequently cited obstacle to health care for these clients.³ Among Latinos, for example, one study found the language barrier as significant as a lack of insurance in predicting Latinos' failure to use health care services.⁴

Failure to provide interpretation and translation to overcome barriers to communication can lead to adverse outcomes. Linguistic barriers are frequently the cause of delays in or denial of service, misdiagnosis, unnecessary tests, more costly or unnecessarily invasive treatment, errors in prescribing and using medication, and lowered client compliance with treatment. In extreme cases, failure to communicate effectively can result in the death of the client.

The following examples highlight some of the dangers associated with failing to provide appropriate interpretation services in health care settings:

¹ The term "limited English proficiency," as used in federal laws and policies, generally refers to individuals whose native language is other than English. The Bilingual Education Act (20 U.S.C. § 7401-7491 (2004) defines "native language" as (1) the language normally used by such individual, or (b) in the case of a child or youth, the language normally used by the parents of the child or youth (20 U.S.C. § 7011 (11) (2004).

² In this report, the term, non-English-speaking, is used to designate LEP, deaf, and/or hard-of-hearing persons indiscriminately.

³ S. Woloshin and others, "Language Barriers in Medicine in the United States," *Journal of the American Medical Association*, vol. 273, no. 9 (1995), pp. 724-728.

⁴ Kathryn Derose and David Baker, "Limited English Proficiency and Latinos' Use of Physician Services," *Medical Care Research and Review*, vol. 57, no. 1 (2000), pp. 76-91.

A migrant worker from southern Mexico was committed to an Oregon state psychiatric hospital where he was diagnosed as a paranoid schizophrenic. When psychiatrists spoke to him in Spanish or English, the man became agitated, waving his arms wildly. The psychiatrists concluded that the man must have been hallucinating. After being detained for two years, it was discovered that the man spoke only Trique, an indigenous language in Mexico. With the help of a Trique interpreter, psychiatrists finally diagnosed him as mentally sane and had him discharged. More than \$100,000 was wasted in unnecessary treatment.⁵

The Hmong language has no word for cancer, or even the concept of the disease. “We’re going to put a fire in you,” is how one inexperienced interpreter tried to explain radiation treatment to the patient, who, as a result, refused treatment.⁶

In many instances, and when they are available, health care providers ask relatives of LEP, deaf, or hard-of-hearing clients—often their children—to serve as interpreters. However, this practice is fraught with problems. Frequently, relatives of non-English-speaking clients—especially children—do not master the clients’ language and, importantly, do not have the linguistic knowledge to translate medical terms critical to the clients’ understanding of their diagnosis and proper treatment. In addition, use of relatives as interpreters undermines confidentiality, and may be a source of embarrassment to clients with sensitive health care issues.⁷ Many argue that the use of family members as interpreters is inappropriate, especially in the area of mental health.⁸

Research has confirmed that use of non-professional interpreters—whether family members or untrained health care staff—is a potentially dangerous practice, with miscommunication between the health care provider and the client a common occurrence. In one study conducted using taped exams of 70 Spanish-speaking children in emergency rooms and clinics, for example, researchers found dozens of problems arising from inaccurate translations, some of which had potentially serious negative consequences.⁹

⁵ Yolanda Vera and Jane Perkins, “No Habla Inglés: Ensuring Linguistically Appropriate Health Care,” *Clearinghouse Review* (May 1995, p. 36).

⁶ Ann Morse, “Language Access: Helping Non-English Speakers Navigate Health and Human Services” (report by the National Conference of State Legislatures Children’s Policy Initiative, January 2003, p. 1).

⁷ Markian Hawryluk, “Lost in the Translation: Ways to Afford Speaking Your Patients’ Languages,” *AMNews*, December 2, 2002.

⁸ Annie Steinberg and Louise Montoya, “Deaf Patients Lead Psychiatrists to New Landscapes,” *Psychiatric Times*, May 1, 2003, p. 78.

⁹ Mike Conway and Ken Carlson, “Language Barriers, Translation Errors a Concern: Hospitals Try to Bridge Gaps with Patients Who Cannot Speak English,” *Modesto Bee*, September 6, 2003, p. A1.

In a study of uninsured persons seeking health care at 23 hospitals in 16 U.S. cities in 2000, less than half of the LEP clients surveyed were able to get the services of an interpreter when needed. This same study found that a significant proportion of these clients reported leaving the hospital without understanding how to take prescribed medications.¹⁰ Another study conducted in Rhode Island between 1999 and 2001 found that half of American Sign Language (ASL) users never had an interpreter at doctors' appointments. Many deaf and hard-of-hearing clients have to bring a relative or friend to interpret, or pay a professional interpreter themselves.¹¹

In response to the problem of linguistic barriers, health care professionals and community advocates in New Hampshire,¹² as in the nation as a whole,¹³ are increasingly aware of the need for health care providers to be prepared for those clients who do not communicate proficiently in English. Many argue that the availability of appropriate interpretation services in health care delivery is essential for LEP, deaf, and hard-of-hearing clients to receive quality care.¹⁴ In one of its publications, the U.S. Commission on Civil Rights reported:

...it is clear that the national health care system is not adequately meeting the interpretation needs of the limited-English-proficient Asian American population. The bilingual family members and other untrained interpreters frequently used by health care providers are a poor substitute for trained health care interpreters... The shortage of interpretive services seriously limits the access of many Asian Americans to health care.¹⁵

This finding is also applicable to LEP people of other national origins,¹⁶ and to the deaf and hard-of-hearing.¹⁷

¹⁰ Dennis Andrulis, Nanette Goodman, and Carol Pryor, "What a Difference an Interpreter Can Make" (Boston, MA: The Access Project, 2002).

¹¹ Victoria A. Wilcox, "At a Loss for Words," *Providence Journal-Bulletin*, September 29, 2002, p. M-01.

¹² New Hampshire Child Advocacy Network, "2003 Children's Agenda: End of Legislative Session Report" (Concord, NH: New Hampshire Child Advocacy Network); Terry Linehan, "Comprehensive Statewide needs Assessment for Deaf and Hard of Hearing Citizens of New Hampshire: Final Report, June 2003 (Concord, NH: Northeast Deaf and Hard of Hearing Services).

¹³ M. Lillie-Blanton and J. Hudman, "Untangling the Web: Race/Ethnicity, Immigration, and the Nation's Health," *American Journal of Public Health* (2001, vol. 91, pp. 1736-8); Andrulis, Goodman, and Pryor, "What a Difference an Interpreter Can Make"; Mara Youdelman and Jane Perkins, "Providing Language Interpretation Services in Health Care Settings: Examples from the Field" (report by the National Health Law Program, 2002); Brian Smedley, Adrienne Smith, and Alan Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: The National Academies Press, 2003).

¹⁴ Andrulis, Goodman, and Pryor, "What a Difference an Interpreter Can Make."

¹⁵ U.S. Commission on Civil Rights, *Civil Rights Issues Facing Asian Americans in the 1990s* (Washington, DC: U.S. Commission on Civil Rights, 1992, p. 163).

¹⁶ Lillie-Blanton and Hudman, "Untangling the Web," pp. 1736-8; "State-Specific Trends in U.S. Live Births to Women Born Outside the 50 States and the District of Columbia—United States, 1990 and 2000," *Morbidity and Mortality Weekly Report* (December 6, 2002, p. 1091).

¹⁷ Wilcox, “At a Loss for Words,” p. M1.

Chapter 2: New Hampshire Demographics

In the United States the majority of LEP persons live in the traditionally high immigrant magnet states of California, Texas, New York, Florida, Illinois, and New Jersey. However, figures from the U.S. Census reveal a growing dispersion of non-English speakers to other states.¹⁸ Even in predominantly rural states, the U.S. population is becoming more linguistically diverse.¹⁹ New Hampshire is no exception to the national trend. Although the absolute numbers remain small, between 1990 and 2000 immigrants to New Hampshire from Asia nearly doubled, those from Latin America increased by 136 percent, and those from Africa tripled.²⁰

In large urban areas in the United States, health care providers have become relatively accustomed and adept at dealing with and treating diverse non-English-speaking clients. Hospitals in urban areas with many immigrants, for instance, often have interpreters on staff.²¹ However, as more immigrants, speaking increasingly diverse languages, move to less urbanized states and areas such as New Hampshire, health care providers often find themselves ill-equipped to understand and to make themselves understood by non-English-speaking newcomers in need of health care.²²

According to the 2000 Census, 96,088 New Hampshire residents over the age of four lived in homes in which a language other than English was spoken.^{23,24} This number represents 8.3 percent of all New Hampshire residents in this age category. In contrast, for the U.S. as a whole, 17.9 percent of all residents over the age of four lived in homes where a non-English language was spoken.²⁵

As Table 1 indicates, the most commonly spoken non-English language in New Hampshire is French—primarily a result of earlier French Canadian immigration.²⁶ The French-speaking population in New Hampshire is predominantly elderly. Between the

¹⁸ Ninez Ponce and Luella Penserga, “Language Access in Health Care: Why the Policy and Practice Inertia?” *Harvard Health Policy Review*, vol. 3, no. 2 (2002).

¹⁹ Youdelman and Perkins, “Providing Language Interpretation Services in Health Care Settings”; ACORN, “Speaking the Language of Care: Language Barriers to Hospital Access in America’s Cities” (Washington, DC: Association of Community Organizations for Reform Now, 2004).

²⁰ Dale Vincent, “As the State Grows, We Become More Ethnically Diverse,” *New Hampshire Sunday News*, July 28, 2002.

²¹ Barry Newman, “For Ill Immigrants, Doctors’ Orders Get Lost in Translation,” *The Wall Street Journal*, Jan. 9, 2003, p. A1,8.

²² ACORN, “Speaking the Language of Care.”

²³ Of this number 28,073 persons do not speak English very well, and 13,830 live in households where no one member over 14 years old can communicate in English (U.S. Census Bureau, Census 2000, Summary File 3, Tables P19, PCT 13, and PCT 14). These persons are at greatest risk of not having their health care needs adequately met because of linguistic barriers.

²⁴ According to the 1990 Census, in contrast, 88,796 people older than four years of age lived in New Hampshire homes in which a non-English language was spoken (see <http://www.census.gov/population/socdem/language/table1.txt>).

²⁵ “Table 5. Detailed List of Languages Spoken at Home for the Population 5 Years and Over by State: 2000,” U.S. Census Bureau.

²⁶ See <http://www2.marianopolis.edu/quebechistory/readings/leaving.htm>.

1990 and 2000 Censuses, the number of French speakers in the state declined from 51,284 to 39,551, or 22.9 percent, while the total number of speakers of non-English languages rose by 8.2 percent. The data suggests that the non-English-speaking population of New Hampshire is becoming increasingly diverse (see Table 1 for a breakdown of the number of speakers for each non-English language spoken by at least 1000 New Hampshire residents in 2000). The number of Spanish speakers, for example, nearly doubled from 9,619 in 1990 to 18,647 in 2000.²⁷

*Table 1. Detailed List of Languages Spoken at Home for the Population 5 Years and Over in New Hampshire: 2000*²⁸

Language	Totals
French	39,551
Spanish	18,647
German	4,788
Greek	3,411
Chinese	3,268
Italian	2,649
Portuguese	2,394
Polish	2,094
Arabic	1,462
Vietnamese	1,449
Korean	1,228
Serbo-Croatian	1,182
Russian	1,009
Other	12,956

The distribution of immigrants and refugees throughout New Hampshire is uneven. At the state level in 2000, 4.4 percent of the population was foreign born. In Manchester (pop: 107,006) and Nashua (pop: 86,605), the state’s two largest cities, the foreign-born population represented 9.4 and 10.1 percent of each respective city’s total population in 2000. During the intercensus period, the growth in the foreign-born population accounted for 43.9 and 46.1 percent of the total population growth of Manchester and Nashua, respectively, while accounting for only 10.2 percent of total population growth statewide.²⁹

The U.S. Census does not report demographic data relevant to persons who are deaf or hard-of-hearing and communicate through ASL. However, some sources estimate the number of deaf and hard-of-hearing persons to be 8.3 percent of the U.S. population, and at 109,655 in the state of New Hampshire.³⁰

²⁷ See <http://www.census.gov/population/socdemo/language/table1.txt> for 1990 Census statistics on language.

²⁸ Adapted from “Table 5. Detailed List of Languages Spoken at Home for the Population 5 Years and Over by State: 2000,” U.S. Census Bureau.

²⁹ See www.fairus.org/html/042nhins.htm.

³⁰ Linehan, “Comprehensive Statewide Needs Assessment for Deaf and Hard of Hearing Citizens of New Hampshire.”

Although the Minnesota-based UnitedHealth Group ranked New Hampshire first among the fifty states in terms of the overall health of its state population in 2000, it identified language barriers between health care providers and immigrant clients as a problem, particularly in that state's large urban centers.³¹ The growing and increasingly diverse LEP communities and the presence of thousands of deaf and hard-of-hearing persons in New Hampshire highlight the need for health care professionals in the state to have in place policies and practices to effectively bridge language-based communication gaps as they arise.

³¹ Mark Haywood, "Granite State Gets a (Mostly) Clean Bill of Health for the Year," *The Union Leader*, November 15, 2000, p. A1.

Chapter 3: Federal and State Civil Rights Regulations and Policy

Title VI of the Civil Rights Act of 1964 states that “No person shall on the ground of race, color, or national origin, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”³² Recipients of federal funds, including Medicaid, may not, based on national origin, deny services, financial aid or other benefits; provide a different service, financial aid or other benefit, or provide them in a different manner from those provided to others under the program; or segregate or separately treat individuals in any matter related to the receipt of any service, financial aid or other benefit.³³ Failure to provide linguistically appropriate services to remove barriers to health care may constitute discrimination by national origin.³⁴

In August 2000, President Clinton signed an Executive Order directing federal agencies to provide guidance on how to improve accessibility to federally-conducted or federally-funded programs for LEP persons.³⁵ To implement this Order, the U.S. Department of Justice (DOJ) issued a policy guidance document clarifying existing Title VI responsibilities and stating that all recipients of federal funds “must take reasonable steps to provide meaningful access.”³⁶

Based on DOJ’s initial policy guidance document in 2000 and subsequent modifications in 2002,³⁷ the U.S. Department of Health and Human Services’ (HHS) Office for Civil Rights issued its own guidance specifically for HHS-funded activities, that affects a wide variety of health care providers, including hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health research programs, state, county, and local health agencies, state Medicaid agencies, public and private contractors, subcontractors and vendors, and physicians.³⁸

Recipients of federal funds must provide language services free of charge. These services may be provided by oral interpretation in person or via telephone and/or by written translation. Appropriate interpretation options include hiring bilingual staff or professional staff interpreters; contracting for interpreters; using telephone interpreter services; using community volunteers; and using family members or friends, if so desired

³² 42 U.S.C. § 2000d (2004).

³³ U.S. Department of Health and Human Services, “OCR Fact Sheet: Your Rights under Title VI of the Civil Rights Act of 1964 (Washington, DC, June 2000).

³⁴ Exec. Order No. 13,166, 65 Fed. Reg. 50,121 (2000) (to be codified in 3 C.F.R.) (hereafter cited as Executive Order 13,166).

³⁵ Executive Order 13,166.

³⁶ U.S. Department of Justice, “Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination against Persons with Limited English Proficiency; Policy Guidance,” 65 Fed. Reg. 50,123 (2000).

³⁷ U.S. Department of Justice, “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons,” 67 Fed. Reg. 41,455 (2002).

³⁸ U.S. Department of Health and Human Services, “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons,” 68 Fed. Reg. 47,311 (2003).

by the LEP patient. However, HHS guidance raises the issues of competency, confidentiality, and privacy if the patient chooses to use friends or family members to interpret.³⁹

HHS guidance outlines four steps for the health care provider receiving federal funds to consider when assessing what services are appropriate for LEP clients. The first is to identify the number or proportion of LEP clients eligible for services or who are likely to be affected by the program. The second is to identify the frequency with which LEP clients come into contact with the health care provider. The third is to ascertain the nature and importance of the program or service. The fourth is to identify the resources at the health care provider's disposal and the costs of accommodating LEP clients. Accommodation to LEP clients naturally differs from community to community, depending to a large extent on the size and diversity of LEP populations. Health care providers in linguistically, culturally, and ethnically diverse Boston, for example, face different sets of expectations than health care providers in predominantly rural New Hampshire.⁴⁰

Section 504 of the Rehabilitation Act of 1973 (Section 504)⁴¹ and the Americans with Disabilities Act of 1990 (ADA)⁴² prohibit certain entities from discriminating against persons with disabilities in the provision of benefits or services or the conduct of programs or activities on the basis of their disability. Section 504 applies to programs or activities that receive federal funds. Title II of the ADA applies to all services, programs and activities conducted by public entities, such as state and local governments, departments, and agencies. The protections of Title II apply regardless of the receipt of federal financial assistance.⁴³

Entities covered by the provisions of Section 504 and the ADA must provide services and programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities; make reasonable modifications in their policies, practices and procedures to avoid discrimination on the basis of disability; and provide auxiliary aids to individuals with disabilities, at no additional cost, where necessary to ensure effective communication with individuals with hearing, vision, or speech impairments. Auxiliary aids include such services or devices as qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunication devices for the deaf (TDDs), videotext displays, readers, taped texts, brailled materials, and large print materials.⁴⁴

³⁹ Ann Morse, "Language Access: Helping Non-English Speakers Navigate Health and Human Services" (report by the National Conference of State Legislatures Children's Policy Initiative, January 2003, p. 7).

⁴⁰ Donna Gartelman, Equal Opportunity Specialist at HHS's Office for Civil Rights in Boston, testimony for the New Hampshire Advisory Committee to the U.S. Commission on Civil Rights, community forum, Manchester, New Hampshire, December 4, 2004, transcript, pp. 8-9 (hereafter cited as Forum Transcript).

⁴¹ 29 U.S.C. § 794 (2004).

⁴² 42 U.S.C. §§ 12101-12213 (2004).

⁴³ 42 U.S.C. § 12132 (2004).

⁴⁴ *Ibid.*

Federal guidelines stipulate that information provided orally for hearing patients must also be available through an ASL interpreter or other forms of effective communication for deaf or hard-of-hearing clients as long as it does not cause a fundamental alteration in the program or does not result in undue financial or administrative burdens.⁴⁵

In addition to federal legislation against discrimination, New Hampshire has its own state regulations prohibiting discrimination. The New Hampshire Commission for Human Rights enforces New Hampshire's statute against discrimination, RSA 354-A, in the areas of employment, housing, and public accommodations, which include health care providers. Both national origin and disability status are protected bases under New Hampshire's law against discrimination. As such, LEP, deaf, and hard-of-hearing persons seeking health care are protected by state law against discrimination in places of public accommodation.⁴⁶

The State of New Hampshire receives federal matching funds for providing language services to LEP applicants and recipients of Medicaid and the State Children's Health Insurance Program.⁴⁷

⁴⁵ See <http://www.hhs.gov/oct/requirec.htm>.

⁴⁶ Katharine Daly, Executive Director, New Hampshire Commission on Civil Rights, Forum Transcript, pp. 31-41.

⁴⁷ NGA Center for Best Practices, "Helping Non-English Speakers Navigate Health and Human Services," at < www.nga.org/center/frontAndCenter/1,1188,C_FRONT_CENTER%5ED_5323,00.html>, April 10, 2003.

Chapter 4: Health Care Provider Practices and Perspectives

Although health care providers in U.S. cities with large non-English-speaking populations view the issue of accommodating linguistic minorities within the health care system as important,⁴⁸ federal guidance encouraging the use of professional interpreters has led some to express concern about the costs, feasibility, and desirability of such a practice. In one study of service delivery to Spanish speakers, more than half of surveyed health care professionals identified cost as the most significant factor mitigating against providing linguistically appropriate accommodation.⁴⁹ Although private interpretation services are available to health care providers in many communities, many insurers will not pay interpretation fees, leaving individual practitioners and institutions in the health care industry to pay for these services.

The American Medical Association has protested that the cost of professional interpretation would place a heavy burden on doctors. Moreover, some argue that many clients would rather rely on a close family member than an unknown professional to interpret for them. However, incomplete grasp of the languages involved, including specialized medical terminology, render reliance on family members as interpreters a potentially dangerous practice.⁵⁰

In addition, recipients of federal funds, such as local Medicaid agencies, hospitals, and managed care organizations have expressed concern about being responsible for providing interpreters, but not receiving reimbursement.⁵¹ However, the U.S. Office of Management and Budget estimates that providing language services would result in only a 0.5 percent increase in the cost of the average health care visit.⁵²

The rate for staff interpreters and language banks ranges from \$25 to \$60 per hour.⁵³ To help keep costs down, hospitals frequently rely on telephone translation services. In Chicago, for example, health care providers have access to dial-up interpreter services, which offer interpretation within five to seven minutes for approximately 150 languages.⁵⁴ These services help meet the needs of small and fluctuating immigrant populations. For larger and more established immigrant populations, bigger health care organizations frequently hire permanent staff to serve as interpreters. For deaf and hard-of-hearing clients, health care providers often use two-way televisions accessible within 10 minutes for ASL interpretation.⁵⁵ However, in 2002 technological solutions such as

⁴⁸ Wirthlin Worldwide, "Hablamos Juntos: We Speak Together" (Report by Wirthlin Worldwide, December 2001), p.3.

⁴⁹ Ibid., p. 10.

⁵⁰ Newman, "For Ill Immigrants, Doctors' Orders Get Lost in Translation," p. A1.

⁵¹ Youdelman and Perkins, "Providing Language Interpretation Services in Health Care Settings."

⁵² Office of Management and Budget, *Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency*, March 14, 2002.

⁵³ Morse, "Language Access," p. 9.

⁵⁴ Tona Kunz, "Open to Interpretation: Local Health Providers Seeking to Meet Community's Diversity Needs," *Chicago Daily Herald*, August 1, 2004, p. 1.

⁵⁵ Kunz, "Open to Interpretation," p. 1.

telephone and videoconference services were at a cost of \$2 to \$3 a minute.⁵⁶ Reimbursement from Medicaid is frequently insufficient to cover the costs of such interpretation services.⁵⁷

Moreover, in office visits and in psychotherapy phone translation services can be clumsy, as well as costly. Many doctors refuse to make appointments with non-English-speaking clients if they do not bring their own interpretation help.⁵⁸ Other physicians have turned to volunteers and community-based programs to meet the needs of their patients who do not communicate well in English.⁵⁹

In New Hampshire, as in the nation as a whole, health care providers are often resistant to hiring professional medical interpreters because of the expense.⁶⁰ However, New Hampshire's Medicaid program contains provisions for reimbursement for medical interpretation, which eases costs for services rendered to Medicaid recipients only. Recently, the amount of reimbursement for health care providers using medical interpreters has increased. Nevertheless, the interpretation needs of non-English-speaking clients in the Medicaid-related health care system are still not fully being met in New Hampshire.⁶¹ This is also the case in the non-Medicaid-related health care system in the state.

Health care providers in New Hampshire have developed approaches to service delivery for LEP, deaf, and hard-of-hearing clients on an institution by institution basis. The examples below illustrate the evolutionary character of the development of linguistically appropriate access to health care in the state. The examples also illustrate the commonly held view among New Hampshire health care providers of the importance of meeting the needs of non-English-speaking clients.⁶²

New Hampshire Department of Health and Human Services

The New Hampshire Department of Health and Human Services (NHDHHS) is responsible for many of the regulatory, programmatic, and financial aspects of New Hampshire's health care system. As such, the agency plays a key role in the planning, delivery, and financing of health care in the state. It provides social and support services to families with chronically ill or disabled members and a range of economic support programs to improve access to medical care by New Hampshire residents. The agency provides its services through 12 District Offices across the state.⁶³ As a leader in health

⁵⁶ Hawryluk, "Lost in the Translation."

⁵⁷ Ibid.

⁵⁸ Newman, "For Ill Immigrants, Doctors' Orders Get Lost in Translation."

⁵⁹ Hawryluk, "Lost in the Translation."

⁶⁰ Susan Wolf-Downes, Executive Director, Northeast Deaf and Hard of Hearing Services, Inc., Forum Transcript, p. 45.

⁶¹ Bill Walker, Director, Minority Health Office, New Hampshire Department of Health and Human Services, Forum Transcript, p. 42.

⁶² Panelists' presentations were summarized from a transcript of the New Hampshire Advisory Committee's December 4, 2003, community forum in Manchester, New Hampshire. The transcript is on file with the Eastern Regional Office of the U.S. Commission on Civil Rights.

⁶³ See http://www.dhhs.state.nh.us/DHHS/DHHS_SITE/ABOUT+DHHS/default.htm.

care delivery in the state, the provisions NHDHHS makes to accommodate non-English-speaking clients helps set the tone and standards for health care providers across the state.

In November 2000, NHDHHS began collecting data on clients whose primary language is other than English, including those clients who are deaf or hard-of-hearing. For that month, NHDHHS tracked seven languages among 145 clients using agency resources. In May 2001, the agency served 162 clients speaking 12 languages, and several months later in July of the same year, 214 clients speaking 16 languages. During the month of May 2002, the NHDHHS served 556 clients speaking 25 languages. In January 2003, 835 people speaking 37 different languages sought service at one of the agency's District Offices. In response to the increasing demand, NHDHHS has taken steps to make its services more accessible to LEP, deaf, and hard-of-hearing clients, translating documents, putting contracts in place for interpreters in the District Offices, and improving its telephone access services.⁶⁴

New Hampshire Hospital Association

The New Hampshire Hospital Association (NHHA) works to preserve regulatory and business climates that support both the clinical and economic performance of health care organizations, expand access to coverage and care, enhance the future viability of essential community providers, and improve public confidence in hospitals and health care statewide.⁶⁵

NHHA members have varying levels of sophistication in terms of providing linguistically attuned services to LEP, deaf, and hard-of-hearing clients. Across the board, however, members of the association express meeting the needs of the client as their primary concern. Health care providers are concerned that clients understand diagnosis and treatment and are able to carry out instructions once at home.⁶⁶

NHHA members also place emphasis on client choice. Health care provider staff at institutions affiliated with the association generally seek to accommodate the desires of non-English-speaking clients in determining how to best bridge communication gaps. Some clients, for example, do not want interpreters present in person because of confidentiality or cultural concerns, even though it is frequently difficult to convey such personal issues as one's medical condition over a telephone device—a method sometimes used to uphold the confidentiality of the patient.⁶⁷

There is great geographic diversity in New Hampshire, which affects the readiness of health care providers in different parts of the state to meet the needs of non-English-speaking clients. What may be appropriate in Manchester or Nashua given the demographic diversity in those cities may not be feasible in more rural Woodsville or

⁶⁴ Walker, pp. 19-21.

⁶⁵ See <http://www.nhha.org/nhha/about>.

⁶⁶ Leslie Melby, Vice President for Government Relations, New Hampshire Hospital Association, Forum Transcript, pp. 81-82.

⁶⁷ Ibid. pp. 82-83.

Lancaster.⁶⁸ In the northern part of the state, for example, most LEP residents have traditionally been French speakers—older residents of French Canadian origin. However, in recent years the LEP population speaking other languages has grown. At the Androscoggin Valley Hospital in Berlin, for example, administrators have recently been challenged with providing medical interpretation and translation in Spanish to better communicate with LEP Latinos moving to the area from Massachusetts.⁶⁹

Different hospitals have adopted varying practices to respond to situations unique to their institution. For example, one hospital with a large Spanish- and Portuguese-speaking clientele with questions about billing and financial assistance designated two interpreters to deal with these questions. The hospital has done this for three years. Word has spread in the community about this hospital's practice, which, in turn, has served to attract even greater numbers of Spanish- and Portuguese-speaking clients to the hospital.⁷⁰

NHHA members have access to an Emergency Referral System, which is available 24 hours a day and seven days a week, to access interpreters. Many members also have the AT&T Language Line, which offers interpretation in 150 languages, and Deaf Talk TV, which offers ASL interpretation. Many health care providers in New Hampshire rely on these services when in-person interpreters are not available or feasible. Some NHHA members also have bilingual staff identified to serve as medical interpreters when needed.^{71,72}

Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire

Dartmouth Hitchcock Medical Center in Lebanon (DHMC) offers an example of how a New Hampshire-based hospital is working to meet the challenges to providing appropriate services to LEP, deaf, and hard-of-hearing clients. DHMC is an ambulatory clinic, as well as an inpatient medical center, providing primary and tertiary care. Lebanon is a relatively small community in rural New Hampshire north and west of the state's large urban centers of Manchester, Nashua and Portsmouth. As such, the challenges faced by DHMC may be indicative of challenges faced by other health care providers in rural areas of the state.

DHMC has provided interpretation for LEP, deaf, and hard-of-hearing clients for years. Although the hospital has had some success in providing interpretation services to deaf and hard-of-hearing clients, challenges remain in this area. In addition, one of the primary challenges DHMC faces is finding foreign language interpreters. Historically, the hospital has used on-call staff to serve as interpreters in emergency situations, and for outpatient and inpatient visits. In relatively rural Lebanon, foreign language interpreters

⁶⁸ Ibid., p. 87.

⁶⁹ Ibid., pp. 83-84.

⁷⁰ Ibid., pp. 88-89.

⁷¹ Ibid., pp. 89-90.

⁷² It is important that interpreters be trained to fully handle complex medical situations in the two languages. Untrained interpreters are frequently not able to translate the range of medical terms in a typical health care setting, thereby putting the patient at risk (Lina Ruiz-Mingote, New Hampshire Advisory Committee member, email communication, September 3, 2004).

external to DHMC frequently live two hours or more from the hospital. To remedy the difficulty in procuring live interpreters in cases of emergency and for routine appointments, the hospital uses telephone interpretation services as a safety net, and recently acquired a video deaf and foreign language interpretation unit primarily for its emergency room as well.⁷³ The hospital uses Deaf Talk Plus, a video sign and foreign language service, that provides access to ASL interpreters as well as interpreters in 20 foreign languages within five to ten minutes of a client's arrival at the emergency department.⁷⁴

Internally, DHMC has encountered some resistance from its staff members to using the telephone and video interpreter systems. Hospital staff prefer in-person interpreters. However, due to an extreme shortage of foreign language interpreters, particularly for less common immigrant languages, the use of in-person interpreters is not feasible in many instances.⁷⁵

Although the need is growing, there are no resources north of Concord, New Hampshire that coordinate foreign language interpreter services. DHMC has entered into collaboration with the Southern New Hampshire Area Health Education Center to test the English and non-English language competence of those hospital staff members providing medical interpretation services. The hospital also has plans to work with Dartmouth College to train students attending the college and residents of the community who speak a foreign language to interpret at DHMC.⁷⁶

Visiting Nurse Association of Manchester and Southern New Hampshire, Inc.

The Visiting Nurse Association (VNA) does home visits in and around Manchester, New Hampshire. VNA's clients speak many different languages and represent many different cultures. To accommodate some of these clients, VNA has bilingual staff and offers interpretation services.⁷⁷

However, in many instances, VNA's clients prefer to have family members or friends present and to translate for them. VNA staff often have to teach family members or friends how to care for the clients when staff is not present in the home. For example, VNA staff have had to train caregivers how to do wound dressings. In this and other instances, VNA finds that using family or friends as interpreters works best.⁷⁸

The cost of hiring a professional interpreter can be prohibitive. VNA pays from 60 to 100 dollars per home visit for interpretation services, which is more than VNA gets in

⁷³ Michele Blanchard, Senior Care Manager, Mary Hitchcock Memorial Hospital, Forum Transcript, pp. 65-68.

⁷⁴ Michele Blanchard, email communication, January 9, 2004.

⁷⁵ Blanchard, Forum Transcript, pp. 65-68.

⁷⁶ Michele Blanchard, faxed communication, August 26, 2004.

⁷⁷ Dottie Gove, Director of Development and Community Relations, Visiting Nurse Association of Manchester and Southern New Hampshire, Forum Transcript, p. 77.

⁷⁸ Ibid., p. 78.

reimbursement for the whole home visit service. To avoid the expense and to meet client needs, bilingual staff often work extra hours.⁷⁹

Prohibitive costs notwithstanding, Dottie Gove, VNA's Director of Development and Community Relations, highlights the role of cultural broker interpreters can play in the health care setting. Ms. Gove recounted an incident of a crying baby in VNA's Child Care Center and Parenting Education Program. A woman who is originally from Sudan took the crying baby, which was not her own, and nursed it, comforting and calming the child. One staff member objected. However, someone at the Center who understood this aspect of Sudanese culture was able to explain that in many communities in Sudan it is common practice for a nursing woman to pick up another woman's baby and nurse it when needed.⁸⁰

Manchester Health Department, Manchester, New Hampshire

The Manchester Health Department's (MHD) mission is to improve the health of individuals, families, and the community through disease prevention, health promotion, and protection from environmental threats.⁸¹ MHD serves clients from a wide variety of national origin backgrounds, including both immigrants and resettled refugees.⁸²

With resettled refugees, MHD works closely with Lutheran Social Services and the International Institute of New Hampshire, two resettlement agencies active in the state. MHD sees all refugees coming into the Manchester area for tuberculosis testing, to conduct brief health assessments, and to provide a health orientation. The two resettlement agencies provide interpreters for the initial assessments.⁸³

In addition to interpretation services offered by the resettlement agencies, MHD has four interpreters on staff, who speak Spanish, Bosnian, Russian, and Vietnamese. However, MHD currently serves a clientele speaking many different languages. For less commonly spoken languages, the agency does not have interpreters on hand, and frequently uses the services of interpreter banks in the region. However, although MHD does receive some grant funding for interpretation services, it is often not sufficient to meet the need.⁸⁴

Earlier in its history, MHD staff relied on pantomime to communicate with non-English-speaking patients. They later made up flashcards based on frequently asked questions, translated from English to the targeted language. The agency then went on to use electronic translators, and translation via the Internet. However, for clients who have visual impairment or who have limited literacy, these means of bridging the communications gap do not work. MHD has found trained interpreters the best way to

⁷⁹ Ibid., p. 79.

⁸⁰ Ibid., p. 81.

⁸¹ See <http://216.204.100.81/CityGov/HLT/Home.html>.

⁸² Irene Proulx, Public Health Specialist, Manchester Health Department, Forum Transcript, pp. 69-70.

⁸³ Ibid., p. 70.

⁸⁴ Ibid., pp. 71-72.

communicate with non-English-speaking clients and currently uses this method whenever possible.⁸⁵

MHD recognizes and values the role interpreters play as cultural brokers. Irene Proulx, public health specialist at MHD, defined cultural competence as, “The ability of individuals and systems to respond respectfully and effectively to people of all cultures. This consists of tailoring delivery to meet patients’ social, cultural, and linguistic needs.” Interpreters help bridge the gap in cultural understanding between the health care provider and the client, in addition to the linguistic gap.⁸⁶

In addition to oral interpretation, MHD has had written materials translated into targeted immigrant and refugee languages. For example, the agency translated its manual on tuberculosis into nine languages. However, agency staff find it is often the tenth language they need, but cannot find, thus pointing to the ongoing challenges of providing appropriate care to LEP clients whose nature and diversity are in continual flux.⁸⁷

⁸⁵ Ibid., pp. 72-74.

⁸⁶ Ibid., p. 75.

⁸⁷ Ibid., pp. 75-76.

Chapter 5: Client Advocate Perspectives

In New Hampshire, language barriers continue to be a problem in spite of steps taken by health care providers to make their services more accessible to LEP clients. A Spanish-speaking LEP mother of a one-year-old with a congenital birth defect, for example, experienced difficulty getting linguistically appropriate services from a hospital in northern New Hampshire. Each time this client visited the hospital, professional interpretation services were not provided. On one occasion, however, hospital staff brought someone up from the cafeteria to interpret for the client. On another, the client's daughter had to spend the night in the hospital. The client did not know what was wrong with her daughter until three days later, when her pediatrician in Manchester contacted the hospital. She was afraid that there may have been a change in the direction of her daughter's treatment without her being informed of this change.⁸⁸

Although the Americans with Disabilities Act was passed in 1990, deaf and hard-of-hearing people seeking health care still face considerable barriers to communication with health care providers. Sometimes the fault is with health care professionals, while many deaf and hard-of-hearing people shun needed care because they dread trying to communicate.⁸⁹

Members of deaf communities, like some members of other minority groups, share a culture that is distinct from that of the majority.⁹⁰ Differences between hearing and deaf culture, life experiences, and the dimensions of language that capture these experiences can be difficult to bridge in health care settings without linguistically appropriate accommodations.⁹¹

In a statewide needs assessment of deaf and hard-of-hearing residents of New Hampshire, issues related to access were foremost on people's minds. Communication barriers abound for deaf and hard-of-hearing persons in hospitals and health care facilities. One informant in the needs assessment stated summarily, "It is a living hell if you can't communicate."⁹²

The needs assessment report observes that health care facilities should have assistive listening devices and TTYs and that staff should know how to access and use the equipment.⁹³ A majority of deaf assessment participants expressed the need for more

⁸⁸ Gregory Orr, New Hampshire Advisory Committee member, Forum Transcript, pp. 93-94. Mr. Orr had contact with the mother of the child.

⁸⁹ Wilcox, "At a Loss for Words," p. M-01.

⁹⁰ The term "deaf" indicates those persons who identify themselves with the deaf community based on a shared culture and communication mode, i.e. ASL. However, not all individuals with a profound hearing loss identify with the deaf community (see Linehan, "Comprehensive Statewide Needs Assessment for Deaf and Hard of Hearing Citizens of New Hampshire").

⁹¹ Steinberg and Montoya, "Deaf Patients Lead Psychiatrists to New Landscapes," p. 78.

⁹² Linehan, "Comprehensive Statewide Needs Assessment for Deaf and Hard of Hearing Citizens of New Hampshire," p. 19.

⁹³ *Ibid.*, p. 20.

skilled, certified interpreters to overcome all too frequent linguistic barriers when seeking health care and other services.⁹⁴

In New Hampshire, many deaf or hard-of-hearing persons seeking health care bring family members along to serve as interpreters. Susan Wolf-Downes of Northeast Deaf and Hard of Hearing Services, Inc. stresses that this practice should be avoided because the average lay person does not know medical terminology the way a certified or licensed interpreter would. In her own experience, Ms. Wolf-Downes finds that the presence of a professional interpreter makes it much easier for her and her physician to communicate during office visits.⁹⁵

New Hampshire organizations representing LEP, deaf, and hard-of-hearing clients of institutions of health care point to the continued need to improve access to health care for these clients. In New Hampshire, there is still much to be done to raise the consciousness of health care providers about the importance of these issues so that non-English-speaking clients get the care they need. However, these and other advocacy groups have taken proactive steps to ease barriers to health care for New Hampshire residents who do not communicate well in English.

Bienestar Mental Program, National Alliance for the Mentally Ill – New Hampshire

The Bienestar Mental Program of the National Alliance for the Mentally Ill of New Hampshire (NAMI) is aimed at ensuring that members of the various Spanish-speaking communities of Nashua, New Hampshire have access to appropriate mental health care. In the area of mental health, where there is stigma attached to those with mental illness, cultural and linguistic competence are especially important. Failure to bridge the communication gap, which is both linguistic and cultural, could lead to inappropriate diagnosis and treatment. Mental health care, perhaps more than any other field of health care, is language bound. Existing language barriers impede LEP clients from necessary access to mental health care.⁹⁶

Confidentiality is particularly important when interpreters are used in a mental health care setting. For example, a Spanish-speaking man who was suffering from severe depression went to a mental health center in New Hampshire with his daughter. The mental health center had no interpretation services and asked the daughter to interpret for center staff and her father. The practice of using family members, especially a child of the patient, to interpret seriously undermines the ability of non-English-speaking clients to get the care they need. In the presence of their children or other family members, clients may withhold information vital to their diagnosis and treatment.⁹⁷

Moreover, when a professional interpreter is available and used, it is important that the interpreter is appropriately trained to work in mental health settings. Interpreters in

⁹⁴ Ibid., p. 23.

⁹⁵ Wolf-Downes, pp. 30-31.

⁹⁶ Aida Cases, Project Coordinator, Bienestar Mental Program, National Alliance for the Mentally Ill – New Hampshire, Forum Transcript, pp. 124-25.

⁹⁷ Ibid., pp. 128-29.

mental health settings must not answer for the patient, which is common practice among untrained interpreters, but must rather interpret what the patient actually expresses verbally.⁹⁸

One of the major difficulties in making the use of professional medical interpreters more widespread in health care settings in New Hampshire is their cost. Most institutions of health care delivery are not willing to pay the interpreters. Cost prevents them from having full-time interpreters on staff. Instead, institutions contact interpreters on call, and generally at the last minute. However, many institutions also are reluctant to hire on-call interpreters, due again to their high cost.⁹⁹

New Hampshire Minority Health Coalition

The New Hampshire Minority Health Coalition (NHMHC) is a partnership of health care professionals, community-based organizations, state and local agencies, local companies, and private citizens, and has as its mission, “to identify populations in the state with barriers to accessing appropriate healthcare, to advocate for adequate and appropriate services and to empower these populations to be active participants in their own health care.”¹⁰⁰

NHMHC has been working with the Medical Interpretation Advisory Board and the Southern New Hampshire Area Health Education Center, as well as various partners, including the Manchester Mental Health Center, Catholic Medical Center, Dartmouth Hitchcock Medical Center, Lutheran Community Services, New Hampshire Community Technical College, the Manchester Community Resource Center, and others to secure funding and to provide professional medical interpreter training so that health care providers in New Hampshire will be able to put into place systems to accommodate LEP clients.¹⁰¹

In the more than two years of its existence, the collaborative effort has trained 105 individuals in medical interpretation, based in communities such as Manchester, Bedford, Nashua, Merrimack, Hudson, and Concord, and speaking more than 22 languages.¹⁰² NHMHC has also trained community members so that they better understand their civil rights when seeking health care.¹⁰³

Refugee Resettlement Program, Lutheran Social Services of New England

In many countries, where multilingualism is the norm, the provision of interpretation in health care settings is also the norm. However, in New Hampshire providing medical interpretation is not yet normalized. When the medical problem is obvious, such as a dislocated shoulder, language barriers are not so consequential. However, if the medical

⁹⁸ Ibid., pp. 131-32.

⁹⁹ Ibid., p. 168.

¹⁰⁰ See <http://www.nhhealthequity.org/aboutnhmh.html>.

¹⁰¹ Jazmin Miranda-Smith, Executive Director, New Hampshire Minority Health Coalition, Forum Transcript, pp. 137-38.

¹⁰² Jazmin Miranda-Smith, faxed communication, August 19, 2004.

¹⁰³ Miranda-Smith, Forum Transcript, pp. 138-40.

condition is more internalized and the health care provider needs to ask probing questions to ascertain the nature of the condition, language barriers become more problematic, according to Dr. Mourad Lakhdari, Medical Case Manager of the Refugee Resettlement Program of Lutheran Social Services of New England (LSSNE).¹⁰⁴

Language barriers have resulted in negative or potentially negative outcomes. For example, members of an entire family—all of whom did not speak English—had the same set of shots twice over three days during visits to a health care provider, when they were only supposed to receive one set of shots. This was due to miscommunication.¹⁰⁵

In another instance, an LEP client had to go to the emergency room of a New Hampshire hospital for treatment. The hospital provided no interpretation services to this client, who had to rely on a family member whose command of English was also poor. For a year, the client thought she had her kidney removed because she misunderstood the health care provider's diagnosis of her condition. It was only after going through her paperwork that she learned the hospital removed her gallbladder.¹⁰⁶

As a further example, LSSNE's school liaison caseworker received a call from a teacher of a young student who had been missing many days from school. The caseworker learned that the student was staying out of school to interpret for his mother, who was sick and needed the child by her side during her many medical related appointments. If the health care providers had interpretation services in place, the child would not have had to miss school to help his mother.¹⁰⁷

Granite State Independent Living

Granite State Independent Living (GSIL) is a private, non-profit organization committed to equal opportunity for all people with disabilities.¹⁰⁸ GSIL works to remove physical, attitudinal, and social barriers to independence for people with disabilities by ensuring the availability of the broadest range of services, advocacy efforts, and social supports.¹⁰⁹ GSIL offers a deaf services program, through which the deaf and hard-of-hearing and health care providers can secure ASL interpreters.¹¹⁰

In New Hampshire, there is a limited supply of ASL interpreters. Moreover, health care providers in the state frequently do not have ASL interpretation services on site. For these reasons, clients needing the assistance of an ASL interpreter are advised to make a request for such an interpreter and to follow up on the request a week before the appointment with the health care provider to ensure the interpreter's availability.¹¹¹

¹⁰⁴ Mourad Lakhdari, Medical Case Manager, Refugee Resettlement Program, Lutheran Social Services of New England, Forum Transcript, pp. 143-44.

¹⁰⁵ Ibid., p. 145.

¹⁰⁶ Ibid., pp. 147-48.

¹⁰⁷ Ibid., p. 148.

¹⁰⁸ See <http://www.gsil.org>.

¹⁰⁹ See <http://www.gsil.org/Who.htm>.

¹¹⁰ Claudia Nixon-Laquerre, Deaf Services/Communication Access Coordinator, Granite State Independent Living, Forum Transcript, p. 150.

¹¹¹ Ibid., p. 152.

Failure to have the assistance of an ASL interpreter during visits with health care providers can lead to undesirable outcomes for deaf and hard-of-hearing clients. In a New Hampshire doctor's office visit where no ASL interpreter was made available, for example, one deaf client with diabetes and very thin skin was instructed to apply a particular kind of tape to his skin. Not understanding the instructions, the client went out and bought adhesive tape from a local store, applied the tape, and subsequently tore off a large swathe of his skin. Had an ASL interpreter been present, the doctor's message would have been properly communicated and the client could have avoided injuring himself.¹¹²

New Hampshire Deaf and Hard of Hearing Services, Inc.

There has been some progress in tailoring linguistically appropriate services to deaf and hard-of-hearing clients of health care institutions. New Hampshire Deaf and Hard of Hearing Services, Inc. (NHDHHS), for example, has experienced a 500 percent increase in requests for ASL interpreters over the recent one year period.¹¹³

However, there is a lot of turnover among ASL interpreters, and training new interpreters is problematic. There is a need to work with graduates of interpreter training programs in New Hampshire to encourage them to stay and work in the state. One way to facilitate the training of future ASL interpreters is to set up a mentorship program so that veteran interpreters can work with new interpreters to keep them in the field.¹¹⁴

Debbie McKinney, advocate and case manager at NHDHHS, argues that the use of TV Talk in health care settings forces many deaf and hard-of-hearing clients to use that technology instead of a live ASL interpreter.¹¹⁵ In addition, health care staff often do not know how to set up the equipment so that it is even usable. Ms. McKinney argues that if a deaf person wants to have a live ASL interpreter present, such an interpreter should be made available.¹¹⁶

New Hampshire Legal Assistance

New Hampshire Legal Assistance (NHLA) has been working for a number of years on the issue of access to health care by non-English-speaking clients. NHLA has found that although many institutions of health care delivery have plans in place to meet the needs of non-English-speaking clients, it is generally only the upper management of such institutions who understand the plans and how they are to function. In many institutions, front office staff are not familiar enough with the plan or are not being encouraged or

¹¹² Ibid., p. 155-56.

¹¹³ Debbie McKinney, Advocate/Case Manager, Northeast Deaf and Hard of Hearing Services, Inc., Forum Transcript, p. 169.

¹¹⁴ Ibid., pp. 171-72.

¹¹⁵ TV Talk, providing quick, long-distance access to professional ASL interpretation services, relies on television monitors and audio receivers and speakers to enable communication between health care providers and deaf and hard-of-hearing clients.

¹¹⁶ McKinney, Forum Transcript, p. 170.

trained to use it and get LEP, deaf, and hard-of-hearing clients the linguistically appropriate services they need.¹¹⁷

NHLA has found that many non-English-speaking clients of health care may get through the door to receive care, but are often told that their needs cannot be met and that they must come back later with their own interpreter. Moreover, when the client does bring an interpreter no effort is made to find out whether the interpreter has adequate linguistic knowledge to meet the demands of a medical setting.¹¹⁸

¹¹⁷ Lynne Parker, Staff Attorney, New Hampshire Legal Assistance, Forum Transcript, p. 163.

¹¹⁸ *Ibid.*, p. 164.

Chapter 6: Findings and Recommendations

Among health care providers in New Hampshire, there is a growing awareness of the need to make services accessible to those clients who do not communicate well in English. However, in spite of this awareness, the need is only partially being met. Many LEP, deaf, and hard-of-hearing residents of the state continue to suffer from limited access to health care because of the failure of health care providers to make appropriate interpretation services available.

Health care providers, clients, and client advocates tend to agree that in-person professionally trained medical interpreters represent the ideal means of overcoming language-based communication gaps. However, such professionals are expensive. Because of this and because of difficulties securing professionally trained interpreters of certain key languages, New Hampshire health care providers are turning to other ways of easing barriers to communication.

Some New Hampshire health care providers, for instance, have identified bilingual staff to serve as interpreters when needed. Others rely on telephone and video services for their professional interpretation needs. Others still have entered partnerships with educational institutions in the state to provide training to students and community members who speak different non-English languages to increase the supply of interpreters.

Based on information gathered at its community forum and additional research, the New Hampshire Advisory Committee makes the following recommendations concerning access to health care in New Hampshire by LEP, deaf, and hard-of-hearing clients:

- Health care providers should conduct needs assessments to ascertain the extent to which LEP, deaf, and hard-of-hearing clients use their services and the extent to which they are able to appropriately accommodate this client population.
- Health care providers should have plans in place which effectively address the needs of LEP, deaf, and hard-of-hearing clients, and staff at appropriate levels should be aware of the plans and be trained in how to implement them when a non-English-speaking client walks through the door.
- Health care providers should continue to explore and develop cost-effective ways to remove the language barriers that prevent LEP, deaf, and hard-of-hearing clients from gaining access to health care of a quality on par with English-speaking clients.
- Health care providers, client advocacy groups, and educational institutions training medical interpreters should work together to identify (1) areas of service delivery to LEP, deaf, and hard-of-hearing clients that need improvement, (2) methods of providing professional interpretation services that meet the needs of both health care providers and diverse non-English-speaking clients, and (3) how

to best provide training opportunities to ensure the availability of a sufficient corps of medical interpreters in the state and its regions.

Health care providers, client advocates, and legislators in other states have also been grappling with how to remove barriers to access to health care by LEP, deaf, and hard-of-hearing clients. In terms of best practices implemented in other states, the National Governor's Association for Best Practices lauded Massachusetts and Rhode Island for enacting legislation to require interpreters in emergency rooms and hospitals, respectively, and Oregon for creating a health care interpreters council.¹¹⁹

Massachusetts' law, which took effect July 1, 2001, requires interpreters in Massachusetts emergency rooms and calls for hospital designation of a coordinator of interpreter services, posting of notices and signage informing emergency room patients of their right to interpreter services, hospitals to perform an annual language needs assessment in their service areas, assurance by hospitals that interpreters have received appropriate training, and hospitals to refrain from encouraging the use of family members to interpret and using minor children to interpret.¹²⁰

Rhode Island's law requires hospitals in the state to provide a qualified interpreter, if an appropriate bilingual clinician is not available to translate, in connection with all services provided to every non-English speaker who is a patient or seeks appropriate care and treatment and is not accompanied or represented by an appropriate qualified interpreter who has attained at least 16 years of age. In addition, Rhode Island hospitals must conspicuously post notice of the above requirement in English and in at least three of the most common foreign languages used by the hospital.¹²¹

The Oregon Health Interpreter Council was created by state statute¹²² to develop testing, qualification, and certification standards for health care interpreters; to coordinate with other states on educational and testing programs; and to examine operational and funding issues. The state statute also requires that the Oregon Department of Human Services establish, subject to available funding, a program for the certification of health care interpreters for non-English-speaking clients.¹²³

Based on best practices identified in other states, the New Hampshire Advisory Committee makes an additional recommendation:

- New Hampshire health care providers and advocates of LEP, deaf, and hard-of-hearing clients should consider working together and with state legislators to

¹¹⁹ National Governors' Association Center for Best Practices, "Helping Non-English Speakers Navigate Health and Human Services," at < www.nga.org/center/frontAndCenter/1,1188,C_FRONT_CENTER%5ED_5323,00.html>, April 10, 2003.

¹²⁰ MASS. ANN. LAWS, ch. 111, § 25J (2004).

¹²¹ R.I. GEN. LAWS § 23-17-54 (2004).

¹²² OR. REV. STAT. § 409.619 (2003).

¹²³ OR. REV. STAT. § 409.621 (2003).

explore options in the establishment of statewide standards for medical interpreters and on the use of interpretation services in health care settings.

Appendix 1: Resources

Federal and State Agencies

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces certain federal civil rights laws that protect the rights of all persons in the United States to receive health and human services without discrimination based on race, color, national origin, disability, age, and in some cases, sex and religion.

If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex or religion by a health care or human services provider (such as a hospital, nursing home, social service agency, etc.) or by a state or local government health or human services agency, you may file a complaint with OCR. Complaints alleging discrimination based on disability by programs directly operated by HHS may also be filed with OCR. You may file a complaint for yourself or for someone else.

U.S. Department of Health and Human Services
Office for Civil Rights
Government Center
John F. Kennedy Federal Building, Room 2100
Boston, MA 02203
617-565-3809 (voice)
617-565-1343 (TDD)

New Hampshire law protects against discrimination on the basis of national origin and disability in public accommodations, which includes health care providers. If you have questions about your rights under state law, you should contact the New Hampshire Commission for Human Rights.

New Hampshire Commission for Human Rights
2 Chenell Drive
Concord, NH 03301-8501
603-271-2767 (voice)
800-735-2964 (TDD)
humanrights@nhsa.state.nh.us (e-mail)

The New Hampshire Department of Health and Human Services' (NHDHHS) Minority Health Office works to encourage the provision of culturally and linguistically appropriate services to New Hampshire residents by NHDHHS; maintains communication with racial, ethnic, and other medically underserved populations to create partnerships to address health disparities; and collaborates and partners with federal and other state minority health offices and New Hampshire health and community agencies regarding health disparity initiatives.

Minority Health Office

New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857
800-852-3345, ext. 3986 (voice)
800-735-2964 (TDD)

Selected Private Organizations

The following is a list of selected private organizations that may be able to provide help and information on the topics covered in this report.

The Bienestar Mental Program of the National Association for the Mentally Ill – New Hampshire (NAMI NH) provides education, support, medical interpretation, and advocacy to the Latino community of Nashua. NAMI NH collaborates with the Nashua mental health system and school district, as well as the Minority Health Office of the New Hampshire Department of Health and Human Services, to address the disparity of equal access due to cultural and language differences in mental health care.

Bienestar Mental Program
National Association for the Mentally Ill – New Hampshire
15 Green Street
Concord, NH 03301
800-242-6264 (voice)
info@naminh.org (e-mail)

The Disabilities Rights Center is dedicated to eliminating barriers existing in New Hampshire to the full and equal enjoyment of civil and other legal rights by people with disabilities.

Disabilities Rights Center
18 Low Avenue
Concord, NH 03302
800-834-1721 (voice and TDD)

Granite State Independent Living (GSIL) is a private, non-profit organization committed to equality of opportunity for all people with disabilities. GSIL is a statewide information, advocacy, and direct services organization run by and for people with disabilities who want to control their own destinies and make their own life choices.

Granite State Independent Living
21 Chenell Drive
Concord, NH 03301
603-228-9680 (voice)
800-826-3700 (TTY/V)

New Hampshire Minority Health Coalition's mission is to identify populations in the state with barriers to accessing appropriate healthcare, to advocate for adequate and appropriate services, and to empower these populations to be active participants in their own health care.

New Hampshire Minority Health Coalition
25 Lowell Street, 3rd Floor
Manchester, NH 03101
866-460-9933 (voice)

Northeast Deaf and Hard of Hearing Services, Inc. (NDHHS) seeks to empower, educate, and advocate for equal access and opportunity for deaf and hard-of-hearing residents of New Hampshire. NDHHS is committed to the provision of services in a culturally sensitive environment, which promote independence and productivity.

Northeast Deaf and Hard of Hearing Services, Inc.
125 Airport Rd.
Concord, NH 03301
800-492-0407 (voice)
866-634-4764 (TTY)

New Hampshire Legal Assistance handles legal matters involving health care and provides free legal help to low-income persons who cannot afford a private attorney.

New Hampshire Legal Assistance
1361 Elm Street
Manchester, NH 03101
800-562-3174 (voice)
naminh@naminh.org (email)