Health Facilities in Illinois and Patient Access to Quality Language Interpreters

A Report of the Illinois Advisory Committee to the United States Commission on Civil Rights

October 2011

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Letter of Transmittal

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U.S. Commission on Civil Rights

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The Illinois Advisory Committee to the U.S. Commission on Civil Rights submits this report, *Health Facilities in Illinois and Patient Access to Quality Language Interpreters,* as part of its responsibility to examine and report on civil rights issues in Illinois under the jurisdiction of the Commission. The Committee has been monitoring the issue of health disparities in Chicago for several years and this report is the culmination of research, a briefing, numerous working group sessions, and, finally, a fact finding meeting on the issue in August 2010. The report was approved by a vote of 18 to 1.

Communication with one's doctor is critical. In fact, federal law and Illinois state law guarantee an individual the right to receive interpreter services if the individual has limited English proficiency ("LEP"). Unfortunately, health facilities are not guaranteed payment for providing this service. As a result, the Committee heard testimony that LEP patients do not always receive interpreter services in health facilities. In addition, the Committee observed that even when interpreter services are provided; it is not always an accurate interpretation.

Because funding is at the heart of the problem, there are no easy solutions. However, in this report, the Committee found that there are a number of recommendations that can be implemented. For instance, healthcare facilities should work with communities to identify and encourage bilingual speakers to pursue careers in healthcare. The healthcare facilities should also provide incentives to these individuals to receive interpreter training.

Finally, the Committee would like to thank Martin Castro, Chair of the U.S. Commission on Civil Rights and formerly the Chair of the Illinois Advisory Committee, who spearheaded the project and presided over the many meetings on the subject.

Respectfully,

Barbara Abrajano, *Chair*
Illinois State Advisory Committee

Illinois Advisory Committee to the U.S. Commission on Civil Rights

– Members designated with an asterisk served on the Committee during the Health Disparities Fact Finding Meeting

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Carterville IL

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Chicago, IL

Betsy Shuman-Moore*
Chicago, IL

Anthony Sisneros*
Springfield, IL

Farhan Younus*
Downers Grove, IL

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INTRODUCTION

The Illinois Advisory Committee ("Committee") to the U.S. Commission on Civil Rights ("Commission") has been monitoring the issue of health disparities in Chicago for several years. The topic originally came to the Committee's attention after research showed that, between 1990 and 1998, health disparities between Black and White communities actually increased in Chicago for the large majority (20 of the 22) of health indicators studied —despite the improvement in racial health disparities for the rest of the country over the same time period.[1] In response to this civil rights issue, the Committee held a briefing meeting where it heard testimony from numerous health providers, health policy analysts, academics, government agencies, and community activists.

After the initial briefing, the Committee voted to examine and undertake a formal report of health disparities in Chicago, but it faced two decisions. First, the Committee had to narrow down the broad issue of health disparities in order to produce a research project with meaningful results. Second, the Committee had to determine the "civil rights nexus" and strategic focus for its project that would distinguish its report from those produced by public health agencies. To make these decisions, the Committee formed a working group that met with health policy experts, health providers, and researchers as well as representatives from community organizations over the course of approximately six months. As a result of these "brainstorming" sessions, the Committee decided that it would focus its health disparities project around issues impacting Chicago-area food deserts and access to quality interpreter services in Chicago health care facilities. Given the divergent topics, the Committee determined that these topics deserved separate consideration and two distinct reports. The second report, "Food Deserts in Chicago," will be issued separately but in tandem with this report. The Committee held a fact finding meeting in August 2010 in preparation for these two reports. See Appendix B.

The civil rights nexus is clear regarding access to quality language interpreters in Illinois' health facilities. Title VI of the Civil Rights Act of 1964 guarantees individuals the right to receive interpreter services from health facilities that receive federal funds.[2] The topic of Title VI enforcement is also an historical issue that the U.S. Commission on Civil Rights has studied, issuing reports that dealt directly with or involved Title VI in 1970, 1971, 1973, 1974, 1992, and 1996. In addition to federal law, health facilities in Illinois must follow the state's Language Assistance Services Act, which is intended to ensure interpreters or bilingual staff will be made available to patients in health facilities who need those services.[3] Unfortunately, as the Committee heard at working group meetings and at the fact finding meeting, healthcare facilities oftentimes struggle to fulfill this mandate. In Illinois, Medicaid and the State Children's Health Insurance Program ("SCHIP") do not reimburse healthcare facilities for the use of interpreter services. When interpreter services are provided at health facilities, the quality of the interpretation is not always of the quality that patients require. Because of these and other issues, the Committee decided that the issue is an important civil rights issue that contributes to the health disparity problem in Chicago.

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[1] Abigail Silva, Steven Whitman, Helen Margellos, and David Ansell, "Evaluating Chicago's Success in Reaching the Healthy People 2000 Goal of Reducing Health Disparities," *Public Health Reports*, vol. 116 (Sept.-Oct. 2001), p. 484-494.

[2] 42 U.S.C. §§ 2000d – 2000d-7.

[3] 210 ILL. COMP. STAT. 87/1-19 (2010).

HEALTH FACILITIES IN ILLINOIS AND PATIENT ACCESS TO QUALITY LANGUAGE INTERPRETERS

Background

Chicago is a major international city with diverse communities composed of people of numerous national origins. The U.S. Census Bureau reported that approximately 22 percent of Chicago's population is foreign born.[4] In addition, approximately 35 percent speak a language other than English at home, and over 18 percent speak English "less than very well." Given this demographic data, health care providers face growing challenges to ensure that patients with limited English proficiency ("LEP") have access to adequate language assistance services. Without such services, these patients may face life-threatening consequences.

Fortunately, LEP individuals are protected under federal civil rights laws from discrimination because national origin is a protected category. Title VI of the Civil Rights Act of 1964 states, in part:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.[5]

In regard to health care services, Title VI guarantees a patient's right to interpretation services in federally-funded medical care, activities, and programs.[6] The law requires any entity receiving federal funds, including hospitals, health departments, health plans, social service agencies, nonprofits, clinics, and physicians to provide language access services to patients.[7]

In 2000, President Clinton signed Executive Order 13166, which explicitly requires both federally-funded and federally-conducted programs and activities to eliminate language barriers for beneficiaries and participants.[8] President Bush affirmed his support for Executive Order 13166 in 2003, and President Obama affirmed his support in 2010. In addition, the Department Health and Human Services, Office of Minority Health promulgated standards for Culturally and Linguistically Appropriate Services in health care, which states in part: "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."[9]

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[4] U.S. Census Bureau, "Quick Tables," n.d., http://factfinder.census.gov/servlet/QTTable?_bm=y&-qr_name=DEC_2000_SF3_U_DP2&-ds_name=DEC_2000_SF3_U&-_lang=en&-_sse=on&-geo_id=16000US1714000 (last accessed July 25, 2011).

[5] Civil Rights Act of 1964, 42 U.S.C. §2000(d).

[6] See Lau v. Nichols, 414 US 563 (1973), holding that the failure of the San Francisco school system to provide English language instruction to approximately 1,800 students of Chinese ancestry who did not speak English, or to provide them with other adequate instructional procedures, denied them a meaningful opportunity to participate in the public educational program, and thus violated Title VI.

[7] See 68 Fed. Reg. 47311(August 8, 2003).

[8] Exec. Order No. 13166, 65 Fed. Reg. 50121(August 16, 2000).

[9] 65 Fed. Reg. 80865(December 22, 2000); and Office of Minority Health, "National Standards on Culturally and Linguistically Appropriate Services," http://www.omhrc.gov/clas (last accessed July 11, 2011).

The State of Illinois, in addition, has passed over 90 laws that address language access in health care facilities.[10] The most comprehensive of these laws is the Language Assistance Services Act, the intent of which is:

> where language or communication barriers exist between patients and the staff of a health facility, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff.[11]

Despite these legislative efforts, barriers still exist for LEP individuals to receive interpreter services from health facilities. As Mr. Arturo Garcia of the U.S. Department of Health and Human Services, Office of Civil Rights, told the Committee:

> We've been investigating these cases since I've been here and that's in 1980, but before then even up until 1977-78. This is still happening. This is not improved. And it's just not involving Spanish speaking individuals, but it involves persons from all different cultures and all different languages. It's a lack of interpreter services being made available in health and human services from the very basic clinics in your neighborhood to the large State agencies and big hospital systems in Illinois.[12]

These barriers created by the lack of interpreter services at health facilities have serious implications. Effective communication between a patient and provider is crucial to the delivery of safe, high-quality care. A study found that the lack of effective communication with a provider, among other things, limits "access, undermines trust in the quality of the medical care received, and decreases the likelihood that patients will receive appropriate follow-up."[13] Dr. Elizabeth Jacobs, Attending Physician at Stroger Hospital of Cook County, discussed the safety and cost concerns related to hospitals not providing proper interpreter services to patients during her presentation at the Committee's fact finding meeting. She provided the Committee with a case that she experienced at a Chicago-area hospital:

> A patient came in and basically this patient's blood was too thin by Coumadin, so it was very dangerous that she could have a bleed in her head or somewhere else in her nervous system, so basically she had to be given medicine and kept in bed for 24 hours to try to reduce this level of medicine. And basically she was Spanish speaking, monolingual Spanish speaking, and the nurse in the evening -- none of the nurses in the evening knew how to actually speak Spanish and apparently didn't know how to access the services that were available for overcoming these language barriers, which at that hour at 11 p.m. was Language Line. This patient needed to use the restroom and she got up to use the restroom and the nurse tried to tell her she had to stay in bed, but what happened was that she couldn't communicate to her, and the patient got increasingly frustrated because she really needed to use the bathroom. The nurse [mistakenly] believed the patient to be agitated so she called -- not understanding that this was not a medical agitation, this was

[10] Mara K. Youdelman, "The Medical Tongue: U.S. Laws and Policies on Language Access," *Health Affairs*, 27, no. 2 (2008): 424-433, 426.
[11] 210 ILL. COMP. STAT. 87/5 (2010).
[12] Arturo Garcia, testimony before the Illinois Advisory Committee to the U.S. Commission on Civil Rights, hearing, Chicago, IL, August 10, 2010, transcript, p. 192 (hereafter cited as Hearing Transcript).
[13] Divi, Koss, Schmaltz, and Loeb. "Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study," *International Journal for Quality in Health Care*, April 2007. 19(2):60-67.

> an agitation of an unfortunate circumstance because she wasn't communicating with her in a language she could understand - she called the resident and the resident actually had the patient what we call medically restrained. Basically, he gave her Benzodiazapine to sedate her and make her stay in bed. It turns out that that patient ended up staying in the hospital an extra two days because they had to wait for these other medications to wear off to have her safely go home.[14]

Furthermore, Mireya Vera, Director of Community and Interpreter Services at Westlake Hospital, provided the Committee with two more examples of what happens when there is a lack of adequate interpreter services at health facilities:

> I had [a] woman come to me at six months, of which she thought, was pregnancy and said, 'I was in a hospital three months ago, I was bleeding a little bit, but I'm wondering why I'm not growing. I'm pregnant, and my baby is not growing.' As I looked into her records I found that she had a miscarriage, and again it was a bilingual person who presumably told her this: she was fine and she was ready to go home; she was just bleeding. I've also had situations of a patient who came in complaining of a horrible headache. In Spanish, when we say it hurts so much I want to die, it does not mean suicide. And what was interpreted by a bilingual staff person was she wants to commit suicide so the patient was admitted to our psyche ward.[15]

In addition to such anecdotal evidence, researchers from The Joint Commission provided quantitative evidence that serious risks to patients occur when quality interpreter service is not provided. The Joint Commission reviewed 1,083 adverse event reports involving both English-speaking and LEP patients at six hospitals. They found that LEP patients were more likely than English-speaking patients to experience an adverse event that caused some physical harm. Over half of the adverse events involving patients with LEP were related to communication problems.[16] Furthermore, Karin Ruschke, President and Owner of International Language Services, Inc., cited a report in her presentation to the Committee. She informed the Committee that Access Project in 2002 surveyed over 4,000 uninsured patients and found that "27 percent of those who needed but did not get an interpreter said they did not understand the instructions for taking their medication, compared to only two percent of those who either got an interpreter or did not need one."[17]

Finally, presenters at the fact finding meeting discussed how difficulties in communication to primary providers is a barrier to a person receiving basic healthcare. If an individual in unable to find a primary care physician with whom he or she can communicate, then that individual is likely to receive no primary care and receive all healthcare needs via emergency rooms. Candace King, Executive Director of the DuPage Federation on Human Services Reform, told the Committee:

> There are rarely or never interpreters available in the offices of private physicians. And as I've learned more about the healthcare world I've learned that the way you get access to a hospital is you get admitted by a doctor, and if there is no doctor around that has hospital

[14]Elizabeth Jacobs Testimony, Hearing Transcript, pp. 211-213.
[15] Mireya Vera, Hearing Transcript, pp. 293-294.
[16] Divi, et al., "Language Proficiency," p. 61.
[17] The Access Project, "What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency," (April 2002), p. 1.

> privileges that speaks your language you're probably not going to get admitted -- your healthcare needs are not going to get met. And so if the only way you're going to get access to a hospital is to go to the emergency room, you're not getting good care. Even though emergency rooms often deliver good care, you need more than that.[18]

If an LEP individual has to receive healthcare from emergency rooms, not only is that person not receiving the most appropriate healthcare but that person is also increasing healthcare costs on the entire system. For some presenters, these connections are beginning to be made. Linda Coronado, who is now retired but worked in healthcare for many years, told the Committee:

> I think most institutions have come to realize that it is much better to provide the service than not to provide the service.,You're talking about a number of different things. One, the public health aspect of it. Two, the community wellness aspect, as well as community relations. And [third], it does affect the bottom line. It avoids having to provide diagnostic testing that need not be done if you have an appropriate interpreter.[19]

Challenges: Funding and Reimbursement

Given the presence of strong legislation requiring interpreters and the high risks associated with not providing interpreters, it is questionable why health facilities do not more readily provide quality interpreter services to LEP individuals. The answer, to some presenters, is money. Julie Yonek of the Institute of Healthcare Studies at Northwestern University Feinberg School of Medicine told the Committee that the major barriers to providing interpreter services are funding and reimbursement.

Ms. Yonek reported that a national survey of hospitals conducted by the American Medical Association ("AMA"), of which 34 Illinois hospitals participated, found that "over 80 percent of the hospitals indicated that they encounter patients with limited English proficiency frequently, which is daily, weekly or monthly."[20] She reported that when asked what services the hospitals had in place to provide these services, the Illinois hospitals used primary telephonic language services followed by bilingual clinical staff.[21] Ms. Yonek added that some hospitals did have interpreters on staff, but it was not the primary mode of service provided.[22] The AMA survey asked hospitals how they were reimbursed for providing services to ESL patients. In Illinois, Ms. Yonek reported that none of the hospitals received reimbursement for these services, and only three percent of hospitals nationally received reimbursement.[23] She added that those hospitals that receive reimbursement received payments through Medicaid.[24] Ms. Yonek summarized the challenge as presented in the AMA survey:

> So the issue then becomes hospitals and healthcare organizations are legally required to provide these services, they are providing these services, but they're incurring the costs. It really becomes a question of sustainability and how that's going to also impact quality.[25]

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[18] Candace King Testimony, Hearing Transcript, p. 303.
[19] Linda Coronado Testimony, Hearing Transcript, p., 310.
[20] Julie Yonek Testimony, Hearing Transcript, p. 204.
[21] Ibid., p. 205.
[22] Ibid.
[23] Ibid., pp. 205-206.
[24] Ibid., p. 206.
[25] Ibid.

Karin Ruschke also discussed the reimbursement and funding of interpreter services. She told the Committee that the "lack of funding [for interpreter services] is the reason why most hospitals use either family members, they use a lot of their bilingual staff even though this staff has not been tested for their competency in both English and the other language, and the result of that is that the quality of care to patients is being sacrificed and medical errors [are] rising."[26] However, she argued that health facilities and health insurance companies may be increasing their costs by not using interpreters because funding interpreters can be cost-effective. She stated:

> [Interpreters are] cost effective especially since the cost of not being compliant with Title VI could lead to medical errors, reduced quality of care, unnecessary diagnostic testing and all of this leads to increased costs of healthcare. This has all been demonstrated very well in the National Health Law Program's recent publication called The High Cost of Language Barriers in Medical Malpractice.[27]

Ms. Ruschke added that the Boston Medical Center documented the use of trained medical interpreters and found using them positively impacts the emergency department services and reduces charges. The results showed the use of trained medical interpreters can increase the appropriate use of clinics, decrease the inappropriate repeat Emergency Room visits, decrease the cost of care, and decrease disparities between English speaking and non-English speaking [patients] in the intensity of the medical care they received.[28]

In addition to the potential cost savings and improved quality of care, the State of Illinois can also receive matching funds from the federal government if it chooses to cover interpreter services. Specifically, Ms. Ruschke stated that under the reimbursement policies for Medicaid and SCHIP, patients covered under these federal programs can receive interpreter services, and the programs will pay up to 70 percent of the cost for Medicaid patients and up to 79 percent for SCHIP patients.[29]

However, given the steep budget deficit in the state, it may be politically difficult to expand coverage currently. Grace Hou, Assistant Secretary for Programs at the Illinois Department of Human Services, expressed more concern about the possibility of moving backward instead of forward in regard to state funding and reimbursement of interpreters in healthcare. Specifically, Ms. Hou stated that the Department of Human Services had its budget cut by $575 million.[30] She provided the Committee with the following example of decisions that have to be made in light of such cuts:

> There's one particular agency that provides mental health services for an array of individuals with different ethnic backgrounds speaking 17 different languages. And so the non-Medicaid grant that they receive from us was to provide interpretation for the Medicaid population that they had because in their estimation they could not afford to pay for an interpreter on top of the clinical services that were being delivered with the rate that was included. And so they were using non-Medicaid funds that we provided to

[26] Karin Ruschke Testimony, Hearing Transcript, p. 259.
[27] Ibid., p. 260.
[28] Ibid., p. 261.
[29] Ibid., pp. 258-259.
[30] Grace Hou Testimony, Hearing Transcript, p. 225.

> supplement or enhance the service package. So when we took away the non-Medicaid money they're no longer able to effectively provide interpreting services. Well, the conversation that we had with the Feds as well as the State was for them to consider interpretation as part of the rate. And so in most instances when you have a bilingual counselor that's effective, that person is providing counseling in Spanish or Chinese, but if you need different interpreters it's difficult to say that the interpretation is part of the rate. And so we're looking at having discussions with the Federal Government as well as our Medicaid agency, but I think that, in the context of shrinking State revenues and to a large extent Federal revenue as well, we need to pay more attention to work that we've done so that we can be moving forward instead of backwards.[31]

Challenge: Quality of Interpreters

In addition to the challenges of funding and reimbursement, Ms. Yonek also mentioned another challenge regarding interpreter services in healthcare: quality. Many presenters told the Committee that too many healthcare facilities rely upon and expect LEP individuals to provide their own "interpreter," which is normally a bilingual friend or relative. They all agreed that relying on bilingual friends and family is not adequate. Statistics support these opinions. The Surgeon General's Workshop on Improving Health Literacy cited a study that found that family members of LEP patients misinterpret 23 to 52 percent of questions asked by physicians.[32]

Unfortunately, Ms. Yonek told the Committee that even when healthcare facilities have some sort of interpreter service in place, the quality may be lacking. She told the Committee:

> Beyond the resource issue it's not just about having the resources in place but having the quality there as well, and that's particularly important when it comes to language access. Because if you have people that are bilingual but they're not trained to interpret the terminology and also maybe they're not able to provide it in a means that's culturally sensitive, then it's going to have an impact on quality and safety of care.[33]

In the AMA study Ms. Yonek cited, it was found that most health facilities surveyed used telephonic interpreter services most often followed by bilingual staff. Although both of these are viable options, Ms. Yonek told the Committee that they also may not always be appropriate or ideal in a medical setting.[34] Specifically, she discussed the varying quality of telephonic interpreter services that some hospitals use, and she lamented that not all services are "trained according to the same standards."[35]

Dr. Elizabeth Jacobs also expressed concern relative to telephonic interpretation:

> The other issue is how to use [telephonic interpreters]. At Cook County we don't have dual headsets or anything so I will talk to someone on the phone and then I have to hand it to the patient and the patient talks to the interpreter and hands it back. You can imagine how poorly that works. The other thing they're not good for is usually the way you see a

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[31] Ibid., p. 201-202.
[32] Surgeon General's Workshop on Improving Health Literacy, "Panel 2: Meeting the Health Literacy Needs of Special Populations," December 11, 2007, http://www.surgeongeneral.gov/topics/healthliteracy/panel2.htm (last accessed July 25, 2011).
[33] Yonek Testimony, Hearing Transcript, p. 210.
[34] Ibid., p. 226.
[35] Ibid., p. 226.

> patient is you talk to them, you examine them, you talk to them again, and with a telephone you got to call them, then call them back, and it also can be rather expensive depending on the cost of the language, how rare the language is, it can be up to $7 a minute. And it also depends on what volume you use. So there are lots of issues that impact its ease in quality and how both providers and patients feel about it.[36]

The Committee also heard testimony regarding problems with hospitals' reliance on bilingual staff to serve as interpreters and what is termed "false fluency" errors. Mireya Vera told the Committee that providing medical interpretation requires more than just some familiarity with the foreign language. Regarding the use of bilingual staff, she said the following:

> [Using bilingual staff is] not an option unless we can guarantee that they have been tested in their proficiency level. Most bilingual staff self-identifies bilingual, which is okay if we can truly prove and assess their proficiency skills in two languages. If they speak the kitchen Spanish or Polish and they are saying booger instead of phlegm, that's not the kind of message we want to give to our patients. I heard a nurse say, 'You will be having boogers in your throat after surgery.' So we really do want to make sure that the proficiency levels are there for bilingual staff. And you don't require high proficiency in all areas and, therefore, it's important to be able to identify this bilingual person, if, in fact, she is bilingual, and whether we can use her at registration, for example, but not at the nursing station. Okay, so that's a real important consideration.[37]

Linda Coronado concurred with Ms. Vera's assessment, and she told the Committee about an experience she had during her employment at Stroger Cook County Hospital:

> One of the experiences that we had at Stroger, which was very interesting, was that we had managed to secure a grant, and part of the grant was to be able to train bilingual staff to be interpreters so that they could be used throughout the system, at our ambulatory sites and just a number of different sites within the system, a system-wide approach. Unfortunately what ended up happening because they had to be tested in order to participate in the program, 50 percent of the people who came to be tested ended up failing the test. Even more so; 50 percent of that number actually could not complete the course. So there is something to be said about when you do use bilingual staff that they are adequately trained and that their proficiencies are tested. Again, they may be able to pass the proficiency exam, but maybe they shouldn't be doing surgical consents, maybe they should be working in registration, giving information, things like that. So I think there are a number of different issues that should be reviewed.[38]

Presenters told the Committee that there is general misunderstanding regarding the skill base required to be an effective medical interpreter. Too often, health facilities believe anyone who speaks a foreign language can serve as an effective interpreter. Presenters strongly tried to change this perception. Some discussed the skill base necessary to be a fully competent medical interpreter. For example, Candace King explained to the Committee how she came to understand the process:

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[36] Jacobs Testimony, Hearing Transcript, p. 227.
[37] Vera Testimony, Hearing Transcript, pp.295-296.
[38] Coronado Testimony, pp. 314-315.

> Something that helped me understand it will help you understand it is to look at three levels of competency. The first question you have is does the person speak the language that he says he speaks fluently? So if I come to you and say I speak Norwegian, and I really don't speak Norwegian, you need a way to make sure that that's true. Second, are they competent as interpreters? Do they know the positioning, the techniques, the ethics, confidentiality, those kinds of issues that make up the skill of an interpreter? The third level is the terminology and content of the particular field in which they're interpreting: medicine, healthcare, human services, legal, educational, those kinds of things. So those are three related areas [of competency], but they're not identical.[39]

Certification and Training Issues

The discussions about the various levels of competency and overall quality of interpretation in healthcare led to considerations of credentialing medical interpreters. Karin Ruschke informed the Committee that the National Council on Interpreting in Healthcare has been professionalizing the field of healthcare interpreting since 1999, and there is now a medical interpreter National Code of Ethics and National Standards of Practice. In addition, the organization, and Ms. Ruschke personally, is working on creating National Standards for Healthcare Interpreter Training Programs.[40] Ms. Ruschke discussed the training programs with the Committee:

> Over the past decade we have actually seen a significant increase in the number of training programs across the country. However, training programs can range from two hours to over 200 hours. And so there's really no continuity in what is being trained. And the National Council's goal is not actually to create one standard curriculum, what we are creating is standards for healthcare interpreter training programs because we recognize there's obviously no one single course or any one approach that we can use across the country and across all languages. However, whatever approach or whatever methodology that we are going to be using in training programs has to ensure that upon completion of the training program that the trainee has the essential skills and knowledge to be able to act as a qualified healthcare interpreter.[41]

Currently, Richard J. Daley College of the Community Colleges of Chicago, offers three-phase training in medical interpretation that includes 120-hours of clinical experience. These types of programs may soon have an official certification process. Karin Ruschke discussed the certification issue with the Committee:

> The other initiative is the certification initiative that is taking place right now. The second most commonly quoted reason for not providing healthcare interpreters, behind funding, is the lack of a good assessment program or a tool that can help hospitals identify who is a good interpreter and who is not, and the Certification Committee for Healthcare Interpreters ("CCHI") was formed to do just that. We have involved experts in the field, and we have engaged all the relevant stakeholders to develop and administer a national valid credible vendor neutral certification program. This is going to ensure that interpreters meet specific demonstrative skills to ensure effective communication

[39]Kind Testimony, Hearing Transcript, pp.. 326-327.
[40]Ruschke Testimony, Hearing Transcript, p. 262.
[41] Ibid., pp. 266 – 267.

> between the patient and healthcare providers so that patients can really concentrate on their healthcare concerns and not on their communication concerns.
> Now, certification is never going to be a substitute for training and it's going to take time and resources to develop into many languages, unlike, for example, when you take your certification for law or for accountant there is an exam that might vary, but it's one exam. With the healthcare interpreter certification the written exam will be the same with a little bit of differences to account for cultural differences, but the second part, the oral exam, I mean, how many languages do we have represented in the United States? And there will never be a certification exam for every single language out there because it's just too resource intensive. So one of the things that we're recommending is for -- states may have their own certification exam, recently the Illinois -- in addition to RID, which is the sign language national certification exam, Illinois also came out with some additional requirements, you had to be a level three or above in order to work in healthcare. What we're looking at is that since there are such limited resources available for this area that we try to pool our resources when we're creating the certification exam that states don't go out and develop their own because we're all competing for the same funding.[42]

Despite hearing presenters' desire that medical interpreter certification become a reality, all presenters agreed that certification should not become immediately mandatory. Ms. Ruschke explained to the Committee, "If certification becomes mandatory it will actually limit the pool right now of qualified healthcare interpreters, and that will have a direct negative impact on the ability for hospitals to meet their Title VI requirements. The field just isn't at the point right now where we can have a mandatory certification."[43] Candace King told the Committee that this concern is empirical and not just theoretical. She told the Committee:

> Let me just add that the deaf community has been way ahead of us in getting certification and almost licensure in place, and they put a structure in place where folks had to pass a test in order to provide interpretation in healthcare settings. And a large number of the people who previously had been doing interpretation didn't pass the test and so suddenly, boom, there was a major shortage of interpreters. And so it actually ended up having the effect of restricting access to interpretation instead of expanding it. So I think that's what we're hoping that as this gets phased in we don't go through that kind of a stage.[44]

Although it seemed clear that certification was needed, it was also not a quick solution to the problem of ensuring quality medical interpreters. Until then, it may be contingent upon health facilities to offer proper training to their bilingual staff. In addition, medical facilities will have to train staff how to do a better job of working with interpreters. Dr. Jacobs of Stroger Cook County Hospital discussed how medical personnel are trained to work with interpreters and patients who do not speak English as a first language:

> So I would say at most places people don't get very good training as to how to work with interpreters. In addition there's training regarding when do you engage [an interpreter] because sometimes someone can speak to you in English because there are some things they can say in English, but they're really cannot understand you. So there's also recognizing when you need to call an interpreter. Then there's recognizing what is the

[42] Ibid., pp. 267-269.
[43] Ibid., p. 269.
[44] King Testimony, Hearing Transcript, p. 318.

> quality of the interpreter. Is the interpreter actually a good interpreter? Are they summarizing? The common example is where the patient and the interpreter say a lot of things and then they turn to you and say, 'They said no.' Then there's teaching them exactly the skills of how to position the interpreter in the room, how to brief them before and after the interpretation, and those sorts of things. We do that for medical students at Cook County and Rush, we do it for medical students and we do it for residents as well. And so there is training. But in terms of the rest of the staff, there's very little training. In terms of the attendings who are already out there in what we say in medical curriculum go teach the hidden curriculum, so there's what we try to teach them in the classroom and there's the doctors who teach them how to practice which is usually different from what you want them to learn. So there's also getting them actual training. So there's a lot of training that still needs to be done, and it's variable how much is done and who it's done with.[45]

Despite these challenges, Dr. Jacobs offered evidence of the impact a hospital training program can have as it relates to serving LEP patients. As she told the Committee:

> After training the interpreters in the 200-hour curriculum a month later we trained all of the healthcare providers, physicians, nurses, lab techs, all of the staff in our hospital, and it had made a world of difference of how interpreters were used, understanding the techniques, understanding that the conversation was between them and the patient, not with the interpreter, and understanding how the patient feels about that. It has encouraged relationships. It has built trust with our hospital. We went from having 17 percent LEP patient population to now 45 to 50 percent. And our population in our area has not changed, but what has changed is how we provide services to the LEP population. So I think it's important that all hospitals provide this. The resources are there. We have good training programs in the city. And it is a matter of standardizing the requirements and the criteria for training, but training is imperative, a hundred hours a minimum or more.[46]

Potential Options for Addressing Challenges

In light of the federal and state mandate and the corresponding lack of full resources Congress and the Illinois state legislature have allocated to fund these mandates, hospitals have had to adopt strategies for overcoming the costs of interpreter services. Ms. Hou suggested that there are models available. "American sign language [is] a model for spoken interpretation to follow. They have a very stringent certification requirement as well as pay levels. So I always think that's the [model] that we can learn [from] and move towards."[47]

In addition, Ms. Yonek told the Committee, "One of the key strategies very effectively and widely used was partnering with external organizations and other stakeholders to share resources -- identify and share resources and thereby reducing some of the costs."[48] Ms. Yonek provided some examples from hospitals in California:

> So what some of these hospitals would do would be to partner with community-based organizations to acquire these services. So, for example, a few of the hospitals actually

[45]Jacobs Testimony, Hearing Transcript, pp. 229-230.
[46] Ibid., pp. 297-298.
[47]Hou Testimony, Hearing Transcript, pp. 231-232.
[48]Yonek Testimony, Hearing Transcript, pp. 206-207.

> reached out to the local community colleges who offered interpreter training programs to collaborate with them and receive services from the students that were training. And also they used those same organizations to provide training for their own staff, which as you may know it's very expensive to provide training for an organization so this was a very effective way of reducing the cost and receiving the resource that was needed.[49]

Using community partners can present difficulties. Linda Coronado told the Committee that "while [developing community partners] is a good model, one of the things that needs to be questioned is whether or not the community partners and the people who are providing these services are trained to be able to provide these services."[50] As previously discussed, medical interpreters need more skills than just knowledge of a basic foreign language. Using community partners would still require some sort of training for the medical setting. Ms. Coronado also discussed other potential problems with using community partners:

> Additionally, if you pull that person out of their job in the community-based organization to go and do an interpretation in a school for an Individual Education Plan or for surgical consent, what happens to the job that that person should be doing while they should be at their agency? And to add insult to injury some of the institutions don't think they have to pay for this. They think it's okay to call the neighborhood community-based organization, have them come provide the service and not have to pay any kind of a stipend to that individual. So you are taxing a community-based organization in a number of different ways, in addition to the institution absolving themselves of having to provide a service that is quality, that is adequate, and that is professional.[51]

However, these obstacles may not be insurmountable, and successful partnerships have occurred. Ms. Yonek cited examples of hospitals in California reaching out to communities to either train community members to become interpreters or to assist community organizations who work to improve communication services. She used an example of one hospital that needed interpretation services for patients from a local community who spoke a remote Mexican dialect. This hospital "went out into the community and recruited individuals who they trained to provide medical interpretation for this particular segment of their population which was very effective."[52] She also used an example of hospitals working together to address the needs of its ESL communities:

> There is a collaborative of about 13 hospitals within California that decided -- there was a new technology called video medical interpreting technology and there was -- through this ability to form a network they were able to seek and receive funding to implement and install this interpreting technology and also what it's allowed them to do is to share their resources. Again, so this technology enabled them to use their own interpreters and also share their interpreters remotely with other hospitals and that's had a big impact on cost as well.[53]

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[49] Ibid., pp. 207-208.
[50] Coronado Testimony, Hearing Transcript, p. 311.
[51] Ibid., pp. 311-312.
[52] Yonek Testimony, Hearing Transcript, p. 208.
[53] Ibid., p. 209.

One potential source identified during the fact finding for health professionals who could also aid in interpreting services is international nurses. However, Marilyn Chapman, Secretary of the Board for the Chicago Bilingual Nurse Consortium, discussed the difficulties that nurses from other countries have getting licensed to practice in Illinois. She said it is difficult in every state, but Illinois is particularly difficult.[54] She told the Committee that at a time when hospitals are in urgent need of bilingual nurses, there are currently 450 trained bilingual nurses in her database, but they are struggling to get educated and licensed to practice in Illinois.[55]

Ms. Chapman explained that nurses from other countries where English is not spoken are required to take the Test of English as a Foreign Language ("TOEFL"). She said the problem is not taking the TOEFL or having to achieve a relatively high score. Rather, she told the Committee that the problem is that the score is only good for two years.[56] Many nurses who studied nursing in other countries may not have received the full realm of training that nurses trained in the United States receive. Ms. Chapman cited as examples psychiatry, which was not recognized as a medical field in Central Europe, and obstetrics because in some countries it was only for midwives.[57] Thus, these nurses have to take additional classes while also submitting their original credentials, translated in English. The process often takes more than two years, which forces these nurses to retake the TOEFL. As Ms. Chapman told the Committee, "Some of our candidates have taken the TOEFL two and three times because it's taken so long to get their paperwork."[58]

Another potential source is reaching out to children in communities with a significant number of LEP individuals in order to steer them towards medical interpreting careers. Layla Suleiman-Gonzalez of the Illinois Latino Family Commission recommended, "there is an opportunity for strengthening a pipeline and a grow-your-own model. We have a lot of kids who actually are bilingual, but we haven't been able to figure out how to connect them to a labor market in the health and human services field and actually take advantage of that field. So I think we need to do better in the pipeline."[59]

Finally, the Committee heard models of training programs within healthcare facilities that effectively developed on-staff interpreters. Dr. Jacobs discussed the success Stroger Hospital has had with its training program. In addition, Mireya Vera of Westlake Hospital provided detail in regard to the extensive pedagogical approach of her facility in regard to interpreter education:

> What we refer to when we speak about standards or competencies is how do you create a two-way conversation with three individuals present, a triadic relationship? You want the provider, the healthcare provider to speak directly with the patient or the patient's family, and the interpreter's primary goal is to achieve that. And so positioning, the using the first person, creating that direct eye contact between the speakers, not with them, is critical to that. You cannot feel like somebody is talking to you if they're turning to talk to the interpreter. So even if you're bilingual and you have the medical terminology, if you will, because you're a doctor or nurse in the other country, you cannot be an interpreter without the training. It's like saying, okay, we all speak English that means I can be an

[54] Marilyn Chapman Testimony, Hearing Transcript, p. 250.
[55] Ibid.
[56] Ibid., pp. 251-252.
[57] Ibid., p. 252.
[58] Ibid., pp. 266-267.
[59] Layla Suleiman-Gonzalez Testimony, Hearing Transcript, p. 244.

English teacher in college. So to know the techniques of what it requires to create that two-way conversation is essential in the training.

In addition, we provide up to 12 hours of ethics. What is the role of the interpreter? How does the interpreter react in certain difficult situations that we know in healthcare comes almost every day? That's actually the second part of the training. The first part of the training is really the technique, how do you create that two-way conversation with three people. The second part becomes not only the medical terminology, 50 percent of it is the patient language too, the colloquial terminology. Even though I speak Spanish, I'm not from Argentina, I'm not from Colombia, so I may not be familiar with that colloquial language of that county or even that of southern Mexico. It's imperative to know how to stop and ask what something means and not assume that because nobody else knows what you're saying that you can pretend to know everything -- you can just say something so you don't look like you don't know.[60]

Recommendations Made to the Committee

The Illinois Advisory Committee informed presenters prior to the fact finding meeting that the focus was moving beyond citing problems to offering solutions. Given the various factors and issues related to medical interpreters, the Committee realizes there is not one cure-all for addressing the problem. However, the Committee wants to place as many possible recommendations on the table for health facilities, communities, and the State of Illinois to consider. This section will summarize the recommendations it heard during the fact finding meeting.

Some presenters made recommendations to the U.S. Commission on Civil Rights ("Commission") as well as other federal agencies. For example, Candace King told the Committee that on numerous occasions she has spoken with healthcare facilities that were recipients of federal money, and that these facilities were unaware that they had Title VI responsibilities. She recommended that the Commission and other federal agencies like the Department of Health and Human Services initiate education campaigns to ensure that health facilities that receive federal funding understand that they must abide by Title VI. This recommendation was echoed by other panelists. Ms. Linda Coronado told the Committee that the federal outreach must be extended to the communities, "The other thing that is important is this issue of outreach. It's not only to the providers, but it's to our immigrant and refugee community organizations. It's to our faith-based organizations. It's to any type of community-based organization that exists within the realm of our communities."[61]

Clearly, the most common recommendation dealt with what many considered the most serious problem: funding and reimbursement. Ms. King suggested that the Commission and other federal agencies lean on state governments to take advantage of matching federal dollars available for medical interpreters. As she told the Committee, "My recommendation would be that this Commission exercise any influence it can to ensure that Medicaid, Medicare, and private insurance reimburse for interpreter services."[62] Since the federal government allows states to reimburse health facilities for medical interpreters in their Medicaid programs, this recommendation is also made to the Illinois Department of Healthcare and Family services, which administers Medicaid in the state. In addition, presenters encouraged the Illinois state legislature to provide funding to the Latino Families Commission so that they can fulfill their

[60] Vera Testimony, Hearing Transcript, pp. 322-324.
[61] Coronado Testimony, Hearing Transcript, pp. 315-316.
[62] King Testimony, Hearing Transcript, p. 303.

mandate to serve Latino families and assist in things such as ensuring medical interpreters are available to the large Latino LEP population in the state.[63]

Ms. Suleiman-Gonzalez told the Committee that some healthcare facilities should consider reallocation of their resources and bilingual staff to serve more efficiently their LEP patients:

> I was very surprised as part of my work with the Commission we had begun doing an assessment of the resources that are going to the Language Line. [It was] reported that 80 percent of the Language Line usage is for Spanish. Now, it seems to me that if you look closely at the Department of Health and Human Services, Office of Civil Rights guidelines that when you have such a large usage of language interpretation services being devoted to one language that perhaps some other strategy might be in order because you have 80 percent of the contract for Language Line going to only one language. I think at that point we have to look at other strategies.[64]

Ms. Suleiman also said:

> I think we're not strategic about the use of our bilingual staff. They're not always allocated to the areas where there is the greatest need, and that's just I think lack of understanding the Latino population shifts and moves. Latinos have grown tremendously in the metro and suburban areas. We still think of Latinos only in the Chicago area, but whether we're talking Rock Island, Rockford, Aurora, East St. Louis, Rantoule, there's a great growing population of Latinos, and staff are not always allocated where they need to be.[65]

Other presenters suggested that an incentive should be used as an impetus for bilingual healthcare staff to become trained in medical interpretation. Grace Hou of the Illinois Department of Human Services reported that "in State Government if you spend a significant portion of your time speaking another language other than English in doing your job you can get a 5 percent bump in your pay."[66] She offered this employee compensation as a way to encourage more medical personnel to become interpreters.

Beyond the funding and reimbursement issue, recommendations were made to a vast number of institutions. Some presenters made suggestions for institutions of medical education. Carmen Velasquez, Director of Olivio Medical Center, made a recommendation for medical schools and other medical education institutions to be more concerned with this issue. She recommended that healthcare providers be trained in a language other than English as part of a healthcare curriculum. She told the Committee that if providers truly want to serve communities, they must be able to communicate with members of the community. She said, "We must value language."[67] For her, hospital Boards must have the will to value language.

Linda Coronado recommended that the State of Illinois improve its enforcement of LASA, the law requiring healthcare facilities to provide interpreters. She told the Committee:

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[63] Suleiman-Gonzalez Testimony, Hearing Transcript, p. 280.
[64] Ibid., pp. 239-240.
[65] Ibid., p. 241.
[66] Hou Testimony, Hearing Transcript, p. 197.
[67] Carmen Velasquez Testimony, Hearing Transcript, p. 287.

I think if I had two recommendations one would be that the issue of enforcement is important. Illinois law actually has an enforcement provision. One of the things that it says is that hospitals [found in violation of the LASA) need to provide information [in the form of a plan of correction] to the Illinois Department of Public Health with regard to their Interpreter Services Program.[68] Who is monitoring that? Most of us I think in the field do not know who is monitoring it. And the other thing that they did was they actually had a provision where there was a hotline that you could call. However, if you called the hotline they didn't always have somebody who was bilingual at the hotline, okay. So what purpose was the hotline? So I guess the issue of enforcement is important.[69]

[68] 210 ILL. COMP. STAT. 87/17.
[69] Coronado Testimony, Hearing Transcript, p. 315.

Summary of Committee Findings and Recommendations

After considering the many recommendations and consulting with affected parties and agencies, the Illinois Advisory Committee makes the following findings and recommendations regarding the problem of access to interpreters in health facilities:

- ***Quantify the Value of Communication***

Effective communication is the key to quality healthcare because it ensures that doctors take accurate histories and make informed diagnoses. It also ensures patients properly use prescription drugs and other treatments, give truly informed consent, and only receive necessary tests. Overall, health facilities that provide accurate interpretations prevented medical errors from happening. The Committee learned that errors - caused by the lack of interpreter services or low-quality interpreter services - result in preventable complications for patients and increased financial and legal risks for health facilities. The Committee recommends that federal agencies and other health researchers study the potential financial savings for health facilities that provide quality interpretation. Until the true costs of quality interpretation is known, it is impossible to determine if it is too expensive.

- ***Fund and Reimburse Interpreter Services***

The Committee finds that governments' and private insurers' unwillingness to reimburse health facilities for providing quality interpreter services to be the largest impediment. Currently, very few private insurers reimburse health providers for the cost of interpreter services. In addition, Medicare also does not pay for these services. The federal government provides partial reimbursement for Medicaid and SCHIP, but presenters stated that the state of Illinois does not currently cover interpreter services under these programs.

The Committee finds a social responsibility for insurers and the state to consider reimbursement for interpreter services in order to provide quality healthcare to LEP individuals. Furthermore, the Committee finds it possible that insuring medical interpreters may be a good investment for insurers and the state as a result of lower financial and legal liability, decreased medical errors, fewer unnecessary procedures and tests, and increased efficiency in health facilities. The Committee encourages the Illinois Department of Health and Family Services to analyze other states that reimburse for interpreter services and receive federal dollars under Medicaid and SCHIP to determine the approximate cost the state would incur if it included coverage for interpreters.

- ***Develop More Qualified Language Interpreters for Healthcare***

The Committee concludes that numerous steps should be taken to ensure the quality of interpreters working in the medical field. First, the State of Illinois should pass legislation limiting the use of children and family members to serve as interpreters in health facilities.

Second, as many presenters recommended, the Certification Commission for Healthcare Interpreters should implement a state certification for medical interpreters in Illinois. However, the Committee strongly recommends that certification should be phased in so that it will not create an immediate dearth of interpreters. For instance, current qualified interpreters working in the field should be given a reasonable period of time to complete necessary training, if necessary, and become certified before any job action is considered.

Third, health facilities should encourage bilingual employees to become trained in medical interpretation. The Daley College of the City Colleges of Chicago system is one place that offers training. Health facilities should consider either paying the tuition for employees who desire to be trained and increase their compensation when they become trained or some combination of those incentives.

Fourth, health facilities in collaboration with community organizations and the city should develop a pipeline between local communities and careers as medical interpreters. The Committee heard testimony how California health facilities involved the community via outreach to community colleges. Health facilities in Chicago should make similar outreach to Daley College to involve students taking courses in medical interpretation. Efforts should also be made to reach younger children to inform them about health careers and medical interpretation.

Fifth, health facilities should tap into the massive international nurse database that Marilyn Chapman of the Chicago Bilingual Nurse Consortium discussed. Health facilities, the Department of Public Health, Latino Family Commission, and other state agencies involved in ensuring these laws are implemented should provide assistance to these international nurses so that they can be licensed to practice and also be certified to interpret in the state.

- ***Implement Federal and State Laws in Health Facilities***

Despite the quantity and breadth of federal and state laws requiring interpreter services in Illinois health facilities, many providers are still unaware of how to comply with many of these laws. State and federal agencies must take the lead in reaching out to and educating health facilities on their responsibilities under these laws. In Illinois, the largely unfunded Latino Family Commission should be given the resources necessary to educate health facilities and families on the federal and state laws requiring medical interpreters and to provide the resources necessary for families to file complaints.

- ***Enforce the Language Assistance Services Act***

The Office of the Governor should coordinate an effort by the Department of Public Health, Department of Human Services, and the Department of Health and Family Services to review the extent of compliance with the Language Assistance Services Act. This review, if deemed necessary, should also consider legislative and other actions to promote implementation of the LASA, including consideration of allowing civil claims against facilities found in violation.

APPENDIX

AGENDA

FACTFINDING MEETING OF THE ILLINOIS ADVISORY COMMITTEE

Wednesday, August 11, 2010

National Museum of Mexican Art
1852 West 19th Street
Chicago, IL 60608

Introductions and Background to Health Disparities Project
9:00 a.m. to 9:15 a.m.

Marty Castro, Chair, Illinois Advisory Committee

Food Desert Panels
Panel 1
9:15 a.m. to 10:20 a.m.

Damon Arnold, Director, Illinois Department of Public Health
Alderman Freddrenna Lyle, City of Chicago Sixth Ward
Maaria Mozaffar, esq., Chair, Illinois Fresh Food Fund Task Force
Jim Bloyd, Regional Health Officer, Cook County Department of Public Health
Joseph Harrington, Assistant Commissioner, Chicago Department of Public Health

Panel 2
10:30 a.m. to 11:20 a.m.

Daniel Block, Coordinator, Fredrick Blum Neighborhood Assistance Center, Chicago State University
Angela Odoms-Young, Assistant Professor, Department of Kinesiology and Nutrition, University of Illinois at Chicago
Monica Peek, Assistant Professor of Medicine, Section of General Internal Medicine, The University of Chicago
Tonya Roberson, Project Manager, Improving Diabetes Care and Outcomes on Chicago's South Side, Section of Internal Medicine, University of Chicago

Panel 3
11:30 a.m. to 12:20 p.m.

Erika Allen, Chicago Projects Manager, Growing Power
Malik Nevels, Executive Director, Illinois African American Coalition for Prevention
Kathleen Duffy, Board member, Dill Pickle Food Co-op

Lunch
12:20 a.m. to 1:15 p.m.

Language Barriers Panels
Panel 1
1:15 p.m. to 2:20 p.m.

Elizabeth Jacobs, Associate Professor of Medicine, Cook County Hospital & Rush University Medical Center
Julie Yonek, Research Associate/Project Director, Center for Healthcare Equity Institute for Healthcare Studies, Northwestern University
Grace Hou, Assistant Secretary, Illinois Department of Human Services
Arturo Garcia, Supervisory, HIPAA Team Leader, U.S. Department of Health and Human Services Office of Civil Rights

Panel 2
2:30 p.m. to 3:20 p.m.

Layla P. Suleiman Gonzalez, State of Illinois Latino Family Commission

Marilyn Chapman, Secretary, Chicago Bilingual Nursing Consortium

Karin Ruschke, President and Owner, International Language Services, Inc.
Esther Sciammarella, Director, Chicago Hispanic Health Coalition

Panel 3
3:30 p.m. to 4:20 p.m.

Linda Coronado
Carmen Velasquez, Executive Director, Alivio Medical Center
Mireya Vera, Director of Interpreter and Community Services, Westlake Hospital
Candace King, Executive Director, DuPage Federation on Human Services Reform

Open Session
4:30 p.m. to 5:00 p.m.

Adjournment
5:00 p.m.