

# **INTERPRETER SERVICES FOR PATIENTS IN MEDICAL AND DENTAL SETTINGS**

**The Interpreter Services Work Group report  
to the Minnesota Legislature in fulfillment of  
2007 Minnesota Laws, Chapter 147, Article 12, Section 13**

**February 4, 2008**

The Interpreter Services Work Group would like to express gratitude for the assistance, time, and effort of the individuals and organizations that participated in the ISWG meetings. The stakeholders participating in the Interpreter Services Work Group included: health care providers, physician clinics, hospitals, health plans, interpreters, interpreter agencies, deaf and hard of hearing advocates, consumers, trade and professional associations, employers, local public health, and state agencies. These participants' input and analysis has been critical to identifying and documenting the issues identified in this report.

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## EXECUTIVE SUMMARY

Accurate and effective communication between patients and health care providers is critical to the delivery of quality health care. Clear communication can be especially difficult when patients do not speak English, either because they have hearing loss or limited English proficiency. When language barriers exist, the inability to adequately communicate can lead to misunderstanding, dissatisfaction, the omission of vital information, misdiagnoses, inappropriate treatment, and failure to comply with treatment protocols.

Recognizing the importance of these communication concerns, the 2007 Minnesota Legislature asked the Commissioner of Health to convene a work group of interested parties to discuss the provision of interpreter services to patients in medical and dental care settings. An Interpreter Services Work Group met from August, 2007 through January, 2008 to discuss issues, document findings, and make recommendations on four topics: 1) ensuring access to interpreter services; 2) complying with requirements of federal law and guidance; 3) developing a quality assurance program to ensure the quality of health care interpreting services; and 4) identifying broad-based funding mechanisms for interpreter services.

The key findings and recommendations resulting from the Interpreter Services Work Group are:

### Access to Interpreter Services

- There are no adequate data sources to fully evaluate the need and provision of language access services in Minnesota's medical, dental and social service settings.
- Although impossible to quantify, evidence shows an increasing need for interpreter services in health care settings. The need is increasing in urban and rural settings, in the amount of services needed, and in the diversity of languages needed.
- National and Minnesota-specific surveys show that health care providers are making efforts to meet the language needs of patients. However, providers face a number of barriers in fully addressing interpreter services needs and many patients face an unmet need for available, high quality interpreter services.
- Evidence suggests that optimal communication, the highest satisfaction, the best outcomes, and the fewest errors with potential clinical consequence occur when patients needing interpreter services have access to trained, professional interpreters or bilingual health care providers.

### Federal Law and Guidance

- Health care providers who are the recipients of federal funds have a legal obligation to take reasonable steps to ensure meaningful access to their programs/activities by limited English proficient patients without undue delay and at no charge. This obligation includes providing language services (e.g., interpreters) that eliminate barriers to communications.
- All health care providers have a legal obligation under the Americans with Disability Act to provide effective communication to people who have a hearing loss. Health care providers may use a variety of auxiliary aids and services, but the result must be communication that is as effective as communication with other individuals without hearing loss. In most circumstances, this means a qualified interpreter is necessary.

### **Quality Assurance Programs and Certification**

- The competency and quality of sign language interpreters is assessed and documented through the Registry of Interpreters for the Deaf (RID), which administers a national certification system for sign language interpreters.
- The certification system of the Registry of Interpreters for the Deaf and its local affiliate, the Minnesota Registry of Interpreters for the Deaf (MRID), provides an adequate framework for ensuring the quality, competency, and ethical behavior of sign language interpreters in Minnesota. Although the certification system is not unique to medical and dental settings, it provides a framework and sufficient set of national standards to ensure accurate and effective communication between patients and clinicians delivering health care.
- The Interpreter Services Work Group recommends that any quality assurance requirements for sign language interpreters in medical and dental situations should be consistent with, and built on, the foundation already established and maintained by RID and MRID.
- There is no state or national certification system for ensuring the quality or competency of spoken language interpreters in health care and social services.
- The National Council on Interpreting in Health Care (NCIHC) has developed and published both a *National Code of Ethics for Interpreters in Health Care* and *National Standards of Practice for Interpreters in Health Care*. This work can serve as a foundation for state and national efforts working toward the development of a certification system.
- There are practical issues that must be resolved prior to the creation of a certification system for spoken language interpreters. The most significant barrier is the need to construct testing mechanisms that are valid for different languages, cultures, and medical situations. The RID testing system cost approximately one million dollars to develop and addressed one language pairing (i.e., English/American Sign Language). A spoken language system would need to address tens of language pairings, each at considerable expense.
- The Interpreter Services Work Group recommends the formation of a statewide registry that identifies and documents spoken language health care interpreters that meet minimal requirements for preparation, skills, and commitment.

### **Broad-Based Funding Mechanisms**

- The Work Group created 11 principles that an ideal funding mechanism should satisfy.
- No feasible funding mechanism is likely to satisfy all of the 11 principles for a broad-based funding mechanism.
- The Work Group identified and discussed three general mechanisms for funding interpreter services: 1) the current funding mechanism; 2) a requirement for health plans and insurers to cover the cost of interpreter services provided to their enrollees; and 3) the creation of an Interpreter Services Funding Pool that would provide compensation to health care providers supplying interpreter services to patients.
- There are no data sources to calculate the overall cost to the health care system of fully meeting the need for interpreter services.
- There was significant disagreement about the best funding mechanism to fully meet the interpreter services needs of patients. The Work Group was unable to come to consensus on the merits of each of the three funding mechanisms discussed.

## BACKGROUND

The 2007 Minnesota Legislature asked the Commissioner of Health to convene a work group of interested parties to discuss the provision of interpreter services to patients in medical and dental care settings. The work group was charged with developing findings, recommendations, and a report for the 2008 Minnesota Legislature on:

- Ensuring access to interpreter services;
- Complying with requirements of federal law and guidance;
- Developing a quality assurance program to ensure the quality of health care interpreting services, including requirements for training and establishing a certification process; and
- Identifying broad-based funding mechanisms for interpreter services.

The Minnesota Department of Health convened a group of interested stakeholders, called the Interpreter Services Work Group (ISWG), which met 11 times from August, 2007 through January, 2008. This report is the result of those discussions.

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## IMPORTANCE OF INTERPRETER SERVICES ISSUES

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Accurate and effective communication between patients and clinicians is critical to the quality of the care provided. Clear communication can be difficult with English-speaking patients when there are issues of low literacy or age to consider. When the patient does not speak English, communication becomes that much more difficult. Likewise, patients cannot fully utilize or negotiate other important health care services if they cannot communicate with the nonclinical staff within health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance with treatment protocols.

Language barriers not only impact the quality of care, but also have financial and legal implications when poor communication leads to poor health outcomes or to unequal access to care. Inadequate and poor communication is expensive and damaging to the health care system.

Health care providers recognize that language access and interpreter services are issues that must be addressed to appropriately deliver health care services to all populations. A Robert Wood Johnson Foundation study in 2002<sup>1</sup> found that 70% of physicians surveyed indicated that language barriers represented a top priority for the health care field.

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## INCREASING NEED FOR INTERPRETER SERVICES

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Issues of language access are growing in importance as evidence demonstrates that the need for interpreter services is growing both in frequency and diversity of language. The U.S. population grew by 13% between 1990 and 2000. However, the foreign born population living in the U.S. increased by 44% during this same period. In 2000, the foreign born population comprised 10 percent of the total population, its highest level

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<sup>1</sup> Wirthlin Worldwide 2002 RWJF Survey.

since 1930. In 2005, the U.S. Census Bureau reported that over 300 different languages are spoken in the U.S. and nearly 52 million people (19% of the U.S. population) speak a language other than English at home.

Minnesota is also experiencing similar changes in its population. The U.S. Department of Homeland Security reported that more immigrants arrived in Minnesota in the year ending Sept. 30, 2005 than in any of the previous 25 years. Likewise, the percentage of births to foreign-born mothers has steadily increased from 5.4% to 17.5% between 1990 and 2005. Minnesota health care providers also report that the increasing need for interpreter services is not just confined to large urban areas. The rural areas of Minnesota are also reporting an escalating need for greater and more diverse interpreter services.

The increasing need of interpreter services raises the overall importance of adequately and appropriately addressing issues related to provision of interpreter services.

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### ACTIVITIES OF THE INTERPRETER SERVICES WORK GROUP

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The Interpreter Services Work Group (ISWG) attempted to identify, collect, and evaluate as much information as possible about the four specific topic areas requested by the Minnesota Legislature. The ISWG held public meetings and attempted to include all stakeholders interested in the topic<sup>2</sup>. The ISWG tried to incorporate the perspectives of the various stakeholders and consider the unique aspects of their positions. For example, the ISWG tried to identify and document differences associated with providing sign language interpreting services to deaf and hard of hearing patients and providing spoken language interpreting services to limited English proficient patients.

The information and data available related to the Legislature's four topics varied greatly. Some topics, such as federal requirements and guidance, had substantial amounts of information. Some topics, such as the impact of interpreters on the delivery of health care, have an ever increasing amount of scientific information available. Unfortunately, other topics have little or no data available. For example, there are no comprehensive data sources that document the number, location, ages, health status, or language spoken for limited English proficient persons or deaf and hard of hearing persons in Minnesota.

The ISWG devoted 2-3 meetings each 2 hours in duration to each of the four topics areas. The highlights and key points from the various discussions are presented in this report.

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<sup>2</sup> A list of stakeholders who served as an Executive Committee for the ISWG is provided in Appendix A

## FEDERAL LAW AND GUIDANCE

The ISWG investigated federal laws and guidance to develop a more detailed understanding of the legal requirements associated with providing interpreter services to patients in medical and dental settings. This section of the report provides an overview of the requirements for spoken language interpreter services and sign language interpreter services. While similar in effect, the spoken language and sign language requirements are derived from distinct legal obligations, and thus are discussed independently.

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### LEGAL REQUIREMENTS - SPOKEN LANGUAGE INTERPRETER SERVICES

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The legal foundation for requirements related to providing spoken language interpreter services, or language access assistance in general, is Section 601 of Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), which states:

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.

Section 602 of Title VI directs federal agencies that extend federal financial assistance to programs/activities to implement the provisions of Section 601 by issuing regulations. The U.S. Department of Health and Human Services (DHHS) promulgated regulations (45 CFR 80.3(b)(2)) that prohibit programs/activities receiving federal financial assistance from utilizing *"...criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin..."*

#### **Background**

In 1974, the Supreme Court ruled that Title VI prohibits conduct that disproportionately affects limited English proficient persons because such conduct constitutes national-origin discrimination.<sup>3</sup> In 1980, DHHS issued a notice that further clarified the connection between language and the Civil Rights Act by stating, *"No person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English."*<sup>4</sup> In August of 2000, President Clinton issued Executive Order 13166,<sup>5</sup> *"Improving Access to Services for Persons with Limited English Proficiency,"* requiring every federal agency that provides financial assistance to non-federal entities to publish guidance on how recipients of federal funds can provide meaningful access to limited English proficient persons and thus comply with Title VI regulations.

In August of 2003, DHHS issued policy guidance<sup>6</sup> to assist recipients of federal funding in fulfilling their responsibilities to provide meaningful access to limited English proficient persons under existing law. This policy guidance clarifies existing legal requirements for limited English proficient persons by providing a description of the factors recipients of federal funding should consider in fulfilling their responsibilities to limited English proficient persons. The guidance and other resources are available at [www.lep.gov](http://www.lep.gov). The following overview is taken from and based on that 2003 policy guidance.

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<sup>3</sup> Lau v. Nichols, 414 U.S. 563 (1974)

<sup>4</sup> 45 Fed. Reg. 82972 (Dec. 17, 1980)

<sup>5</sup> 65 Fed. Reg. 50121 (Aug. 16, 2000)

<sup>6</sup> 68 Fed. Reg. 47311 (Aug. 8, 2003)

### **Who is Covered**

DHHS regulations require all recipients of federal financial assistance from DHHS to provide meaningful access to limited English proficient persons. Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance. DHHS further clarified the applicability of the requirements in the following situations:

- Subrecipients are covered when federal funds are passed through from one recipient to a subrecipient;
- Coverage extends to a recipient's entire program or activity (i.e., to all parts of a recipient's operations). This is true even if only one part of the recipient's activity receives the federal assistance;
- Recipients in jurisdictions in which English has been declared the official language continue to be subject to federal nondiscrimination requirements, including those applicable to the provision of federally assisted services to persons with limited English proficiency; and
- Title VI regulations do not apply to any federal financial assistance by way of insurance or guaranty contracts, and therefore, "recipients of DHHS assistance" does not include health care providers who only receive Medicare Part B payments.

### **Who is a Limited English Proficient Individual**

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English are limited English proficient and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

### **Four Factors to Determine Limited English Proficient Obligations**

Recipients of federal funds are required to take reasonable steps to ensure meaningful access to their programs/activities by limited English proficient persons without undue delay and at no charge. To ensure meaningful access by limited English proficient persons to critical services while not imposing undue burdens on business and local government, the DHHS policy guidance describes an individualized assessment that recipients of federal funds should perform to balance four factors:

- **The number or proportion of limited English proficient persons eligible to be served or likely to be encountered by the program or grantee.** The greater the number or proportion of limited English proficient persons, the more likely language services are needed. Recipients should first examine their prior experiences with limited English proficient encounters and determine the breadth and scope of language services that were needed. It is important in conducting this analysis to include language minority populations that are eligible for programs/activities but may be underserved because of existing language barriers.
- **The frequency with which limited English proficient individuals come in contact with the program.** The more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed. However recipients that serve limited English proficient persons on an unpredictable or infrequent basis should use this balancing analysis to determine what to do if a limited English proficient individual seeks services, even if it is as simple as being prepared to use commercially available telephonic interpretation services to obtain immediate interpreter services.
- **The nature and importance of the program, activity, or service provided by the program to people's lives.** The more important the recipient's program/activity and the more significant the programs' possible consequences on limited English proficient individuals, the more likely

language services are needed. A recipient of federal funds needs to determine whether denial or delay of access to services could have serious or life-threatening implications for the limited English proficient individual. Thus, the recipient should consider the importance and urgency of its program/activity. If the activity is both important and urgent, it is more likely that relatively immediate language services are needed.

- **The resources available to the grantee/recipient and costs.** A recipient's level of resources and the costs imposed by providing language access may have an impact on the nature of the steps a recipient should take to comply with Title VI. Smaller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets. Resource and cost issues can often be reduced by technological advances and recipients should carefully explore the most cost-effective means of delivering competent and accurate language services before limiting services due to resource concerns. Large entities and those entities serving a significant number or proportion of limited English proficient persons should ensure that their resource limitations are well-substantiated before using this factor as a reason to limit language assistance.

### **Other Considerations Related to Limited English Proficient Obligations**

Regardless of the type of language services provided, the quality and accuracy of those services are critical to avoid serious consequences to the limited English proficient person. Consequently, when using interpreters, recipients should take reasonable steps to assess whether the interpreters: 1) demonstrate proficiency in and ability to communicate information accurately in both English and in the other language; 2) employ the appropriate mode of interpreting; 3) have knowledge in both languages of any specialized terms or concepts peculiar to the recipient's program or activity and of any particularized vocabulary used by the limited English proficient person; and 4) understand and follow confidentiality and impartiality rules to the same extent as the recipient employee for whom they are interpreting.

To be meaningfully effective, language assistance should be timely. While there is no single definition for "timely" that is applicable to all types of interactions, one clear guide is that the language assistance should be provided at a time and place that avoids the effective denial of the service or that imposes an undue burden or delay in important services for a limited English proficient person. When the timeliness of services is important, and delay would result in the effective denial of service, language assistance likely cannot be unduly delayed.

The DHHS policy guidance identifies a variety of options for providing competent interpreters in a timely manner, including the use of family members or friends as interpreters. However, the guidance provides a number of cautions in the use of such non-professional interpreters by noting that the recipient needs to consider issues of competence, appropriateness, conflicts of interest, and confidentiality in evaluating the use of non-professional interpreters. Recipients should take reasonable steps to ascertain that family, legal guardians, caretakers, and other informal interpreters are not only competent in the circumstances, but are also appropriate in light of the circumstances and subject matter of the program, service or activity.

### **Development of an Implementation Plan**

Although not required, the DHHS policy guidance encourages recipients of federal funds to develop an implementation plan to address the identified needs of the limited English proficient populations it serves. The development and maintenance of a periodically updated written plan on language assistance for limited English proficient individuals can be an appropriate and cost-effective means of documenting compliance with Title VI and providing a framework for the provision of timely and effective language assistance. For recipients who decide to develop a written implementation plan, DHHS identifies five elements that are typically part of effective implementation plan.

- **Identifying Limited English Proficient Individuals Who Need Language Assistance** – This element describes how recipients will identify limited English proficient persons with whom it has contact.
- **Language Assistance Measures** – This element includes information about the ways in which language assistance will be provided and may include: 1) types of language services available; 2) how staff can obtain those services; 3) how to respond to limited English proficient individuals; 4) how to ensure competency of interpreter services.
- **Training Staff** – This element describes a process for identifying staff that need to be trained regarding the recipient's limited English proficiency plan, a process for training them, and the identification of the outcomes of the training.
- **Providing Notice to Limited English Proficient Persons** – This element describes how a recipient provides notice of the services that are available to limited English proficient persons.
- **Monitoring and Updating the Limited English Proficiency Plan** – This element describes the process that recipient uses to monitor its implementation of the plan and for updating the plan as necessary.

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## LEGAL REQUIREMENTS - SIGN LANGUAGE INTERPRETER SERVICES

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The legal foundation for requirements related to providing sign language interpreter services, or language access assistance in general, are Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), Titles II and III of the Americans with Disabilities Act (42 U.S.C. 12131-12189), U.S. Department of Justice (DOJ) regulations for the obligations of state and local government (28 C.F.R. Part 35), and DOJ regulations for the obligations of public accommodations under Title III (28 C.F.R. Parts 35-36).

The U.S. Department of Justice regulations establish that all private health care providers are considered places of public accommodation and are covered by Title III of the ADA regardless of the size of the office or number of employees. The DOJ provides guidance and resources at [www.ada.gov](http://www.ada.gov). The following overview is taken from and based on the DOJ guidance and material created by the National Association of the Deaf at [www.nad.org](http://www.nad.org).

### Who is Covered

Title III of the ADA applies to all public and private health care providers, regardless of the size of the office or the number of employees. Title III applies to both physical and mental health care providers. Similarly, Title II of the ADA applies to state and local government activities, programs, services and includes public health and social services. Both Title II and III provide protections for disabled patients receiving medical or dental services in a public health clinic and/or a public hospital.

### Who is Protected by the ADA

The ADA protects all individuals with a physical or mental impairment that substantially limits one or more of the individual's major life activities. This protection includes individuals with hearing loss.

### ADA Obligations

Under Titles II and III of the ADA all health care providers have a duty to provide effective communication to people who have a hearing loss. The communication needs to be equally effective as communication with other individuals without hearing loss. A health care provider must communicate equally effectively with customers, clients, and other individuals with hearing loss who are seeking or receiving its services. It is

important to note that such individuals may not always be "patients" of the health care provider and depending on the circumstances can include parents, guardians, and spouses of the patient.

Health care providers may use a variety of auxiliary aids and services to ensure effective communication, including qualified interpreters, assistive listening devices, notetakers, written materials, television decoders, and telecommunications devices for the deaf. The auxiliary aid requirement is flexible, and the health care provider can choose among various alternatives as long as the result is effective communication for the deaf or hard of hearing individual. The Justice Department expects that health care providers will consult with an individual and consider carefully their self-assessed communication needs before using a particular aid or service.

The ADA does not require the provision of any auxiliary aid or service that would result in an undue burden or in a fundamental alteration in the nature of the goods or services provided by a health care provider. The DOJ defines undue burden as "*significant difficulty or expense*" and identifies a number of factors to consider in determining if an action is an undue burden, including the cost of the aid or service, the overall financial resources of the health care provider, the number of the provider's employees, legitimate necessary safety requirements, the effect on the resources and operation of the provider, and the difficulty of locating or providing the aid or service. Even if a particular aid creates an undue burden, the health care provider still has the duty to furnish an alternative auxiliary aid or service that would not result in a fundamental alteration or undue burden.

In some situations, the cost of providing an auxiliary aid or service (e.g., an interpreter) may exceed the charge to the patient for that very same service. A health care provider is expected to treat the costs of providing auxiliary aids and services as part of their annual overhead costs of operating a business. Accordingly, so long as the provision of the auxiliary aid or service does not impose an undue burden on the provider's business and does not fundamentally alter the provider's services, the provider may be obligated to pay for the auxiliary aid or service in this situation.

A health care provider cannot charge a patient for the costs of providing auxiliary aids and services.

#### **Other Considerations Related to ADA Obligations**

Regardless of the type of auxiliary aids and services provided, quality and accuracy of those services is critical to avoid serious consequences to a person. Auxiliary aids and services are often needed to provide safe and effective medical treatment. Consequently, a provider using an interpreter needs to ensure that the interpreter is qualified and able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized medical terminology and vocabulary.

Providers also need to understand that there are various kinds of interpreters and should ascertain the particular language needs of the deaf or hard of hearing patient before using an interpreter. Some individuals may require interpreters who are fluent in American Sign Language, a language that has a grammar and syntax that is different from the English language. Others individuals may require interpreters who use: 1) Signed English - a form of signing which uses the same word order as does English; 2) Oral Interpreters - who take special care to articulate words for deaf or hard of hearing individual; or 3) Cued Speech Interpreters - who give visual cues to assist in lipreading.

As in spoken language interpreting, health care providers should be cautious about using family members and friends to interpret and the best practice is to not use family members and friends to interpret. Family members often do not possess sufficient sign language skills to effectively interpret in a medical setting. Even if they are skilled enough in sign language to communicate, family members and friends are very often too emotionally or personally involved to interpret effectively, accurately, and impartially. Finally, using family members and friends as interpreters can cause problems in maintaining patient confidentiality.

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## CONCLUSIONS

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All health care providers have a legal obligation under the Americans with Disability Act to provide effective communication to people who have a hearing loss. Health care providers may use a variety of auxiliary aids and services, but the result must be communication that is as effective as communication with other individuals without hearing loss. In most circumstances, this means a qualified interpreter is necessary. Similarly, health care providers who are the recipients of federal funds have a legal obligation to take reasonable steps to ensure meaningful access to their programs/activities by limited English proficient patients. This obligation includes providing language services (e.g., interpreters) that eliminate barriers to communications.

## ACCESS TO INTERPRETER SERVICES

The ISWG attempted to explore individuals' access to interpreter services broadly. This exploration included trying to: 1) identify the amount and type of interpreter services needed; 2) determine the extent to which that need is being met; and 3) assess how interpreter services impact the quality of health care delivered. In conducting this analysis the ISWG encountered a number of challenges, which included:

- There are no comprehensive data sources that document the number, location, ages, health status, or language spoken for limited English proficient persons in Minnesota;
- There are no data sources that document the number, location, ages, degree of hearing loss, or language needs for deaf and hard of hearing persons in Minnesota;
- There is only partial information on the extent to which the need for interpreter services is being met, nationally and in Minnesota, and the information is only for spoken language interpreting; and
- While there is a small, but growing, body of scientific literature on how spoken language interpreter services impact the quality of health care delivered, there is very little research on how sign language interpreter services impact the quality of health care.<sup>7 8</sup>

The ISWG attempted to overcome these challenges by combining a variety of data sources, by examining national data, and by trying to generalize existing research to all populations. Although it is not possible to quantify all of the conclusions, the ISWG generally found:

- The need for interpreter services is growing, both in the number of people needing the services, as well as, the number of different languages that need to be accommodated;
- Health care providers are not adequately meeting the needs for interpreter services; and
- The use of professional, trained interpreters clearly improves the quality of health care delivered.

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## IDENTIFYING THE NEED FOR INTERPRETER SERVICES

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It is very difficult to accurately determine the amount and type of interpreter services needed in medical and dental settings. There are no comprehensive data sources that document the number, location, ages, health status, or language spoken for limited English proficient persons in Minnesota. Similarly, there are no data sources that document the number, location, ages, degree of hearing loss, or language needs for deaf and hard of hearing persons in Minnesota. However, the ISWG was able to identify a number of trends both nationally, and in Minnesota that can help in understanding the need for interpreter services.

There is evidence that the need for interpreter services is growing in amount and type. The U.S. population grew by 13% between 1990 and 2000. However, the foreign born population living in the U.S. increased by 44% to 28.4 million people during this period. In 2000, the foreign born population comprised 10 percent of the total population, its highest since 1930. In 2005, the U.S. Census Bureau reported that over 300 different

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<sup>7</sup> See – L.M. Harmer 1999. Health Care Delivery and Deaf People: Practice, Problems, and Recommendations for Change. *Journal of Deaf Studies and Deaf Education* 4:2, Spring 1999

<sup>8</sup> See also – A.G. Steinberg, et al. 2006. Health Care System Accessibility Experiences and Perceptions of Deaf People. *Journal of General Internal Medicine* 2006; 21:260–266.

languages are spoken in the U.S. and nearly 52 million people (19% of the U.S. population) speak a language other than English at home.

Minnesota is also experiencing similar changes in its population. The U.S. Department of Homeland Security reported that more immigrants arrived in Minnesota in the year ending Sept. 30, 2005 than in any of the previous 25 years. The 15,456 arrivals placed Minnesota 17th among the states in immigration for the reporting period and accounted for 1.4 percent of the U.S. total. Minnesota has the highest proportion of refugees in the U.S. It has the largest population of Somali immigrants in the U.S. and the second largest population of Hmong. From 2000 to 2005, 68,929 immigrants have moved to Minnesota. By comparison, from 1990 to 1999, 73,733 immigrants came to Minnesota and from 1982 (earliest data for all of Minnesota) to 1989, 46,712 arrived here.

The percent of Minnesota births to foreign-born mothers also provides evidence of an increasing need for interpreter services. From 1990 to 2005, the percent of births to foreign-born mothers has steadily increased from 5.4% to 17.5%.

The ISWG did not find data that specifically identified the frequency of interpreter services needed, the location where the services are needed, nor the languages needed. However, the ISWG identified that the Minnesota Department of Education (MDE) provides one of the best sources of information for helping identify the location and type of services need. The MDE provides counts, by county, of the primary home language for Minnesota school-aged children.<sup>9</sup> These counts show the number of homes in each county with school-aged children that speak one of 10 languages: Arabic, Cambodian, Hmong, Loatian, Oromo, Russian, Serbo-Croatian, Somali, Spanish, and Vietnamese. These 10 maps are presented in Appendix C and present an increasingly, language-diverse picture of Minnesota's population. These data and maps represent the best available proxy of the need for language services. Unfortunately, there are no similar data sources for deaf and heard of hearing individuals.

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## MEETING THE NEED FOR INTERPRETER SERVICES

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### National Surveys

The ISWG identified two national surveys that explored the extent to which health care providers are meeting the need for interpreter services. The survey findings are consistent with similar Minnesota surveys and in the opinion of the ISWG applicable to Minnesota.

The first survey<sup>10</sup> was conducted by the Health Research and Educational Trust (HRET - the research and educational affiliate of the American Hospital Association) to seek information about patient language services in hospitals. HRET's survey of 1,983 hospitals found that hospitals frequently encounter limited English proficient patients and use a variety of means to meet their interpreting needs. Specifically, the survey found that: 1) 82% of hospitals use staff interpreters most frequently for providing language services; 2) 92% of hospitals said telephonic services are the most available resource for providing language services; and 3) 88% of hospitals reported providing language services during off-hours. The study also identified barriers hospitals face in providing appropriate language services as:

- Staff has no means of identifying patients who need language services before they arrive at the hospital (53%)

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<sup>9</sup> Minnesota Department of Education:  
[http://education.state.mn.us/MDE/Data/Maps/Home\\_Primary\\_Languages/index.html](http://education.state.mn.us/MDE/Data/Maps/Home_Primary_Languages/index.html)

<sup>10</sup> Hasnain-Wynia, Yonek, Pierce, Kang, Greising, Health Research and Educational Trust, 2006

- Cost/reimbursement concerns (48%)
- Lack of tools and training resources (41%)
- Other barriers (39%)
- Lack of community-level data (27%)
- Staff feels uncomfortable asking patients to provide information about their primary language (11%)

The second survey<sup>11</sup> was a national survey of internal medicine physicians. Like the previous study, this study showed internists frequently encounter limited English proficient patients. In contrast to the hospitals, the physicians tend to use different means of addressing patients' language needs. Specifically, the survey found that the most frequent methods for providing language services were: 1) bilingual staff (36%); 2) bilingual health care provider (31%); and 3) ad hoc interpreters (29%). The least frequent methods for providing language service were: 1) Onsite interpreters provided by a language agency or contractor; 2) Remote interpreters, telephonic services; and 3) Staff hired primarily to provide interpretation services.

**Minnesota Surveys**

The ISWG identified two Minnesota-specific surveys that addressed issues of interpreter services in Minnesota. The first study<sup>12</sup> by the Minnesota Medical Association was consistent with the national surveys and found that Minnesota physicians frequently encounter limited English proficient patients and that 88% use language interpreter services in their clinic. Table 1 describes the survey respondents' ability accommodate language needs, methods for meeting those needs, and barriers to meeting those needs.

<b>Are you able to accommodate language interpreter needs when they have not previously been arranged/requested?</b>	<b>Which language interpreter services are offered at your clinic/practice?</b>	<b>What barriers limit your ability to access language interpreter services?</b>
58.2% Frequently 24.1% Occasionally 2.3% Never 3.6% No Response	55.2% External service 49.6% In-house service 46.4% Telephone service 37.2% Bilingual staff 2.4% Other	37.2% Waiting time 27.6% Cost 15.6% Availability 8.4% Don't know options/resources 2.7% Other

The MMA survey also noted that physicians expressed frustration with: 1) the sole availability of untrained interpreters such as relatives; 2) misinformation and lack of support/guidance from the clinic on the necessity of interpreters; and 3) bilingual support staff that may not be adequately trained in medical interpretation.

The second Minnesota-specific survey was a statewide survey of 4,902 Minnesota Health Care Program (MHCP) enrollees conducted by the Minnesota Department of Human Services.<sup>13</sup> This survey was designed to assess racial and ethnic disparities in the use of preventive and other health services, as well as barriers that discourage the use of those services (e.g., language services).

<sup>11</sup> American College of Physicians, Position Paper, 2007

<sup>12</sup> Results of a Needs Assessment Survey Administered to Physician Members of the Minnesota Medical Association, Minnesota Medicine, 2004

<sup>13</sup> Disparities and Barriers to Utilization among Minnesota Health Care Program Enrollees, Minnesota Department of Human Service, 2003

The survey asked Hispanic/Latino, Hmong, and Somali enrollees to rate the availability and quality of interpreter services. The survey found that:

- Interpreters are least available for Hmong - 59% of adults and 75% of parents report problems getting an interpreter when needed;
- Many Somalis reported not getting an interpreter when needed - about 50% of adults and parents report problems getting an interpreter when needed; and
- Of the three groups, interpreters are most available for Hispanic/Latinos; however, as many as 33% report problems with interpreter availability.

When asked how much having an interpreter helps them understand what the doctor is asking, what is being done during the visit, or helps the doctor understand what they are trying to say, the survey found:

- Hmong are most likely to provide negative ratings - 73% of adults and 53% of parents;
- Somalis are second with about 50% of adults and 35% of parents providing negative ratings; and
- Hispanic/Latinos provided negative ratings for 30% of adults and parents.

Both the national and Minnesota-specific surveys show that the majority of health care providers are making efforts to meet the language needs of limited English proficient patients. However, providers face a number of barriers in fully meeting those interpreter service needs. The survey by the Department of Human Services demonstrates that despite the efforts of health care providers many patients still face an unmet need for available, high quality interpreter services.

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## INTERPRETER SERVICES IMPACT ON QUALITY OF CARE

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There is an ever-growing body of scientific literature that shows that having a trained, spoken language interpreter can improve the quality of care a limited English proficient person receives. The literature shows that the use of a trained interpreter can benefit patients and help to: 1) have a better perceived understanding of their diagnosis and treatment; 2) have greater satisfaction with their care; 3) receive more appropriate care; and 4) achieve outcomes equal to English speakers.

The ISWG found that almost all of the scientific literature focused on spoken language interpreters. However, a trained interpreter facilitates communications between a patient and the health care provider, and there is no reason to believe that the findings for spoken language interpreters would not generally be consistent with the impact of sign language interpreters.

In considering the scientific literature, it is important to note that the literature often distinguish between a "professional" or "trained" interpreter and an ad hoc interpreter (e.g., family and friends). Unfortunately, the literature does not use a common standard for "professional" or "trained." However, the literature is clear that using a trained interpreter generally produces higher quality results than using an ad hoc interpreter.

### **Interpreter Services Impact on Perceived Understanding**

A study in the Journal of the American Medical Association<sup>14</sup> found that limited English proficient patients who need, but do not get interpreters have a worse perceived understanding of their diagnosis and treatment and

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<sup>14</sup> Baker, D.W., et al. 1996. Use and effectiveness of interpreters in an emergency department. JAMA 275: 783-88.

90% wish that their provider had explained things better. Table 2 shows the impact of having an interpreter on perceived understanding.

<b>Patient's Interpreter Needs</b>	<b>Good to Excellent Perceived Understanding</b>	
	<b>Diagnosis</b>	<b>Treatment</b>
<b>Not Needed</b>	67%	86%
<b>Needed &amp; Provided</b>	57%	82%
<b>Needed &amp; Not Provided</b>	38%	58%

**Interpreter Services Impact on Patient Satisfaction**

Numerous studies have examined limited English proficient patients' satisfaction with their care and the impact having a trained interpreter, an ad hoc interpreter, and not having an interpreter. The results of these surveys can be summarized as:

- Limited English proficient patients with trained, professional interpreters present when care is delivered have higher satisfaction with care;<sup>15 16</sup>
- Limited English proficient patients who need, but do not get interpreters are least satisfied with their care;<sup>17 18</sup> and
- Limited English proficient patients and clinicians have higher satisfaction when using professional interpreters than when using ad hoc interpreters.<sup>15 16 17</sup>

Another study<sup>19</sup> conducted in Switzerland and published in the British Journal of General Practice found that training clinicians in how to use professional interpreters resulted in: 1) increased patient satisfaction with quality of communication; 2) Physicians increasing their demand for professional interpreters; and 3) Physicians became more aware of communication issues when dealing with foreign language speakers.

**Interpreter Services Impact on Care Received and Outcomes**

Studies that have looked at the impact of trained interpreters on the amount and outcomes of health care services have generally found that the use of interpreters helps achieve the desired outcomes, such as:

<sup>15</sup> Kuo, D., and M. J. Fagan. 1999. Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. Journal of General Internal Medicine 14:547-50.

<sup>16</sup> Lee, L. J., et al. 2002. Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. Journal of General Internal Medicine 17:641-45

<sup>17</sup> Baker, D.W., et al. 1998. Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. Medical Care 36: 1461-70.

<sup>18</sup> Derose, K. P., et al. 2001. Does Physician Gender Affect Satisfaction of Men and Women Visiting the Emergency Department? Journal of General Internal Medicine 16: 218-26.

<sup>19</sup> Bischoff, A., et al. 2003. Improving Communication between Physicians and Patients Who Speak a Foreign Language. British Journal of General Practice 53: 541-6.

- Use of trained professional interpreters was associated with a decrease in disparities for utilization of outpatient preventive services,<sup>20</sup> increased intensity of emergency department services,<sup>21</sup> reduced emergency department return and referral rates<sup>21</sup>, and lower admission rates from the emergency department;<sup>22</sup>
- Limited English proficient patients using trained, professional interpreters received care that met the American Diabetes Association guidelines and received care that was as good as the care for English-speaking patients;<sup>23</sup>
- Limited English proficient patients who need, but do not get interpreters have more tests done creating a higher overall cost<sup>22</sup>, are more likely to receive intravenous hydration and to be admitted to the hospitalized,<sup>22</sup> and are at greater risk of being discharged from the emergency department without a follow-up appointment.<sup>24</sup>

The overall body of literature is best summarized by a Glenn Flores quote that appeared in an article<sup>25</sup> reviewing the impact of medical interpreter services on the quality of health care:

"This systematic review of the literature indicates that additional studies employing rigorous methods are needed on the most effective and least costly ways to provide interpreter services to LEP patients. But available evidence suggests that optimal communication, the highest satisfaction, the best outcomes, and the fewest errors with potential clinical consequence occur when LEP patients have access to trained professional interpreters or bilingual health care providers."

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<sup>20</sup> Jacobs, E. A., et al. 2001. Impact of interpreter services on delivery of health care to limited-English proficient patients. *Journal of General Internal Medicine* 16:468-74.

<sup>21</sup> Bernstein, J., et al. 2002. Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up. *Journal of Immigrant Health* 4: 171-6.

<sup>22</sup> Hampers, L. C., and J. E. McNulty. 2002. Professional Interpreters and Bilingual Physicians in a Pediatric Emergency Department: Effect on Resource Utilization. *Archives of Pediatric of Adolescent Medicine* 156: 1108-13.

<sup>23</sup> Tocher, T., and E. Larson. 1998. "Quality of Diabetes Care for Non-English-Speaking Patients: A Comparative Study." *Western Journal of Medicine* 168: 504-11.

<sup>24</sup> Sarver, J., and D. W. Baker. 2000. "Effect of Language Barriers on Follow-up Appointments after an Emergency Department Visit." *Journal of General Internal Medicine* 15: 256-64.

<sup>25</sup> Flores, G. 2005. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. *Medical Care Research and Review* 62: 255-99.

## QUALITY ASSURANCE FOR INTERPRETER SERVICES

The US Department of Health and Human Services' Office of Minority Health made the following observation in a report titled, *National Standards for Culturally and Linguistically Appropriate Services*:<sup>26</sup>

Accurate and effective communication between patients/consumers and clinicians is the most essential component of the health care encounter. Patients/consumers cannot fully utilize or negotiate other important services if they cannot communicate with the nonclinical staff of health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual person for delivering language services—they must assess and ensure the training and competency of individuals who deliver such services.

The scientific literature is clear that using a trained interpreter generally produces higher quality results than using an ad hoc interpreter, such as family or friends. Therefore to ensure the quality of interpreter services provided, it is critical that there be some mechanism for addressing the qualifications and competency of medical interpreters.

The types of mechanisms needed for ensuring high quality interpreter services are similar for both spoken language and sign language interpreters. Quality assurance needs for both spoken and sign language interpreters include training, assessment of language skills, demonstration of interpreting proficiency, adherence to ethical standards, and participation in continuing education activities to maintain and improve skills. However, the mechanisms for ensuring the quality of sign language interpreters is significantly more advanced than the mechanisms for ensuring the quality of spoken language interpreters. Given the differences in the ability to address the qualifications and competency of two types of interpreters, this report addresses the issues separately, starting with sign language interpreters.

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## QUALITY ASSURANCE FOR SIGN LANGUAGE INTERPRETERS

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The competency of sign language interpreters is assessed and documented through the Registry of Interpreters for the Deaf (RID), which administers a national certification system for sign language interpreters. RID is a national, non-profit membership organization dedicated to providing forums and an organizational structure for the continued growth and development of the profession of interpretation and transliteration of American Sign Language and English. RID supports its members by providing the foundation needed to launch and sustain careers while ensuring quality service to the Deaf community. RID uses a four-pronged approach to ensuring quality:

- **Education** - RID provides educational opportunities for new and professional interpreters through a Professional Development Committee and through a Certification Maintenance Program, which monitors the continued skill development of certified interpreters and ensures that practitioners maintain their skill level and keep up with developments in the interpreting field.
- **Standards** – RID establishes standards that serve to define high quality sign language interpreting. RID uses a tri-fold approach to the standards it maintains for its certification:

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<sup>26</sup> National Standards for Culturally and Linguistically Appropriate Services in Health Care, U.S. Department of Health and Human Services, Office of Minority Health, March 2001

- A **National Testing System**, which strives to maintain strict adherence to nationally recognized testing industry standards of validity, reliability, equity and legal defensibility.
- A **Certified Maintenance Program**, which monitors and nourishes the continued skill development of certified interpreters is monitored and nourished.
- The **Ethical Practices System** and **NAD-RID Code of Professional Conduct**, which provide guidance and enforcement to professionalism and conduct. The Ethical Practices System provides an opportunity for consumers to address concerns or file complaints regarding the quality of interpreter services, and the Code of Professional Conduct sets the standards to which all individuals holding RID certification are expected to adhere.
- **Relationships** - As a growing, recognized profession, interpreters need valuable networking opportunities with each other as well as key stakeholders to further advance the profession through relationship-building. RID provides national, state and local forums in addition to an organizational structure for this growth.
- **Resources** – RID serves as an information clearinghouse and provides its members with the necessary tools to succeed in their career and move the profession forward. RID distributes information to its members through such means as, affiliate chapter and regional support, a monthly member newsletter, publications offered through RID Press, current and user-friendly Web site, and a biennial conference.

#### **National Interpreter Certification – Sign Language**

RID's National Testing System is essential to ensuring the quality of sign language interpreters. It also serves as a lesson that highlights the challenges associated with developing a certification testing system for spoken language interpreters.

RID's National Testing System does not provide testing or certification specifically for medical interpreting, rather it tests and certifies interpreters as generalist with skills in a broad range of general interpreting assignments. The testing is performed in two parts: Part 1) a written examination; and Part 2) an interview and performance examination. The testing system has three performance levels for professional interpreters:

1. **NIC** - Individuals who achieve the NIC level have passed the NIC Knowledge exam. They have also scored within the standard range of a professional interpreter on the interview and performance portions of the test.
2. **NIC Advanced** - Individuals who achieved the NIC Advanced level have passed the NIC Knowledge exam; scored within the standard range of a professional interpreter on the interview portion; and scored within the high range on the performance portion of the test.
3. **NIC Master** - Individuals who achieved the NIC Master level have passed the NIC Knowledge exam. They have scored within the high range of a professional interpreter on both the interview and performance portions of the test.

The development of the National Testing System identifies one of the significant challenges in testing and certifying interpreters – cost. RID needed to ensure that its testing system was valid, reliable, and easily defensible. The cost of developing its current testing system was \$950,000. The cost of operating its certification system is approximately \$550,000 comprised of \$300,000 for testing, \$125,000 for certification maintenance, and \$125,000 for consumer protection activities. These costs also do not reflect the significant amount of time that is donated by the many stakeholders dedicated to the success of the system.

The significant costs also highlight the challenges associated with certifying spoken language interpreters. RID certifies essentially one language pairing – American Sign Language and English. In spoken language, there are many such language pairings and all would need testing requirements tailored to the unique needs of each language and culture.

In 2006, RID had approximately 13,000 members - 6,213 were RID Certified members, 4,139 were Associate members (non-RID certified professional interpreters), 940 Student members, and 1,059 members in other categories (e.g., organizational).

### **Certification Levels Appropriate for Health Care Settings**

Specific certification levels appropriate for healthcare settings have been defined in many Twin Cities hospitals by settlement agreements between consumers and healthcare facilities.<sup>27</sup> In most Twin Cities' hospitals, the following certifications are considered to be minimum qualifications for sign language interpreters:

- Certificate of Transliteration and Certificate of Interpretation (CI and CT);
- NAD IV or V; or
- Comprehensive Skills Certificate (CSC).

Health care providers in other settings should carefully consider the applicability of these standards as the minimum qualifications for their settings.

### **NAD-RID Code of Professional Conduct**

The National Association of the Deaf and the Registry of Interpreters for the Deaf uphold high standards of professionalism and ethical conduct for interpreters. Embodied in this Code of Professional Conduct are seven tenets setting forth guiding principles for professional behavior. The seven tenets of this Code of Professional Conduct are:

1. Interpreters adhere to standards of confidential communication.
2. Interpreters possess the professional skills and knowledge required for the specific interpreting situation.
3. Interpreters conduct themselves in a manner appropriate to the specific interpreting situation.
4. Interpreters demonstrate respect for consumers.
5. Interpreters demonstrate respect for colleagues, interns, and students of the profession.
6. Interpreters maintain ethical business practices.
7. Interpreters engage in professional development.

### **Minnesota Registry of Interpreters for the Deaf (MRID)**

The Minnesota Registry of Interpreters for the Deaf (MRID) is a state affiliate chapter of the national organization, RID. MRID is a non-profit organization of professional interpreters, consumers, and interested persons. MRID was established and incorporated in 1971 with the support and encouragement of the

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<sup>27</sup> Consent decree, United States of America and State of Minnesota v. Fairview Health Services, US District Court, District of Minnesota #04-4955

Minnesota Association of Deaf Citizens (MADC). As of October 2007, MRID had 506 members in the following classes: 380 RID certified members; 88 Associate members (non-RID certified professional interpreters); 30 Student members; 7 Organization members; and 1 Supporting member.

The Interpreter Services Work Group believes that RID and its local affiliate, MRID, provides an adequate framework for ensuring the quality, competency, and ethical behavior of sign language interpreters in Minnesota. Although the certification system is not unique to medical and dental settings, it provides a framework and sufficient set of national standards to ensure accurate and effective communication between patients and clinicians delivering health care.

The Interpreter Services Work Group recommends that any quality assurance requirements for sign language interpreters in medical and dental situations should be consistent and built on the foundation already established and maintained by RID and MRID.

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### QUALITY ASSURANCE FOR SPOKEN LANGUAGE INTERPRETERS

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Unlike the registry for sign language interpreters, there is no state or national certification system for ensuring the quality or competency of spoken language interpreters. While no registry of spoken language interpreters exists, there have been a number of national efforts to enhance the professionalism of spoken language interpreting, improve the quality of interpreting, and foster consistency in the quality of interpreting. One organization that has been spearheading many of these efforts is the National Council on Interpreting in Health Care (NCIHC), whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health care for individuals with limited English proficiency.<sup>28</sup>

#### **National Council on Interpreting in Health Care Standards**

In 2004, the NCIHC described the steps it believed necessary to create a shared understanding of what is considered high quality and ethically appropriate practice for medical interpreting:<sup>29</sup>

... the National Council on Interpreting in Health Care identified three steps that needed to take place on a national level in order to standardize the expectations that the health care industry and patients should have of interpreters and to raise the quality of health care interpreting. The first step was to create and build support for a single Code of Ethics that would guide the practice of interpreters working in health care venues. The second step was to develop a nationally accepted, unified set of Standards of Practice based on the Code of Ethics that would define competent practice in the field. The third step was to create a national certification process that would set a standard for qualification as a professional health care interpreter.

In support of these necessary steps, the NCIHC published both a National Code of Ethics for Interpreters in Health Care (2004)<sup>29</sup> and National Standards of Practice for Interpreters in Health Care (2005).<sup>30</sup> These standards of practice are a set of guidelines that define the tasks and skills interpreters should be able to perform in the course of fulfilling the duties of the profession. The standards describe what is considered "best practice" by the profession and help to ensure a consistent quality of performance. For health care interpreters, the standards define the acceptable ways by which they can meet the core obligations of their

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<sup>28</sup> See the NCIHC website at: [www.ncihc.org](http://www.ncihc.org)

<sup>29</sup> NCIHC, 2004. National Code of Ethics for Interpreters in Health Care

<sup>30</sup> NCIHC, 2005. National Standards of Practice for Interpreters in Health Care.

profession – the accurate and complete transmission of messages between a patient and provider who do not speak the same language in order to support the patient-provider therapeutic relationship (NCIHC, 2005).

### **Code of Ethics for Interpreters**

The NCIHC Code of Ethics for Interpreters in Health Care contains the following nine core principles:

1. The interpreter treats as confidential, within the treating team, all information learned in the performance of their professional duties, while observing relevant requirements regarding disclosure.
2. The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context.
3. The interpreter strives to maintain impartiality and refrains from counseling, advising or projecting personal biases or beliefs.
4. The interpreter maintains the boundaries of the professional role, refraining from personal involvement.
5. The interpreter continuously strives to develop awareness of his/her own and other (including biomedical) cultures encountered in the performance of their professional duties.
6. The interpreter treats all parties with respect.
7. When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem.
8. The interpreter strives to continually further his/her knowledge and skills.
9. The interpreter must at all times act in a professional and ethical manner.

### **National Standards of Practice for Health Care Interpreters**

The NCIHC developed 32 standards of practice grouped into nine categories, which link back to one of the nine ethical principles of the National Code of Ethics. For each of the categories there is an objective that defines the overall goal of that category and the corresponding set of standards. The NCIHC's 32 standards of practice grouped into nine categories are:

- **Accuracy - To enable other parties to know precisely what each speaker has said.**
  1. The interpreter renders all messages accurately and completely, without adding, omitting, or substituting.
  2. The interpreter replicates the register, style, and tone of the speaker.
  3. The interpreter advises parties that everything said will be interpreted.
  4. The interpreter manages the flow of communication.
  5. The interpreter corrects errors in interpretation.
  6. The interpreter maintains transparency.

- **Confidentiality - To honor the private and personal nature of the health care interaction and maintain trust.**
  7. The interpreter maintains confidentiality and does not disclose information outside the treating team, except with the patient's consent or if required by law.
  8. The interpreter protects written patient information in his or her possession.
- **Impartiality - To eliminate the effect of interpreter bias or preference.**
  9. The interpreter does not allow personal judgments or cultural values to influence objectivity.
  10. The interpreter discloses potential conflicts of interest, withdrawing from assignments if necessary.
- **Respect - To acknowledge the inherent dignity of all parties in the interpreted encounter.**
  11. The interpreter uses professional, culturally appropriate ways of showing respect.
  12. The interpreter promotes direct communication among all parties in the encounter.
  13. The interpreter promotes patient autonomy.
- **Cultural Awareness - To facilitate communication across cultural differences.**
  14. The interpreter strives to understand the cultures associated with the languages he or she interprets, including biomedical culture.
  15. The interpreter alerts all parties to any significant cultural misunderstanding that arises.
- **Role Boundaries - To clarify the scope and limits of the interpreting role, in order to avoid conflicts of interest.**
  16. The interpreter limits personal involvement with all parties during the interpreting assignment.
  17. The interpreter limits his or her professional activity to interpreting within an encounter.
  18. The interpreter with an additional role adheres to all interpreting standards of practice while interpreting.
- **Professionalism - To uphold the public's trust in the interpreting profession.**
  19. The interpreter is honest and ethical in all business practices.
  20. The interpreter is prepared for all assignments.
  21. The interpreter discloses skill limitations with respect to particular assignments.
  22. The interpreter avoids sight translation, especially of complex or critical documents, if he or she lacks sight translation skills.
  23. The interpreter is accountable for professional performance.
  24. The interpreter advocates for working conditions that support quality interpreting.
  25. The interpreter shows respect for professionals with whom he or she works.
  26. The interpreter acts in a manner befitting the dignity of the profession and appropriate to the setting.
- **Professional Development - To attain the highest possible level of competence and service.**

27. The interpreter continues to develop language and cultural knowledge and interpreting skills.
  28. The interpreter seeks feedback to improve his or her performance.
  29. The interpreter supports the professional development of fellow interpreters.
  30. The interpreter participates in organizations and activities that contribute to the development of the profession.
- **Advocacy - To prevent harm to parties that the interpreter serves.**
    31. The interpreter may speak out to protect an individual from serious harm.
    32. The interpreter may advocate on behalf of a party or group to correct mistreatment or abuse.

### **Challenges to Developing a Certification System**

While the NCIHC's principles provide a solid philosophical foundation for high quality and ethical medical interpreting, a number of challenges remain in converting that foundation into an operational certification system. Some of the practical issues that must be resolved prior to the creation of a certification system include:

- Designing testing mechanisms that are valid for different languages, cultures, and medical situations. The RID testing system cost approximately one million dollars to develop and addressed one language pairing (i.e., English/American Sign Language). A spoken language system would need to address tens of language pairings, each at considerable expense.
- Determining and defining any pre-requisites to taking certification examinations (e.g., education, experience, prior training, proof of language proficiency, etc.).
- Finding a funding mechanism that supports the certification system. The funding mechanism would need to ensure that there are sufficient resources to operate the system, while keeping the testing mechanism affordable. If the cost of testing is too expensive, interpreters will not have much incentive to become certified.
- Developing mechanisms that avoid penalizing non-certified interpreters who may be used to interpret short interactions for which a professional interpreter would never be called in the first place.
- Ensuring that there is adequate and affordable training that will allow candidates to meet the certification requirements.

While all of these issues are being considered at both the state and national level, solving all of the challenges is at least 5-10 years away. In Minnesota, a group of interpreters, interpreter service agencies, institutions involved in interpreter training, health care organizations, and state agencies, known as the Minnesota Interpreting Stakeholder Group (ISG),<sup>31</sup> a committee of the Upper Midwest Translators and Interpreters Association (UMTIA), have been collaboratively addressing these challenges.

To advance the much needed development of an interpreter certification system, the ISWG supports and endorses the following recommendation from the Minnesota Interpreting Stakeholder Group:

#### **Recommendation:**

"The Minnesota Interpreting Stakeholder Group (ISG) recommends the formation of a statewide

<sup>31</sup> Note: The ISG is distinct from the ISWG formed to meet the statutory requirements associated with this report.

registry of spoken language health care interpreters until a national certification process for spoken language health care interpreters is available. Listing on the registry should require:

- Fulfillment of education and training requirements (based on the National Standards of Practice, National Council for Interpreting in Health Care [NCIHC]);
- Demonstration of language proficiency and interpreting skill (such as the American Council for the Teaching of Foreign Languages [ACTFL] Advanced High or higher);
- Agreement to abide by an interpreting code of ethics (endorsed by the Upper Midwest Translators and Interpreters Association [UMTIA]); and
- Listing of the results of a criminal background check.

A research group should be convened to:

- Review where such a registry should be hosted;
- Develop recommendations with regard to languages for which testing and training do not exist; and
- Establish and maintain the standards for inclusion in the registry.

The ISWG believes that a statewide registry, maintained by either a private-sector or public-sector entity, that identifies and documents interpreters' preparation, skills, and commitment will enhance the quality and professionalism of spoken language health care interpreters. Such a repository would help to ensure that patients receive the highest quality health care.

## BROAD-BASED FUNDING MECHANISMS

One of the challenges that health care providers report in supplying quality, professional interpreting services to patients is costs. In many situations, health care providers report that the cost of providing interpreting services can exceed the cost and/or charges of the underlying health care services. The expense of interpreting services often creates a barrier to the provision of those services.

Although some health care payers (e.g., Minnesota Health Care Programs and workers compensation) reimburse health care providers for the provision of interpreter services, most do not. Many payers believe that such costs should be part of a health care provider's overhead and incorporated into health care providers' overall rate structure. Health care providers report that it is difficult to incorporate such expenses into competitively negotiated rates with payers. Likewise, providers report that attempting to include such expenses into the overall rates disadvantages health care providers that provide services to large numbers of individuals needing interpreting services.

Health care providers' concerns about the expense of providing interpreter services are consistent with state and national surveys. Almost all surveys looking at barriers to the provision of language services identify cost as one of the most significant barriers to patients consistently receiving adequate language services. In the ISWG's meetings, there was considerable disagreement between stakeholders about the fairest mechanism to cover the expenses associated with providing interpreter services.

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### PRINCIPLES FOR AN INTERPRETER SERVICES FUNDING MECHANISM

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In an effort to forge agreement between stakeholder groups and provide a method for evaluating any type of funding mechanism, the ISWG created 11 principles that an ideal funding mechanism should satisfy. It was noted that any feasible funding mechanism is likely to address some of the principles more fully than other principles. The ISWG's principles are:

#### **Broad-Based Funding Mechanism Principles**

1. A funding mechanism should support the delivery and accessibility of high quality health care.
2. A funding mechanism should support the measurement and evaluation of interpreter services, accessibility, and quality to ensure that the interpreter services are adding value to the health care delivery system.
3. A funding mechanism should be stable and adequate to meet the need for interpreter services.
4. A funding mechanism should encourage and support the efficient and effective provision of interpreter services to minimize the overall system costs of providing needed services.
5. A funding mechanism should be based on the actual cost (market rate) of providing interpreter services, which can often include activities and time other than the time a provider spends with a patient.
6. A funding mechanism should be equitable for all patients needing interpreter services regardless of their: A) income levels; B) insurance status (i.e., insured/uninsured); and C) payer type (e.g., public/private, health/workers compensation, etc.).

7. A funding mechanism should fairly distribute the costs of interpreter services to ensure that costs do not fall disproportionately on health care providers (and perhaps payers) serving higher percentages of deaf and hard of hearing patients or limited English proficient patients.
8. A funding mechanism should be operationally simple with minimal red tape to avoid further fragmentation of our health care financing.
9. A funding mechanism should be designed to safeguard against fraud and abuse.
10. A funding mechanism should encourage interpreters to enter and remain in the health care field to facilitate equilibrium between the supply and demand for interpreter services.
11. A funding mechanism should encourage competitiveness by supporting new technologies and other advances in providing interpreter services that further supports meaningful access and patient care.

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### THREE BROAD-BASED FUNDING MECHANISMS

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The ISWG identified and discussed three general mechanisms for funding interpreter services:

1. The current funding mechanism;
2. A requirement for health plans and insurers to cover the cost of interpreter services provided to their enrollees; and
3. The creation of an Interpreter Services Funding Pool that would provide compensation to health care providers supplying interpreter services to patients.

In discussing each of the three funding mechanisms, the ISWG attempted to identify how the funding mechanism satisfied the Broad-Based Funding Mechanism Principles. There was significant disagreement between stakeholders on all aspects of the funding question. Likewise, some of the funding ideas were less well developed than others, so it was not always possible to evaluate the mechanisms in detail.

One of the challenges to evaluating any funding mechanism is that there is very little data available on: 1) the overall need for interpreter services, including the language or location of the need; 2) the degree to which the need is currently being met; 3) the impact the met need and unmet need are having on patients in the health care delivery system; and 4) the overall cost to the health care system of fully meeting the need for interpreter services. Given these limitations, the ISWG evaluated the following three mechanisms.

#### **Current Funding Mechanism**

Health care providers recognize that they have the legal obligation to provide adequate interpreter services to their patients. The current funding mechanism to address that obligation is a combination of: 1) health care providers paying for the expenses and attempting to incorporate those expenses into their rates when possible; and 2) health care providers receiving reimbursement from select payers (e.g., public programs and workers compensation). The ISWG discussions identified the issues for the current funding mechanism:

- The mechanism does not fairly distribute the costs of interpreter services, in that the expenses disproportionately affect health care providers serving higher percentages of deaf and hard of hearing patients or limited English proficient patients.
- Health care providers report having difficulty always satisfying the language needs of patients. Likewise, patients report that they do not always receive adequate language services. Hence,

despite providers' best intentions, the current mechanism for interpreter services does not always support the delivery and accessibility of high quality health care.

- The mechanism does not provide adequate support for interpreters to enter and remain in the health care field. For many, less frequently spoken languages, it can be difficult for interpreters to find full time employment, either salaried or independent contract. Consequently, it is difficult to maintain the availability of the professionally trained interpreters in these languages.
- The mechanism does not generally provide a systematic method for collecting data about the need for interpreters, supply of interpreters, or quality of interpreter services. Under the current mechanism, only payers that pay for interpreter services and collect administrative claims data have the ability to easily evaluate the role of interpreter services in the health care delivery system. Although health care providers frequently report costs as a barrier to providing interpreter services, there is little data to evaluate the extent of the barrier.
- Even when payers reimburse health care providers under the current mechanism, those payments are often substantially less the providers' actual cost for providing services. Hence, the current reimbursement is may not be adequately associated with the actual cost of providing interpreter services.

The current funding mechanism places the majority of the responsibility of paying for interpreter services onto health care providers. Providers report having difficulty absorbing these costs, which contributes to an under provision of interpreter services in the health care delivery system.

#### **Requirements for Health Plans to Cover Interpreter Costs**

A second funding mechanism places a requirement on health plans and insurers to cover the cost of interpreter services provided to their enrollees. This funding mechanism is captured in Senate File 827.4<sup>32</sup> from the 2007 Session of the Minnesota Legislature. This mechanism would: 1) require health plans to cover sign language interpreter services provided to deaf and hard of hearing enrollees and limited English proficient enrollees; 2) allow health plans the flexibility to pay for staff interpreters or to create a network of interpreters eligible for payment; and 3) allows health plans to set minimum quality standards for interpreters to be eligible reimbursement.

This funding mechanism would only apply to health plans subject to state regulation. That is, this requirement would only apply to the fully-insured market and could not be mandatorily extended to self-insured, ERISA plans. The ISWG discussions identified the issues for the current funding mechanism:

- There was significant disagreement about whether or not this funding mechanism would fairly distribute the costs of interpreter services to ensure that costs do not fall disproportionately on health care providers (and perhaps payers) serving higher percentages of deaf and hard of hearing patients or limited English proficient patients. Health care providers generally believed that this mechanism more fairly distributed the costs of interpreter services, because it allowed them to be reimbursed for interpreting services and allowed payers to more broadly incorporate those expenses into their premium structure. Health plans and employers generally believed that this mechanism does not fairly distribute the costs of interpreter services, because it pushes the expenses only onto the premiums of fully-insured enrollees. Health plans and employers expressed concern that this funding mechanism will not address language issues for the self-insured health plan enrollees or the uninsured, while increasing the premiums of fully-insured health plan enrollees. Employers in particular noted that such requirements on fully-insured insurance products and the associated costs will continue to push employers into self-insured products.

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<sup>32</sup> <http://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S0827.4.html&session=Is85>

- Some stakeholders noted that this funding mechanism is not equitable for all patients in that it does not cover the uninsured or the self-insured. However, other stakeholders believed that this mechanism is fairer than the current funding mechanism, which provide interpreter services as a covered plan benefit for an even smaller set of health plan members/public program enrollees.
- This system would build on the current administrative claims systems. As such, this system would be: 1) operationally simple with minimal new processes that further fragment health care financing; 2) able to safeguard against fraud and abuse in a manner similar to that used for other health care services; and 3) able to use claim data to evaluate the value of interpreter services in the health care system.
- Some stakeholders questioned whether this funding mechanism would encourage and support the efficient and effective provision of interpreter services. Although this funding mechanism would give health care providers increased reimbursement, it is unclear if extending the current mechanism's payment rules would incent health care providers to find the most efficient way to provide appropriate language services.

Most of the discussion related to this funding mechanism focused on the fairness of shifting interpreter expenses from providers to fully-insured health plans. Complicating the discussion was the lack of information about the amount of those expenses and their possible impact on premiums. While all stakeholders agreed that a funding mechanism that applied to all payers or otherwise more broadly distributed the costs would be beneficial, the stakeholders disagreed if this mechanism moved in that direction.

#### **Creation of an Interpreter Services Funding Pool**

The ISWG discussed a variety of other funding mechanisms that can be grouped together and described as the creation of an Interpreter Services Funding Pool that would reimburse health care providers that provide interpreter services to patients. All of the pooling ideas shared some common aspects, such as needing a funding source for the pool and a mechanism to receive reimbursement from the pool. Some of the key details that would be needed for any pool are:

**Interpreter Services Funding Pool - Funding Source** – The creation of a central pool requires some on-going mechanism to fund the pool. The ISWG discussed the following possible sources:

- The Health Care Access Fund
- The General Fund
- Property taxes
- Grants or other non-state dollars

While the stakeholders identified these as possible sources of funding a central pool, the stakeholders did not agree on the best source of the funds.

**Interpreter Services Funding Pool - Amount of Funding** – The ISWG was not able to obtain data on the amount of funding that a pool would require to fully meet the unmet need for interpreter services. All stakeholders were able to agree that any pooling mechanism should not displace current funding mechanism; particularly funds that might be receiving federal matching funds.

**Interpreter Services Funding Pool – Receiving Reimbursement** – The ISWG did not generally have the time to create a detailed mechanism for health care providers to receive reimbursement from the pool for

interpreter services. However, the ISWG considered two mechanisms that serve as examples of feasible reimbursement mechanisms:

- Health care providers could be required to submit requests for reimbursement every 6-12 months. These submissions would include aggregate data about their interpreter expenses, amount of interpreter service, language needs, and other data. The pool would then pay a pro rata share of health care providers' interpreter expenses up to the amount available in the pool.
- Health care providers would be required to submit administrative claim data to the pool and the pool would use that data to provide payment. Given the uncertainty about the volume of claims, the pool may need to use the claims to pay a pro rata share of expenses.

The ISWG was not able to more fully develop an interpreter services funding pool mechanism, however almost all stakeholders believed that there should be further research into the development of some pooling mechanism. However, even with the current level of detail the ISWG was able to discuss this funding mechanism and compare this general mechanism to the ISWG principles:

- This mechanism has the potential to most fairly distribute the costs of interpreter services through the use of funding source support by a broad tax (e.g., HCAF or the General Fund). Although some of the sources, such as property taxes would not meet this criterion.
- Stakeholders were concerned that this model would need to be carefully designed to avoid displacing current funding sources, particularly reimbursement from public programs.
- Stakeholders also noted that the funding source for the pool would have a significant impact on the stability of the pool. For example, grants and property taxes are not particularly stable sources, whereas the General Fund and Health Care Access Fund tend to be more stable.
- This mechanism is equitable in that it would apply to all patients, including the uninsured.
- Some stakeholders were concerned about the cost and efficiency of such a funding mechanism. This mechanism would create an additional financing mechanism for the health care delivery system, and could be expensive to operate. Likewise, the exact details of the reimbursement mechanism would be required to determine if the pool would be able to safeguard against fraud and abuse.
- Some stakeholders were also concerned that a pool would not be able to encourage competitiveness by supporting new technologies and other advances in providing interpreter services that further support meaningful access. Unless the pooling mechanism includes incentives for providers to be efficient in their provision of interpreter services, this mechanism may not help to keep the interpreter services cost under control and to ensure adequate provision of language services.

The ISWG was unable to find consensus around on the advantages and disadvantages of these three funding mechanisms. Even comparing the funding mechanism to the 11 principles generated significant difference between stakeholders. Consequently, the ISWG is unable to offer any specific recommendations on the adoption of a specific funding mechanism.

## CONCLUSIONS

Accurate and effective communication between patients and health care providers is critical to the delivery of quality health care. When language barriers exist, the inability to adequately communicate can lead to misunderstanding, dissatisfaction, the omission of vital information, misdiagnoses, inappropriate treatment, and failure to comply with treatment protocols.

The ISWG has documented through its discussion and through this report to the Minnesota Legislature that:

- Health care providers have a legal obligation to ensure meaningful access to their programs/activities by limited English proficient patients, including providing language services that eliminate barriers to communications. Providers also have a legal obligation to provide effective communication to people who have a hearing loss. Health care providers may use a variety of auxiliary aids and services, but the result must be communication that is equally effective as communication with other individuals without hearing loss.
- Surveys show that health care providers are making efforts to meet the language needs of patients. However, providers face a number of barriers in fully addressing interpreter services needs and many patients face an unmet need for available, high quality interpreter services.
- Evidence demonstrates an increasing need for interpreter services in health care settings.
- The scientific evidence suggests that providing patients with trained, professional interpreters leads to optimal communication, the highest satisfaction, the best outcomes, and the fewest errors with clinical consequence occur.
- The competency and quality of sign language interpreters is assessed and documented through the Registry of Interpreters for the Deaf (RID), which administers a national certification system for sign language interpreters. This system provides an adequate framework and standards to ensure effective communication between patients and clinicians delivering health care
- There is no state or national certification system for ensuring the quality or competency of spoken language interpreters working in health care and the development of such a certification system is 5-10 year away. An important interim step would be the development of a statewide health care interpreter registry, either in the private or public sector.
- The Work Group identified and discussed three general mechanisms for funding interpreter services: 1) the current funding mechanism; 2) a requirement for health plans and insurers to cover the cost of interpreter services provided to their enrollees; and 3) the creation of an Interpreter Services Funding Pool that would provide compensation to health care providers supplying interpreter services to patients.
- Evaluating the funding mechanisms was difficult because: 1) there are no data sources to calculate the overall cost to the health care system of fully meeting the need for interpreter services; and 2) no feasible funding mechanism is likely to satisfy all of the ISWG's principles for an ideal, broad-based funding mechanism.
- There was significant disagreement about the best funding mechanism to fully meet the interpreter services needs of patients. The ISWG was unable to come to consensus on the merits, advantages, and disadvantages of any particular funding mechanism.

## APPENDIX A ISWG EXECUTIVE COMMITTEE PARTICIPANTS

The following individuals served as an Executive Committee for the Interpreter Services Work Group. The Executive Committee represented key stakeholders and directed the activities of the Work Group.

Pat Adams

Dakota County Public Health Director on behalf of the Local Public Health Association of Minnesota  
Representing: Local Public Health & Social Service Agencies

Marty Barnum CSC,

Minnesota Department of Human Services: Deaf and Hard of Hearing Division  
Representing: Sign Language Interpreters

Carol Berg

UCare Minnesota  
Representing: Interpreting Stakeholder Group

Sue Dicker

Minnesota Department of Health: Refuge Health Program  
Representing: Consumers of Spoken Language Interpreting

Bruce Downing

University of Minnesota  
Representing: Interpreter Training

Alejandro Maldonado

Minnesota Department of Human Services: Limited English Proficiency Coordinator  
Representing: State Agencies – Spoken Language Interpreters

Mursal Khaliif

Fairview Health Services  
Representing: Hospitals

Kathryn Kmit

Minnesota Council of Health Plans  
Representing: Health Plans

Judy Neppel

Minnesota Rural Health Association  
Representing: Rural Representatives

Heather Ortiz CI CT

Minnesota Department of Human Services: Deaf and Hard of Hearing Division  
Representing: State Agencies – Sign Language Interpreters

Dave Renner

Minnesota Medical Association  
Representing: Health Care Providers

Phillip Riveness

Noran Neurological Clinic, on behalf of the Minnesota Medical Group Management Association

Representing: Clinic Administrators

Erin Sexton

Representing: Minnesota Chamber of Commerce

Representing: Health Care Purchasers/Employers

Minh Tong

Kim Tong Translation Service

Representing: Spoken Language Interpreter Service Agencies

Cynthia Weitzel

Minnesota Commission Serving Deaf & Hard of Hearing People

Representing: Consumers of Sign Language Interpreting

## APPENDIX B RESOURCES

### **[www.lep.gov](http://www.lep.gov)**

LEP.gov is maintained by the Federal Interagency Working Group on Limited English Proficiency. This website serves as a clearinghouse, providing and linking to information, tools, and technical assistance regarding Limited English Proficiency and language services for federal agencies, recipients of federal funds, users of federal programs, federally assisted programs, and other stakeholders.

### **[www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf](http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf)**

A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations – Developed for the Office of Minority Health, US Department of Health and Human Services by the American Institutes for Research.

### **[www.lep.gov/lep\\_aug2005.pdf](http://www.lep.gov/lep_aug2005.pdf)**

Brochure – Limited English Proficiency: What Federal Agencies and Federally Assisted Programs Should Know About Providing Services to limited English proficient Individuals – Developed by the US Department of Justice, Civil Rights Division.

### **[www.lep.gov/LEP\\_beneficiary\\_brochure.pdf](http://www.lep.gov/LEP_beneficiary_brochure.pdf)**

Brochure – Know Your Rights – Developed by the Federal Interagency Working Group on Limited English Proficiency. The brochure is available in the Arabic, Cambodian, Chinese, Creole, English, Hmong, Korean, Russian, Spanish, and Vietnamese languages.

### **[www.usdoj.gov/crt/cor/coord/titlevi.htm](http://www.usdoj.gov/crt/cor/coord/titlevi.htm)**

US Department of Justice, Civil Rights Division, web page devoted to Title VI of the Civil Rights Act of 1964. This webpage provides access to documents, publications, training, and complaint process materials.

### **[www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf](http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf)**

US 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.

### **[www.healthlaw.org](http://www.healthlaw.org)**

Website of the National Health Law Program. Click on Language Access for language access resources and legal publications

### **[www.kff.org/uninsured/upload/Ensuring-Linguistic-Access-in-Health-Care-Settings-An-Overview-of-Current-Legal-Rights-and-Responsibilities-PDF.pdf](http://www.kff.org/uninsured/upload/Ensuring-Linguistic-Access-in-Health-Care-Settings-An-Overview-of-Current-Legal-Rights-and-Responsibilities-PDF.pdf)**

Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities. Prepared by the National Law Program for the Kaiser Commission on Medicaid and the Uninsured.

### **[www.omhrc.gov/assets/pdf/checked/finalreport.pdf](http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf)**

CLAS Standards - National Standards for Culturally and Linguistically Appropriate Services in Health Care. Authored by the US Department of Health and Human Services, Office of Minority Health. Full report directed toward health care organizations and individual providers.

### **[www.hhs.gov/ocr/504ada.pdf](http://www.hhs.gov/ocr/504ada.pdf)**

Your Rights Under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990. Fact sheet developed by the US Department of Health and Human Services, Office of Civil Rights, for individuals.

**[www.usdoj.gov/crt/ada/hospcombrprt.pdf](http://www.usdoj.gov/crt/ada/hospcombrprt.pdf)**

Communicating with Deaf and Hard of Hearing People in Hospital Settings. Developed by the US Department of Justice, Civil Rights Division, Disability Rights Division, informing hospitals of their obligations to effectively communicate with patients, family members, and hospital visitors who are deaf or hard of hearing.

**[www.mmaonline.net/pdf/toolkitoninterpreterservices2004.pdf](http://www.mmaonline.net/pdf/toolkitoninterpreterservices2004.pdf)**

A Physician's Guide to Language Interpreter Services. Minnesota Medical Association, 2004. Includes an overview of regulations, reimbursement issues, and sample forms.

**[www.ada.gov](http://www.ada.gov)**

The Americans with Disabilities Act - Home Page. Information and technical assistance for the Americans with Disabilities Act developed the US Department of Justice.

**[www.rid.org](http://www.rid.org)**

Registry of Interpreters for the Deaf. Includes Code of Professional Conduct, Code of Ethics for sign language interpreters, and certification levels.

**[www.mrid.org](http://www.mrid.org)**

Minnesota Registry of Interpreters for the Deaf. Minnesota Chapter of Registry of Interpreters for the Deaf.

**[www.ncihc.org](http://www.ncihc.org)**

National Council on Interpreting in Health Care. Includes recommended standards of practice and code of ethics for spoken language interpreting in health care settings.

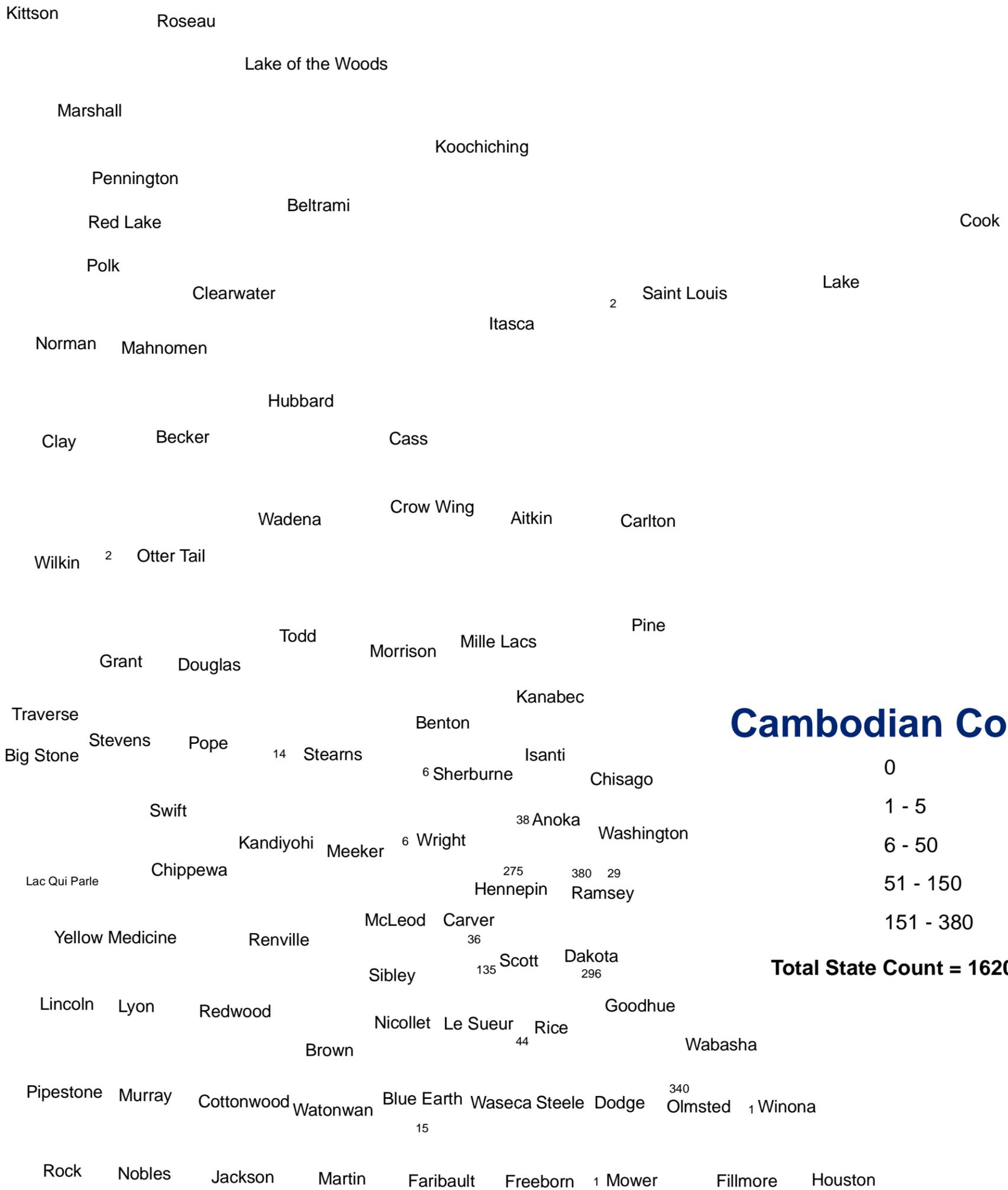
## **APPENDIX C PRIMARY HOME LANGUAGE COUNTS – BY COUNTY**

The following data and maps were created by the Minnesota Department of Education. The data used to create these maps are gathered through the Minnesota public school system. Families who speak languages other than English but do not have children in the public school system are not included in these numbers. In addition, the data are self reported and reflect only responses that indicate that a language other than English is the primary home language. Therefore it is likely that the numbers of families speaking languages other than English is greater than the numbers reflected on these maps.





# Primary Home Language Counts by County 2006-2007 Cambodian



## Cambodian Counts

- 0
- 1 - 5
- 6 - 50
- 51 - 150
- 151 - 380

**Total State Count = 1620**



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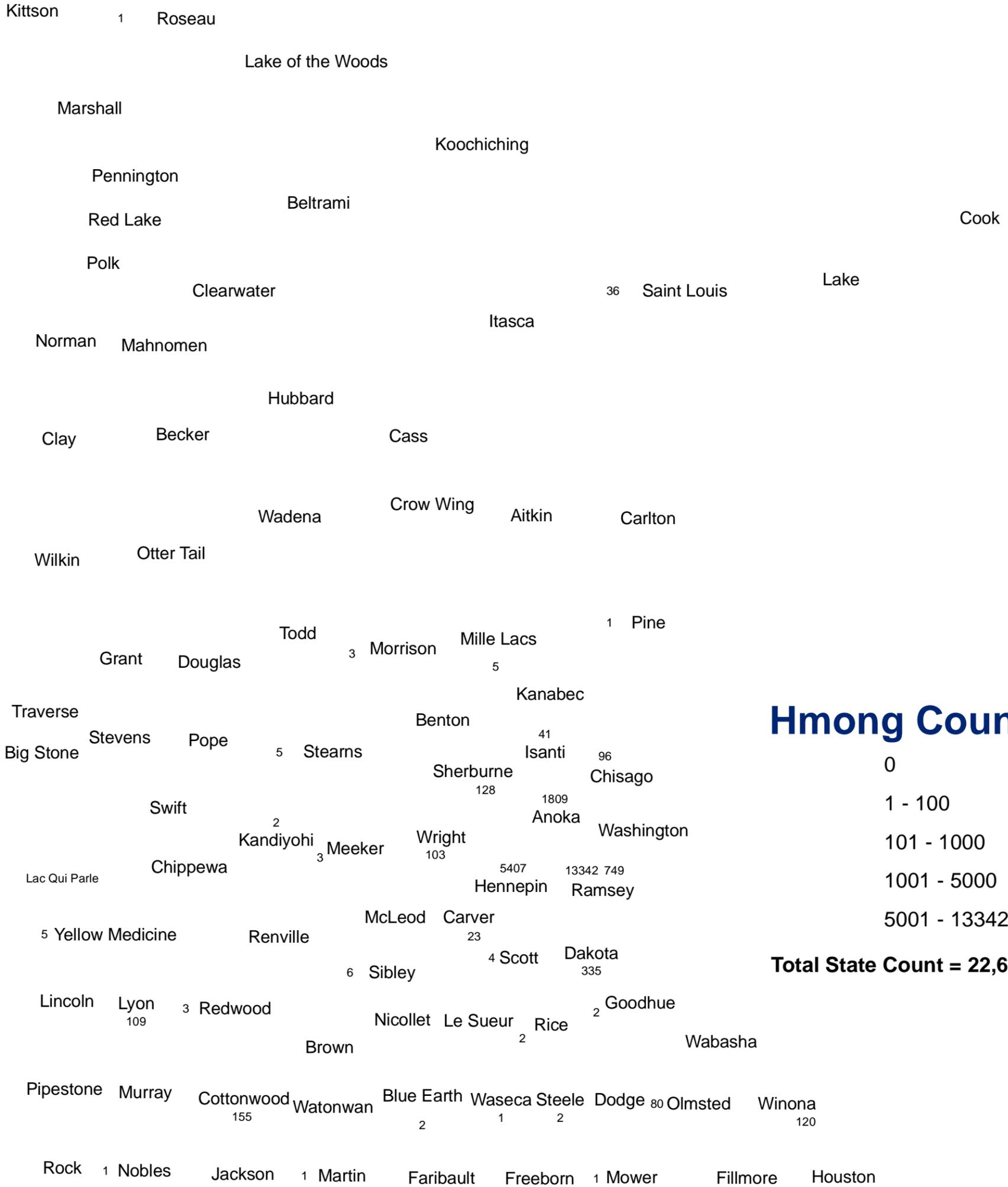
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Project Track #: M0023  
Location: c:\ArcGIS\_Projects\M0023 JS/IT



# Primary Home Language Counts by County 2006-2007 Hmong



## Hmong Counts

- 0
- 1 - 100
- 101 - 1000
- 1001 - 5000
- 5001 - 13342

**Total State Count = 22,665**



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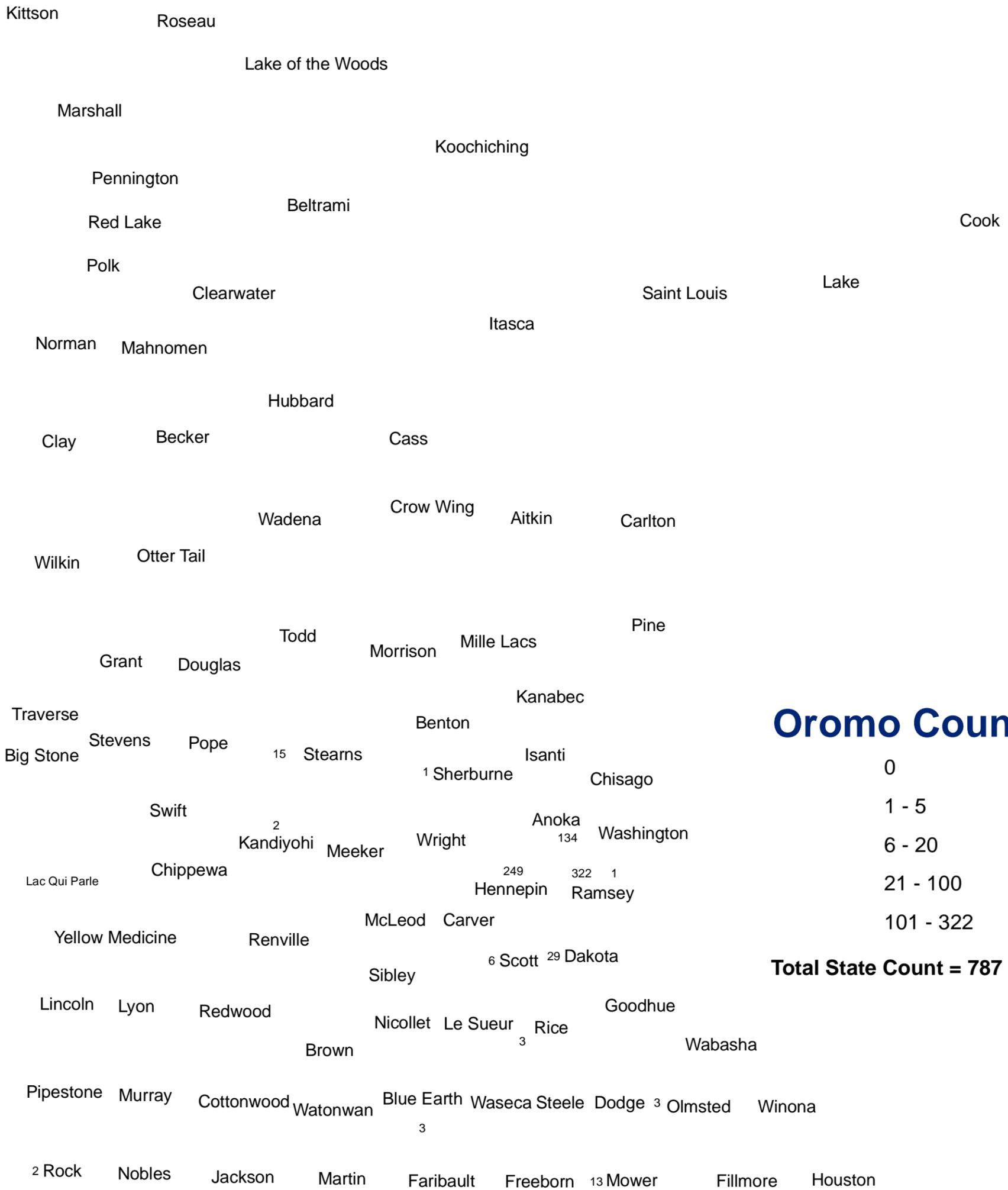
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# Primary Home Language Counts by County 2006-2007

## Oromo



### Oromo Counts

- 0
- 1 - 5
- 6 - 20
- 21 - 100
- 101 - 322

**Total State Count = 787**



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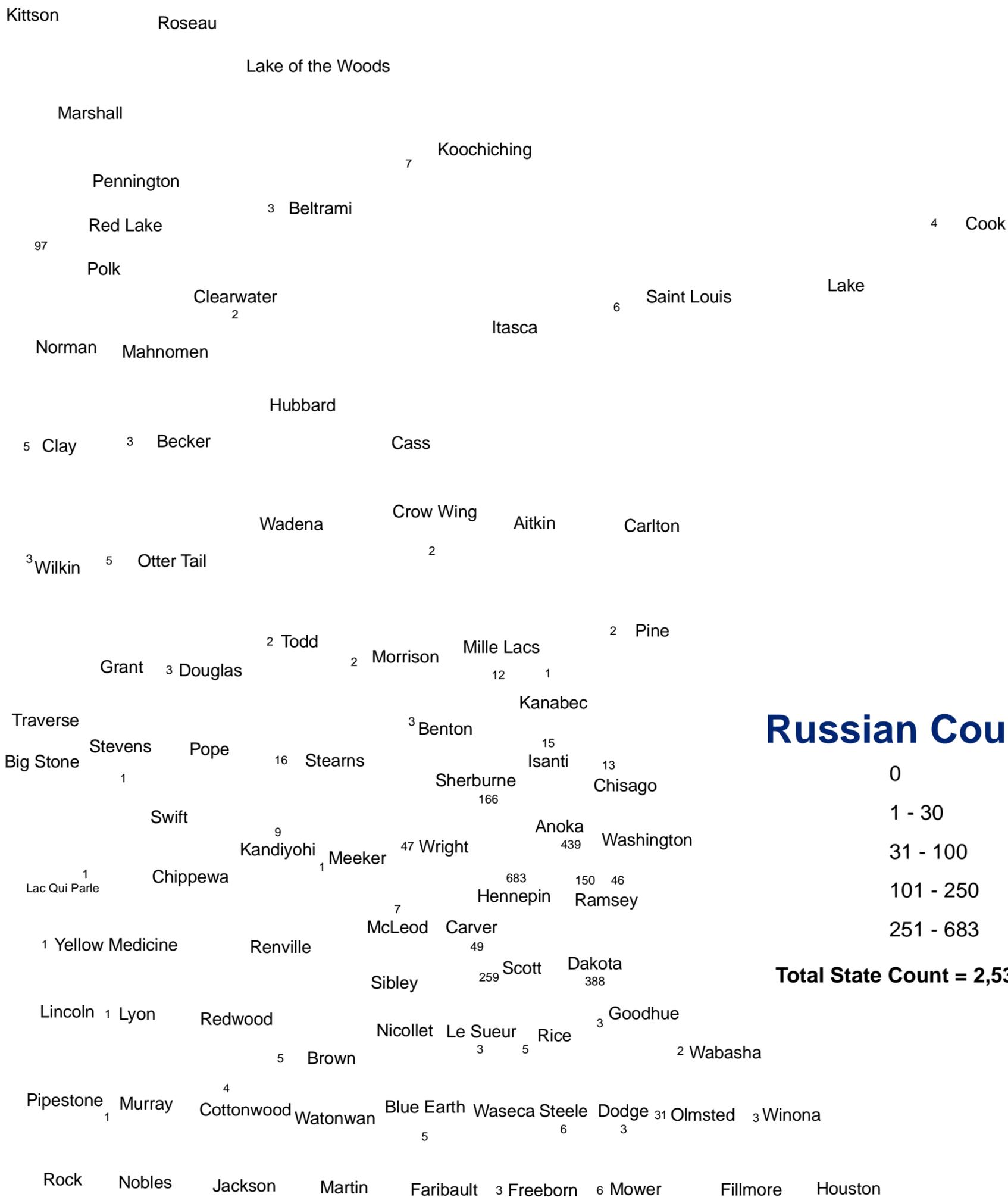
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# Primary Home Language Counts by County 2006-2007 Russian



## Russian Counts

- 0
- 1 - 30
- 31 - 100
- 101 - 250
- 251 - 683

**Total State Count = 2,534**



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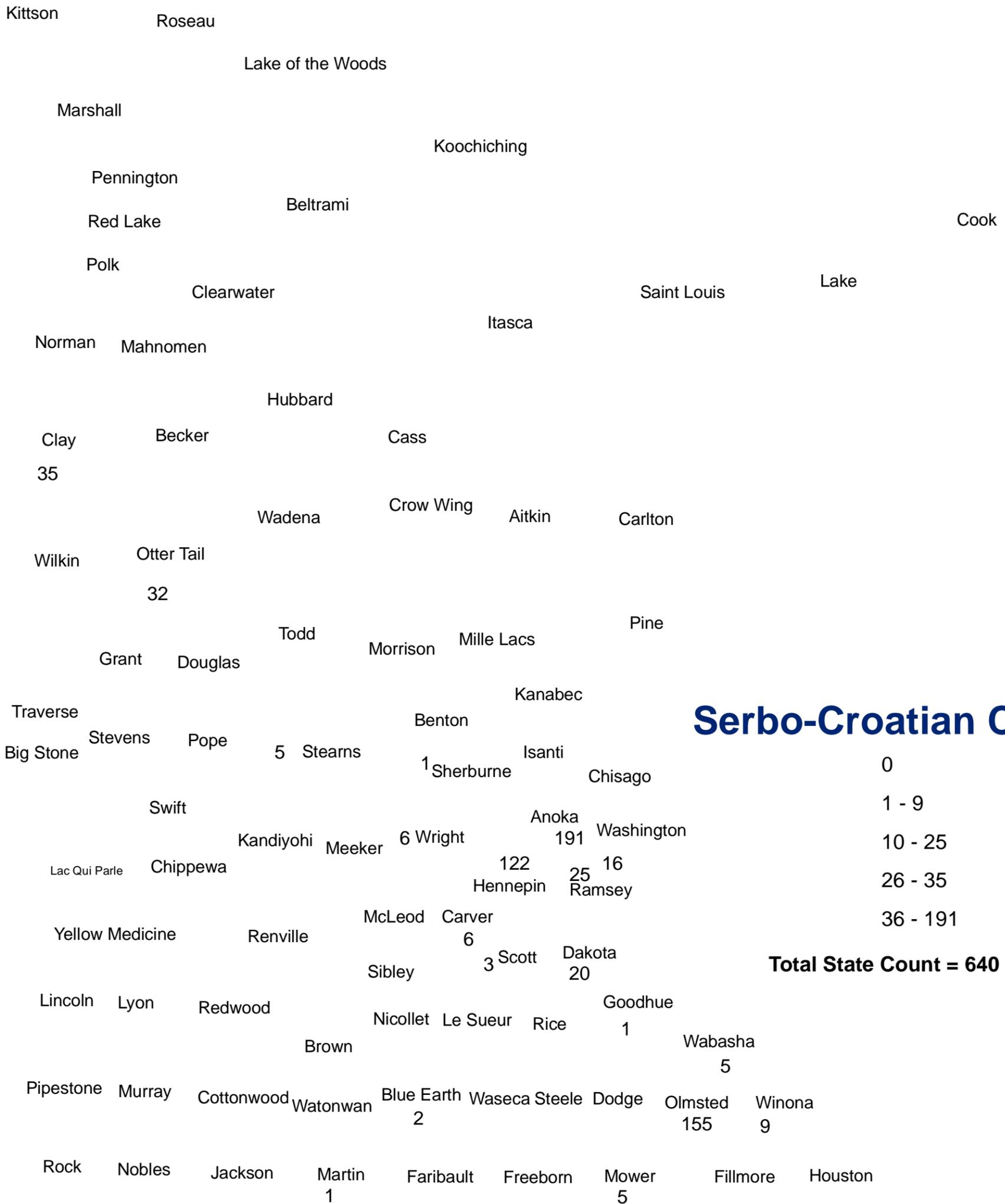
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# Primary Home Language Counts by County 2006-2007 Serbo-Croatian



## Serbo-Croatian Counts

- 0
- 1 - 9
- 10 - 25
- 26 - 35
- 36 - 191

**Total State Count = 640**



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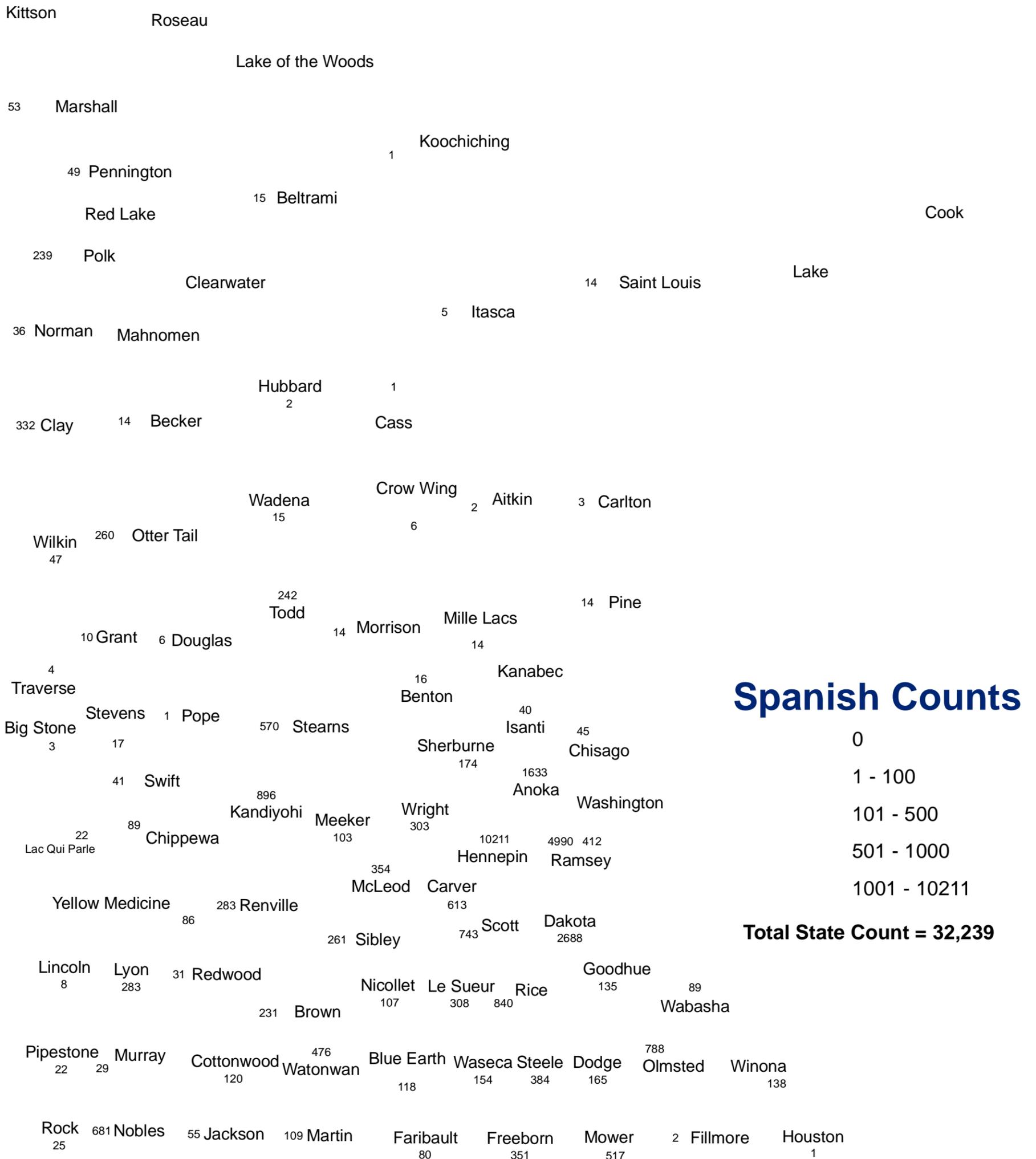
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# Primary Home Language Counts by County 2006-2007 Spanish



## Spanish Counts

- 0
- 1 - 100
- 101 - 500
- 501 - 1000
- 1001 - 10211

**Total State Count = 32,239**



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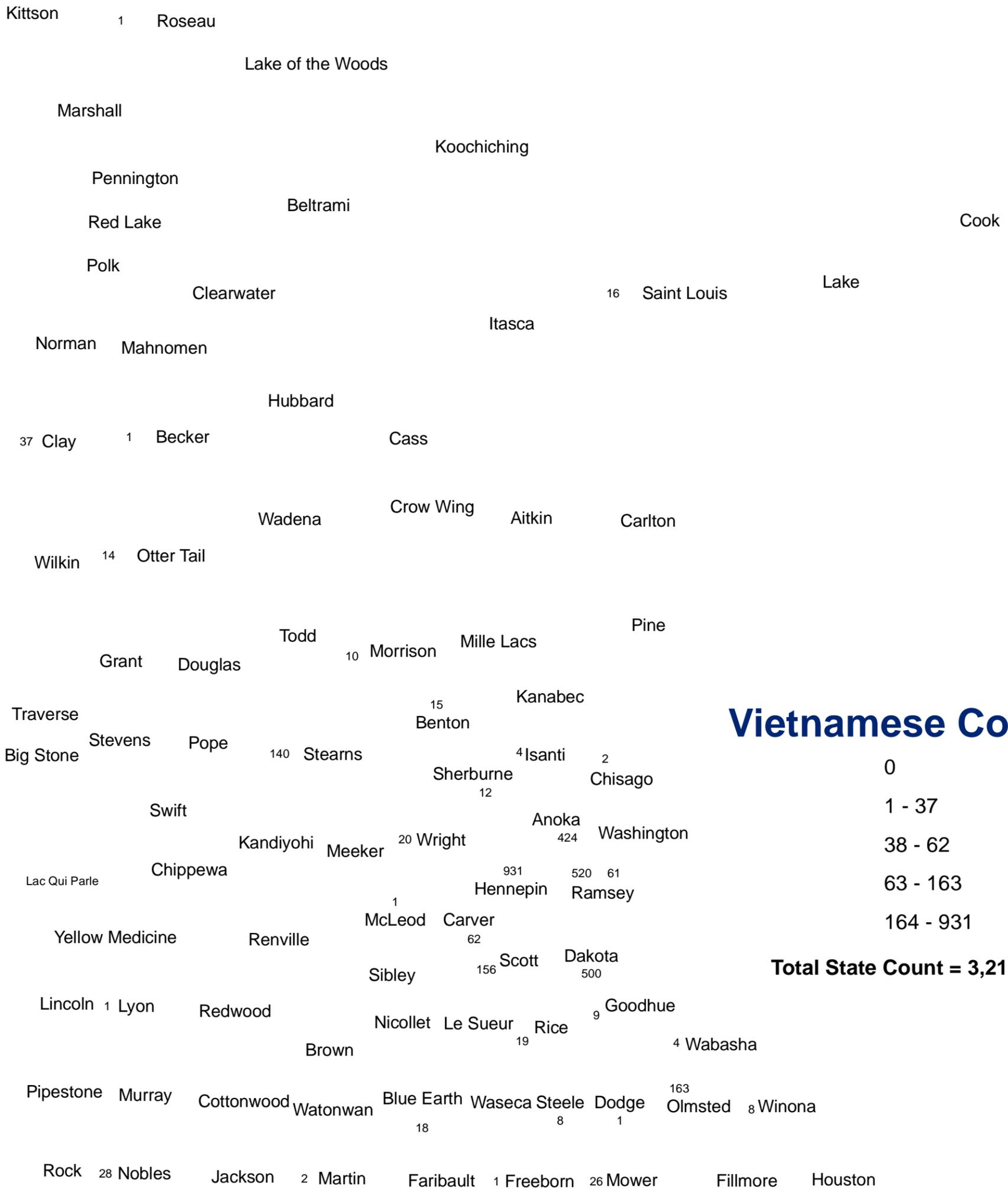
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# Primary Home Language Counts by County 2006-2007 Vietnamese



## Vietnamese Counts

- 0
- 1 - 37
- 38 - 62
- 63 - 163
- 164 - 931

**Total State Count = 3,215**



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