



What a Difference an Interpreter Can Make

Health Care Experiences of Uninsured with Limited English Proficiency

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About The Access Project

The Access Project is a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. The project receives its funding from a variety of public and private sources.

The mission of The Access Project is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. The Access Project conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. It seeks to enhance the knowledge and skills of community leaders to strengthen the voice of underserved communities in the public and private policy discussions that directly affect them.

If you have any questions or would like to learn more about our work, please contact us.

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Executive Summary

As the United States becomes more ethnically and racially diverse, health care providers face growing challenges to ensure that patients with limited English proficiency (LEP) have adequate language assistance services, such as access to interpreters and written materials translated into their native language. The importance of such services is underlined by the recent promulgation of federal standards on culturally and linguistically appropriate services in health care settings, as well as federal requirements that all entities that receive federal funds, including health care organizations, must offer language assistance services to patients with LEP at all points of contact with their systems.¹

This report, based on a survey of 4,161 uninsured respondents who received health care between May and August of 2000 at 23 primarily safety net hospitals in 16 cities, compares the perceptions and experiences of adults who needed and easily got an interpreter with those who needed and did not get an interpreter (or had difficulty getting one), and with other uninsured who did not need an interpreter. Overall, the uninsured who got an interpreter had similar or more positive experiences at the hospital where they received care than the uninsured without language barriers. However, adults who needed and did not get an interpreter had more negative perceptions about their health care experiences than those who either got interpreter services or did not need them.

“The hospital is very clean, but...I saw how people who don't speak English are treated like they are nothing.”

Key Findings

Perceptions of Hospital Attitudes toward the Uninsured

Three of four (74%) respondents needing and getting an interpreter said that the facility they used was “open and accepting,” compared to fewer than half (45%) of the respondents who needed and did not get an interpreter and 57% who did not need an interpreter.

Satisfaction with Medical and Support Staff Encounters

Those who needed but did not get an interpreter were the least likely to report satisfaction with the courtesy and helpfulness of medical and support staff.

Understanding Medication Instructions and Paying for Prescription Drugs

Among uninsured whose doctor prescribed medication, 27% of those who needed but did not get an interpreter said they did not understand the instructions for taking their medications, compared to only 2% of those who either got an interpreter or did not need one.

Among the uninsured who reported needing help paying for their medications, one third (32%) of those who needed and got an interpreter

“I would tell the doctor ‘okay,’ but I didn't understand anything [about taking my medications].”

“ I didn’t buy the medicines because I didn’t understand the instructions. ”

said staff “always” asked them if they needed help — a rate five times that for those who needed an interpreter but did not get one (6%).

Paying for General Medical Care

Among those who reported needing help to pay for their medical care, more than half of those who needed but did not get an interpreter (54%) said staff “never” asked if they needed financial assistance, while only one-third (36%) of those who needed and got an interpreter said they were “never” asked.

Effects of Financial Experiences on Likely Future Health Care Use

Among those who reported having unpaid bills or being in debt to the hospital where they received care, respondents who needed an interpreter but did not get one were much more likely to say they would not seek care at that facility in the future because of their debt (40%) than those who needed and got an interpreter (26%) and those who did not need an interpreter (21%).

One third (32%) of those who needed an interpreter but did not get one said they would not use the hospital in the future if they became insured, as did one-quarter (24%) of those who did not need an interpreter. However, only 9% of those who needed and got an interpreter said they would not use the hospital in the future if they had insurance coverage.

Implications of Survey Findings

- A significant portion of respondents who needed but did not get an interpreter reported leaving the hospital without understanding how to take prescribed medications. The finding suggests a strong need for improving oral and written communication about medication instructions for uninsured with limited English proficiency.
- Having access to interpreter services may enhance access to care by lessening the likelihood that uninsured with limited English proficiency will avoid or delay needed health care or switch facilities frequently because of unpaid medical bills.
- Improving communication about financial information and financial assistance programs with non-English speaking patients may potentially benefit hospitals, as well as patients, by expanding hospitals’ ability to obtain at least some payment for services provided, rather than none, when a patient cannot afford to pay for care.
- Reducing language barriers that may affect health care access and quality requires financial resources for hospitals and other health care providers. Currently, only five states (Hawaii, Maine, Minnesota, Utah and Washington) take advantage of federal Medicaid and SCHIP matching funds available to help health care institutions cover the cost of providing language assistance services. Many more states could pursue this funding strategy or other funding options.

“ They should keep in mind that there are Latinos who only speak Spanish, and we need information about payment plans. ”

I. Introduction

As the United States becomes more ethnically and racially diverse, health care providers face growing challenges to ensure that patients with limited English proficiency (LEP) have access to adequate language assistance services. Where such assistance is not available to meet patient needs, lack of proficiency in English may have significant, if not life-threatening, consequences. Linguistic barriers can impede access to timely health care, as well as patients' ability to communicate symptoms, follow medical advice and understand medication instructions.

Census data convey a sense of the growing portion of the U.S. population that is likely to experience LEP.² It has grown to 11% today, compared to 8% in 1990.³ The U.S. Hispanic population grew 58% between 1990 and 2000, to 35.3 million.⁴ In cities with large numbers of Hispanics, significant portions of the population are native Spanish speakers who do not speak English well or at all. Proportions range from 7% in New York City and Chicago, 16% in Houston and Los Angeles, to 33% in Miami.⁵

Lack of insurance among these populations, particularly in urban centers, compounds the challenges to the health care system. The latest figures show that Hispanics are more than twice as likely to be uninsured as the general population (33% vs. 14%),⁶ and immigrants are more likely to be uninsured than those born in the United States.⁷ As has been well-documented, the uninsured are less likely to have a regular source of care, more likely to delay care, more likely to say that they have not received needed care — and more likely to depend on safety net institutions than those who have health insurance.^{8,9}

The uninsured who also have a limited command of English often face more significant challenges navigating the health care system and communicating with providers. A recent national survey of adults found that 43% of Hispanics who primarily speak Spanish reported communication problems with their physicians, compared to 26% of Hispanics who primarily speak English.¹⁰ Several studies of patients with language barriers who visited an urban hospital emergency department found these patients to be less satisfied with their care, less willing to return to that facility,¹¹ and less likely to be given a follow-up appointment¹² compared to those without language barriers. Others have found that non-English speakers are less likely to have a usual source of care¹³ or receive preventive care such as mammography and pap smear tests.¹⁴

In August 2000, the federal Office for Civil Rights (OCR) of the Department of Health and Human Services mandated that any entities that receive federal funds, including health care organizations (e.g., through Medicaid or the Children's Health Insurance Program), "must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."¹⁵ This is not a new law, but rather a clarification of Title

“The receptionist told me to speak English or to find someone who does.”

“I went with my cousin and she helped me, because neither the doctor nor the nurse knew Spanish.”

VI of the Civil Rights Act of 1964. Essentially, service providers who fail to provide meaningful access to individuals with LEP are considered to be discriminating based on national origin.

This issue brief focuses on those individuals who face two sets of health care barriers — lack of health insurance and limited English proficiency — who obtained care in a safety net hospital. Working with local community partners, The Access Project gathered information about the experiences of the uninsured through the Community Access Monitoring Survey. Survey respondents were uninsured adults who received care in the previous year at selected local health care facilities, which included 23 urban and suburban hospitals in 16 cities. The hospitals were largely safety-net facilities, that is, those that treat a large number of uninsured patients. Native Spanish speakers made up 95% of respondents with LEP included in the survey.¹⁶

“ I was treated OK [but]
because we can't speak
English, they don't
listen to us. ”

Uninsured respondents who needed and obtained interpreter services fared as well as or better than uninsured respondents without language barriers with respect to their perceptions of the hospital's treatment of the uninsured; satisfaction with the helpfulness of medical and support staff; being asked if they needed help paying for their medical care or prescription drugs, among those who reported needing help; and their likelihood of using the hospital in the future if they became insured.

On each of these same measures, uninsured respondents with language barriers for whom interpreters were not readily available were much more likely to report negative responses and, among those in debt to the hospital, were more likely to say that their debt would keep them from returning to the facility for care in the future, compared to the group who needed and obtained interpreter services. Regarding patient safety, the results lend support to the value of interpreter services for assuring that uninsured LEP patients understand instructions for taking their prescription medications.

II. Survey Methods and Data Sample

Survey Methods

The Access Project designed the Community Access Monitoring Survey (CAMS) project to help local organizations enhance their effectiveness in promoting increased access to health care for the uninsured in their communities. The Access Project provided financial and technical assistance to 24 community organizations in 18 states to survey over 10,000 uninsured patients receiving care in 58 hospitals and clinics. To be eligible to participate, respondents had to have received care during the previous year, while uninsured, at one of the facilities included in the study.

Conducted between May and August 2000, the survey was based on a non-probability sample. Community groups chose facilities based in part on their ability to identify a sufficient number of uninsured who had received care at the facility in the past year. Surveyors recruited respondents in neighborhoods served by targeted facilities, at places such as community

centers, meal programs, grocery stores, employment offices, and by going door-to-door. In order to meet the goal of interviewing a minimum of 150 respondents per facility, most hospitals included in the CAMS project were urban or suburban hospitals that treat the uninsured. This report is based on findings from these 23 hospitals. (See the Appendix for a list of the included hospitals.)

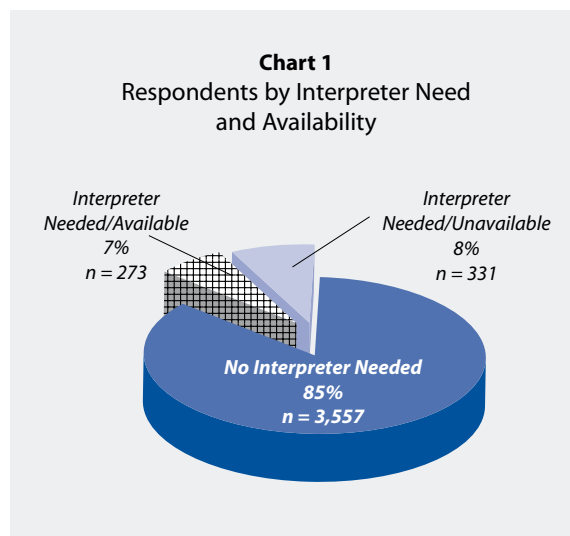
The survey asked respondents a range of questions about their experiences at the facility, including the facility's reputation for treating the uninsured; how medical and support staff treated them; ease of access to services; difficulty paying for prescription drugs and medical care; need for financial assistance to pay for medications and care; indebtedness to the facility and whether it would affect future use of the facility; interest in using the facility in the future if insurance paid for care; need for and access to interpretation services; and the availability of information for those with limited proficiency in English.

Data Sample

The analysis for this issue brief is limited to surveys of 4,161 uninsured respondents¹⁷ reporting on the 23 urban and suburban hospitals in 15 cities included in the sampling frame.* Of this total, 3,557 (85%) of the uninsured answered "No" when asked if they needed help with translation "because you spoke little or no English;" in this report, they are called the No Interpreter Needed group.

The remainder answering "Yes" were asked about the availability of an interpreter to assist them, with 273 (7%) reporting that an interpreter was "Very available — the doctor or nurse spoke my language and was there for treatment" or "Available — an interpreter was there when I was treated;" they are referred to as the Interpreter Needed/Available group. Another 331 who needed interpreter assistance (8%) said an interpreter was "Not very available — the wait for someone who spoke my language was a long time" or "Unavailable — someone with me (a friend or family member) had to translate;" they are referred to as the Interpreter Needed/Unavailable group. Because all but 5% of respondents needing interpreters were native Spanish speakers, we excluded surveys of respondents requiring interpreters for other languages (See Chart 1).

Each group was compared to the other two independently, using a one-way analysis of variance (ANOVA). Unless otherwise noted, all results reported are significant at the 5% level ($p < .05$).

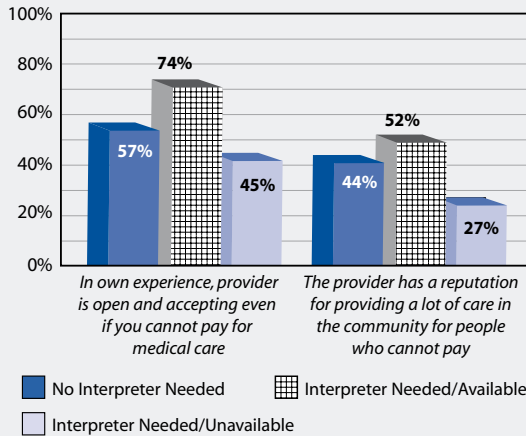


*Of the 23 hospitals reported on, 17 included respondents reporting a need for interpreter services. Six facilities accounted for 67% of respondents needing and obtaining interpreter services, 71% needing but not obtaining an interpreter, and 18 percent of uninsured not needing such help. 85% of uninsured who completed the survey in Spanish obtained care at these same six facilities. This concentration of respondents with limited English proficiency in a small number of facilities is a result of non-probability sampling and therefore does not represent a true distribution of where those with LEP obtained care. Therefore, we cannot measure the effect of interpretation services on survey responses independently from hospital characteristics, which could potentially bias the results. However, we obtained similar results when we conducted analyses with and without the six hospitals.

The three groups varied somewhat on several demographic measures. Respondents with LEP were more likely to be under age 30 and female compared to the No Interpreter Needed group. Both LEP groups had high proportions of Hispanics compared with the No Interpreter Needed group.

No differences appeared among respondents in the three groups regarding the number of or reasons for their visits in the past year.

Chart 2
Respondents with Positive Perceptions of Provider’s Openness to Uninsured and Reputation in Community



III. Key Findings

Perceptions of Hospital Attitudes Toward the Uninsured

To identify how access to interpreter services among uninsured with limited English proficiency (LEP) affected perceptions of the hospital used, respondents were asked about the hospital’s “openness” in offering services if they could not pay for medical care, and about the hospital’s reputation for providing treatment to people in the community who cannot pay for their medical care. Responses differed significantly by interpreter need and availability. Three quarters (74%) of the Interpreter Needed/Available group said that the facility was open and accepting, compared to 57 percent of the No Interpreter Needed group and less than half (45%) of the Interpreter Needed/Unavailable group (See Chart 2).

Commenting on the community reputation of the hospital they used, half (52%) of the Interpreter Needed/Available respondents said the hospital provides “a lot of care in the community for people who cannot pay.” Just over one-quarter (27%) of the Interpreter Needed/Unavailable respondents gave this response. The same was true for 44% of respondents not needing interpreter services.

Table 1
Respondents who Reported Very Satisfactory or Satisfactory Interactions with Staff

	No Interpreter Needed	Interpreter Needed/Available	Interpreter Needed/Unavailable
Receptionists/ admitting clerks	86%	93%	76%
Nurses	89%	95%	78%
Physician assistants	91%	96%	78%
Examining physicians	92%	97%	88%
Social workers	77%	95%	69%
Billing clerks	74%	80%	54%
Pharmacy staff	87%	91%	66%

Denominator excludes respondents who answered “don’t know” or “not applicable.” This accounts for half the responses for social workers and pharmacy staff and one-third of the responses for billing clerks.

Satisfaction with Medical and Support Staff Encounters

All respondents were asked to rate their satisfaction with the overall “courtesy” and “helpfulness” of medical staff (e.g., nurses, examining physicians and physician assistants) and support staff (e.g., admitting and billing clerks, social workers, pharmacists). In both the No Interpreter Needed and Interpreter Needed/Available groups, 9 out of 10 or more rated the courtesy and helpfulness of medical staff as either very satisfactory or satisfactory, with the latter group most likely to be satisfied. The Interpreter Needed/Unavailable respondents were least likely to rate their encounters with medical staff as satisfactory. Fewer than 8 out of 10 of the Interpreter Needed/Unavailable respondents gave medical staff, with the exception of examining physicians, satisfactory ratings on helpfulness and courtesy (See Table 1).

Satisfactory ratings for support staff were much lower compared with medical staff across all three groups, with the Interpreter Needed/Unavailable group least likely to report satisfaction with the helpfulness of social workers, billing clerks or pharmacists.

Understanding Medication Instructions and Paying for Prescription Drugs

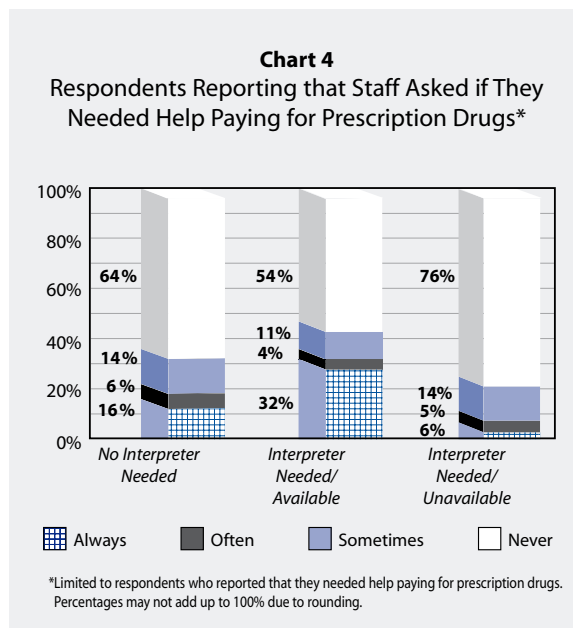
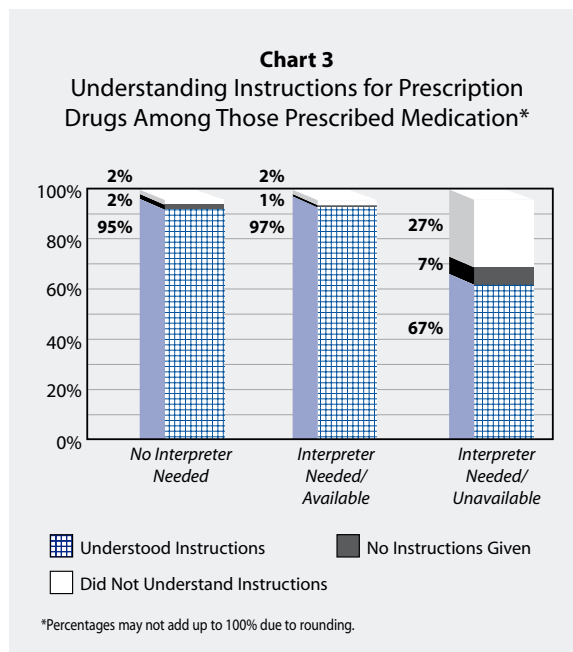
Surveyed individuals were asked about their experiences related to prescription drugs during any visits in the last year to the hospital in question while they were uninsured. Between 71% and 79% of each of the three groups were prescribed medication during any of their visits.

With national attention focused on medication errors and patient safety, the results highlight how lack of adequate communication can pose health risks for patients with LEP. Over one quarter (27%) of the Interpreter Needed/Unavailable respondents said they did not understand their medication instructions (another 7% said no instructions were given). This compares with only 2% of respondents in each of the other two groups who said that they did not understand instructions for taking their medications at home (See Chart 3).

In response to questions about paying for prescription drugs, nearly one-third (31%) of the Interpreter Needed/Available group and 40% of each of the other two groups said it was “very difficult” to pay for the cost of medications. When asked if they needed help in paying for their medication, nearly half (48%) of respondents in the No Interpreter Needed group and 4 in 10 (39%) in each of the LEP groups answered “Yes.” Among those needing help, one third (32%) of the Interpreter Needed/Available respondents said staff “always” asked if they needed help — a rate twice that for the No Interpreter Needed respondents (16%) and five times that for the Interpreter Needed/Unavailable respondents (6%). More than three in four respondents in the latter group (76%) said that staff “never” asked if they needed help paying for their prescriptions (See Chart 4).

Paying for General Medical Care

We asked respondents a set of questions about their need for financial assistance to pay for their medical care; whether help, if needed, was offered; and the type of financial assistance provided. The groups did not differ in the proportion saying they needed “help in paying the medical bill” (range: 64%–68%). However, among those who needed financial help, more than half of the respondents in the No Interpreter Needed (55%) and Interpreter Needed/Unavailable (54%) groups said staff “never” asked if they needed



financial assistance, compared to just over one-third (36%) of the respondents in the Interpreter Needed/Available group (See Chart 5).

A similar pattern emerged when respondents were asked if any hospital staff offered to help them get financial assistance to pay for care. Of those who said staff “sometimes,” “often,” or “always” offered to help them get financial assistance, the Interpreter Needed/Available respondents were most likely to say the hospital offered to completely waive the bill, reduce the amount required to pay, or find a charitable organization to help pay the bill. The Interpreter Needed/Unavailable respondents were most likely to report only being offered a monthly installment plan for paying off their bill in full (See Chart 6, pg. 9).

“There is a sign that said to bring your own interpreter.”

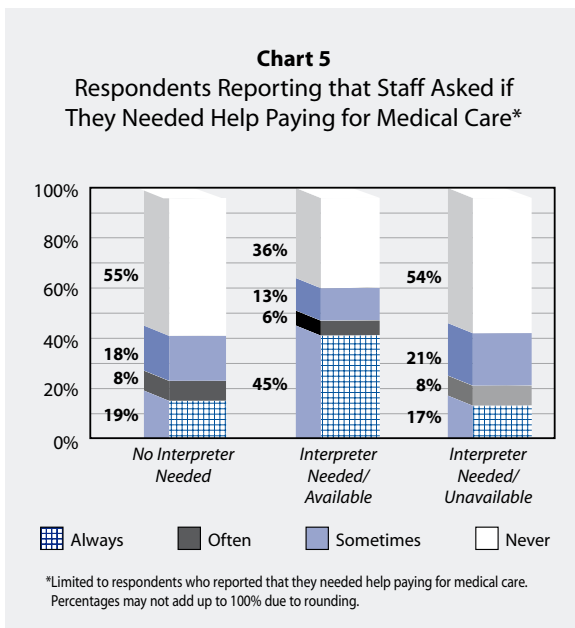
Availability of Signs and Written Materials in Spanish

In addition to their much higher rate of reporting a lack of offered assistance in paying for medical care and prescription drugs, respondents in the Interpreter Needed/Unavailable group were nearly twice as likely as those in the Interpreter Needed/Available group to report that there were no signs in their native language in the admitting or waiting areas (72% vs. 34%). When asked if the facility provided written information in the respondent’s language, more than three-quarters (78%) of the Interpreter Needed/Unavailable group said “No,” compared to only one third (34%) of the Interpreter Needed/Available group.

Effects of Financial Experiences on Likely Future Use of the Facility

To understand the relationship between uninsured patients’ financial experiences and their attitudes about seeking health care in the future, we asked respondents how the amount and method of payment for medical care at the hospital they visited would affect their likelihood of using that facility in the future. The Interpreter Needed/Unavailable respondents were about twice as likely as the No Interpreter Needed and the Interpreter Needed/Available respondents to say they would not seek care at that facility in the future because of the cost and methods of payment (22%, 9% and 12%, respectively). Another 14%, 8% and 9%, respectively, said they would go to another facility in the future. In contrast, more than one in five of the Interpreter Needed/Available group (22%) said the cost of medical care at the current hospital “will make it easier to seek care” there in the future, compared to only 14% of both the No Interpreter Needed and the Interpreter Needed/Unavailable groups.

Similar portions — just over half — of uninsured LEP respondents for whom interpreters were and were not available (52% and 55% respectively), and 61% of the No Interpreter Needed respondents, reported having unpaid bills or being in debt to the facility in question. Among those with



unpaid bills or debt, however, the Interpreter Needed/Unavailable respondents were much more likely (40%) to say they would not seek care at that facility in the future because of this debt than the Interpreter Needed/Available (26%) and No Interpreter Needed (21%) respondents (See Chart 7).

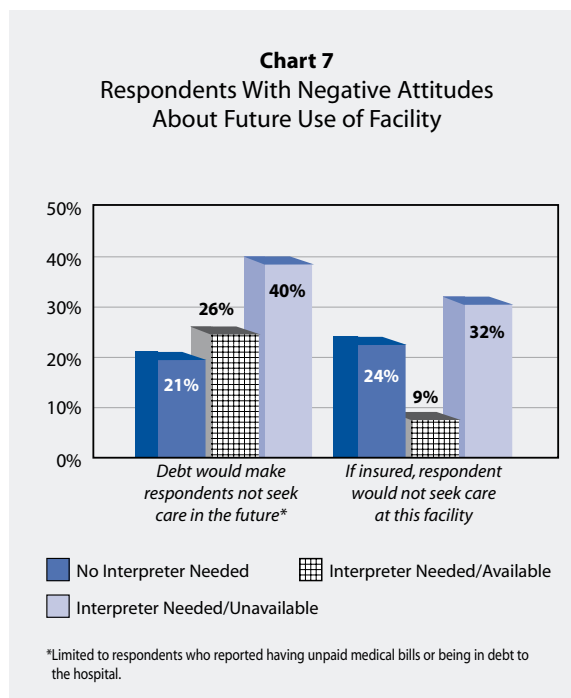
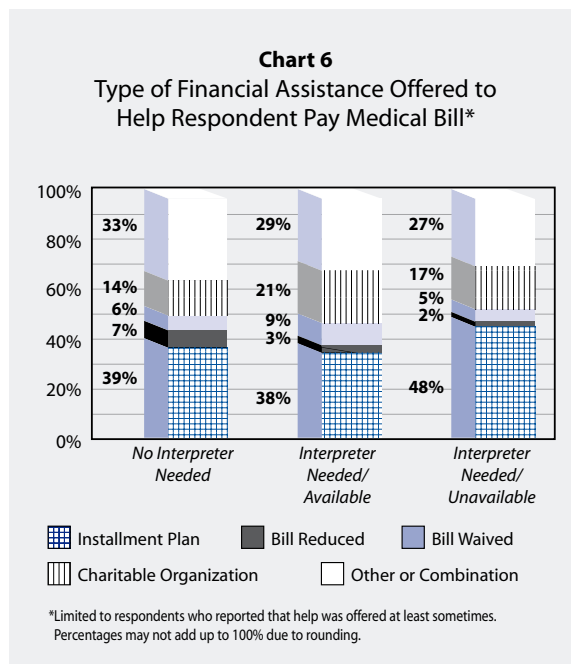
Respondents were also asked about their likelihood of using the same facility in the future, if they became insured. One third (32%) of the Interpreter Needed/Unavailable respondents said they would not use the facility in the future if they became insured, as did one-quarter (24%) of the No Interpreter Needed respondents. In contrast, fewer than 1 in 10 (9%) of the Interpreter Needed/Available respondents said they would not use the hospital in the future if they had insurance coverage.

IV. Implications for Health Care Access and Quality Among Uninsured with Limited English Proficiency

The survey findings suggest that many immigrants and residents with limited English proficiency face special challenges in obtaining adequate health care and paying for it. The results show dramatic differences in the health care experiences of those with limited English proficiency who had interpreters available and those who did not. On most measures, the uninsured who needed an interpreter and had access to one had experiences similar to or more positive than the uninsured without language barriers.

Impact of Language Assistance Services on Quality of Care and Access to Care

The higher proportion of the Interpreter Needed/Unavailable respondents who reported leaving the hospital without understanding how to take their prescribed medications is perhaps the most significant survey finding related to quality of care. In addition, half or more of all the uninsured surveyed did not rate encounters with a hospital pharmacist, presumably because they did not have contact with one, while respondents in the Interpreter Needed/Unavailable group who did rate pharmacists gave them the second lowest rating of satisfaction among categories of hospital staff. These findings suggest that individuals who need and cannot obtain an interpreter face significant communication barriers that affect their understanding of how



““ They should have more bilingual personnel. They didn't explain to me if I could return for treatment before settling my account. ””

to use prescribed medications. (It is not known whether these respondents received written instructions translated into their primary language.) The potential health risks that could result from taking medications inappropriately highlight the need for effective oral and written instructions for LEP patients about proper medication use in a language they can understand and in a culturally sensitive manner.¹⁸

The survey findings also suggest that uninsured patients who have similar perceptions of their financial needs may not receive the same information about opportunities for financial help with medical expenses because of language or cultural barriers — unless they have access to an interpreter. Language barriers to receiving financial assistance information may have consequences for access to care. Among LEP uninsured who were in debt to their hospital, those without an interpreter were more likely than those with an interpreter to say their debt would deter them from using the hospital in the future.

This finding raises concerns about where else these patients might turn for care or to what extent they might delay or avoid needed care because of financial concerns, which could ultimately lead to higher treatment costs. Having access to interpreter services may enhance access to care by lessening the likelihood that LEP uninsured will avoid or delay needed health care or switch facilities frequently because of unpaid medical bills. The strong association between having access to an interpreter if needed and perceiving that a hospital gives a welcoming feeling to uninsured patients also suggests that interpreter services may be a valuable tool for improving access to timely medical care.

The Business Case for Interpreter Services

Consistently offering the same information about financial assistance programs to LEP and English-speaking patients may also simply be good for business. Improving LEP patients' access to financial assistance information may increase the likelihood that hospitals can obtain at least some payment for services provided, rather than none, when patients cannot afford to pay for care. Without an interpreter to facilitate communication between patients and billing staff or social workers, hospitals may also be missing opportunities to enroll eligible patients with LEP into public or private sector insurance or payment programs.

At the same time, offering interpreter services may be a valuable strategy for attracting and retaining future insured patients with LEP. More than 9 of 10 LEP patients who did get interpreters said they would return to their present facility if they became insured. These survey findings suggest that patients needing interpreter services, if given a broader choice of providers, would seek out health care facilities that provide them. Offering interpreter services may improve patient revenues of safety net hospitals in the long-term, in addition to improving patient care in the short- and long-term.

Expanding the Research Agenda

Patients who were provided interpreters when needed often reported better experiences than those not requiring interpreters. Perhaps more effective communication with providers through the provision of interpreters by itself explains the differences in patients' perceptions of their experiences. However, some of the institutions where LEP respondents rated their experiences more positively may have undertaken broader, organization-wide efforts to address cultural competence beyond simply providing an interpreter. The strong relationship found between reporting access to interpreters and reporting translated signage and written materials suggests a broader effort. This potential relationship needs further investigation to confirm the prevalence and importance of these and other organizational strategies.

Potential Directions for Urban Hospitals and Their Sources of Support

Limitations of this study make conclusions about uninsured adults' perceptions of their experiences using safety net facilities suggestive rather than definitive. Nonetheless, the consistency of the survey's findings with other research underscores the need for hospitals to reduce language barriers between patients and their medical and support staff. In this context, the results provide direction for health care institutions committed to creating an environment that benefits all patients, regardless of their language and ethnic or cultural heritage.

California, Massachusetts, and other states, as well as the federal government, have taken the lead in recommending or requiring that health care institutions provide sufficient bilingual staff or interpreters, along with culturally competent care, to meet the needs of patients who come from diverse cultural backgrounds and speak languages other than English. In addition, federal agencies are currently in the process of publishing, or republishing, documents that clarify requirements under Title VI of the Civil Rights Act for institutions that receive federal funds on the provision for services to LEP patients.¹⁹

While Title VI does not provide specific funding for language assistance services, a variety of governmental and private funding sources do exist. For example, federal Medicaid and SCHIP matching funds are available to help cover the cost of such services for states.²⁰ Under this option, states can directly contract with and pay language assistance agencies, or providers can pay for interpreters and then receive state reimbursement to defray the costs. Currently, however, only five states have chosen to exercise this option (Hawaii, Maine, Minnesota, Utah, and Washington). Health care institutions in other states might consider encouraging state officials to take advantage of this funding source, as well as exploring other potential sources of funding.

The federal and state efforts underway are a testament to the growing recognition of interpreter services as an important component of health care quality. Understanding how well health care institutions are currently

“ We should have translators at the hospital, because it is a problem finding someone to translate — and they charge a lot. ”

meeting this and other needs of vulnerable populations, such as the uninsured, is an important step for policymakers and community leaders to take in assuring that our health care system — and safety net providers in particular — have the resources to provide adequate and timely health care to all who need it.

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Appendix:

Urban and Suburban Hospitals Included in the Community Access Monitoring Survey

Facility	Location
Yuma Regional Medical Center	Yuma, AZ
Community Hospital	Fresno, CA
University Medical Center	Fresno County, CA
Halifax Medical Center	Halifax, FL
Tallahassee Memorial Healthcare Emergency Room	Tallahassee, FL
Memorial Hospital	West Volusia County, FL
Palmyra Medical Center	Albany, GA
Phoebe Putney Memorial Hospital's Emergency Center	Albany, GA
Mercy Medical Center	Nampa, ID
Magic Valley Regional Medical Center	Twin Falls, ID
Earl K. Long Medical Center	Baton Rouge, LA
Sunrise Hospital and Medical Center	Las Vegas, NV
University Medical Center	Las Vegas, NV
Montefiore Medical Center	The Bronx, NY
North Central Bronx Hospital	The Bronx, NY
Wake Medical Center	Raleigh, NC
University Hospital	Cincinnati, OH
Cleveland Clinic	Cleveland, OH
Huron Hospital	Cleveland, OH
Metrohealth Hospital	Cleveland, OH
University Hospital	Cleveland, OH
The Memphis Regional Medical Center	Memphis, TN
INOVA Alexandria Hospital	Alexandria, VA

Endnotes

- 1 National Standards for Culturally and Linguistically Appropriate Services in Health Care, U.S. Department of Health and Human Services, Office of Minority Health, Washington, D.C., March 2001. See www.hhs.gov/ocr/lep for complete details on the standards.
- 2 According to the National Health Law Program, a person with limited English proficiency is “unable to speak, read, write or understand the English language at a level that permits him/her to interact effectively with health and social service agencies and providers.”
- 3 Computations based on Census 2000 Supplementary Survey Summary Tables (for selected cities), U.S. Bureau of the Census, <http://factfinder.census.gov/home/en/acldata.html>. For 1990 data: U.S. Bureau of the Census, Census of Population and Housing, 1990 Census Summary Tape 3.
- 4 B. Guzman, “The Hispanic Population: Census Brief 2000,” U.S. Bureau of the Census, May 2001.
- 5 Computations based on Census 2000 Supplementary Survey Summary Tables (for selected cities), U.S. Bureau of the Census; <http://factfinder.census.gov/home/en/acldata.html>.
- 6 U.S. Census Bureau, Health Insurance Coverage 2000, <http://www.census.gov/hhes/hlthins/hlthin00/hi00tc.html>.
- 7 C. L. Schur, J. Feldman. Running in Place: How Job Characteristics, Immigrant Status and Family Structure Keep Hispanics Uninsured, The Commonwealth Fund, May, 2001.
- 8 M.E. Lewin and S. Altman, Eds., *America’s Health Care Safety Net: Intact but Endangered*, Institute of Medicine, National Academy Press, Washington D.C., (2000) p. 1.
- 9 L. Duchon, C. Schoen, M. M. Doty, K. Davis, E. Strumpg, S. Bruegman, Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk, The Commonwealth Fund, New York, December 2001.
- 10 K.S. Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans*, The Commonwealth Fund, New York (March 2002).
- 11 O. Carrasquillo, J. Orav, T. Brennan, H. Burstin, “Impact of Language Barriers on Patient Satisfaction in an Emergency Department,” *Journal of General Internal Medicine*, 14 (1999): 82-87.
- 12 J. Sarver, D. W. Baker, “Effect of Language Barriers on Follow-Up Appointments After an Emergency Department Visit,” *Journal of General Internal Medicine*, 15 (2000): 256-264.
- 13 B. Kirkman-Liff, D. Mondragon, “Language of Interview: Relevance for Research of Southwest Hispanics,” *American Journal of Public Health*, 81 (1991): 1399-404.
- 14 S. Woloshin, L. Schwartz, S. Katz, G. Welch, “Is Language a Barrier to the Use of Preventive Services,” *Journal of General Internal Medicine*, 12 (1997): 472-477.
- 15 National Standards for Culturally and Linguistically Appropriate Services in Health Care, p. 65.
- 16 The survey was administered in English and Spanish only, with 15 percent of LEP respondents taking the survey in English. A family member or friend may have interpreted the survey questions for these respondents or their English proficiency may have been adequate to answer survey questions but not communicate adequately with a physician or other medical or support staff.
- 17 Originally, 4,522 uninsured individuals were interviewed, of whom 361 were excluded based on missing data or inconsistent responses to multiple questions about their need for and the availability of interpreter services.
- 18 Proceedings of the National Conference on Quality Health Care for Culturally Diverse Populations, New York Academy of Medicine, New York, NY, October 1–4, 1998. See p. 25 for presentation remarks by Anne Fadiman, “The Spirit Catches You and You Fall Down: The Challenges of Cultural Competence.”
- 19 65 Fed. Reg. 50123 Department of Justice, Enforcement of Title VI of the Civil Rights Act of 1964 — National Origin Discrimination Against Persons with Limited English Proficiency (August 16, 2000); Department of Justice, Memorandum for Heads of Departments and Agencies General Counsels and Civil Rights Directors Re: Executive Order 13166 (Oct. 26, 2001), <http://www.usdoj.gov/crt/cor/lep/Oct26Memorandum.htm>.
- 20 See Health Care Financing Administration, Dear State Medicaid Director (August 31, 2000), <http://www.hcfa.gov/Medicaid/letters/smd83100.htm>.