

HEALTH CARE FOR A POPULATION WITH LIMITED ENGLISH PROFICIENCY

*Findings from a
Sample of
Connecticut
Organizations*

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Contributors & Acknowledgments

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Ms. Hin-McCormick previously served as the Clinical Director of Community Renewal's Team Outpatient Clinic, which offers Asian Family Services as one of their programs. In this capacity, she observed that a lack of language services posed as a barrier in primary, mental health, and other care settings. She feels confident to speak about the growing need for language services among the Connecticut (CT) Asian community.

*Community Health Center Association of CT (CHCACT)*¹, Evelyn Barnum

The Community Health Center Association of CT works closely with policy makers on health care issues. This organization also provides training and resources to empower federally qualified health centers (FQHCs). With the support of CHCACT, FQHCs deliver high quality health care that is comprehensive, family-oriented, and culturally competent.

Community Health Center (CHC), Inc., Margaret Flinter

The Community Health Center delivers medical, dental, and behavioral health care and related social services to populations who experience barriers gaining access to such services elsewhere. They are also the first CT health care organization to fully embrace language service provision as a standard of care. As a part of their commitment to high quality health care, they offer a telephonic language-line.

Eastern CT Area Health Education Center (AHEC), Maritza Rosado

Eastern CT AHEC fosters partnerships in healthcare and education to strengthen the health workforce. As a part of their goal to cultivate a well of community health workers, they coordinate and organize education programs for medical and social service workers. One such program addresses training medical interpreters through their CT AHEC Medical Interpreter Certificate².

Generations Family Health Center, Arvind Shaw

Generations delivers high quality, patient-focused, affordable health care to all their patients. Among their clients, one in three receives Medicaid and one in five would be best served in a language other than English.³ Medical care, dental care, and case management capture just a few of the many services that Generations administers its clients.

Hispanic Health Council, Grace Damio

The Hispanic Health Council seeks to improve the health and social well-being of Latinos and Latinas and other diverse people groups.⁴ Their bilingual and bicultural teams coordinate program and research partnerships. The HHC also advocates for the elimination of health disparities.

¹ http://www.chcact.org/Content/Who_We_Are.asp

² <http://www.easternctahec.org/ihcs/>

³ <http://www.genhealth.org/Of%20our%20clients%20in%202007.01.mht>

⁴ <http://www.hispanichealth.com/hhc/mission>

Interpreters and Translators, Inc., Francesco Pagano

ITI, Inc. is a woman and minority owned full-service language company that extends expertise in over 170 languages. Their services include: in-person, telephonic, video remote interpreting and translation services.⁵ In Connecticut, they administer language services for approximately 70 languages.

Lao Association of CT, Howard Phengosome

This community non-profit organization works to unite Laotian Americans in the state of CT. The Lao Association achieves this by preserving Lao culture, arts, and language. They not only advocate for the health and thus the language needs of the Lao community, but some organization members also actively serve as interpreters for ITI, Inc.

Mijoba Communications, Nadesha Mijoba

Mijoba Communications specializes in linguistic, cultural, and ethnic issues. In addition to advocacy on these topics, this consultation firm also conducts hospital evaluations, trains interpreters, promotes cultural competence, and delivers direct interpretation services.

Naugatuck Valley Project, Liz Rosa

The Naugatuck Valley Project advocates for immigrant services, job training, and many other issues relevant to the Valley region of CT. They do this by organizing and empowering the region's low- and moderate- income community. Their Medical Interpretation and Translation Project, for instance, connected local providers and the community in a partnership to create a stronger interpretation services system.⁶

Planned Parenthood of Southern New England, Janette Walker

Planned Parenthood delivers reproductive health care and sexual health education. Nineteen health centers in Connecticut and Rhode Island comprise Planned Parenthood of Southern New England. To implement reproductive and sexual health services, this organization accommodates medical interpretation services. Further, they can boast of 16 trained medical interpreters across 12 of their locations.

211 Infoline, Annette Buckley

211 Infoline extends free informational and referral services. Operated by CT United Way, this organization connects CT callers with multilingual staff for information referrals or help during a crisis.⁷ A 2011 report finds that their top 10 requests included information about health supportive services, public assistance programs, and outpatient mental health care.⁸ 211 Infoline translated their web page into 52 languages.

⁵ <http://www.ititranslates.com/about-us>

⁶ <http://www.naugatuckvalleyproject.org/campaigns.htm>

⁷ <http://www.211ct.org/referweb/landing.aspx>

⁸ <http://www.ctunitedway.org/Media/AnnualReport/Annual2011.pdf>

Methods

This report sought to elucidate the 2012 health care landscape for the population with limited English proficiency (LEP) in the state of Connecticut (CT). In February and March of this year, Jamey Bell, Executive Director of Connecticut Voices for Children, with the help of Dorothy Sheu, a Master in Public Health candidate at the time, conducted interviews with medical interpretation service stakeholders. With input from the CT Health Foundation, they identified 34 organizations that previously participated in the CT Coalition for Medical Interpretation. Of these stakeholders, 33 were contacted, 13 responded, and 12 interviewed. Interview questions concerned MIS need, access, quality, and resource availability, organization activities relating to interpretation services, and awareness of Title VI of the 1964 Civil Rights Act. This report aggregates interview responses from a sample of key individuals involved with LEP-related work in CT. While the voices documented in this report belong to staff at health care organizations, community groups, and even distributors of medical interpretation services (MIS), they may not fully represent the experiences of the LEP population and those who serve them.

What is the Need?

The CT population with LEP captures a diverse collection of languages and language needs that vary from location to location. While some organizations reported that their dominant language of need was “*Puerto Rican*”, others said Spanish, and still others Mandarin. Additional languages mentioned include Portuguese, Albanian, Polish, Karen, Creole, Guatemalan, French, Arabic, Bengali, Turkish, and other South Asian languages. A MIS supplier disclosed that they supplied services for 65-70 languages in CT. Of these, 80% of their CT clientele required Spanish interpretation services. Interviewees expressed that people of LEP across all languages met obstacles identifying and accessing bilingual providers.

To offer an enumeration of the need for LEP services, one respondent organization shared that, in the month of February (2012), they used MIS 2157 times for 26 languages, totaling 23,000 minutes. Other respondents found that among those who used MIS, middle-aged and elderly patients tended to need MIS more frequently than others. Federally qualified health centers used MIS frequently, as many of their patients were of LEP.

Almost every respondent acknowledged that they worked with a diverse population with diverse needs, and nearly all identified cost (limited budget) and time (for training) as barriers to providing more interpretation services. Only a few respondents kept enumerations of language needs.

Accessing Health Care with Language Services

Interactions with the Department of Social Services (DSS) (Medicaid Recipients Only)

While many respondents recalled great difficulty getting Medicaid applications processed through the Department of Social Services (DSS), some respondents found little trouble with the experience. Those who encountered minimal issues went on to relay how their organization had systems in place for working with DSS. More specifically, these organizations comprised of staff or volunteers who translated the application, guided people of LEP through the application, and then faxed their application to the DSS.

The Department of Social Services [commits to effective communication](#)⁹ with people of LEP. Still, respondents noted that language served as a barrier to utilizing DSS services. One respondent relayed an account at the DSS when a staff member yelled at a woman with LEP. The staff member then sent the woman with LEP to the back of the line due to her limited English language proficiency. In some cases, the DSS made an effort to communicate with its visitors with LEP; however, they utilized any available staff to interpret rather than trained interpreters. One respondent stated that most people of LEP do not even think about going to the DSS without bringing their own interpreter. Additional DSS complaints focused on staff attitudes, the application for Medicaid, and processing time of the application.

Once a person obtains Medicaid, the HUSKY/Charter Oak plan should coordinate for MIS provision. The HUSKY/Charter Oak Plan covers the cost of MIS for its patients.¹⁰ However, to set up MIS, patients need to take the initiative to call the HUSKY/Charter Oak Plan¹¹ within 72 hours of their appointments¹². A LEP patient could alert the Plan of the need for MIS by calling a specific phone number; however, the HUSKY/Charter Oak Members' website did not present this information nor did the plan offer brochures¹³. Thus, patients did not receive information on this 72 hour requirement.

⁹ <http://www.ct.gov/dss/lib/dss/pdfs/aapolicystatement11.pdf>

¹⁰ The direct MIS service providers bill the Community Health Network (CHN) and CHN in turn pays the provider.

¹¹ 1.800.859.9889

¹² According to Gail DiGioia of the Community Health Network, interpretation services are provided by ITI, Inc. for face-to-face interpretation and by ATT Language Line for telephonic interpretation.

¹³ On April 4, 2012, Dorothy called the HUSKY/Charter Oak Plan telephone number and this is what the customer service representative relayed. He also confirmed, after checking with his supervisor, that face-to-face services were available for both those on the HUSKY and Charter Oak Plan. He repeatedly mentioned face-to-face services and made no mention of telephonics or other MIS options.

Context of Health Care Access

Source of Health Insurance & Place of Care

Title VI [of the 1964 Civil Rights Act](#)¹⁴ applies to all health care providers who receive federal funding. Title VI mandates that these providers offer oral and written language services to LEP individuals.

While providers should be aware of Title VI, respondents disclosed that many private providers lack the funding to provide meaningful access to MIS. As a result, even those who are “*definitely aware of [the] obligation*” consequentially “*do what they can with what they have*”. One respondent remarked that “*providers will take Medicaid patients because they have to and this becomes an issue of quantity over quality*”. They went on to say that Medicaid patients faced obstacles securing a timely appointment, and when at the appointment, being seen in a timely manner.

Interview findings suggested that people of LEP both with and without public health insurance (e.g. Medicaid vs. private insurance) faced obstacles securing health care appointments. For example, people of LEP found limitations in the venue they could receive their care; more specifically, larger medical providers (e.g. hospitals, clinics) took more patients with LEP than private providers or practices did.

There also existed some differences in the health care access experiences between people of LEP with and without public insurance. For example, people of LEP without public insurance commonly received instruction to bring their own interpreter. As a result, patients “*don’t show up to an appointment because they don’t have an interpreter*”. As a reminder, and to quote one respondent, “*You can’t focus solely on the Medicaid population!*”

How Aware are People of Title VI?

- Respondents felt that most federally-funded patients were unaware of their right to MIS.
- They also noted that populations who newly arrived from other countries may not have been aware that they were entitled to such services.

For Those Aware of Title VI, What is Access Like?

- Respondents believed that communities of people who were aware of their right still had trouble accessing MIS.
- Some barriers to seeking out MIS with health care included fear of jeopardizing eligibility for citizenship, discomfort with the need to ask for services, and concern for losing access to health care entirely.

Primary Care vs. Specialists

Respondents unanimously stated that a person with LEP encountered greater trouble getting an appointment with a specialist than a general practitioner. For example, some respondents recalled that it is “*nearly impossible*” to find a psychiatrist and even harder to find a multilingual psychiatrist. Even once a person with LEP secured an appointment, specialists rarely propositioned MIS. The offices of specialists often demanded that the patient arrive with an interpreter.

Specialists took fewer federally funded patients. Specialists also tended to work with interpreters less frequently. Interestingly, interpreters preferred not to work with specialists: “*We do not deal with*

¹⁴ <http://www.justice.gov/crt/about/cor/coord/titlevistat.php>

specialists because they won't pay. Specialists often receive patients who do not receive federal funding. When patients get to the point of needing a specialist, our services end."

Most respondents stated that they did not know why specialists tended to provide less MIS. Some respondents believed that specialists such as cardiologists, neurosurgeons, and gynecologists did not want to see patients because of risk—these specialists did not know if they were getting accurate information due to the possibility of unreliable interpretation services. Other respondents believed that providing MIS for specialty care was harder; MIS for behavioral health was a commonly cited example.

More on Mental Health Interpreting

Within specialty care, respondents repeatedly brought up mental health care as one of the most challenging services for which to provide interpretation services. Respondents argued that interpreting for mental health differs from interpreting for physical health. One respondent went on to clarify that mental health interpretation requires literal interpretation; this direct form of interpretation avoids compromising what is conveyed (which is important when gauging cognitive functioning). Further, disrupting the conversation between patient-provider during a mental health consult may break the connection and trust between patient and provider. This interviewee described the role of a mental health interpreter as solely a “conduit”. One other respondent hypothesized that the shortage of mental health interpreters in CT correlated with the higher skill set needed of mental health interpretation.

In addition to the skill set involved in interpreting for mental health, respondents discussed the relationship between comfort and interpreting during a mental health consultation. They disclosed that some patients found it uncomfortable enough to talk to a psychologist, and even more uncomfortable when a third person sat in the room or when someone who could be seen spoke for the patient over the phone.

The Health Care Experience for the CT Population with LEP

Quality of Care

Safety

Respondents agreed that, generally speaking, when people of LEP received professional MIS, health became better than the health of those who did not get MIS. To give an example of how failure to use adequate interpretation can endanger patient safety, one respondent discussed the scenario in which children performed interpretations. The interviewee expounded that using a child as an interpreter put the child in an uncomfortable position. Feeling embarrassed by the information conveyed by the doctor, the child may have chosen against relaying every single statement the patient made. Respondents often cited medical errors as a consequence such types of miscommunication between patients and providers.

Patient-Centered

To incorporate the patient's background and beliefs in a clinical interaction, respondents stressed the importance of understanding between patient and provider. They defined understanding to require, at minimum, communication of concepts and inclusion of patient voice.

A few interviewees spoke about the relationship between culture and patient-centered care for populations of LEP. More specifically, they discussed how certain ideas do not translate well across languages or belief systems. Two respondents expounded on this idea with the example of mental versus physical health care. They remarked that many cultures do not distinguish between mind and body. They suggested that providers or interpreters needed to first explain to their clients that the dominant health care system in the US separates mental from physical health services; after doing so, providers could then refer clients to mental health or physical health services. Respondents elaborated that when providers did not elucidate these nuances, patients were less likely to understand clinical exchanges or comply with clinical instructions. Respondents recommended that interpreters help identify these gaps so that providers can impart necessary explanations. Further, interviewees believed that providers required general cultural sensitivity training; this would not only increase familiarity of providers with cultural context, but also help providers to identify and address moments of cultural miscommunication.

To understand a patient's beliefs, providers must listen to what patients have to say. On top of language or belief differences, patients also differed in communication in other ways. For example, two respondents remarked that people of Asian ethnicity often did not speak up when there was a need to do so. The interviewees both went on to describe how it was often the case that Asian clients would not proactively seek out a service; but rather, someone else had to ask them if they wanted MIS. If providers and interpreters did not know about this need for voice, then communication posed as a barrier to understanding patient preferences and thus to receiving patient-centered care.

Timeliness

Many respondents agreed that low English proficiency populations came across delays when they scheduled an appointment. People of LEP received a later appointment date than that given to non-LEP populations. People of LEP waited longer than proficient English speakers in the waiting room to be seen.

People of LEP spent more time in the consultation room than English proficient patients did. People of LEP faced longer delays than their English-proficient counterparts when filling a prescription.

Less timely care may occur for many reasons, interviewees explained. For example, delayed scheduling resulted from the low supply of Medicaid providers or the difficulty of getting to providers. One respondent shared that a patient received an appointment with a specialist two hours away. The patient preferred an appointment closer to home because work, family, and transportation served as barriers to attending this appointment. Unfortunately, getting an appointment closer to where the patient lived could have pushed back the appointment date.

Patients additionally encountered delays at the clinical office for many reasons. Delays in the waiting room occurred if a patient arrived without prior notice of MIS need, preventing staff from using formalized MIS systems. A lack of formalized MIS systems may have also led to impaired timeliness of care because staff needed time to identify or find interpreters. Another source of delay in the clinical setting resulted from a shortage of interpretation services. Without a bountiful supply of interpreters (i.e. in-person, by telephone, etc.), patients waited until someone became available.

Delays may have occurred after the appointment as well. More specifically, prescriptions that were not translated for patients at the pharmacy led to delay. One interviewee described how finding a friend or family member to translate the prescription kept a patient from taking their medicine in a timely manner. Time lost while searching for a translator or taking the medicine without understanding the instructions, one respondent suggested, may lead to delays in recovery time or medical problems.

Efficiency

Lack of efficiency posed an issue for population of LEP both during the clinical appointment and afterwards. Efficiency during a clinical appointment broke down when a patient who needed MIS arrived unannounced, when the provider or interpreter did not know how to manage the interpretation exchange (e.g. give time for each party to speak), and of course, if providers failed to provide MIS. In one case, a mother with LEP left her baby at the hospital for observation post birth when she went home to rest. At home, she received a phone call in English from the hospital. She could not understand the telephone message until she found an acquaintance to interpret for her. Once she did, she learned that the hospital transferred her baby to another hospital. No one used her language to communicate with her prior to leaving the hospital, nor on the phone, to let her know that her baby's complications needed attention and possible transfer.

Effectiveness

Interviewees discussed the importance of physicians to identify effective interpreting, or to tell whether or not patient and provider understood one another. They posited that whether the interpreting was effective would not only affect treatment, but also patient adherence and subsequent pursuit of care. A lack of understanding between patient and provider may have led to a longer recovery time.

Equitable

Across different health care contexts, interview findings revealed that inequities exist. Unequal health care service quality existed at many levels: those who did and did not have LEP, those with LEP who had publically versus privately funded medical insurance, those who sought specialty versus primary care, and between those who visited a private practice versus larger medical institution.

What Resources are Available?

People of LEP encountered diverse experiences with MIS at medical appointments. While some patients communicated with providers through an organization's MIS system, others were told to bring their own interpreters, and still others could not even find providers willing to take them.

Professional In-Person Interpreters

Within health care organizations, the trained interpretation workforce varied from place to place. For example, while one organization had 16 medical interpreters, others had none. While some organizations required a diverse and high number of interpreters, others on an average day may have only demanded one interpreter for one language.

Few respondent organizations disclosed contracting in-person interpreters. Among those who had, even fewer used the service recently. Some employed in-person interpretation services only in special circumstances. For example, for one organization, the only time they hired an in-person interpreter was when they were providing care to a confined patient.

The supply of professional in-person interpreters in CT has been said to be few. To provide an example, one respondent estimates that CT supplies only 2 qualified mental health interpreters. Thus, CT needs increased training of people who can serve as bilingual, proficient interpreters.

In addition to professional resources, community organizations also presented a source for interpretation services. In some cases, workers from community organizations received training and got contracted to serve as interpreters. This was especially so for minority languages in CT. Using community resources for interpretation became problematic if the interpreter did not receive training or if they were repeatedly called upon to provide pro bono services.

Ad Hoc Interpreting

Most respondents reported some instance of the use of family and friends for interpretation at appointments. To provide an example, grandparents sometimes asked their grandchildren to interpret. In some cases like this, clinic staff told patients that children may not know medical terminology, cautioned about the sensitivity of medical issues, and advised against the use of minors to interpret. In many other cases, interviewees witnessed providers who asked a member of the cleaning staff to interpret. Many respondents emphasized that using nonqualified staff to interpret served as a barrier to health. One interviewee posited that ad hoc interpreting may have led patients to misunderstanding the clinical exchange or subsequent notifications.

Remote Interpreting

Remote interpreting, such as video-teleconferencing or tele-interpreting, presented another option for providing MIS. In addition to in-person interpreters, ITI, Inc. rendered interpretations over the phone (telephonics), as well as translations. Drawing on language resources from across the nation, ITI, Inc. supplied most majority and minority languages. However, even with this wider resource base, access to MIS presented an issue when multiple people of a minority language required an interpreter concurrently. A few organizations had the capacity available (e.g. already set up) to use video-teleconferencing, either as a function of emergency preparedness or for sign language. No one said they utilized video-teleconferencing. One person revealed that they did not find video-teleconferencing personable.

The majority of respondents used telephonics when their organization employed MIS. For some,

telephonics represented their main source of interpretation. For others, telephonics served a secondary route of action—it was only used *if* a staff member did not speak the patient’s language or *if* no interpreter could be physically present at the appointment.

Opinions about Telephonics Differ from Respondent to Respondent:

Telephonics’ Strengths	<ul style="list-style-type: none"> Some respondents regarded telephonics as a “good tool” and a source of efficiency.
	<ul style="list-style-type: none"> Telephonics, or language line, rendered an “endless supply” of service. <p>This is especially crucial for circumstances where demand exceeds available resources. This occurred when there was one Spanish-speaking staff member and two Spanish-speaking patients with concurrently scheduled appointments, or when a patient spoke a minority language to which the provider could not cater.</p>

Telephonics’ Limitations	<ul style="list-style-type: none"> Those who cautioned against telephonics stated that patients may not be comfortable speaking with a stranger over the phone or to someone they could not see.
	<p>One respondent relayed that patients have refused to use telephonics and consequentially opted out of interpretation services. This may have led to an incomplete medical history and/or exchange of information (e.g. health education, medication instructions).</p>
	<ul style="list-style-type: none"> Others drew attention to the distinction between verbal and nonverbal communication.
	<p>An interpreter over the telephone may miss gestures and expressions of the patient that were important to the message communicated.</p>

Translated Materials/ Signage

Community members worked with local hospitals (e.g. Griffin, Waterbury, St Mary’s) to identify areas in the hospitals that needed signage. Further, this same organization of community members produced a health care navigation manual for populations with LEP. They additionally created cards that people of LEP can carry around and use to communicate their language preference.

Trained, Bilingual-Proficient Clinicians and Staff

Few patients accessed a bilingual provider.

As an alternative to bilingual physicians, respondents stated that bilingual proficient and trained staff could also facilitate communication and understanding between patient and provider. Many organizations recalled using staff as MIS. While some staff received training and were deemed bilingual proficient, many were neither. Respondents said that most people who performed interpretations had been identified to be bilingual (but not assessed) and have not received training. Using untrained, bilingual staff really presented an issue when the staff member had no medical background.

One respondent cautioned that the quantity (and quality) of trained staff reflected resources available more so than it did need.

Respondents discussed barriers to training:

- Awareness of need: *“We did not know about the importance of HIPPA or confidentiality [as a part of the interpretation process]”*
- Recruitment of staff: *“Hard to recruit staff but once staff is recruited, quality is not an issue for delivery”*
- Funding: *“There is a need for training at an affordable cost, not ~\$1000”*
- Time: *“Training involves long hours and exams“*
- Stress: *“Organizations need a quality assurance program for staff who work dual roles as interpreters on top of their primary position”*
- Relevance: *“Training programs do not specialize in our community’s culture”*

Respondents explained that effective interpretation entails: (but is not limited to)

- Adult education strategies
- How to empower and advocate for the patient
- Communication skills
- Knowledge of medical terminology
- Cultural competence and sensitivity

Respondents shared the training programs they used:

- "Bridging the Gap"¹⁵
 - Cost: \$750 (includes new textbook, other training publications, inclusion in the Bridging the Gap Registry, eligibility to enroll in advanced modules)
 - Duration: 40 hrs
 - Subject matter: Basic interpreting skills, ethics, communication techniques, medical vocabulary, key health care information, communication skills for advocacy, how to draft practical, working solutions, professional development
 - Other details: Contingent on passing a language proficiency assessment. Registration is limited to 20 participants.
- " Interpreting in Health Care and Community Settings"¹⁶
 - Cost: \$725 (includes language proficiency assessment, course fees, and materials)
 - Duration: 48 hours of highly interactive practice sessions and role-plays
 - Subject matter: Interpreting techniques, guiding the encounter, and memory skills; health care in cultural perspective; structure and principles of US health care; biomedical practitioners, methods of diagnosis and medical terminology; the human body
 - Other details: Certificate offered by CT AHEC; tuition assistance available through Workforce Investment Act

¹⁵ <http://www.xculture.org/BTGclassdesc.php>

¹⁶ http://www.easternctahhec.org/page.php?Section_ID=9&Page_ID=28

Coalition Activities

Organization Activities- 2006-2007

In 2006-2007, respondents participated in a variety of LEP-related activities. Most engaged in providing direct services and/or advocacy. Examples of activities included, but were not limited to, direct MIS service provision (e.g. interpretation), working with hospitals to improve LEP accessibility, training of staff, and developing a health system navigation manual for Spanish-speakers of LEP. In one instance, community members met with local hospitals to discuss the needs of the community and to evaluate the current resources available for the population of LEP.

Members interacted with legislators and advocated for funding to support MIS. Through the collective efforts of the Coalition, the General Assembly directed the Commissioner of DSS in 2007 to amend the state Medicaid plan to add medical interpretation as a covered service. In 2008, they directed the commissioner to include these services as covered Medicaid service no later than 2009. This deadline to add medical interpretation as a covered service was pushed back (by the General Assembly in the 2009 session, and again last session). Now, under current law, the Commissioner has until July 1 2013 to amend the state plan.

Organization Activities- Current

In 2012, most organizations participated in direct provision of MIS—some created formalized systems for accessing MIS, evaluated their staff for bilingual proficiency, and/or trained their staff. One organization provided an example of a MIS system in which they scheduled all interpretation services at the same time that the appointment was made. This organization also offered one bilingual staff member “on staff hourly”. Many organizations still engaged in grassroots advocacy. Some did this by raising awareness of the right to MIS for LEP populations receiving federal insurance. Others stressed the importance of MIS for quality health care. While access continues to present a problem, many more respondents expressed concern about MIS quality. Interviewees said that health care providers reported more positive experiences with timely reimbursement when placing claims through Hewlett Packard. Direct MIS-related service providers did not come upon impediments to receiving reimbursement from DSS.

Future Directions

General Tips Mentioned

Regarding MIS Awareness

- Raise awareness among providers and patients concerning the link between MIS and health.
- Advise providers about practical ways they can follow through with providing MIS.
- Make providers aware of Title VI if they are not already.
- Involve community organizations in disseminating Title VI information to the LEP community

Regarding MIS Access

- Create a health care environment where patients are not scared to ask for MIS
- Make signage in multiple languages that fit the area's demographic need
- Install double phones in patient rooms
- Offer multiple types of MIS options for the patient (e.g. in-person, telephonics)
- Outreach to the community (e.g. photo *novela*: "Medical Interpreter: Now we're talking")
- Provide a simple health navigation resource (for example, contact Naugatuck Valley Project)

Regarding MIS Practice & Quality

- Test for bilingual proficiency, do not just assume someone bilingual is proficient
- Train bilingual proficient staff; speaking a language does not mean one can facilitate communication
- Update trained/bilingual-proficient staff with medical terminology.
- Assure training that involves understanding adult education strategies, extensive knowledge on how to empower interpreters, communication skills, and medical terminology.
- Practice sensitivity to differences in how words or concepts translate across languages or cultures; practice health education or utilize cultural brokers as necessary
- Know how to spot a bad interpreter (on phone or in person).
- If staff serves as an interpreter on top of their regular role, be considerate of their workload (or, implement quality assurance programs)

Learning More, Locally

Several organizations possessed more information not directly presented in this report. For example, Naugatuck Valley Project conducted focus group interviews concerning the experience of accessing services in the Valley (MIS included). Some respondents actually conducted evaluations or assessments on their own organization or of local hospitals. Furthermore, finance departments may have information on the frequency of MIS use. Datasets on utilization (e.g. calls, languages, minutes per call) were also kept by some organizations. Finally, the Southern Connecticut State University survey investigated language services for patients with LEP in CT health care centers.