

# **Language Access Resources**

## **from Proceedings of the Medical Leadership Council on Language Access**

### **Meetings 2002 - 2004**

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**Language Access Resources  
Medical Leadership Council on Language Access  
Meetings 2002-2004**

**TABLE OF CONTENTS**

<b>Section I. Overview</b>	<b>[Tab 1]</b>
Introduction	
Medical Leadership Council Members	
Medical Leadership Council Public Policy Principles	
Council Projects	
Other Language Access Projects	
<b>Section II.</b>	<b>[Tab 2]</b>
Summary of Research on the Need for Language Access Services	
<b>Section III.</b>	<b>[Tab 3]</b>
Mandates & Encouragement: Laws, Regulations and Policies	
<b>Section IV.</b>	<b>[Tab 4]</b>
Language Access Services: Models, Technology and Pilots	
<b>Section V.</b>	<b>[Tab 5]</b>
Financing & Payment: Considerations and Options	
<b>Section VI. Resources</b>	<b>[Tab 6]</b>
Organizations	
Publications	
<b>Appendix A</b>	<b>[Tab 7]</b>
Medical Leadership Council on Language Access: An annotated list of member organizations	

## **Section I. Overview**

## **INTRODUCTION**

A group of 28 organizations comprise the Medical Leadership Council on Language Access, founded by The California Endowment and convened by the California Academy of Family Physicians (CAFP) biannually since June 2002. Together, the Council members are developing strategies for financing and delivering interpreter and translation services to the millions of Californians who need them.

This guide provides resources developed by the Council as of September 2004, including:

- the Council's Statement of Public Policy Principals;
- an overview of research documenting the need for language access services in health care;
- an overview of relevant technology;
- an overview of financing and payment concerns and potential solutions;
- a summary of legislative and regulatory approaches;
- lists of organizations, publications, and web sites for more information.

### **About The Medical Leadership Council**

In an effort to improve the delivery of health care services to limited-English proficient (LEP) Californians, health care, medical, and advocacy organizations from across the state joined together in June 2002 to create The California Endowment's Medical Leadership Council on Language Access. The California Endowment funds the Council and the CAFP serves as the lead administrative organization.

"Ensuring access to high quality health care for California's limited-English proficient communities is a priority of The California Endowment," said Robert K. Ross, MD, president and CEO of the Endowment, at the first Council meeting on June 19, 2002 in Los Angeles. "By bringing together health care leaders from across the state, we are assembling the best possible resources for identifying solutions to the challenges of providing and funding interpreter and translation services."

The Council is an unprecedented model for members of organized medicine, health plans, hospitals and consumer advocates to work together to identify policy and funding solutions for the problems confronting health care providers who want to offer language-access services to support quality health care. The group will continue meeting biannually at least through spring of 2005.

This project is part of a larger language access initiative, which The California Endowment has divided into Applied Research, Policy and Systems Change, and Training and Curricula Development sections. The Council is part of the Policy and Systems Change group.

## **MEDICAL LEADERSHIP COUNCIL MEMBERS**

The members of the Medical Leadership Council on Language Access include the following organizations. An annotated Council member list is included in Appendix A.

- American Academy of Pediatrics, District IX
- American College of Emergency Physicians, California Chapter
- American College of Obstetricians and Gynecologists, District IX
- American College of Physicians, California Chapter
- Asian Pacific Islander American Health Forum
- California Academy of Family Physicians
- California Association of Public Hospitals and Health Systems
- California Healthcare Association
- California Latino Medical Association
- California Medical Association
- California Primary Care Association
- Catholic Healthcare West
- Fresno-Madera Medical Society
- Golden State Medical Association
- Los Angeles County Medical Association
- Native Wellness and Advocacy
- San Diego County Medical Society
- San Francisco Medical Society
- Santa Clara County Medical Association
- Sierra-Sacramento Valley Medical Association
- St. Joseph Health System
- Sutter Health
- WellPoint Health System

Scripps Health and Kaiser Permanente, other California Endowment grantees in the Language Access initiative, are invited guests at each meeting.

In the spring of 2004 the original Council roster was expanded to include:

- Alameda Contra Costa Medical Association
- California Medical Association Foundation
- Orange County Medical Association
- San Bernardino County Medical Society
- San Mateo County Medical Association

## **PUBLIC POLICY PRINCIPLES FOR LANGUAGE ACCESS AND INTERPRETER SERVICES IN CALIFORNIA (2003)**

*“A physician’s first responsibility is the care of his or her patients. Colleagues and I already see large numbers of patients who speak little or no English, and official estimates indicate that by 2010, about 50 percent of California’s population may have language access needs. Medical Leadership Council members want to ensure that all patients in California have true access to health care. To provide the outstanding care we strive to deliver, physicians and patients need to be able to communicate clearly.”*

*— Leonard Fromer, MD, California Academy of Family Physicians*

### **► The Council’s Public Policy Principles outline:**

- **The importance of language access;**
- **Organizing principles for provider education, workforce issues, organization and access, written resources, quality assessment, and payment; and**
- **Policy options for implementation in the state’s Medicaid (Medi-Cal) program, State Children’s Health Insurance Program (SCHIP) (Healthy Families), Medicare and managed care.**

The Council’s “Public Policy Principles for Language Access and Interpreter Services in California” have been endorsed by the following organizations:

- American Academy of Pediatrics, California
- American College of Emergency Physicians, California Chapter
- American Indian Health Professionals of California
- Asian Pacific Islander American Health Forum
- California Academy of Family Physicians
- California Association of Public Hospitals and Health Systems
- California Chapter of the American College of Physicians
- California Healthcare Association
- California Medical Association
- California Primary Care Association
- Catholic Healthcare West
- Golden State Medical Association
- San Diego County Medical Society
- San Francisco Medical Society
- Santa Clara County Medical Society
- Scripps Health System
- Sierra-Sacramento Valley Medical Society
- St. Joseph Health System
- Sutter Health

## **Public Policy Principles...cont.**

A major purpose of the policy position paper is to serve as a starting point for dialogue with other interested parties, including state officials. Representatives of the Council organizations have visited lawmakers to recommend ways to improve language access services and are promoting action on these principles among their many thousands of physician and community members.

The Council hosted a panel of administrative officials at the September 18, 2003 meeting, led by California Endowment Program Officer Ignatius Bau, JD. The panel included Lesley Cummings, Executive Director, Managed Risk Medical Insurance Board; Grantland Johnson, Director, Health and Human Services Agency; and Jim Tucker, Acting Director, Department of Managed Health Care.

“It is really important to keep up a consistent effort, calling on the state government to improve in this area,” said Cummings, who also noted that the state budget shortfall and resulting rate freeze for services provided by health plans are challenges to such efforts.

Johnson agreed with the need to improve language access services. “An ad hoc approach to providing these services clearly won’t be sufficient,” he said. “By 2010, about 50 percent of our population may have language access needs.”

“Delaying conversations about payment and expectations will prevent success (of providing these services) because some people will do one thing, others another, and some will do nothing,” Tucker said in support of the Council’s work of beginning to clarify the issues.

Since most Council members agreed on the public policy principles, “we will continue to work together on adopting policies and implementing practices that will put those principles into operation in ways that ultimately ensure critical language access for all Californians,” said Fromer.

“This is groundbreaking work,” noted Robert K. Ross, MD, President & CEO of The California Endowment and sponsor of the Council meetings. “This is the first time that such a broad coalition of physician and medical association leaders has focused on the serious need to provide interpretation and translation services to patients with limited-English proficiency.”

**Medical Leadership Council on Language Access  
Public Policy Principles for Language Access and Interpreter Services in California**

**1. Introduction**

Importance of Language Access for Quality Care:

- The organizations that comprise The California Endowment’s Medical Leadership Council on Language Access are committed to cultural and linguistic competence in the provision of medical care, and believe that effective communication with patients is essential to quality care, access to care, and assuring a patient’s adherence to treatment plans, all of which are important to the delivery of good health care with successful outcomes.

**2. Organizing Principles**

Provider Education:

- Medical societies and provider associations should continue to work with their members to educate them about LEP issues and disseminate resources so that physicians and other health care providers are able to continually improve access to quality care received by their LEP patients.
- The Office for Civil Rights should disseminate information and provide technical assistance about best practices in the provision of culturally and linguistically sensitive care delivery.

Workforce Issues:

- The State of California should encourage the racial, ethnic and linguistic diversity of its health care workforce to reflect the needs of its population.
- To meet the needs of LEP patients, the State of California should provide incentives for the development of a trained interpreter workforce.

Organization & Access:

- Language assistance services, including, but not limited to, bilingual providers and staff, dedicated staff interpreters, contract interpreters, telephonic language lines, translated written materials, and translated signage, can be essential elements of an effective health care delivery system and can assure and improve the quality of care.
- Any language access requirements placed on physicians and other health care providers must recognize the logistical difficulties in the provision of interpreter services for unusual/rarely encountered languages and in urgent/emergent situations, and provide exemptions and additional assistance for these situations, as appropriate.

## Public Policy Principles for Language Access and Interpreter Services in California

### Organization & Access...cont.

- State, regional and local systems of language assistance service should take into account the limited capabilities and resources of health plans, hospitals, clinics, health departments, medical groups, physician practices and other health care providers. To the extent possible, there should be efforts to collaborate, coordinate and centralize the provision of language assistance services to increase efficiencies and minimize costs and administrative burdens.

### Written Resources:

- The state and other interested stakeholders should examine the feasibility of statewide or local clearinghouses for translated materials that could increase access to quality health education, medication information, and other health-related information.

### Quality Assessment:

- Quality assessment of interpreter services should be the duty of the State of California or other purchasers of health care services and must include both training, testing and/or standards-setting.
- In its consideration of quality assessment, the State should consider existing models such as models in other states and models developed by health care entities.<sup>i</sup>

### Payment:

- Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity.
- The primary financial entity (state, insurance company, or managed care company) should contract with and pay interpreters directly unless medical groups or physicians explicitly choose to accept risk for such services in their contracts. This precludes ultimate physician and other providers of care, including medical groups, from unwillingly bearing the burden or expense of providing interpreter services.
- There should be consideration of reimbursement of physician office bilingual staff who serve as interpreters, as long as they have been trained and assessed for linguistic competency. There should be consideration of compensation for bilingual physicians who would otherwise require an interpreter, provided they have been assessed for linguistic competency.

## 3. Policy Options

### Medi-Cal/SCHIP/Medicare

- The State of California should seek federal matching funds for the provision of interpreter services for patients in the Medi-Cal and Healthy Families programs.
- The State of California and Council members should work with federal policy makers to ensure that language services are a covered benefit under the Medicare program.

## Public Policy Principles for Language Access and Interpreter Services in California

Medi-Cal/SCHIP/Medicare...cont.

- The proportion of the Federal match for language assistance services should be increased significantly so as to remove a significant barrier to adequate care.
- Ideally, the State or federal government would organize a centralized service for interpretation that can be accessed easily by physicians. Models with significant promise include that in place in Washington state and the national telephonic interpreting service in Australia. The State of California should support a regional pilot project to test delivery models for such a service.

Managed Care:

- Both public and private HMOs should be asked to take explicit responsibility for paying and arranging for interpreter services as a covered benefit for members with the caveat that such services are the responsibility of the primary financial entity (HMO or purchaser) and are not to be born by fiscal intermediaries such as local medical groups or physicians and other providers, unless physicians/groups/other providers have explicitly contracted for the provision of interpreter services.
- Managed care organizations should negotiate with both public and private payors for adequate reimbursement to cover the expenses of interpreter services so that they can establish services without burdening physicians.
- Managed care plans should provide incentives to providers to improve the accessibility of their services to LEP patients.

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<sup>1</sup> Resources include:

- The State of Washington, Department of Social & Health Services, Language Testing and Certification Program website: <http://www.dshs.wa.gov/msa/ltc/>
- California Primary Care Association, *Providing Health Care to Limited English Proficient Patients: A Manual of Promising Practices*, 117 pages, 2001.
- National Health Law Program, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field*, 54 pages, May 2002.
- The California Healthcare Interpreting Association's website: <http://www.chia.ws/>

Asian Pacific Health Care Venture, Inc., *A Functional Manual for Providing Linguistically Competent Health Care Services as Developed by a Community Health Center*, and website: <http://www.aapcho.org>.

## **PROJECTS of the MEDICAL LEADERSHIP COUNCIL ON LANGUAGE ACCESS**

- ▶ **The California Endowment funded six new language access projects in 2004. These projects were proposed by Council organizations and based on shared understandings among Council members about ways to increase language access. They were announced at the Council's fifth meeting in May 2004 in Los Angeles.**

### **Continuing Medical Education for Improved Language Access**

California Academy of Family Physicians

Susan Hogeland, CAE, Executive Vice President; Laura Johnson-Morasch, MPH, CAE, Executive Director, CAFP Foundation

Project leaders will develop a continuing medical education (CME) curriculum for physicians, including topics such as working with interpreters, office logistics, and translation issues and resources. The syllabus will include a toolkit of items physicians can use, such as model policies and procedures for working with interpreters, language skills assessments, staff training materials, and a resource directory. Trained physicians will serve as faculty to deliver 10 trainings to medical societies and other groups, with the goal of training 600 physicians between October 2004 and October 2005.

### **Language Access – The Language of Health Care**

California Latino Medical Association

Christine Gonzalez, MBA, Executive Director

Project leaders will develop a CME curriculum and seminar for physicians who serve Limited English Proficiency and monolingual Spanish-speaking patients. Leaders will first convene focus groups with patient populations this year to learn more about their needs and preferences. They also will conduct focus groups with non-Spanish-speaking physicians serving Latino patient populations, and then will share data and collaborate with the California Academy of Family Physicians on CME curriculum development.

### **Serving LEP Patients: Special Needs in Providing Women's Health Care**

American College of Obstetricians and Gynecologists, District IX

Tracey St. Julien, Executive Director, Elizabeth Lyster, MD, MPH, FACOG

Leaders for this project will study issues, methods, and challenges specific to Ob/Gyn practice over the next two years. Leaders will design and conduct a baseline survey of 3,400 practicing OB/Gyn members to gather information on the awareness of language access issues, attitudes about how to best address the needs of LEP patients, and knowledge and use of language assistance services. In addition, they will conduct two focus groups with physicians and two with LEP patients to obtain additional information. Project leaders then will develop and distribute a report of their findings and recommendations, with the goal of improving communication between women's health care providers and their LEP patients.

## **COUNCIL PROJECTS...cont.**

### **CAL/ACEP Language Access Project**

American College of Emergency Physicians, California Chapter;  
Paul Kivela, MD, President; Terrie Page, Executive Director; Katie Hurt, MD

Project leaders will develop an educational lecture on the legal background and options for technology to meet the legal requirements for providing language access in emergency departments. The lecture then will be delivered – at meetings and on a CD-ROM – to the state’s 3,000 emergency room physicians in the next year. Project leaders will also develop a Web-based survey to measure the impact of the training and to help define policies and practices to best meet the needs of LEP patients in emergency settings.

### **St. Joseph Health System Language Access Initiative**

St. Joseph Health System  
Maya Dunne, Vice President, Community Outreach; George Avila, Community Outreach Analyst

The St. Joseph Health System (SJHS) began initial work in language access with a grant from The California Endowment in March 2002 to conduct an assessment of language access programs and systems in place at its 14 hospitals in California and Texas. Project leaders interviewed hospital staff at key points of entry, including emergency rooms, operating rooms, admitting offices, interpreter services, and community clinics. They found that hospitals had developed several innovative programs to address the needs of LEP patients in the communities they serve. Additionally, the project leaders found areas for improvement such as additional education needed on legal guidance and use of proper interpreters.

Project leaders subsequently developed a report and recommendations based on this initial assessment, which were approved by the SJHS Board of Trustees and Executive Management Team and were to be implemented system-wide.

In March 2004, SJHS received additional funding from The California Endowment to continue its language access work. Funded activities include establishing a system-wide language access lead at the System Office; establishing language access coordinators in San Bernardino and Humboldt County hospitals to put them on the same level as other SJHS hospitals; institutionalizing a Spanish Medical Interpreter and Competency assessment by partnering with Healthy House Within a Match Coalition; holding Spanish medical interpreter training and assessing Spanish interpreter competency for volunteer interpreter staff; training providers on how to work with in-person and telephonic interpreters; holding system-wide convening of Language Access Coordinators and Vice President/Language Access leads to monitor system improvements in language access.

## **COUNCIL PROJECTS...cont.**

In addition to the grant, SJHS will be providing in-kind support by providing legal assistance to all entities to ensure compliance with state and federal mandates; developing a Human Resources template for orienting new employees to language access services; establishing a system-wide contract with a telephonic interpreter services provider to increase access to care; implementing a system to track LEP patients while they are staying at SJHS hospitals; and modifying patient satisfaction surveys to capture LEP patients' quality of care.

### **Model Hospital Policies and Procedures for Language Access**

California Health Care Safety Net Institute, the education and research affiliate of the California Association of Public Hospitals and Health Systems  
Wendy Jameson, MPH, MPP, Executive Director; Melinda Paras, Consultant

Because many hospitals have taken steps to provide language access services, but few have created full access for Limited-English-Proficiency (LEP) patients, and because more than half of the patients at public hospitals are LEP, leaders of this project plan to establish practical, operational policies and procedures for language access and eliminate the need to revisit these issues at every hospital. Building on existing language access standards and guidelines, as well as best practices from hospitals around the country, they will draft hospital language access policies and procedures, and select three reviewer hospitals to take the draft through internal medical and administrative review processes within the next year.

Topics will include how to request interpreter services, how to identify patient languages, how to create a bilingual-designated-personnel policy and signage policy, how to outfit hospitals for language access, and others. Final model policies and procedures will be widely disseminated throughout the hospital industry.

## **OTHER LANGUAGE ACCESS PROJECTS**

### **California Medical Association (CMA)**

Robin Flagg, MPH, Associate Director for Policy, Medical and Regulatory Policy, reported on a new CMA project at the November 2002 Council meeting.

Flagg provided an overview of the Interpreter Services Program CMA developed with support from The California Endowment. The community-based volunteer program, designed to provide interpreter services for physicians who treat LEP patients, offers a directory of volunteers in 22 Northern California counties.

When a physician needs an interpreter, he or she can call CMA at 1-866-241-4CMA. CMA staff gather information about the patient visit, secure a volunteer interpreter from the pool of about 25, and confirm with the physician's office. CMA was at that time expanding this program to Santa Clara County.

## **OTHER LANGUAGE ACCESS PROJECTS...cont.**

### **American College of Obstetrics and Gynecology, District IX**

Josephine Von Herzen, MD, FACOG, President, and Executive Director Tracey St. Julien reported at the November 2002 Council meeting on a comparison of the findings of language access surveys administered in the fall of 2002 to ACOG District IX members and a similar survey administered by the California Academy of Family Physicians to Council organizations.

ACOG's questions included:

- How many languages do you encounter in your patient population?
- What are the most commonly spoken languages among LEP patients?
- How do you handle translation/interpretation in your practice?
- How important do you consider language access for good health care?
- Do you collect reimbursement for interpreter services?
- Would you make use of interpreter services if you had a source of funding for these services?

Among the results:

- 37 % of ACOG members surveyed and 49% in the CAFP survey encounter five or more languages among their patients.
- 96% of ACOG members consider language access "high" or "extremely high" in importance for good health care.
- 79% of ACOG members say they rely on family members for interpretation services; 72% rely on office staff; 30% rely on hospital interpreters; and 12% rely on AT&T interpreters.
- 58% of those in the CAFP survey rely on their own bilingual skills; 22% on staff members; 22% on hospital interpreters; 21% on family members; 10% on community interpreters; 10% on friends; and 6% on community resources.
- 100% of ACOG members and 98% of those in the CAFP survey do not collect reimbursement for interpreter services.
- 81% of ACOG members and 79% of those in the CAFP survey would make use of interpreter services if they had a source of funding for these services.

For more information, contact CAFP Executive Director Susan Hogeland at 415/345-8667, [shogeland@familydocs.org](mailto:shogeland@familydocs.org) or ACOG Executive Director Tracey St. Julien at 916/442-8865, [tjulien@acog.org](mailto:tjulien@acog.org).

## **OTHER LANGUAGE ACCESS PROJECTS...cont.**

### **The California Endowment**

Ignatius Bau, JD, Program Officer at The California Endowment, described the following language access-related projects at the May 2004 Council meeting to give members an idea of other projects across the country. The California Endowment:

- Has funded the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to study cultural and language access practices at 60 hospitals nationwide to look for best practices and models, and to review JCAHO's own accreditation requirements on language access to see if they should be strengthened.
- Has funded the National Committee on Quality Assurance (NCQA) to review its accreditation measures on cultural competence and language access to see if they should be strengthened, and to consider whether it might be appropriate to develop HEDIS-type measures and link them to clinical outcomes or patient satisfaction ratings. The Endowment also funded NCQA to examine its work on patient consent, looking at links with language and literacy.
- Continues to fund and work with the National Health Law Program, a national coalition, in similar ways as it is working with the Medical Leadership Council on Language Access in California, and plans to work with labor and business groups as well.
- Is funding language access projects on technologies, including a scientifically-designed study of the model of remote simultaneous translation, using headsets, currently underway in New York. Project leaders expect to have findings by the end of 2004. Another project, in Alameda County and San Francisco, is studying the use of videoconference technology, and is in the early stages; data collection has just begun.
- Is working with the California Healthcare Interpreting Association and national organizations to examine language access tools developed at San Diego State University; community college trainings; other trainings developed by Gayle Tang, Director of National Linguistics and Cultural Programs at Kaiser Permanente; ways to test language competency; training methods; and other work. The long-term goal is to develop national standards and training.

### **The Robert Wood Johnson Foundation**

The Robert Wood Johnson Foundation is working with Molina Healthcare of California on a large initiative, *Hablamos Juntos: Improving Patient-Provider Communications for Latinos*. Project leaders invited Gayle Tang at Kaiser Permanente, a member of the Medical Leadership Council on Language Access, to develop a train the trainer program to build language access capacity at specific sites. Leaders now are implementing the program and building the business case. They expect to be able to identify best practices about a year from now.

## **OTHER LANGUAGE ACCESS PROJECTS...cont.**

### **The Commonwealth Fund:**

- The Commonwealth Fund has funded the Health Research and Educational Trust (HRET), which completed a study and in May 2004 released the report, “Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals.” Based on site visits to six leading hospitals and health systems and a nationwide survey of hospitals, the researchers concluded that “hospitals can do more to collect data on patient race, ethnicity, and language,” and that “standardization would better support efforts to eliminate health care disparities.”

## **Section II. The Need for Language Access: Summary of Research**

## SUMMARY OF RESEARCH ON THE NEED FOR LANGUAGE ACCESS SERVICES

*According to the Census 2000 Supplemental Survey, 39.5 percent of Californians – 14 million people - speak a language other than English at home. Many would benefit from language assistance when accessing health care services.*

- ▶ **The number of immigrants to the U.S. who speak little or no English has been rapidly increasing in recent years, and at the same time, a large volume of health care research is showing that ethnic and racial minorities suffer poorer health outcomes than the white, English-speaking population overall. Health services researchers have demonstrated that language barriers are associated with increased risk of medication errors, longer emergency room stays, higher health care costs, and decreased patient satisfaction.**

One of every four Californians is foreign born, and more than 100 languages are spoken in California, including Arabic, Armenian, Bosnian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Russian, Tagalog, Spanish and Vietnamese.

Using 2000 U.S. Census Bureau data, The California Endowment developed a map of California that shows the percentage of the population that speaks a language other than English at home, and the percentage that say they speak English less than “very well.” Here are some examples:

California County	Percent of Californians Who Speak a Language Other Than English at Home	Percent of Californians Who Speak English Less Than “Very Well”
San Francisco	45.7%	25.0%
Alameda	36.8%	17.7%
Santa Clara	45.4%	22.0%
Los Angeles	54.1%	28.9%
San Diego	33.0%	15.0%
Imperial	67.8%	34.3%

- In April 2002, Brandeis University released a report showing that Limited English Proficiency (LEP) hospital patients face a much greater risk of medical error and misdiagnosis when they are not provided with an interpreter.
- In March 2002 the Institute of Medicine (IOM) released a report which showed that minorities receive a lower quality of care than whites, even when their insurance and income are the same. The IOM review of more than 100 studies conducted over the past decade concluded that these disparities contributed to higher death rates among minorities from cancer, heart disease, diabetes and HIV infection.

## SUMMARY OF RESEARCH...cont.

The IOM panel cited “subtle racial prejudice and differences in the quality of health plans as possible reasons why even insured minorities get worse care.” IOM recommendations include “additional research to understand how bias affects care, efforts to increase the number of minority physicians, and the use of interpreters to ease communication between doctors and patients who do not speak English.” (New York Times, 3/21/02)

- In a national survey, children whose parents responded in English were 2.6 times more likely to have a usual source of care than those whose parents responded in Spanish. (Am J Pub Health 2000, 90:1771-4).
- Patients who experienced a language barrier during the medical encounter were significantly less likely to be discharged from the ER with a follow-up appointment than other patients. (JGIM 1999, 14:82-87)
- Disparities between LEP and non-LEP patients in colorectal screening and flu shots decreased after implementation of an interpreter services program. (JGIM 2001, 16: 468-74)
- Spanish-speaking patients discharged from the ER were less likely than English-speaking patients to understand their diagnoses, prescribed medications, special instructions, and plans for follow-up care. (J Emerg Med 1997, 15:1-7)
- Pediatric patients whose families were assessed to have a “language barrier” with the physician had higher charges (\$38) and longer stays (20 minutes) than those without language barriers. (Peds 1999, 103(6):1253-1256)
- A 22-year-old non-English-speaking man in Miami was awarded a lifetime settlement of \$71 million as a result of a missed stroke. The ER staff assumed his mother’s use of the word “intoxicado” meant he had a drug overdose. (Med Econ 1984, June:289-92)
- A pregnant Spanish-speaking woman was seen in a Chicago ER for pre-term bleeding. Another patient was used to interpret; she left the ER believing her pregnancy was on track. Two months later, wondering why her baby had not grown, she again sought care. On reviewing her medical records, it was discovered that the woman had in fact lost her baby that night in the ER. (J Healthcare Poor Underserved 1998, 9:S80-100)

**Section III. Mandates & Encouragement:  
Laws, Regulations and Policies**

## MANDATES & ENCOURAGEMENT: LAWS, REGULATIONS, AND POLICIES

- ▶ **Federal, state and local laws mandate the provision of interpreter and translation services to patients with limited English proficiency. Following is a summary of existing and proposed requirements.**

### Federal Policies

**1964:** Title VI of the Civil Rights Act of 1964 and subsequent regulations prohibit not only intentional discrimination based on race, color or national origin in any program or activity that receives federal financial assistance, but also policies and practices that may appear neutral but have the effect of such discrimination. This is the section of law under which language-access complaints are filed and its requirements govern areas including health care, where most providers and facilities receive some form of federal reimbursement.

At the November 2002 meeting of the Medical Leadership Council on Language Access, Ira Pollack, Manager of Region IX of the Department of Health and Human Services Office of Civil Rights, presented an overview of the federal requirements for language access services and a summary of how the DHHS Office of Civil Rights handles complaints and investigations.

As outlined by Pollack, Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of national origin by any recipient of federal funding.

**1974:** A 1974 U.S. Supreme Court decision (*Lau v. Nichols*) established that Title VI prohibits discrimination based on limited English proficiency.

The DHHS Office of Civil Rights is charged with enforcing Title VI, and when the department receives complaints staff members investigate. According to Pollack, based on policy guidance issued by the Department of Justice (2002, below), four main factors are considered when evaluating compliance:

- a) the proportion of LEP patients served
- b) the frequency of contact with LEP patients
- c) the importance of the program; and
- d) the resources available.

Pollack stressed that the Office works with physicians and others to resolve complaints, and has brought only one action in the past 20 years to a hearing.

**1998:** President Clinton and Secretary of Health and Human Services Donna Shalala launched the federal Initiative to Eliminate Racial and Ethnic Disparities in Health Care, which since has focused attention on improving the health status of people of color nationwide. (Current HHS Secretary Tommy Thompson continues to support this initiative, which focuses on six areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS, and immunizations.)

## **MANDATES & ENCOURAGEMENT**

### **Federal Policies...cont.**

- 2000:** The Clinton Administration issued Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency,” affirming the 1974 prohibition (above) and outlining the requirement of equal access to federally funded health care and services for LEP patients.
- 2000:** Office of Civil Rights released the “Title VI Prohibition Against National Origin Discrimination as It Affects Persons with Limited English Proficiency: Policy Guidance.”
- 2000:** The Department of Health and Human Services Office of Minority Health issued “National Standards on Culturally and Linguistically Appropriate Services in Health Care – Final Report.” In addition, JCAHO Accreditation and NCQA (HEDIS measures) both added interpreter/language services as a reporting requirement.
- 2002:** The Department of Justice re-affirmed Executive Order 13166 and issued policy guidance.
- 2002:** The federal Center for Medicaid and Medicare Services issued a final regulation for Medicaid managed care programs that includes a requirement for language access.
- 2003:** Josh R. Valdez, DPA, the Secretary’s Regional Director for Region IX of the U.S. Department of Health and Human Services (DHHS) addressed the Medical Leadership Council on Language Access at its March 2003 meeting, underscoring the Bush Administration’s support for language access services.
- 2003:** U.S. Department of Health & Human Services Guidance: Speaking at the September 2003 Medical Leadership Council meeting, Alice Hm Chen, MD, MPH, Soros Advocacy Fellow at the Asian and Pacific Islander American Health Forum, provided an overview of the recently re-published federal guidelines for services to Limited English Proficiency patients, noting that they remain similar to those released previously. The National Health Law Program (NHeLP) has developed a document, “Side-by-Side: Comparison of HHS Aug. 2000/Feb. 2002 LEP Guidance to DOJ June 2002 and HHS Aug. 2003 Guidance,” which can be ordered by calling NHeLP at 202/289-7661.

The bottom line, said Chen, is that the U.S. Department of Health and Human Services investigates only upon receiving a patient’s complaint, and then works closely to help the physician’s office or other entity come into compliance with federal regulations. The agency does not have the authority to “close down a physician’s office” or take similar action, she explained.

- 2004:** The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is expected to include language access in revised accreditation standards, effective this year.

## **MANDATES & ENCOURAGEMENT...cont**

### **State of California**

California Endowment Program Officer Ignatius Bau, JD, provided a California policy update at the September 2003 Council meeting. Legal mandates for the provision of interpreter and/or translation services include the Dymally-Alatorre Bilingual Services Act, the California Health & Safety Code Section 1259, Department of Health Services regulations, and Managed Risk Medical Insurance Board regulations.

- Medi-Cal managed care contracts, CA Department of Health Services (DHS) policy letters, Healthy Families contracts, and the CA Health and Safety Code in a section governing acute care hospitals all establish requirements for oral interpretation and written translation.
- The Dymally-Alatorre Act (1973) requires language access services for state and local government agencies that serve a “substantial number of non-English-speaking people.”
- In 2002, the Oakland Health Department began providing language access services, observing a 10,000 LEP population threshold.
- In San Francisco, the threshold is 5%, or 10,000 LEP population per supervisorial district.
- AB 982, signed by Governor Davis in October 2002, is designed to increase the number of primary care physicians and dentists practicing in historically underserved areas by providing grants to help pay for the high cost of attending medical or dental school. Some \$6 million over three years will come from the Medical and Dental Boards toward educational loan repayments for practitioners working in underserved areas. The program, administered by the Office of Statewide Health Planning and Development, will give priority to applicants who speak Medi-Cal threshold languages, and will consider applicants’ economic status as well.
- The Department of Consumer Affairs (DCA) and DHS formed a Task Force on Culturally and Linguistically Competent Physicians and Dentists, which held public hearings, consulted experts, and adopted (October 2002) recommendations for continuing education and cultural competence certification. The next steps for implementation – e.g., by DCA or DHS – have not yet been established.
- The Department of Managed Health Care and Office of Patient Advocate issued a Consumer Report Card in October 2003 that included data voluntarily reported on LEP-related services.
- Language access questions are included on the Consumer Assessment of Health Plans Survey.
- CA DHS and the Managed Risk Medical Insurance Board (MRMIB) are monitoring language access services in Medi-Cal managed care and the Healthy Families program.

## **MANDATES & ENCOURAGEMENT**

### **State of California...cont.**

- State Senate Bill SB 853 – Healthcare Language Assistance - 2004

This bill (by Martha Escutia, D-Norwalk) clarified that Knox-Keene health plan licensure standards include requirements for health plans to provide access to culturally and linguistically appropriate health care services, such as trained interpreters and translated documents. The law will require the Department of Managed Health Care (DMHC) to establish these standards by regulation by 2006.

There currently are no specific standards or requirements for commercial plans. There are requirements that apply only to government-sponsored health care programs such as Medi-Cal and Healthy Families. Specifically, this law requires the DMHC to:

- Develop standards for access to qualified health interpreters for persons who have limited English proficiency and requirements for informing enrollees of their ability to access interpreters;
- Specify the documents that must be translated and specify the languages;
- Regulate the methods health plans must use to assess the cultural and linguistic needs of their enrollees;
- Monitor and enforce compliance.

In developing these standards, DMHC is required to consider other applicable guidelines and standards such as the Medi-Cal managed care contract requirements and the federal Office of Civil Rights guidance.

### **Working with Legislators**

Representatives of Council organizations met with legislators and their staffs during the Council meeting in Sacramento in September 2004 in a session moderated by Barbara Masters, Public Policy Director at The California Endowment. Council members also visited other legislators' offices the following day. Legislators on both days encouraged the Council to continue educating legislators and their staffs about the need for language access services and funding. Council members talked with the following representatives:

- State Assemblyman Alan Nakanishi, MD, (R-10th District, Stockton/Modesto/Lodi), vice chair of the Assembly Higher Education Committee and a member of the Health Committee and the Aging and Long-Term Care Committee
- Joycelyn Martinez Wade from Wilma Chan's office; Assembly Majority Leader Wilma Chan (D-16th District, Oakland/Piedmont/Alameda) is a member of the Assembly Health Committee
- Renee Pittin from Leland Yee's office; Assemblyman Leland Yee (D-12th District, San Francisco) is a member of the Assembly Health Committee and the Business and Professions Committee, among others, and chair of the Assembly Select Committee on Children's Physical and Mental Well-Being in Diverse California Communities.

## **MANDATES & ENCOURAGEMENT**

### **Working with Legislators...cont.**

- Sandra Fargas from Senator Denise Ducheny's office; Senator Denise Ducheny (D-40th District, San Diego) is chair of the Senate Housing and Development Committee and a member of the Budget Committee
- Ana Matosantos, a consultant to the Senate Budget and Fiscal Review Committee;
- Nicole Vazquez, a consultant to the Senate Health and Human Services Committee.
- Matthew Siverling, policy consultant to Lieutenant Governor Cruz Bustamante
- Suzanne Wierbinski in the office of Senator Martha Escutia, JD (D-District 30, Norwalk), a member of the Senate Health & Human Service Committee and the Appropriations Committee, among others;
- Jay DeFuria, consultant to the Senate Business & Professions Committee;
- Peter Hansel, consultant to the Senate Health & Human Services Committee;
- Debra Roth, consultant to the Assembly Committee on Health.

**Section IV. Language Access Services:  
Models, Technology and Pilots**

## LANGUAGE ACCESS SERVICES: MODELS, TECHNOLOGY AND PILOTS

- ▶ **Physicians, hospitals and health plans each provide interpreter services in a variety of ways, and new methods and technology are becoming available as well. At present, various physicians, hospitals, clinics and health plans seek individual solutions to the problems of funding and providing these critical services. The Endowment and members of the Council, however, are joining together to seek large-scale solutions.**

### **Models for Providing Language Access Services**

At the March 2003 meeting participants learned firsthand about innovative new technologies that can make language access easier and more effective. One new method is simultaneous interpretation with the physician, patient and interpreter wearing wireless headsets – similar to those used at the United Nations – that allow the physician to speak and hear in one language, and the patient in another. Another new method is videoconferencing, linking a patient and physician at one location to an interpreter at another location through the use of computers with video cameras and microphones. A demonstration project funded by The California Endowment and the Office of Minority Health is currently underway at Alameda County Medical Center to evaluate the clinical and cost-effectiveness of providing interpreter services by videoconference.

Cynthia Roat, MPH, presented an overview of models for language access services in health care and led meeting participants through a discussion of the advantages and disadvantages of each. These included the bilingual patient model, bilingual provider model, ad hoc interpreter models, and dedicated interpreter models. She also discussed modes of service provision, including face-to-face, telephonic, and video. A mix of models is the norm in larger institutions, she explained, allowing the use of whichever model is best for a specific situation. In smaller practice situations, however, options are fewer.

- **Bilingual Patient Model**

This involves offering patients courses in English as a Second Language (ESL) as a means of allowing them to communicate with providers in English. A disadvantage of this model is that it may be several years before a patient can fully discuss his or her health in English. An advantage is that eventually the patient may be fully able to speak on her own behalf.

- **Bilingual Provider Model**

This involves hiring bilingual clinical staff members in order to provide services to patients in their language of preference. Providers may be native speakers of English who have learned a second language, or native speakers of a language other than English who have learned English as a second language. An advantage of this model is having clinical staff members who can communicate accurately and effectively with patients. A challenge is that many physicians see patients who speak any one of a number of languages, and the medical office is unlikely to have clinical staff members fluent in each of the necessary languages.

## **SERVICES: MODELS, TECHNOLOGY AND PILOTS...cont.**

- **Ad Hoc Interpreter Models**

These include working with bilingual clinical staff (e.g., MDs, PAs, RNs), support staff (e.g., medical assistants; receptionists; food service, housekeeping, maintenance staff), community organization case managers (e.g., refugee resettlement organizations), and family and friends. A disadvantage across all categories in this model is the concept of “false fluency,” which means that those speaking with patients might not be proficient enough to interpret complex medical questions, diagnoses and instructions.

Disadvantages of working with support staff include the fact that their primary work often falls behind while they work as interpreters. An advantage to working with family and friends is that they often are easy to access, including when they accompany a patient to an office visit. The federal Office of Civil Rights, however, discourages the use of family and friends as interpreters, as research shows they often provide inaccurate and incomplete interpreter services. Physicians and other health care providers should ask patients who decline a professional interpreter in lieu of family or friends to sign a release of liability for errors related to interpretation.

- **Dedicated Interpreter Models**

These include staff interpreters, contract interpreters, agency interpreters, and volunteer interpreters. The advantages and disadvantages vary depending on mode of service delivery, level of patient demand, frequency of use, location of medical center or physician’s office (urban or remote), and number of translators available.

### **New Technology: Headsets**

In a session chaired by Alice Chen, MD, MPH, Soros Physician Advocacy Fellow at the Asian Pacific Islander American Health Forum, presenters demonstrated the skills and technology needed to provide both simultaneous interpretation, which was done using wireless headsets similar to those used at the United Nations, and remote consecutive interpretation, using a laptop computer and Web camera.

Carlos Javier Gonzalez, Director of Language Initiatives at the Center for Immigrant Health at the New York University School of Medicine, and William Wood from SimulMed, Inc., demonstrated a technology called Remote Simultaneous Medical Interpretation (RSMI).

In this method, the physician, patient and interpreter all wear headsets, and the interpreter speaks simultaneously along with each of the other two. If the physician speaks English, for example, and the patient speaks Spanish, the interpreter simultaneously interprets the physician’s communications into Spanish and the patient’s communications into English. Each party can set his or her headphones to receive just English or just Spanish interpretation. In this way, the patient hears the physician’s communications in Spanish at the very same time the physician is actually talking.

## **SERVICES: MODELS, TECHNOLOGY AND PILOTS...cont.**

Similarly, the physician hears the patient's communications in English at the same time the patient is actually speaking. Proponents of this method like the decreased time needed for interpretation and find the interaction more closely resembles that of a physician and patient speaking the same language. One disadvantage to RSMI is the need for highly trained interpreters. It is also very difficult to do this type of interpretation for extended periods of time, so staffing is a challenge.

For more information on Remote Simultaneous Medical Interpretation (RSMI) and the demonstration project visit <http://www.med.nyu.edu/cih/language/index.html>, or contact Javier Gonzalez, Director of Language Initiatives, Center for Immigrant Health, NYU College of Medicine, at (212) 263-8783, or by email at [gonzac05@popmail.med.nyu.edu](mailto:gonzac05@popmail.med.nyu.edu).

### **New Technology: Computers and Videoconferencing**

In another demonstration, Gonzalez provided remote consecutive interpretation from another room, communicating with a physician and patient by using two computers, each equipped with a video camera and microphone, and linked by a wireless connection. (A network connection can also be used.) Live, real-time images and sounds of the patient and physician interaction were transmitted from the exam-room video camera and microphone, using the exam-room computer, to the interpreter, who was sitting at a computer, also outfitted with a video camera and microphone.

This allowed the interpreter to see the two and understand the specific meaning of questions like, "Does it hurt here?" and "I've been having pain here." It also was possible for the physician and patient to see the interpreter on a small-picture inset on their computer screen, and, of course, hear him. In this demonstration, the interpreter provided consecutive interpretation, speaking immediately after the physician or patient in the relevant language.

In 2001, the nonprofit organization Health Access of California led clinical trials of videoconference medical interpretation at Highland Hospital, which is part of the Alameda County Medical Center system, and San Francisco General Hospital, part of the San Francisco Community Health Network. Both patients and physicians rated the method highly.

In March 2003, the Alameda County Medical Center launched the largest demonstration project of its kind in the U.S. to further evaluate this videoconferencing approach as a way to better serve patients with limited English skills. With a \$918,840 grant from The California Endowment and a \$350,000 grant from the Office of Minority Health, the Medical Center plans to put 15 video-conferencing units in place within four months, a total of 40 units within a year, and 20 more units at San Francisco General Hospital, which is cooperating in this venture. Because these units run over an intranet, the hardware costs are about \$5,000. It is hoped that this price will continue to decrease. As this model gains acceptance and staffing efficiencies are attained, that aspect of the service should become more affordable, as well.

**SERVICES: MODELS, TECHNOLOGY AND PILOTS**  
**Computers and Videoconferencing...cont.**

At the March 2003 Council meeting presenters Melinda Paras, Director of Communications, Policy and Planning at the medical center, and Raymond Otake, JD, Chief Technology Advisor for Health Access of California and Chief Information and HIPAA Privacy Officer at the Community Health Center Network, provided an overview of this demonstration project and the local community needs for language access services.

Eliseo Perez-Stable, MD, will be leading the project to measure outcomes and perform cost-benefit analyses. Dr. Perez-Stable is a Professor of Medicine at the University of California, San Francisco School of Medicine and Chief, Division of General Internal Medicine at UCSF. He also is co-director of the UCSF Medical Effectiveness Research Center for Diverse Populations (MERC) and Director of the Center for Aging in Diverse Communities (CADC).

For more information on Videoconferencing Medical Interpretation (VMI) and VMI at the Alameda County Medical Center, visit <http://www.acmedctr.org/press030227.htm>, <http://www.acmedctr.org/Jan2001.pdf>.

## **Section V. Financing & Payment: Considerations & Options**

## FINANCING & PAYMENT: CONSIDERATIONS & OPTIONS

*“The provision of linguistically appropriate health care services is essential to improving the health of the state’s more than six million Limited English Proficient residents. The Endowment is committed to working with stakeholders to create solutions to improve the cultural competence of the state’s health care systems so that all Californians have equal access to care.”*

Robert K. Ross, MD, President & CEO, The California Endowment

- ▶ **Though fully committed to providing language access services to patients, member organizations of the Medical Leadership Council on Language Access are acutely aware of the challenge of paying for these services. Throughout the first two years of meetings, Council members have discussed financing and payment models, pilots, and related policy goals.**

### November 2002 Panel

Presenters at the November 2002 meeting included representatives from Washington and Utah, two states that have significant experience with state-funded interpreter services; a representative of the Region IX Department of Health and Human Services; and a policy expert on language access provision and financing efforts nationwide.

### **Joyce Gaufin, Manager of the Interpretive Services Program serving patients in the fee-for-service environment for the Division of Health Care Financing, Utah Department of Health.**

Utah’s Medicaid program provides contracted interpretive services for Medicaid providers and employees in a state that serves 141,000 Medicaid, 21,000 CHIP and 4,000 PCN clients. The department began working on the current system in 1995 after the Office of Ethnic Health had issued a guide listing interpreters, but contracting for services still was complex. Department staff members wanted to establish a process that would not create undue administrative burden for Medicaid or providers, and they wanted physicians to be able to call and order services as needed.

They researched efforts in other states, established criteria for interpreters, distributed an RFP in May 2000 and subsequently signed six contracts to cover on-site interpreting, phone interpreting, and written translation, covering 100 languages and providing services statewide, 24/7. The program covered 1,628 fee-for-service encounters in an 18-month period, and physicians and patients reported being pleased with the results. The average cost per encounter was \$39.39. For more information: [www.health.state.ut.us/medicaid/interpreter.pdf](http://www.health.state.ut.us/medicaid/interpreter.pdf) and [jgaufin@utah.gov](mailto:jgaufin@utah.gov).

**FINANCING & PAYMENT**  
**November 2002 Panel...cont.**

**Thomas Gray, Section Manager, Transportation and Interpreter Services, Division of Customer Support, Medical Assistance Administration, Washington State Department of Social and Health Services**

Gray provided an overview of a new “broker” system Washington state was to begin using in January 2003 to provide interpreter services. The state serves 900,000 Medicaid patients. The current state contracting is primarily through the Department of Social & Health Services (DSHS) (34%) with a mix of state and federal funds, and the Medical Assistance Administration (66%), with mostly Medicaid funds. They purchase approximately \$16 million in services each year, and serve some 180,000 LEP patients.

Under the new “broker” system, it was planned that nine brokers would serve 13 geographic areas of the state, securing both language and transportation services. This program was to serve all of DSHS, not just Medicaid. “It’s a professional distribution model with accountability and ensured quality,” Gray said. “We believe it will offer increased coordination, higher service quality, better cost containment and fraud control.” The state was aiming to save \$2.6 million in the first six months and \$12 million in the next biennium. For more information:

<http://fortress.wa.gov/dshs/maa/InterpreterServices> and Program Manager Tim Roth at [rothtw@dshs.wa.gov](mailto:rothtw@dshs.wa.gov).

**Ignatius Bau, JD, Program Officer at The California Endowment, Deputy Director for Policy and Programs at the Asian and Pacific Islander American Health Forum (APIAHF) in 2002**

Bau presented financing models from other states and suggested questions leaders in California might begin addressing. In Hawaii, for example, language assistance services agencies bill the state under Medicaid and SCHIP. In Maine and Minnesota, providers bill directly under Medicaid and SCHIP. In Massachusetts, state legislation requires interpreters for emergency room care and acute psychiatric services at acute care hospitals. Payments to hospitals are authorized under Medicaid managed care but have not yet been implemented.

Current examples include Asian Health Services in Oakland, which uses primarily bilingual staff to interpret; the Alameda Alliance for Health, which uses interpreter services; and Blue Cross, which has contracts for Medi-Cal in 13 counties and uses a mix of a language line and community-based interpreter access programs. In individual physician offices, Medicaid pays between \$25 and \$45 an hour for interpreter services.

## **FINANCING & PAYMENT**

### **November 2002 Panel...cont.**

Next steps in California could include surveying other states to help determine what the most appropriate financing model might look like; reviewing statutes and administrative policies already in place; establishing a billing code for interpreter services and including it in any state plan; carefully considering the context of the state budget, since any financing mechanism will require state matching funds; and combining both governmental and non-governmental leadership to develop options. For more information: [www.apiahf.org](http://www.apiahf.org).

### **May 2004 Panel**

Following are excerpts from the panel moderated by Ignatius Bau, Program Director at The California Endowment. Council organizations acknowledged that given our state's fiscal and budget problems, it's unlikely money will be allocated by the state in the near future to improve language access services. Panelists considered ways to proceed in the current environment.

#### **Kelvin Quan, MPH, JD, Chief Financial Officer and General Counsel, Alameda Alliance for Health**

“Alameda Alliance for Health, the Medi-Cal managed care plan for Alameda County, is proud of its language access services. The Alliance serves 95,000 patients; 45% of those are LEP. The Alliance pays the full cost for professional medical interpreters directly to interpreters themselves.

“Healthy Families puts direct responsibility on health plans to provide language access services. We have promoted multilingual skills and staff in member services and provider services – we’ve been deliberate about that. We also translate key documents in equivalent quality to English documents and produce bilingual documents whenever possible. Our provider directory, which is translated into English and three threshold languages, is affectionately referred to as “MOAD” for the “Mother of all directories.”

“We track with a high degree of accuracy the race, ethnicity and language of each member and inform each Primary Care Provider (PCP) of his or her assigned members’ languages – before the patient ever sees a physician, so the physician knows each patient’s language needs before the visit. We also identified and contracted with qualified medical interpreters/vendors. Through our contract management, the Alliance monitors quality and makes sure that interpreters are regularly available. If the primary vendor is not available, then the Alliance calls upon our secondary vendor.

“We get a call from a physician’s office, and then we schedule the interpreter. We require the physician’s office to call the patient the night before to say an interpreter will be at the appointment, in an effort to decrease no-shows. We also pay physicians for using the service, to acknowledge it takes additional time to get this in place and extra

**FINANCING & PAYMENT**  
**May 2004 Panel...cont.**

skill to know how to work with an interpreter. We provide an additional billing code – we offer it, but not many physicians use it; they don't bill us.

“The California Endowment funded us to partner with Kaiser Permanente to develop a physician-assessment tool for language proficiency of doctors and their staff, rather than simply relying on self-assessment and reporting.

“We also are scheduled to roll out a program of “I speak” cards to patients, with their language stated, with information in English on one side and the patient's primary language on the other about how to access language services.

“The California Endowment has also funded us to promote patient-centered care, awareness and abilities among all staff and physicians in a Cultural Competency Training Program with measures of the effectiveness of the training intervention.

Suggestions for the future: “Some in health care have asked for justification for language access through cost-benefit analyses – asking, for example, if we can show that by using an interpreter we can decrease the length of stay or the number of diagnostic tests. There's no hard or compelling research on this yet, though studies are in progress. Like preventive care, it can be difficult to link the intervention here and now with improved health status either in the short term or long term, like 20 years down the road. Aside from the cost-benefit reasons that might support language access, the health care industry must also consider it an issue of social justice and of providing patient-centered care.”

**Beatriz Solís, MPH,**  
**Director, Cultural and Linguistic Services, LA Care**

“We serve 800,000 patients in Los Angeles. We surveyed the patient population and then developed simple, cost-effective language-access services. We got our policies, procedures and contracts in alignment in order to ensure the fulfillment of services throughout our network.

“From our assessments, we found that many bilingual staff function as interpreters but they are not trained and have not been tested. We received generous support from The California Endowment to provide health care interpreter training that would be assessable and mobile. We have now trained 25 organizations, from community-based to physician staff, hospital staff to HMOs. We offer two types of trainings - a four-hour training, approved for Continuing Medical Education, on how to work with an interpreter and a 40-hour health care interpreter training, also CME-approved.

## **FINANCING & PAYMENT**

### **May 2004 Panel...cont.**

“To determine the best option for providing telephonic interpreting, we did a cost-benefit analysis of telephonic interpreting companies and conducted a focus group with staff that have worked through such an interpreter. We wanted to know what experiences staff were having with the current vendor at that time and we wanted to know specific information from telephonic companies on HIPPA compliance, trained interpreters, language variety, detailed reporting capabilities and disaster recovery mechanisms. Then we chose a company and trained all staff that would need to access the service on how to work effectively through a telephonic interpreter.

“In another pilot study we tested the use of a low-cost solution to access a telephonic interpreter - through handset/headset technology. Once we completed the pilot among a complex county comprehensive clinic, provider office and traditional safety net clinic, we presented our study results to our Board of Governors. The Board agreed that the results indicated that it would be worthwhile to implement this system in all of our contracted traditional and safety net provider clinics. This Board Strategic Initiative at LA Care authorized staff to implement the project at clinic sites, provide training on how to work with an interpreter, and conduct baseline assessments.

“We also made particular efforts to provide “after-hours” coverage. Nurse advice lines are particularly popular after hours, so we contracted with a large organization to provide the service. We had to train even this group about language access. Although they’re large, national and well known, they hadn’t been making language access services available and were not aware of the need or the regulatory requirements.

Suggestions for the future: “Coordinate among health plans and the private sector so all a physician’s office has to do is call “1-800-interpret” to access an interpreter. Providing training must be continuous and consistent. Any program developed needs to be woven into the health care business practice so it’s core to the business rather than ancillary.

“We know we are reducing emergency room visits, hospitalizations, and use of inappropriate technology. Maybe eventually we can provide a financial reward to physicians for using language-appropriate services because of the money it ultimately will save.”

### **Ellen Wu**

#### **Executive Director, California Pan-Ethnic Health Network (CPEHN)**

“It’s important to push the issue, even when there’s no funding, to use the time to educate and build awareness. We can at least work with health plans, where some funding is available for services.

## **FINANCING & PAYMENT**

### **May 2004 Panel...cont.**

#### **Susan Fleischmann, MD, Medical Director, Venice Family Medicine Clinic and President, Board of Directors, California Primary Care Association**

“Some 70% of our patients speak Spanish only. Our clinic is considered to be doing a good job of providing culturally and linguistically good care. All staff either speak the patient’s language or use a translator.

“We rely on bilingual clinical staff, dedicated interpreters on staff, telephonic services, especially when funded by a health plan if the patient is insured, and volunteer lay interpreters. How do we pay for it? It’s difficult, it’s mostly unfunded. We also rely on foundation grants.

Suggestions for the future: “Language access services should be specifically funded in all insurance/coverage, and services should be consistent across health plans. We also should get more patients to choose their own physicians instead of just getting one by default because we could link them with physicians who speak their languages.”

#### **Tom Riley, Executive Director, California Healthcare Interpreting Association**

“With The California Endowment’s help, we now have 800 members - not just interpreters anymore, but also nurses, physicians, community organizations, and others. We also have a larger board and an advisory board. Over the past two years we’ve been considering how we can best assess and rate quality, and we did pilot hospital assessments last fall.

Suggestions for the future: “First, make sure people understand the value of interpreter services – quantify it. Any time the benefits of a service are not quantified, it gets ignored in the policy and payment arenas, but if you can show the value, the market increase, the cost savings, it helps. Second, include the services contractually, thus underscoring their value. And third, educate people about the medical errors that happen, the better outcomes and risk management that result. When the Office of Patient Advocate sends out a report card that includes language access, employers with large numbers of LEP employees will think they’re not accessing the health services the employer is paying for, unless language access is included.”

**FINANCING & PAYMENT**  
**May 2004 Panel...cont.**

**Wendy Jameson, MPH, MPP, Executive Director, California Safety Net Institute –  
California Association of Public Hospitals and Health Systems**

“Public hospitals now pay for interpreters out of their operations budget - a combination of pay differentials for bilingual staff, staff and contract interpreters, remote telephonic services, and videoconferencing. Neither Medi-Cal nor county indigent services funding sources pay directly – it would be a big help because we’re experiencing layoffs and closures in public hospitals.

Part of the issue is finding more cost-effective ways to provide language access services – relying only on in-person, face-to-face services covering multiple languages in a large hospital, with an ER, 24/7, is probably not viable. So we’re experimenting with other ways – including remote video and telephonic voice interpretation and possibly establishing a medical interpreter bank that can serve several hospital systems.”

**Section VI. Resources**  
**Organizations & Publications**

## **ORGANIZATIONS**

### **The California Endowment**

[www.calendow.org](http://www.calendow.org)

Direct link to the Endowment's Cultural Competence Language Access Initiative:

[www.calendow.org/program\\_areas/in\\_cul\\_lang\\_access.stm](http://www.calendow.org/program_areas/in_cul_lang_access.stm)

The California Endowment's mission is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. The California Endowment is a private, statewide health foundation created in 1996 as a result of Blue Cross of California's creation of WellPoint Health Networks, a for-profit corporation.

The Endowment's work involves a dual focus: grant making and policy and advocacy. This work focuses on four program areas Access, Work Force Diversity, Cultural Competence and Disparities in Health. Our multicultural approach to health is defined not only by race and ethnicity, but financial status, cultural beliefs, gender, age, sexual orientation, geographic location, immigration status, and physical or mental abilities. This approach seeks to mobilize the talents, cultures and assets of California's diverse populations to improve the quality of our health systems and to promote health at the level of communities.

### **California Healthcare Interpreting Association**

[www.chia.ws/index.php](http://www.chia.ws/index.php)

CHIA promotes safe, ethical, accurate and complete communication between patients and providers who speak different languages. The Association does this by encouraging the use of high-quality healthcare interpreting by medical organizations. CHIA works to bring healthcare interpreters & providers together to overcome linguistic and cultural barriers to high-quality care.

CHIA objectives include: establishing standards of practice; adopting a code of ethics, creating an Interpreter Certification Program, sponsoring internships and scholarships; advocating for cross-cultural awareness through education of healthcare professionals; encouraging the development of advanced level training in health care interpretation at institutions of higher education; promoting the networking of institutions that provide Interpretation Services; and making recommendations on policies affecting patients with limited or no English proficiency.

### **California Pan-Ethnic Health Network (CPEHN)**

[www.cpehn.org](http://www.cpehn.org)

CPEHN is a multicultural health network of community-based organizations, providers, and policy experts, established in 1992 by Asian & Pacific Islander American Health Forum, California Black Health Network, California Rural Indian Health Board, and Latino Coalition for a Healthy California. CPEHN monitors, analyzes, and informs health care policies and legislation affecting minority populations, and works to bring together diverse constituencies—community, government, academia, and the private sector—to

## **ORGANIZATIONS...cont.**

engage in dialog and build effective advocacy efforts to improve the health of communities of color. Ellen Wu, MPH, is CPEHN's Executive Director.

CPEHN's cultural and linguistic policy work have included advocacy for cultural and linguistic requirements in Medi-Cal managed care and Healthy Families programs; assessment of language access services as part of the Office of the Patient Advocate HMO Report Card; Participation on the Task Force on Culturally and Linguistically Competent Physicians and Dentists (see report issued in 2000, [www.dca.ca.gov/cltaskforce/final\\_report.htm](http://www.dca.ca.gov/cltaskforce/final_report.htm)); and support of California Senate Bill 853 on language services, in 2003.

### **Federal Interagency Working Group on Limited English Proficiency**

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

Federal Interagency Working Group on Limited English Proficiency works to build awareness of the need and methods to ensure that limited English proficient persons have meaningful access to important federal and federally assisted programs, and to ensure implementation of language access requirements under Title VI, the Title VI regulations, and Executive Order 13166 in a consistent and effective manner across agencies. The Working Group was created at the request of the Assistant Attorney General for Civil Rights and includes members representing more than 35 federal agencies.

Their website, [www.LEP.gov](http://www.LEP.gov), promotes a positive and cooperative understanding of the importance of language access to federal programs and federally assisted programs. The site also acts 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 and federally assisted programs, and other stakeholders.

### **Hablamos Juntos “We Speak Together”**

[www.hablamosjuntos.org](http://www.hablamosjuntos.org)

Hablamos Juntos works to improve communication between health care providers and their patients with limited English proficiency. Their goal is to develop affordable models that will help doctors, hospitals and their staff care for a changing patient population by funding ten demonstration sites in regions with established or emerging fast-growing Latino populations.

Hablamos Juntos is developing affordable models for health care organization to offer language services by funding ten demonstration sites in regions with new and fast-growing Latino populations. Their demonstration sites are located across the country in ten states in both rural and urban communities, where they focus on three areas for improving communication: 1) increasing the availability and quality of interpreter services for Spanish-speaking patients in health care facilities; 2) providing useful health care related materials in Spanish, and 3), developing easy-to-understand ways for non-English speaking patients to navigate health care facilities.

## **ORGANIZATIONS...cont.**

Hablamos Juntos is a project funded by the Robert Wood Johnson Foundation, and administered by the Tomás Rivera Policy Institute, an affiliated research unit of the University of Southern California, School of Policy, Planning and Development and of the Institute for Social and Economic Research and Policy at Columbia University.

### **The Institute of Medicine**

[www.iom.edu](http://www.iom.edu)

The nation turns to the Institute of Medicine (IOM) of the National Academies for science-based advice on matters of biomedical science, medicine, and health. A nonprofit organization specifically created for this purpose as well as an honorific membership organization, the IOM was chartered in 1970 as a component of the National Academy of Sciences. The Institute provides a vital service by working outside the framework of government to ensure scientifically informed analysis and independent guidance. The IOM's mission is to serve as adviser to the nation to improve health. The Institute provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large.

### **National Council on Interpreting in Health Care (NCIHC)**

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

The mission of the National Council on Interpreting in Health Care 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. Starting as an informal working group in 1994, the NCIHC was formally established in 1998. The group is composed of leaders from around the country who work as medical interpreters, interpreter service coordinators and trainers, clinicians, policymakers, advocates and researchers.

The NCIHC's goals include establishing a framework for culturally competent health care interpreting, standards for the provision of interpreter services in health care settings and a code of ethics for interpreters in health care; developing and monitoring policies, research, and model practices; sponsoring a national dialogue of diverse voices and interests on related issues; and acting as a clearinghouse on programs and policies to improve language access to health care for limited-English-proficient (LEP) patients.

### **National Health Law Program**

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

The National Health Law Program is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities. NHeLP serves legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people.

## **ORGANIZATIONS...cont.**

### **US Department of Health and Human Services, Office for Civil Rights, Limited English Proficiency Resources**

[www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep)

The Department of Health and Human Services, through the Office for Civil Rights, promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination.

Through prevention and elimination of unlawful discrimination, the Office for Civil Rights helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

Through investigation, voluntary dispute resolution, enforcement, technical assistance, policy development and information services, OCR will protect the civil rights of all individuals who are subject to discrimination in health and human services programs. OCR works with HHS Operating and Staff Divisions to make civil rights concerns an integral part of HHS programs, and the success of its compliance program will be reflected in the full participation of persons of diverse backgrounds and capabilities in health and human services programs nationwide.

## PUBLICATIONS

Materials in this section include publications from the:

- California Endowment
- California Healthcare Interpreting Association
- California Primary Care Association
- California Academy of Family Physicians
- State of California's Office of the Patient Advocate
- Commonwealth Fund (in conjunction with The National Health Law Program)
- National Council on Interpreting in Health Care

They can all be viewed and downloaded in Adobe Acrobat (PDF) format by following the links provided.

### **Publications of The California Endowment**

[www.calendow.org/reference/publications/cultural\\_competence.stm](http://www.calendow.org/reference/publications/cultural_competence.stm)

All of the following California Endowment publications on Language Access and related Cultural Competence issues can be viewed and downloaded (in PDF format) from the Endowment's website using the link above. Copies may also be obtained by calling 800/449-4149, ext. 3271.

- *In the Right Words: Addressing Language and Culture in Providing Healthcare (2003)*  
This report, created by Grantmakers in Health with the support of The Endowment and Robert Wood Johnson Foundation, describes the consequences of language barriers on health care outcomes, provides an overview of relevant laws and policies, and highlights strategies for improving language access. It focuses on the challenges and opportunities around ensuring language access for the growing number of individuals who have limited English proficiency.
- *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention*  
With 224 different languages being spoken within California, the need for health care interpreters has risen sharply. Created by the California Healthcare Interpreting Association, this publication provides an overview on the complex role of health care interpreters, as well as provides protocols for the field.
- *Health Care Interpreter Training in the State of California*  
In a 1997 survey of medical interpreter training programs, it was discovered that only three programs in California prepared interpreters for health care settings. This 2003 report analyzes trends in interpreter training throughout the state, and provides a compendium of service providers.

## PUBLICATIONS...cont.

- *Language Barriers in Health Care Settings: An Annotated Bibliography of Research Literature*  
A publication designed to serve as a compendium of resources related to language access issues in health care. Prepared for The California Endowment by Elizabeth A. Jacobs, MD, MPP, Alice Hm Chen, MD, MPH, et al.
- *Health Care Interpreters in California*  
The Center for the Health Professions, University of California, San Francisco  
One out of every five Californians - over six million people - does not speak English well and would benefit from the services of health care interpreters. "Health Care Interpreters in California," published by a grantee of The California Endowment, is an issue brief that offers a look at a small but growing professional work force that is trying to meet California's multi-lingual needs.
- *How to Choose and Use a Language Agency: A Guide for Health and Social Service Providers Who Wish to Contract with Language Agencies* (updated 03/07/2003).  
There is a growing awareness of the importance of quality language services in supporting the needs of Limited English Proficient populations. This report, which is designed for health and human services administrators, examines what to look for in a language agency, how to choose an appropriate provider and what to expect from service.
- *Highlights From The Promotore/Community Health Workers Grantee Convening June 2000*  
In June 2000, community health workers convened to discuss community-driven health outreach worker (promotores) models. This publication discusses the challenges and successes that frequently accompany such programs and summarizes the topics addressed at the event.
- "Improving Access to Health Care for LEP Health Care Consumers," from *Health ...In Brief*, Policy Issues Facing a Diverse California, April, 2003, Vol. 2, Issue 1. With more than 100 languages spoken throughout California, ensuring that people with limited English proficiency can communicate with their health care providers is critically important to their receiving quality health care services. This *Health ...in Brief* presents some options for how California can obtain federal reimbursement for such services.

## **PUBLICATIONS...cont.**

- *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals, 2003*  
In support of The Endowment's Cultural Competence program, this report provides guidance on content, training methods and modalities, evaluation and qualifications of teachers and trainers. These principles and standards are designed to accompany the Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards, adopted by the Office of Minority Health. This publication is intended to complement *A Manager's Guide to Cultural Competence Education for Health Care Professionals – 2003*, and *Resources in Cultural Competence Education for Health Care Professionals – 2003*.
- *A Manager's Guide to Cultural Competence Education for Health Care Professionals – 2003*  
This manager's guide includes information on how to structure a cultural competence training program, as well as resources to assist in setting up a training program to identify qualified trainers, and to assess the cultural competence of organizations and their personnel.
- *Resources in Cultural Competence Education for Health Care Professionals – 2003*  
This report is designed to assist health care professionals in their efforts to provide culturally appropriate education with the goal of contributing to the overall improvement in the quality of health care for all consumers.

### **California Healthcare Interpreting Association**

[www.calendow.org/reference/publications/pdf/cultural/ca\\_standards\\_healthcare\\_interpreters.pdf](http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf)

*California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention*

This publication from the California Healthcare Interpreting Association provides an overview on the complex role of health care interpreters, and provides protocols for the field.

### **California Primary Care Association**

[www.cPCA.org/resources/research/pdf/PPGuide.pdf](http://www.cPCA.org/resources/research/pdf/PPGuide.pdf)

*Providing Health Care to Limited English Proficient (LEP) Patients:*

*A Manual of Promising Practices*

Outlines the steps various California health centers, of varying LEP population and organizational size, have addressed the needs of their LEP patients and provides examples of how different California community clinics and health centers are providing language access service. Published by the California Primary Care Association with grant support from the Bureau of Primary Health Care Division of Programs for Special Populations, and The California Endowment.

## **PUBLICATIONS...cont.**

### **California Academy of Family Physicians**

[www.familydocs.org/publications.html](http://www.familydocs.org/publications.html)

#### *Medical Jargon and Clear Communication*

This monograph, published in conjunction with Molina Healthcare through the Robert Wood Johnson Hablamos Juntos grant program, provides an overview of clear health care communication principles. It presents an overview of cross-cultural communication issues, and the special importance of clear, jargon-free communication with diverse populations. Includes one hour of Category 1 CME credit.

### **California Office of the Patient Advocate**

[http://www.opa.ca.gov/report\\_card/pdf\\_files/opa\\_report\\_cards\\_en.pdf](http://www.opa.ca.gov/report_card/pdf_files/opa_report_cards_en.pdf)

#### *State of California HMO Report Card: How does your HMO rate on quality and service?*

The State of California's Office of the Patient Advocate (OPA) publishes the Quality of Care Report Card each year to provide Californians with comparative information on the performance of the state's largest HMOs and medical groups. The Card includes a list of California HMOs that provide services in languages other than English, including telephone interpreters, access to in-person interpreters, a bilingual provider list, non-English printer materials, and language barrier complaint monitoring.

### **The Commonwealth Fund**

[www.cmwf.org/publications/publications\\_show.htm?doc\\_id=221272](http://www.cmwf.org/publications/publications_show.htm?doc_id=221272)

*Providing Language Interpretation Services in Health Care Settings: Examples from the Field*, by Mara Youdelman and Jane Perkins, National Health Law Program, May 2002 Field Report

“While general recognition exists that ensuring access to language services improves the quality of health care provided to individuals with LEP, recipients of federal funds, such as state and local Medicaid agencies, hospitals, and managed care organizations, expressed concern about EO [Executive Order] 13166 and HHS guidance, citing that they would be responsible for providing interpreters yet not receive reimbursement. A recent report from the Office of Management and Budget, however, estimates that language services would only add an extra 0.5 percent to the cost of the average health care visit.<sup>3</sup> Moreover, the Centers for Medicare and Medicaid Services (CMS) have informed states that federal reimbursement for language services is available for Medicaid and State Children's Health Insurance Program (SCHIP) enrollees.

“These facts notwithstanding, health care providers have raised legitimate concerns about providing language services for patients with LEP. To address some of these concerns, the National Health Law Program, with funding from The Commonwealth Fund, undertook an assessment of programs under way to improve access to interpreter services in health care settings.”

## **PUBLICATIONS...cont.**

### **National Council on Interpreting in Health Care (NCIHC), Working Papers Series**

[www.ncihc.org/workingpapers.htm](http://www.ncihc.org/workingpapers.htm)

These documents from the NCIHC are designed to provide answers to commonly-asked questions regarding health care interpreting. The Working Papers are drafted by a committee of experts, or sometimes by a single expert at the request of a committee, and reflect discussions held by the Council as a whole. Drafts are reviewed by the entire board and their input is integrated into the final product. The documents are works in progress and represent the current best thinking in the field, and may be adapted in the future as the field grows and matures.

These and other Papers in the series can be viewed and downloaded from NCIHC using the link above:

- *Guide to Interpreter Positioning in Health Care Settings*, November 2003
- *A National Code of Ethics for Interpreters in Health Care*, July 2004
- *Linguistically Appropriate Access and Services; An Evaluation and Review for Healthcare Organizations*, by Charles Anderson, M.P.A., June 2002
- *Models for the Provision of Language Access in Health Care Settings*, by Bruce Downing, Ph.D., and Cynthia E. Roat, MPH, March 2002
- *Models for the Provision of Health Care Interpreter Training*, produced under a contract between Hablamos Juntos and NCIHC, February 2002

**Appendix A:**  
**Annotated List of Member Organizations**

## APPENDIX A

### Medical Leadership Council on Language Access: Annotated List of Member Organizations

#### **Alameda Contra Costa Medical Association**

[www.aacma.org](http://www.aacma.org)

The Alameda-Contra Costa Medical Association is a professional association of physicians throughout Alameda and Contra Costa Counties dedicated to addressing local health issues of concern to their patients and their profession.

#### **American Academy of Pediatrics, District IX**

[www.aap-ca.com](http://www.aap-ca.com)

The California District of the American Academy of Pediatrics is a group of over 5,000 board-certified pediatrician members from four California regional chapters. Their mission is to promote the health and well-being of all California's children.

#### **American College of Emergency Physicians, California Chapter**

[www.calacep.org](http://www.calacep.org)

The California Chapter of the American College of Emergency Physicians (CAL/ACEP) includes more than 2,000 California emergency physicians, practicing in a wide variety of settings, including large and small groups, academic centers, and managed care. CAL/ACEP represents and advocates for emergency physicians and the patients they serve. They identify areas of mutual concern and work toward concrete improvements in the practice of emergency medicine at the state and national levels.

#### **American College of Obstetricians and Gynecologists, District IX**

[www.acog.org/from\\_home/acog\\_districts/dist\\_web.cfm?recno=13](http://www.acog.org/from_home/acog_districts/dist_web.cfm?recno=13)

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of professionals providing health care for women, and today has over 46,000 members. ACOG serves as a strong advocate for quality health care for women; maintains standards of clinical practice and continuing education for its members; promotes patient education, understanding, and involvement in medical care; and increased awareness of changing women's health care issues.

#### **American College of Physicians, California Chapter**

[www.acponline.org/chapters/ca](http://www.acponline.org/chapters/ca)

The American College of Physicians (ACP) is the nation's largest medical specialty society. Its mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.

#### **Asian Pacific Islander American Health Forum**

[www.apiahf.org](http://www.apiahf.org)

The mission of APIAHF is to enable Asian Americans and Pacific Islanders to attain the highest possible level of health and well-being. It envisions a multicultural society where Asian American and Pacific Islander communities are included and represented in health, political, social and economic areas, and where there is social justice for all.

### **California Academy of Family Physicians**

[www.familydocs.org](http://www.familydocs.org)

CAFP has been advancing the cause of family physicians and their patients since 1948. With nearly 7,000 members, including active practicing family physicians, residents in family medicine, and medical students interested in the specialty, CAFP is the largest primary care medical society in California, and the largest chapter of the American Academy of Family Physicians.

### **California Association of Health Plans**

[www.calhealthplans.com](http://www.calhealthplans.com)

CAHP is a statewide trade association representing the majority of licensed health care service plans. Through legislative advocacy, informational communications, and collaborative efforts with other organizations, CAHP promotes high quality affordable health care to California consumers.

### **California Association of Public Hospitals and Health Systems**

[www.caph.org](http://www.caph.org)

CAPH is a statewide trade association representing 30 public and not-for profit hospitals, academic medical centers, and comprehensive health care systems working on the front lines of health care in California. Operating in 17 counties, CAPH members assist in meeting the counties' legal mandate to provide health care to indigent residents, and share a mission to ensure access to a full spectrum of health care services to all persons, regardless of insurance status or ability to pay. Public hospitals deliver care to low-income and uninsured individuals and provide essential community services such as emergency, trauma and burn care and services for special-needs children. As teaching hospitals they train more than half of the new doctors in the state.

### **California Healthcare Association**

[www.calhealth.org/public/about/index.html](http://www.calhealth.org/public/about/index.html)

Through effective leadership and member participation, CHA seeks to develop consensus, establish public priorities, and represent and serve hospitals, health systems and other health care providers. In concert with its member organizations, CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals, health systems and other health care providers can continue to provide high-quality patient care.

### **California Latino Medical Association**

[www.calma.org](http://www.calma.org)

With a membership of more than 3,000 Latino physicians, CaLMA is the largest ethnic physician association in the State of California and is committed to providing culturally sensitive health care of the highest quality to Latinos and their families.

### **California Medical Association**

[www.cmanet.org](http://www.cmanet.org)

The California Medical Association's mission is to promote the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession; to promote similar interests in its component societies; and to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

### **California Medical Association Foundation**

[www.calmedfoundation.org](http://www.calmedfoundation.org)

The CMA Foundation, a partnership of leaders in medicine, related health professions and community, supports advances in individual and community health. To fulfill its mission, the CMA Foundation acts as a bridge linking physicians to their communities. The Foundation works in collaboration with many partners to achieve significant improvement in key health issues. They receive funding for projects through physician, corporate, and foundation support.

### **California Primary Care Association**

<http://www.cPCA.org>

California Primary Care Association (CPCA) represents more than 600 not-for-profit community clinics and health centers that provide comprehensive, quality health care services, particularly for low-income, uninsured and underserved Californians. CPCA's diverse membership includes community and free clinics, federally funded and federally designated clinics, rural and urban clinics, large and small clinic corporations and clinics dedicated to special needs and special populations. Their mission is to promote and facilitate equal access to quality health care for individuals and families through organized primary care clinics and clinic networks that, among other things, seek to maintain cost-effective, affordable medical services, as well as meet the linguistic and cultural needs of California's diverse population.

### **Catholic Healthcare West**

[www.chwhealth.com](http://www.chwhealth.com)

Catholic Healthcare West, serving the western United States, strives to be a spiritually-oriented and community-focused health care system passionate about improving patient care, enhancing work life quality and collaborating with others to create a just health system. Catholic Healthcare West dedicates its resources to delivering compassionate, high quality, affordable health services; serving and advocating for our sisters and brothers who are poor and disenfranchised; and partnering with others in the community to improve the quality of life.

**Fresno-Madera Medical Society**

[www.fmms.org](http://www.fmms.org)

The Fresno-Madera Medical Society promotes the art and science of medicine, the care and well-being of patients, the enhancement of the public's health, and the general welfare of the medical profession; to cooperate with organizations of like purpose; and to unite with similar societies in California as component societies of the California Medical Association.

**Golden State Medical Association**

The objectives of the Golden State Medical Association are advancing the art and science of medicine, increasing the efficiency of patient care, improving community health, maintaining a high standard of medical ethics, and carrying out the stated objectives of the National Medical Association at the state level as approved and directed by the Golden State Medical Association Board of Counselors.

**Los Angeles County Medical Association**

[www.lacmanet.org](http://www.lacmanet.org)

The Los Angeles County Medical Association is a professional association representing physicians in all modes of practice and specialties, including solo practitioners, small- and large-group or hospital-based physicians, and students, interns and residents.

**Orange County Medical Association**

[www.ocma.org](http://www.ocma.org)

The Orange County Medical Association, a non-profit voluntary organization, is designed to promote the science and art of medicine, the protection of public health, and the betterment of the medical profession.

**San Bernardino County Medical Society**

[www.sbcms.org](http://www.sbcms.org)

The purpose of the San Bernardino County Medical Society, founded in 1878, is to promote and develop the art and the science of medicine, to conserve and protect the public health, and to promote the betterment of the medical profession.

**San Diego County Medical Society**

[www.sdcms.org](http://www.sdcms.org)

The San Diego County Medical Society seeks to return satisfaction to the practice of medicine for physician members and their patients. The mission of the San Diego County Medical Society is to represent and serve all physicians and their patients in order to preserve quality of care and enhance the role of medicine in society.

### **San Francisco Medical Society**

[www.sfms.org](http://www.sfms.org)

The San Francisco Medical Society, founded in 1868, is the eighth largest society in California and one of the 42 county organizations chartered by the California Medical Association. The San Francisco Medical Society advocates for the interests of physicians and their patients in the improvement of public health. The purpose of the Society is to promote and develop the science and art of medicine, to conserve and protect the public health, to promote the betterment of the medical profession, and to cooperate with organizations of like purposes.

### **San Mateo County Medical Association**

[www.smcma.org](http://www.smcma.org)

The San Mateo County Medical Association represents, educates and serves physicians and promotes quality medical care for the people of San Mateo County.

### **Santa Clara County Medical Association**

[www.sccma.org](http://www.sccma.org)

### **Sierra-Sacramento Valley Medical Association**

[www.ssvms.org](http://www.ssvms.org)

The Sierra-Sacramento Valley Medical Association is a voluntary, nonprofit organization of medical doctors and doctors of osteopathy. With over 1,200 physician members in active practice and several hundred retired members, they are the largest physician organization in their region. The Association is dedicated to upholding the authority and autonomy of physicians in the delivery of professional and ethical medical care.

### **St. Joseph Health System**

[www.stjhs.org](http://www.stjhs.org)

St. Joseph Health System is organized into three regions - Northern California, Southern California and West Texas/Eastern New Mexico - and consists of 15 acute care hospitals, as well as home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. St. Joseph's mission is to extend the Catholic healthcare ministry of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities they serve.

### **Sutter Health**

[www.sutterhealth.org](http://www.sutterhealth.org)

Sutter Health is one of the nation's leading not-for-profit health care organizations. The Sutter Health network consists of some of Northern California's most respected physician organizations, more than two dozen acute care hospitals, physician and nurse training programs, medical research facilities, region-wide home health, hospice and occupational health networks, and long term care centers. Sutter Health affiliates serve more than 20 Northern California counties. Their mission is to enhance the health and well-being of people in the communities they serve, through a not-for-profit commitment to compassion and excellence in health care services.

**WellPoint Health System**

[www.wellpoint.com](http://www.wellpoint.com)

WellPoint Health Networks Inc., the nation's second largest health plan, serves the health care needs of 15.5 million medical members and 46.2 million specialty members nationwide through Blue Cross of California, Blue Cross Blue Shield of Georgia, Blue Cross Blue Shield of Missouri, Blue Cross Blue Shield of Wisconsin, HealthLink and UniCare.

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