

APPENDIX B

Summary of Key Informant Findings: Aggregated Responses from Key Informant Interviews

What do you think would be useful to investigate in order to move policy, both institutional and public?

- Important to talk to provider community. Get decision makers in the mix. It will be very helpful to get NHHA and the hospitals they represent involved in a realistic discussion. The tone is kind of adversarial now but hospitals understand their Title VI obligation. The state has made progress (though slow) and people are willing to work together. Find out about OCR complaints and their resolution,
- Document the need. Collect numbers because it's important to prove need not being met.
- How to make services more culturally responsive?
- Collect written policies from all hospitals
- Explore how to use local infrastructure to solve language issues
- Study perceptions of facilities & trends in buy-in (whether administrators see this as a priority)
- Quality performance review--12 of 26 hospital don't use JCAHO but opt for state survey thru CMS; not sure if they ask CLAS (Culturally and Linguistically Appropriate Services) questions
- Needs of LEP & better picture of which providers are providing services to LEP
- More about delivery of interpretive services; Is quality care being delivered?
- Inventory of who offers services, where & what they charge, languages, capacity
- Best way to use mass media outlets to serve LEP population; who listens to what media or radio outlets?

What would you most like to see in a report on the needs of LEP patients in New Hampshire?

- Maybe we should summarize costs to facilities of establishing interpreter programs compared to potential malpractice suits. Liability may be what it takes to move agenda; malpractice
- Make case for financial support – give examples of successes.
- Appeal to people in administrative roles to follow their mission
- Until forced to track, hospitals don't do it. If JCAHO (Joint Commission on Accreditation of Health Care Organizations) said they had to collect numbers, they would. Use stick! The threat of a law suit or that they will be in the newspaper could change things. No law suits right now. OCR seems to be only in education mode now. Nothing happens without a lawsuit; organize and orchestrate.
- Suggest a state wide coalition with the governor's endorsement. Bill Walker could lead this. Address "isms" and create a political agenda.
- Create a defining number, equivalent to the poverty line, regarding interpreter services. What is the number needed vs. number provided. Label the gap. Track the state's progress in addressing the issue, narrowing the gap/disparity.
- Need outside guidance on what has worked in other service venues (like immunization)
- Document the need and how related to health disparities. Could help to design interventions but need data that show how many going for care need interpreters
- Explain why important not to use family members
- Report needs to address:
 1. Defined criteria for competency in any language. Solid and acceptable standards across the state.
 2. Consistent data collection regarding needs and services to address those needs.
 3. Models to consider replicating/adapting. University of Maine is one source they found useful.

- Need to make financial case – short and long-term advantages for health of community and productivity because argument that it is the *right* thing to do doesn't really have any weight with people looking at bottom line.
- Find more accurate community data; Let's look at census tracts and compare to hospital visits from that population
- What the community health centers are experiencing (uninsured, chronic issues) is going to become main stream. We have time to prepare and do prevention now. Not one person or organization's responsibility but everyone's.
- Need for cultural brokers, training in using the U.S. health care system. For example, patients will wait in the ED all day rather than visit a PCP's office. Developing bilingual and bicultural clinicians essential. Build community cultural competence capacity.

Are there any issues that you believe need to be avoided or finessed in the report?

- We need to be careful illuminating immigration issue & numbers. Don't want to expose those who are most vulnerable, who we must protect.
- Undocumented LEP residents often do not seek care or complain about language services. Will documenting unmet needs of this population draw INS attention?
- Many undocumented immigrants need services – we shouldn't avoid this issue but be careful.
- Dialogues don't happen well in the state. Who would convene? MIAB lacks political legitimacy. Mayor, Board of Alderman, County Government, State need to be at the table.

What is your perception of how LEP clients get served?

- Hospitals deal with it when people come through the door, without a lot of forethought and no prior arrangements, so too often use language line. No good system is in place.
- Quality varies incredibly. Expectation is that people should interpret for free.
- If call for lab results, phone interface is very difficult; Tele-communications system is horrible -- doubles or quadruples time
- It's very difficult to assess quality: for most part satisfied; best case is bi-lingual provider.
- National Assn. of Community Health Centers was asked about translating all health centers' forms using software program, but adding a disclaimer. Advice: "Attempting to do more is better than fear and doing nothing. Effort is important." Get resources into people's hands.
- Firm belief that people are more likely to come if someone speaks their language.
- Health Centers don't have capacity as numbers of LEP grow. Can't cover well
- Concerned about what gets "lost in translation."
- Must empower consumers to ask for language services.
- Sensitivity is sometimes more important than language or other knowledge. Can the clinician/ staff member connect with the client?
- In hospital ER's, vast majority using family members & untrained staff
- Perceptions are very different in different hospital departments. Some are much more in tune. Reception consistently bad; if patient can't speak English, told to go home. ER more receptive because don't want anyone dying in ER.
- Administrators may not have put policies into action
- Manchester has small pockets, 4-10 families, of individuals speaking languages for which an interpreter may not be available.

How deaf and hard of hearing patients are served:

- LEP patients and advocates can learn from deaf and hard of hearing community who have more resources and experience.
- Deaf and hard of hearing nationally operate as a counter culture, rather than a subculture. Political and social rules strong in the community. Every deaf or hard of hearing person in Manchester

knows each other. Greater unity than other groups. Know ADA rights—agencies have to bear the costs of serving. Public events must have an interpreter.

- Several reported deaf and hard of hearing patients are better organized and served than LEP. They are generally more assertive, knowledgeable consumers.
- New England Deaf and Hard of Hearing and Granite State are service providers and advocates.
- Anecdotes were reported regarding “unrealistic expectations” of interpretation.
- Is video interpretation an acceptable substitute?

How large is the unmet need across the state for interpreter services in your view?

- Some health centers report they never see LEP patient on own w/o interpreter; never use children and rarely use family members. However, many materials aren’t translated. Spanish and Bosnian are well covered but not others.
- Across state: Unmet need in other facilities is huge. Many providers see AT&T access as sufficient: end of conversation.
- Part of problem is we don’t know unmet need.
- The unmet need for interpreter services varies widely by institution, even within Manchester.
- North of Manchester is a “wasteland” for LEP residents.
- Majority of LEP patients seen without interpreters especially when go for ancillary services
- There needs to be a service for scheduling appointments.
- The unmet need is much larger in the west and north because there are so few interpreters available.
- State is not ready for the present and growing LEP population. Manchester EDs without 24/7 Spanish speaker/interpreter coverage not acceptable.
- We were urged to find a way to measure those who don’t make a request for interpreters or don’t go for care at all. Current utilization does not equal need. System presently documents only those who show up.
- “My 1st priority is getting adequate language services to those who show up now. Doing outreach to bring more people into a limited, under-funded system isn’t the best next step.”
- Provider mentality is often “If I keep track, I have to serve.”
- Medicaid program in 2003 had 2,627 LEP recipients (only 83 used interpreter services that year). Does it mean people aren’t seeking services? Are they being seen at health centers?
- In southern NH, we have inadequate numbers of interpreters to fill need. If look at private practices or specialty care, non-existent.

What sources do you currently use to provide interpreter services? What is your perception of the sources available?

- Bilingual clinicians strongly preferred to any form of interpretation
- Dental clinic recently hired a bilingual/bicultural dental hygienist who has made a great difference for Spanish speaking patients.
- Some facilities encourage family members to provide interpretation for LEP patients. Most often it is a patient’s child who interprets, but other family members wish to be present as well.
- Language line is the primary source in many settings.
- Access to qualified interpreters is improving substantially.
- One respondent uses professional interpreters on an as needed basis. He views professional interpreters as essential to their work. Children and family members are not used as interpreters.
- Beyond language line, many facilities use Language Bank interpreters. Others have sufficient volume to hire their own trained interpreters as staff. Some use bilingual staff as interpreters. Level of screening, training, and compensation for these staff vary significantly. Some organizations report contracting directly with individual interpreters at reduced cost vs. professional services. Several organizations report combining two or more methods cited above.

- One hospital relies on employees who are foreign language volunteers. They receive no training but the coordinator makes sure they “feel comfortable” interpreting. They also provide 800 #'s to language line
- Phone services for deaf and hard of hearing common.
- Granite State and New England Deaf and Hard of Hearing were cited as sources for ASL (American Sign Language) interpreters.

We think it is vital to document need and capacity. What information do you find useful to collect? What data does your organization track? Do you know if anyone counts the need or units of service provided? What sources of data do you rely on?

- If able to collect data in **consistent way**, would give better picture; everyone asking different questions so hard to make comparisons
- Need to document need and demand much better
- Some just began collecting ethnicity and language on intake forms in past year
- Some facilities collect data but don't use it effectively.
- One CEO basically knows that his line item for interpreters is huge. Most others know how much they spend on language line but don't keep track of what languages requested or in what setting, e.g. emergency room
- Discharge data doesn't include language
- How does one ask sensitively about mixed ethnicity?
- Uniform Data Systems (UDS) are collected for HRSA and Bureau of Primary Health Care. Question asked is “*How many of your users are best served by language other than English?*” Bi-state PCA has the 2002 date, and 2003 will be available in Feb. They will share numbers with us, e.g. MCHC response was 33%
- Data show incredible growth in need and diversity of languages
- Encouraged to talk to enrollment coordinators and CFO's to get real numbers. Some hospitals & clinics rely on bi-lingual people on staff and contract with translators but often patients bring someone.
- LEP population is most apparent in Nashua and Manchester
- Many do not collect language data in writing or orally. Were advised that oral collection could lead to charges of discrimination based on language (national origin).
- “We don't collect as much as we need.” For language line receive number of contacts, minutes, cost, and perhaps languages. For internal interpreters have complete data: interpreter, language, time, service location. For external interpreters: minutes, language and agency.
- Some track by individual and language each time an internal interpreter is used.
- Put pressure on Medicaid to do better data collection, e.g. “Asian” listed as language
- Medicaid collects: language prevalence, # of enrolled interpreters & languages; utilization – paid & units of service
- One hospital responded they had too many employees and affiliates so no way to keep track of requests for interpreters.

What resistance do you see to providing interpreters?

- Financing has been major barrier. We heard cost issue repeatedly: Cost is key. It's all about cost. Cost is a big issue; hospitals say they can't subsidize. Cost, esp. for FQHC's who are on the brink of extinction. \$800,000 cut in this fiscal year; no meaningful support from state. Unfunded mandate is how providers see this. Especially affects small providers where there is no critical mass for services. Basic issue is lack of financial support. Language line is prohibitively expensive. Cost associated because hospitals' computer systems would have to be changed to collect linguistic data. Organizations are losing money and reluctant to provide services for unfunded mandate. Increased time is required to work with an interpreter. Creates another barrier. Direct cost of interpreter and indirect cost of lower productivity.

- Liability questions – whose interpreters do you use? If not certified, are they covered by your liability? One hospital uses liability issue as excuse to use AT&T language line exclusively because it's certified.
- Private specialists expect LEP people to bring family member.
- Sometimes clients resistant to having another person in the room
- Lack of ownership and responsibility, or willingness to bear burden of costs.
- May take law suit or at least bring more legal pressure. Many want to know what happened with OCR investigations in New Hampshire. [Other state results may be valuable, but less powerful.]
- Some facilities not understanding the law.
- How determine if interpreters are qualified is troublesome. One provider uses formal screening for internal staff.
- Providers must create a plan of operation. Adds time burden to train and use staff.
- [Flores study indicates clinically important errors are greatest with family members. Trained staff still make errors. Need continuing education, evaluation. Certification?]
- Some “English only” mentality is also in play.
- Thinking that phone line is good enough
- Systems are not in place
- Again, common attitude is “If I keep track, I have to serve”
- Generally sees a lack of understanding of need; of why interpreters are important and why not appropriate to use family members
- Many providers don't know that language bank even exists or how to access services; an inventory of all options would be helpful
- Cost is a significant concern, particularly for Spanish speaking clients. > 30% of clients are Spanish speaking and represent a greater and greater burden on the total services budget. Lack of bilingual clinicians leads to greater burden.
- Lack of commitment to issue/populations. Cost. No unified voice for advocacy.
- Rising health care costs could be an issue. Emergency Departments and private practices view providing interpreter services as a cost. Federal support and interpreter training could help.
- LEP patients need access to health care, education and the legal system. Need to address issues to rally around.

New Hampshire Medicaid provides reimbursement for interpreter services. What is your perception of how that system works?

- Because reimbursement rates are very low, this alternative is little used
- \$15/hr is all they pay
- FQHC rap-around-rate doesn't allow them to use Medicaid enrolled interpreters.
- Some hospitals do not presently receive Medicaid reimbursement for its interpreter services. The current billing system is difficult.
- One hospital is developing a pilot dental care Medicaid reimbursement system. Its dental practice has both high Medicaid and high LEP patient loads.
- So complex – different providers are reimbursed in different ways and there is no manual that explains it all
- New pilot is being set up -- a system option where charge for visit and provider bills Medicaid; Diane Peterson set it up thru Child Health Services in Manchester.

What would you like to see in a survey? What questions should be asked and answered and by whom?

General

- Find out how community health centers do this well & document
- Make sure that North Country and other rural areas included.
- Don't make the same mistakes as some previous surveys that were not objective enough, used leading questions or were based on very small sample size

Providers

- Don't ask providers about perceptions, but practices
- Document number of LEP patients they believe they serve; what languages and how served
- What makes them tell patients to bring their own interpreters?
- Do you have professional interpreters or use family members or none?
- Talk w/ ER managers at the 4 hospitals (2 in Manchester and 2 in Nashua); do spot surveys & track for one month – day, evening & night shift to discover need in Social services/case management, community health services, emergency department, OB and other high volume outpatient areas
- What would encourage providers to use trained interpreters?

Hospital administrators

- Ask “what are their policies; are they in compliance w/ OCR?”
- Make sure people who are implementing programs are trained and that it exists on more than paper.
- Would they contribute to a shared interpreter pool?
- Volume of visits generated; is there a coordinator in place? What materials are translated into other languages?
- Liability and certification concerns
- Need to know more about *who* delivers language services
- Talk to HR directors: Are they recruiting bi-lingual staff and offering incentive pay? Are they teaching Spanish to staff?
- Criteria to become a qualified medical interpreter? New Hampshire facilities should have guidelines to show to Joint Commission and others.

Mental Health Providers

- State authority designates 10 regional MH providers who bill through Medicaid. All the executive directors meet monthly at the Division of Behavioral Health. Linda Saunders Paquette is assistant director so we could ask her for access to the group.

Interpreters

- Ask Interpreters what rate they see as adequate
- How should providers best be trained to work with them?

Limited English Proficient population

- Survey LEP population itself. Ask how they would like to be informed or notified of their right to an interpreter. Ask LEP groups:
 - What most useful to help you understand healthcare delivery system?
 - What kinds of tool useful and where are you seeking services
 - Do you understand system and benefit of having a medical home & a primary provider?
- People tired of being researched so be creative about how approach people. Consider using focus groups or parties. Hang out at Nashua soup kitchen to talk to people there.

Interviewees:

1. Kim Anastasiou, Nashua Dental Connection
2. Marty Boldin, formerly of Child Health Services
3. Ann Dancy, Lutheran Social Services
4. Nancy Dumont, Bi-State Primary Care Assn.
5. Kim Firth, Office of Planning and Research at NH Health Planning & Medicaid Program
6. Real Gilbert, Director WORDS (interpreter/translation company in Manchester)
7. Irene Graveline, Community Health Services at Catholic Medical Center
8. Peter Janell, Manchester Mental Health Center
9. Shawn LaFrance, Foundation for Healthy Communities
10. Kris McCracken, Manchester Community Health Center
11. Leslie Melby, NH Hospital Assn.
12. Paul Mertzik, Community Health Services at Catholic Medical Center
13. Jazmin Miranda-Smith, NH Minority Health Coalition
14. Lina Ruiz Mingote, Neighborhood Housing Services of Greater Nashua
15. Lynne Parker, NH Legal Assistance
16. Paula Smith, Southern NH AHEC
17. Linda Sprague, Office of Minority Health & community organizer in Nashua
18. Peggy Tagme, HR Dept at St. Joseph Healthcare
19. Bill Walker, Director Minority Health, NH HHS

Interviewers:

Nancy Kohn, The Access Project

Beau Stubblefield-Tave, The Stubblefield-Tave Group