



A Blueprint for Success: Bringing Language Access to Millions of Californians



CPEHN

California Pan-Ethnic Health Network



*We would like to thank our generous funders
who supported part of this work:*

The California Endowment
The California Wellness Foundation
The San Francisco Foundation

*We would also like to thank
Marty Martinez and Sarah Mercer for
their commitment to the passage
and implementation of SB 853.*

The California Pan-Ethnic Health Network (CPEHN) works to ensure that all Californians have access to quality health care and can live healthy lives. We gather the strength of communities of color to build a united and powerful voice in health advocacy. Together, we work to evolve health care from a one-size-fits-all approach to a system that works for people from all cultural and ethnic backgrounds. For more information about CPEHN go to www.cpehn.org.



IMAGINE GOING TO THE DOCTOR ONLY TO FIND THAT **NO ONE SPEAKS YOUR LANGUAGE.** You can't tell them what they need to know to make you feel better. Or your health plan sends you information on how to fill a prescription, but it's not in the language you can read so you don't know what to do.

These are familiar situations that our communities face every day when trying to get care. But not anymore. Through our advocacy efforts, the California Pan-Ethnic Health Network (CPEHN) has won new rules that require health plans to provide interpreters and translated documents so that our communities will be able to get the same care and services as everyone else.

In 2003, CPEHN sponsored SB 853, the Health Care Language Assistance Act. The first of its kind in the country, this bill holds health plans accountable for the provision of linguistically-appropriate services – requiring the California Department of Managed Health Care (DMHC) to develop standards for interpreter services, translation of materials, and the collection of race, ethnicity, and language data.

The following case study documents CPEHN's advocacy efforts over nearly a decade in passing and implementing SB 853, which goes into full effect on January 1, 2009. Facing hurdles that ranged from health plan opposition to rapid administrative turnover due to the 2003 gubernatorial recall, the passage and implementation of SB 853 is a tribute to CPEHN's tenacious advocacy and commitment to ensuring the needs of communities of color are met. It is our hope that the new law, as well as CPEHN's community-driven approach to our policy work, will serve as a model for future efforts to address the health inequities that continue to plague our nation.

For more information and tools to inform our communities of their rights to language services, visit our website at www.cpehn.org.

“Requiring health plans to provide equal access to language services is a model for the rest of the country.”

— Ellen Wu
Executive Director, CPEHN
Oakland Tribune
February 17, 2006



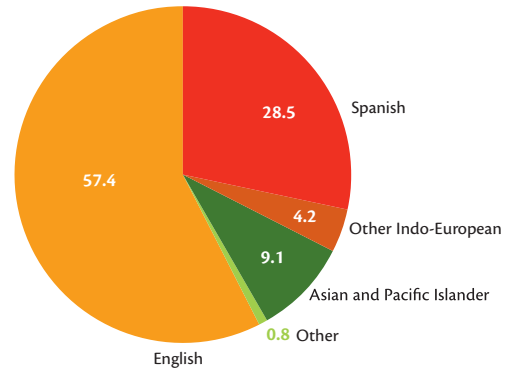
The Need for Language Services

California’s population is one of the most diverse in the country, especially with respect to language needs – the state’s residents speak over 100 different languages. While the state reaps many benefits from its diversity, California has a public health responsibility to address the health disparities our communities experience.

“It’s not just about quality care, though that is important. It’s about human dignity.”

— Cindy Ehnes
Director, California
Department of Managed
Health Care
Oakland Tribune
February 17, 2006

Current statistics show that more than 40% of Californians do not speak English at home, and an estimated 6 to 7 million Californians are limited English proficient – meaning they speak English less than “very well”. For some populations, such as Vietnamese and Korean speakers, over 60% are limited-English proficient (LEP), and as a result, they and other LEP individuals are faced with language and cultural barriers when seeking care (2007 American Community Survey).



Unable to communicate clearly with their health care providers, patients face an increased risk of misdiagnoses and misunderstandings, resulting in lower quality care and reduced adherence to medication and discharge instructions. These adverse outcomes are unacceptable. The provision of interpreters and translated documents are essential services for providing quality care to all Californians.

CPEHN Takes the Lead

As California’s only statewide multicultural health advocacy organization, CPEHN is a leader in the movement to expand access to quality, affordable health care, of which language services is a critical component. After playing an instrumental role in the 1990’s to secure the rights of Medi-Cal and Healthy Families enrollees to interpreter services, we turned our focus to expanding those rights to people who get their health insurance through their employer or the private market.

In 2000, the Patient Bill of Rights established the Department of Managed Health Care (DMHC) to regulate HMO services in the state. Working with the Managed Care Consumer Advocacy Collaborative, comprised of the Center for Health Care Rights, Consumers Union, Health Access, Latino Issues Forum, Western Center on Law and Poverty, and CPEHN, we provided guidance to the new Department on its initial series of regulations. Our analysis of the Knox-Keene Act of 1975, the state law governing HMOs, convinced us that DMHC had the authority to



require health plans to provide language services. We initiated a campaign to advocate that DMHC include in each new regulation, particularly regulations related to grievance processes and independent medical reviews (IMR), specific requirements related to the provision of interpreters and translated documents. Our administrative advocacy efforts included many one-on-one meetings with DMHC Director Daniel Zingale and staff, testifying at hearings, and providing written comments on draft regulations.

Despite our strong legal argument, our year's worth of relentless advocacy was met with the Department's frustrating conclusion that regulating cultural and linguistic services was outside the scope of their authority under the Knox-Keene Act. We had to find another way to fight for health equity for our communities.

Legislative Action

With the administrative door closed, CPEHN turned to the legislature. We recruited legislative co-sponsors, the Mexican American Legal Defense and Education Fund (MALDEF) and Western Center on Law and Poverty (WCLP), as well as a champion in the legislature to author the bill, Senator Martha Escutia. Working with a diverse group of stakeholders, we developed legislation that would explicitly give DMHC the authority to regulate cultural and linguistic services provided by health plans. The resulting bill, SB 853, was introduced in the Senate in the spring of 2003.

As expected, SB 853 quickly faced significant health plan opposition. Prepared for a hard battle, CPEHN united California's diverse communities in support of the bill. We mobilized our constituents through our convenings and action alerts, and asked them to testify at committee hearings. By bringing the voices of communities to Sacramento, we made a strong case that California's changing demographics demanded new approaches to care. It was time for our health care system to adapt or face severe consequences down the road as our state becomes increasingly diverse.

In the end, this historic legislation was signed by Governor Gray Davis. Not only did we prove that we can change the system, but we won more than we even hoped. SB 853 required not only health plans to provide language services, but all health insurance providers as well.

The Long Road to Implementation

Once the bill became law, our work was still not done. The bill was just the first step in the changes that were needed. Equally important in the advocacy process is making sure a bill is implemented as intended. The first step in this process is ensuring the regulations drafted in response to the bill are strong and meet our





communities' needs. Although DMHC was required to have the new regulations completed by January 2006, the timeline was considerably delayed due to a state budget deficit and the special election of Governor Arnold Schwarzenegger, which resulted in a shakeup of the DMHC staff that we had worked so long to educate on these issues. But working with other advocates such as the Asian Pacific American Legal Center, Asian & Pacific Islander American Health Forum, Health Access, Latino Coalition for a Healthy California, Latino Issues Forum, and the National Health Law Program, CPEHN set up a series of frequent meetings with the new DMHC staff to educate them about cultural and linguistic requirements in other state programs, best practices for language services and data collection, and our vision of what the implementing regulations should look like.

“Through my experience, it is clear that no child or anyone should be forced to interpret for one’s own family members.”

— Sylvia Park, Asian Health Services

Testimony at DMHC Hearing, February 16, 2006

The first draft of the regulations was not released until February 2007. In order to make sure that the final regulations were strong, CPEHN again mobilized our communities to make their voices heard. We reached out, and with the help of organizations such as Asian Health Services, PALS for Health, and La Clínica de la Raza, organized community members to testify at public hearings DMHC held across the state. Our community members told their personal stories, describing their fear of navigating the health system and the inappropriate care they received when interpreters were not used. These stories were extremely powerful and effective in advocating for the need for strong language access regulations.

In particular, CPEHN focused on the need for the regulations to include a requirement that health plans collect the race and ethnicity data of their enrollees. We reached out to public health experts and respected researchers, such as our partners at the UCLA Center for Health Policy Research, to provide testimony on SB 853’s potential for reducing health disparities if race and ethnicity data collection was included as part of the regulations.

“I went to a pretty decent medical school, Johns Hopkins in Baltimore and lesson number one is that the patient’s history makes up 70 percent of the diagnosis. So that patient’s story is just carried in words, is the critical element in whether we, as practitioners, are going to get this right. And sometimes we have only one chance to make a positive impact on our patient’s health. Incorrect understanding can turn that into a negative experience.”

— John Pescetti, MD, La Clínica de la Raza

Testimony at DMHC Hearing, February 16, 2006



As a result of our mobilizing efforts, the second draft of the regulations was much stronger. The new draft included a provision requiring health plans to collect information about their members' race and ethnicity. It was another great success.

Unfortunately, some health plans were conducting their own advocacy campaign and as a result, the third draft of the regulation was considerably weakened. In particular, we were disappointed with the changes that were made to how the plans were to notify their members about the availability of the new language services. Earlier drafts required them to distribute a notice in ten or more languages about the right to interpretation services. The third draft only required this notice to be sent in the plan's threshold languages—which would often be only one or two languages. This was despite the fact that under the new law, everyone who needs an interpreter, regardless of whether their language is a plan's threshold language, has a right to have one.

In response to this back tread, CPEHN helped orchestrate an emergency conference call with DMHC's Director Cindy Ehnes, urging her to delay submitting the regulations for approval. While our appeal did not work, we did garner DMHC's commitment to continue to work with us on the implementation of the regulations. We also worked with the media to highlight our disappointment about the weakened regulations, using it as a strategy to continue to hold DMHC and the health plans accountable for ensuring quality care is provided to all Californians.

Our Work is Not Done

The full implementation of SB 853 on January 1, 2009 is an historic landmark in our efforts to ensure access to culturally and linguistically appropriate care. In order for the new rules to be successful, we must hold DMHC accountable for monitoring health plan compliance. We urge DMHC to do all they can to get health plans to distribute notices to enrollees about their right to interpreters in multiple languages.

To this end, we worked with DMHC to create a single page standard notice informing consumers of their right to an interpreter in ten languages. It also provides the number for DMHC's complaint line to encourage our communities to speak up if their rights are violated. DMHC agreed to encourage health plans to distribute this, although they would not require it.

Continuing our efforts to ensure that our communities are fully informed of their right to an interpreter, in 2008 we partnered with Latino Issues Forum in sponsoring legislation, AB 3027 (De la Torre), that would have required health plans to send out the notice that was developed. Unfortunately, due to the state



"We didn't expect such a big change, and all of it negative."

— Marty Martinez
Policy Director, CPEHN
Sacramento Bee
January 7, 2007



budget deficit, the bill did not advance. We continue to monitor and push DMHC and health plans to appropriately and adequately educate members about their rights to quality health care.

In addition, we have provided DMHC with guidance on creating monitoring tools and survey instruments to ensure health plans are meeting their obligations under the law. We conducted a training on cultural competency and best practices to the HMO Helpline staff to more effectively address the needs of LEP enrollees and help them access the new language services. As a result, the Helpline is investigating how they can develop a menu tree in multiple languages.

We have also shared resources and tools with health plans to help ensure they are giving the best possible care to their patients. We must make sure that health plans continue to improve the quality of services provided to their enrollees, such as developing data collection and management systems that can better address the racial and ethnic disparities our communities experience. In the summer of 2008, CPEHN helped organize a series of conference calls hosted by DMHC to help health plans identify best practices for language services. The subjects covered included best practices for data collection, providing language services at all points of contact, and holding cultural competency training for health plan staff.

Finally, we must ensure our communities know about their new rights to language services, demand them from their providers, and know the process of filing a complaint if they are denied these rights. Through hosting convenings, partnering with ethnic media, and providing information to our communities, we hope to get the word out that finally our communities have the right to the care we deserve.

For more information and tools to inform our communities of their rights to language services, go to our website at www.cpehn.org.





Summary of Key Provisions of SB 853 and Its Regulations

1. Needs Assessment

All health plans and insurers are required to assess the language needs and demographic profile of their enrollee population. Demographic profile in this case means, at minimum, the identification of the enrollee's race, ethnicity, and preferred spoken and written languages. Data collected under this provision will be used to calculate the plan's threshold languages and to help identify racial and ethnic disparities.

2. Interpreter Services

All health plans and insurers are required to develop and submit policies and procedures outlining their provision of quality, accessible interpretation to their enrollees at no cost. These policies must specify all points of contact where language assistance may be reasonably anticipated, types and availability of qualified interpretation services, and provisions for timely access.

Summary of SB 853 and its regulations:

1. Health plans must conduct a needs assessment to calculate threshold languages and collect race, ethnicity, and language data of their enrollees.
2. Health plans must provide quality, accessible, and timely access to interpreters at all points of contact and at no cost to the enrollee.
3. Health plans must translate vital documents into threshold languages.
4. Health plans must ensure interpreters are trained and competent, and that translated materials are of high quality.
5. Health plans must notify their enrollees of the availability of no cost interpreter and translation services.
6. Health plans must train staff on language access policies and procedures, as well as how to work with interpreters and limited English patients.

The range of interpretation services may include, but are not limited to:

- Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting.
- Hiring staff interpreters who are trained and competent in the skill of interpreting.
- Contracting with an outside interpreter service for trained and competent interpreters.
- Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting; and
- Contracting for telephone, videoconferencing, or other telecommunications-supported language interpretation services.

3. Translation

Health plans and insurers are required to translate vital documents into threshold languages. Vital documents are those that contain important information and/or affect legal rights or obligations. They are defined in the regulations as including: applications; consent forms; letters containing important information regarding eligibility and participation; notices pertaining to denial, reduction, modification, or termination of services and benefits; and the right to file grievance or appeal.



The threshold languages that vital documents must be translated into are those needed by enough of the plan's enrollee population to meet the threshold criteria. After the needs assessment is conducted, a plan should have knowledge of the number of enrollees who speak a language other than English and what languages they speak. The formula for determining at what point a specific language group becomes eligible to receive translated documents varies by plan size:

- For health plans with a million or more enrollees: they must translate vital documents into the top two non-English languages, plus any language whose number of speakers in the plan is either 15,000 enrollees or greater, or totals 0.75% of the enrollee population.
- For plans with 300,000 to one million enrollees: vital documents must be translated into the top non-English language plus languages whose speakers are 6,000 enrollees or 1% of the enrollee population.
- For plans with less than 300,000 enrollees: vital documents must be translated into any language whose speakers total 3,000 enrollees or 5% of the enrollee population.

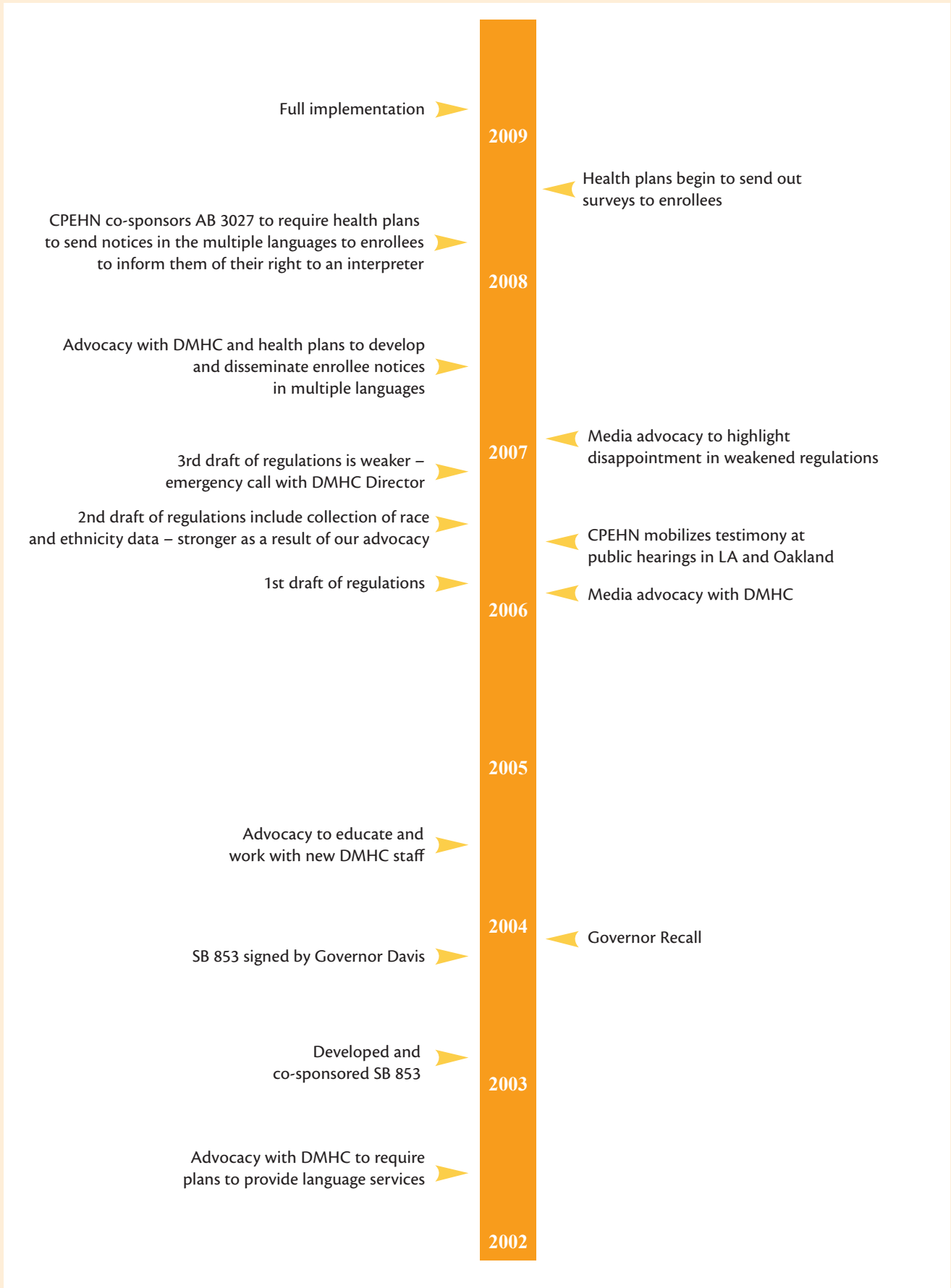
For documents that are not standardized, but are written for a specific enrollee about his or her medical condition or coverage, a plan is not required to translate the document, but must include a DMHC-approved written notice of the availability of interpretation and translation services in multiple languages (at a minimum, the plan's threshold languages).

4. Quality Assurance and Interpreter Proficiency

The health plan and insurer's language assistance standards must include provisions to ensure the quality of interpretation and translation services. Interpreters are required to have a documented and demonstrated proficiency in both English and the target language; a fundamental knowledge of health care terminology; and education and training in interpreting ethics, conduct, and confidentiality. The translators of documents also must have demonstrated competence and provide assurances that the materials are of the same high quality as the English version and are an accurate translation of the contents.

5. Enrollee Notification

Health plans and insurers are required to develop processes for informing enrollees of the availability of language assistance services, that these services are at no charge to the enrollees, and an explanation of how to access the services. At a minimum, these include methods for identifying an enrollee's language assistance needs at all anticipated points of contact and facilitating access to language services. Direct contact methods will be complemented by including statements, in English and in, at a minimum, the plan's threshold languages, about the availability of free language assistance services and how to access them in brochures, newsletters, and other materials that are routinely disseminated to the plan's enrollees.





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