
Access to Health Care for Vulnerable Populations

Lao American Seniors
in Metropolitan
Chicago

Prepared for the Asian
American Institute
by the South Asian American
Policy and Research Institute

The study aims to contribute to the information available on the needs of Lao Americans with limited English proficiency in the Chicago area, in furtherance of the broader goal of increasing the availability and quality of interpretation services provided by health care providers.

June 30, 2010

Access to Health for Vulnerable Populations: Lao American Seniors

Table of Contents

I.	Acknowledgments	3
II.	Background and Goals	4
III.	Methods.....	8
IV.	Results	9
V.	Discussion	12
VI.	Recommendations.....	15
	Appendix: Survey Instrument	19

I. Acknowledgments

Asian American Institute (AAI) was established in 1992 as a pan-Asian not-for-profit 501(c)(3) organization. Its mission is to empower the Asian American community through advocacy, research, education, and coalition-building.

Asian American Institute is a member of Asian American Center for Advancing Justice, along with its affiliates: Asian American Justice Center, Asian Law Caucus, and Asian Pacific American Legal Center.

AAI thanks the following individuals and organizations for their valuable and generous support for this project:

Asian American Justice Center
The Ford Foundation
The Field Foundation of Illinois
BlueCross BlueShield of Illinois

Winnie Chan
Simran Chatha
Jennifer Chen
Ami Gandhi
Mae Hong
Lao American Community Services (LACS)
Lao American Organization of Elgin (LAOE)
Annie Mui
Thavone Nyatso
Thomas Pravongviengkham
Myron Quon
Emily Rader
South Asian American Policy and Research Institute (SAAPRI)
Joanna Su
K. Sujata

II. Background and Goals

The need for health care is a basic human need that affects the daily lives and well-being of all people. Patients' ability to communicate with government and private-sector health care providers is the first step toward receiving health care, and this ability to communicate depends greatly on language proficiency. According to the most recent three-year American Community Survey (ACS)¹, there are millions of Americans who are limited English proficient (LEP), including citizens and legal permanent residents.² Language access is a crucial aspect of the provision of effective health care in the United States.

Language access is a serious concern for Asian Americans. The most recent three-year American Community Survey shows that, among the 280 million people in the United States age five and older, over 19% (55 million people) speak a language other than English at home.³ Of those who speak a language other than English at home, 44% (24 million people) speak English less than "very well."⁴ The majority of those who speak a language other than English at home speak Spanish or Spanish Creole.⁵ However, a substantial portion of the LEP population is Asian American -- 8.2 million people speak Asian or Pacific Island languages instead of English at home, and nearly 49% of them speak English less than "very well."⁶ More significantly, there are nearly 1.5 million "linguistically isolated" households speaking Asian and Pacific Island languages (meaning that no one over age 14 in a given household speaks English "very well"), making up nearly 28% of all linguistically isolated households in the United States.⁷ Nowhere is this more apparent than among Lao Americans.

The federal government and courts have recognized that language minorities are legally entitled to meaningful access to federally-funded programs. There are several laws -- including significant federal legislation, orders, and regulations -- that protect LEP

¹ The American Community Survey is a continuously ongoing survey conducted by the United States Census Bureau that asks in-depth questions to three million housing units annually from across every county in the nation.

² U.S. Census Bureau, 2006-2008 American Community Survey, Characteristics of People by Language Spoken at Home, available at http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2008_3YR_G00_S1603&-ds_name=ACS_2008_3YR_G00_&-lang=en&-caller=geoselect&-state=st&-format=.

³ U.S. Census Bureau, 2006-2008 American Community Survey, Language Spoken at Home, available at http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2008_3YR_G00_S1601&-ds_name=ACS_2008_3YR_G00_&-lang=en&-caller=geoselect&-state=st&-format=.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ U.S. Census Bureau, 2006-2008 American Community Survey, Linguistic Isolation, available at http://factfinder.census.gov/servlet/STTable?_bm=y&-state=st&-qr_name=ACS_2008_3YR_G00_S1602&-ds_name=ACS_2008_3YR_G00_&-redoLog=true&-caller=geoselect&-geo_id=01000US&-format=&-lang=en; U.S. Census Bureau, 2006-2008 American Community Survey, Households and Families, available at http://factfinder.census.gov/servlet/STTable?_bm=y&-state=st&-qr_name=ACS_2008_3YR_G00_S1101&-ds_name=ACS_2008_3YR_G00_&-redoLog=true&-caller=geoselect&-geo_id=01000US&-format=&-lang=en.

individuals in the health care context. Title VI of the federal Civil Rights Act of 1964 and its corresponding regulations require recipients of federal money to take reasonable steps to provide “meaningful access” for LEP individuals to participate in its programs and activities.⁸ Virtually all health care institutions -- including hospitals, nursing homes, home health agencies, managed care organizations, entities with health or social service research programs (including universities), state, county, and local health agencies, and state Medicaid agencies -- receive some form of federal financial assistance and are thereby governed by the United States Department of Health and Human Services (HHS) regulations and guidelines, as described further in the Discussion section below.

Though there are federal and state requirements that protect LEP persons, many of these language assistance mandates are unfunded. The burden of complying with these requirements falls on the agencies themselves – 85% of them supply interpretation and translation services, but only 44% are funded to do so.⁹ This lack of funding strains limited community resources and is a significant obstacle to the provision of appropriate language services to those who need it. As a result, LEP patients often are obliged to bring relatives, friends, neighbors, and other untrained individuals to provide ad hoc interpretation during health care visits. The use of untrained individuals can result in a number of problems, including:

- Breach of confidentiality which may have safety implications;
- Accidental omission of key information;
- Misinterpretation of health care terminology; and
- Lack of true, informed consent from the patient.

The use of minor children as interpreters poses additional problems because this places an undue burden on children who do not have the vocabulary or maturity to adequately interpret, while also damaging the parent-child relationship dynamic. Finally, adult LEP patients are unlikely to disclose sensitive health care information in front of their children, which can result in misdiagnosis and a failure to treat the underlying health condition.

It is generally accepted that language minorities face barriers when seeking health care, but there is insufficient research on the specific unmet language access needs of Asian Americans. This study aims to contribute to the information available on the needs of LEP Lao American seniors in the Chicago area, with the broader goal of increasing the availability and quality of interpretation services provided by key health care providers in metropolitan Chicago. It documents the experiences of Lao American patients at various hospitals and clinics in Elgin and Chicago.

⁸ *Id.*; Enforcement of Title VI of the Civil Rights Act of 1964 – National Origin Discrimination Against Persons With Limited English Proficiency, 65 Fed. Reg. 50,123 (Dep’t of Justice Aug. 16, 2000), available at <http://www.justice.gov/crt/cor/Pubs/eolep.pdf> (“DOJ Guideline”).

⁹ Paul Igasaki and Max Niedzwiecki, *Aging Among Southeast Asian Americans in California: Assessing Strengths and Challenges, Strategizing for the Future* (2004), at 4, available at <http://www.searac.org/aging-seamer-fin.pdf> (“SEARAC Report”).

Lao Americans¹⁰

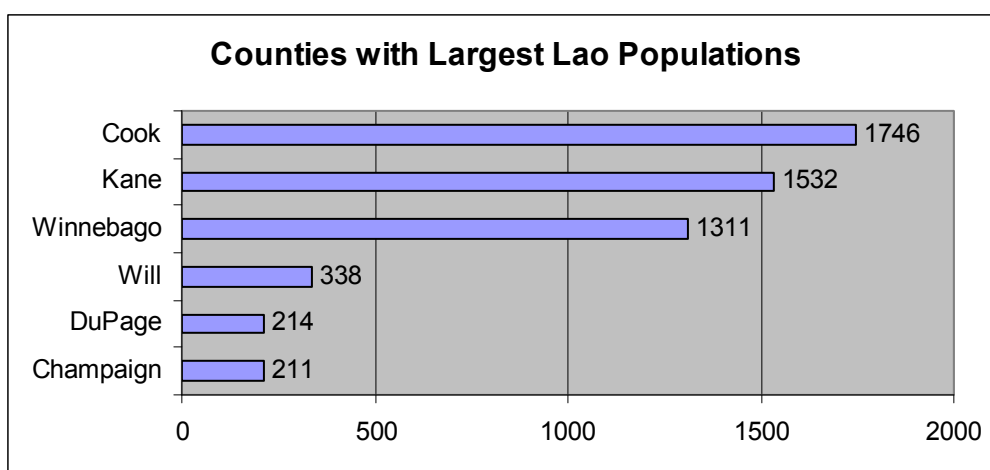
Lao Americans are composed of several different ethnic groups that have their own distinct culture, language, and history. The multiethnic groups from Laos include the Hmong, LuMein, Khmu, Lao, Tai Dam, and Tai Lue. The 2000 United States Census found 198,203 Lao Americans (not including Hmong, but including mixed-race and mixed-ethnicity Laotians). However, these groups are typically undercounted in the United States Census. Nearly all Lao Americans arrived in the United States as refugees after the Vietnam War.

The majority of Lao Americans live in California, Texas, Minnesota, Washington, and North Carolina. The 2000 per capita income of Lao Americans was \$11,454, compared to \$21,587 for the U.S. population overall, and just 7.6% have a bachelor's degree. 17% of Lao families live below the poverty level. Nationwide, 32% of Lao Americans are linguistically isolated, meaning that no one in the household aged 14 and older can speak English well.

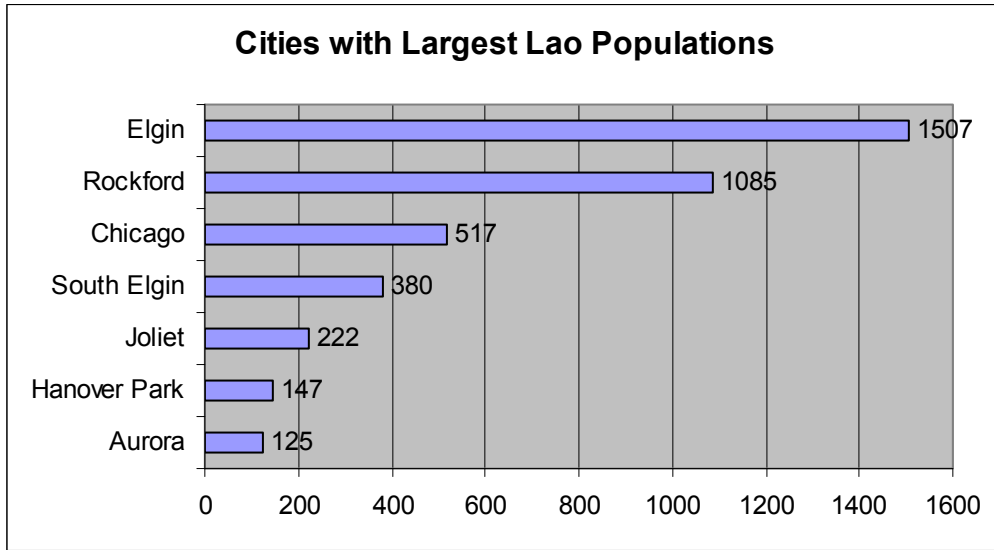
Some of the main health issues in the Lao American community are :

- Lung disease is the #1 cause of death for Lao Americans (87.3% of men die because of lung cancer).
- Liver cancer is the #2 cause of death in the Lao American community. They are the #1 carriers of Hepatitis B in the U.S.
- Lao American girls have the highest teen pregnancy rates of all racial or ethnic group in California.

In Illinois, Lao Americans are a significant population in the Elgin area. According to the 2000 Census, there were at least 5,973 Laotian Americans statewide, while community leaders estimate the number at around 8,000.



¹⁰ Asian American Giving, *A Brief Look at the Laotian American Community* (April 14, 2010), available at <http://www.asianamericangiving.com/2010/04/a-brief-look-at-the-laotian-american-community.html>.



III. Methods

AAI developed a one-page, 16-item questionnaire that collected respondents' demographic information, utilization of selected public benefits programs, and information relating to their most recent medical visit, including access to language services. A copy of the survey is included in the Appendix.

Bilingual volunteers from the Lao American Organization of Elgin (LAOE) and the Lao American Community Services (LACS) in Chicago conducted the survey with community members in 2008. LAOE leaders felt that the written survey need not be translated into Laotian, and they orally translated the questionnaire to participants instead. A similar method was used by LACS.

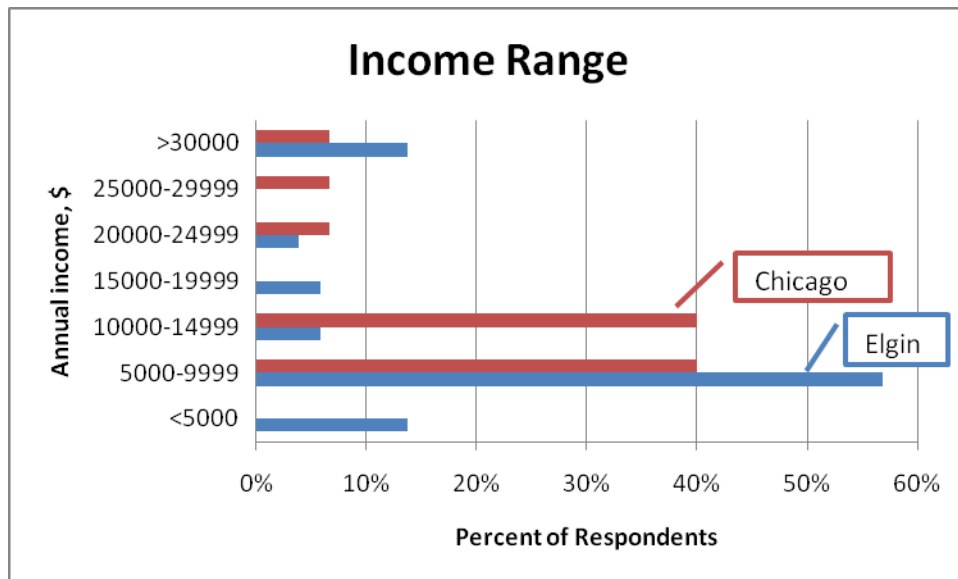
IV. Results

Fifty-five respondents completed the survey with LAOE: 25 (49%) were women and 30 (55%) were men. Respondents' ages ranged from 55 to 84; the average age was 66. The majority of respondents (64%) were from Elgin, with 18% from South Elgin and the remaining 18% residing in other nearby suburbs.

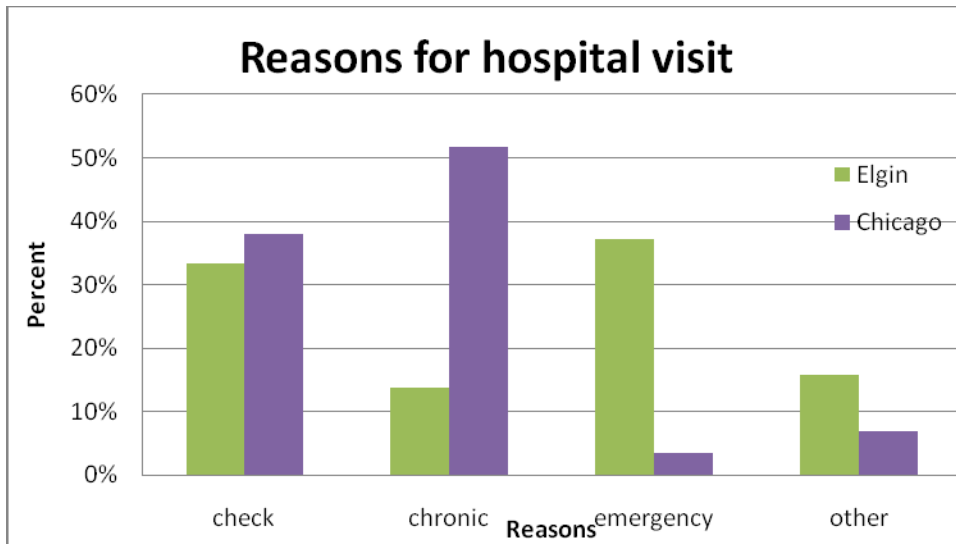
Twenty-nine respondents completed the survey in Chicago: 16 (55%) were men and 13 (45%) were women. They ranged in age from 41 to 83 with an average age of 63. Only two of the respondents indicated that they spoke English well with the others indicating limited proficiency in English.

The majority of respondents from Elgin reported receiving public benefits: 64% reported receiving Medicare, 36% received Medicaid, and 9% received SSI. 4% do not receive any income.

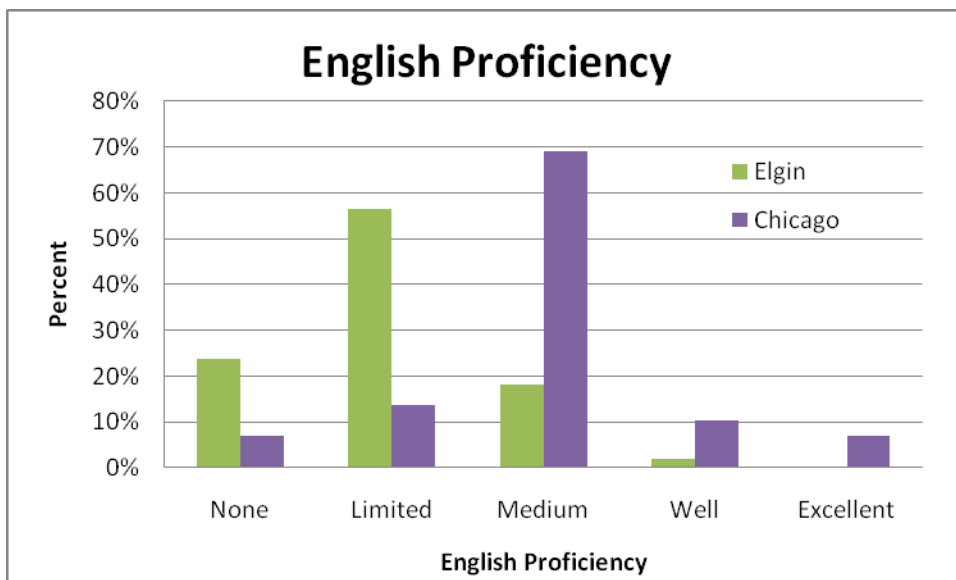
In Chicago, 75% reported receiving public benefits: 45% receiving Medicare and the 48% receiving Medicaid. 66% received Supplemental Security Income (SSI).



Eighty percent of the respondents reported visiting the two major hospitals in the area: 60% went to one hospital and 24% reported going to another hospital in Elgin. In Chicago, a third visited a major hospital and another third went to a private clinic. The remaining visited other area hospitals including the county hospital.



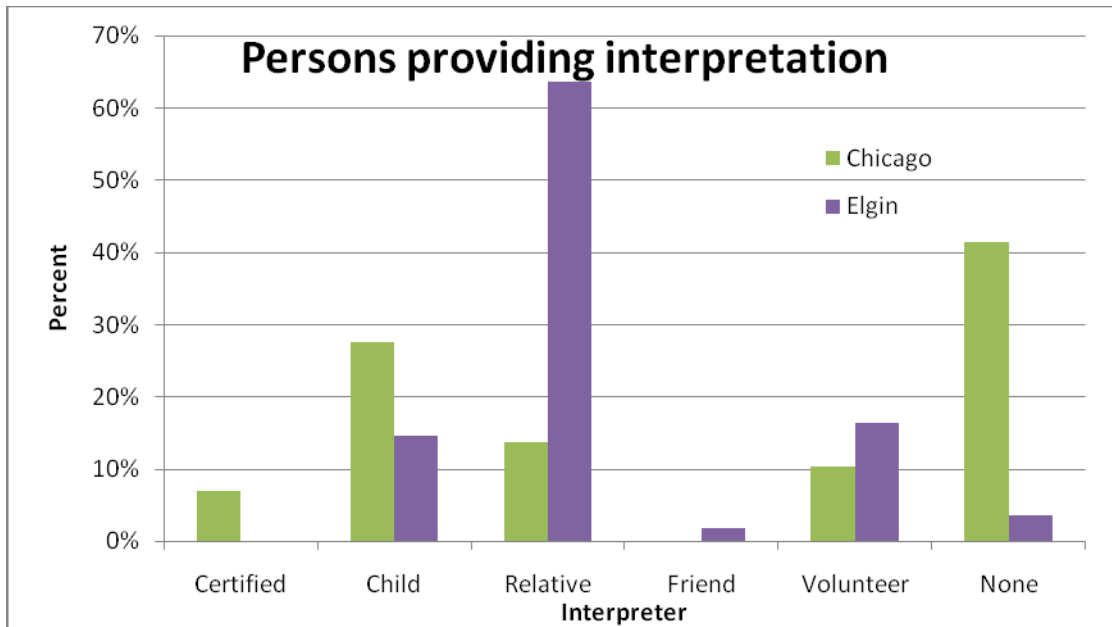
All of the respondents from Elgin reported some limitations with their ability to speak English. On the whole the Chicago respondents indicated higher English proficiency compared to those from Elgin. However, even in Chicago, only two of the respondents reported that they spoke English extremely well.



In 85% of the visits, the Elgin respondents reported that no interpreter was offered by the hospital. 66% of those who received an offer of an interpreter were seeking emergency treatment. However, this accounts for only 16% of all respondents who sought emergency treatment. None of the respondents indicated that they received the assistance of certified interpreters. This is a serious issue, given that most respondents indicated their limited English speaking abilities.

In the case of the LACS respondents, only 9% indicated that they were offered interpreter services. Only two respondents indicated that they had certified interpreters. None of those requesting emergency services were offered interpreter services.

Respondents reported using their adult children or other relatives to provide interpretation in the majority of their health care visits, as can be seen on the following chart:



V. Discussion

To put the above research results into context, language access issues in the health care realm are critically important because language access services affect access to care; quality of care; health outcomes and health status; patient satisfaction; and cost of care.¹¹ Research has shown that language barriers create significant problems with access to health care. For example, non-English speaking patients are less likely to use primary and preventive care services and are more likely to use emergency rooms.¹² Additionally, language barriers lead to fewer physician visits and reduced receipt of preventive services by LEP patients, even after controlling for factors such as literacy, health status, health insurance, regular source of care, and economic indicators.¹³ Research has also shown that language barriers impair LEP patients' communication with health care providers and affect how LEP persons perceive their health care encounters.¹⁴ Health care providers frequently identify language or cultural barriers as elements that hinder the quality of patient education for diabetes care.¹⁵ In short, there is voluminous research documenting the relationship between language access services and racial and ethnic disparities in health care, and it shows that language access affects nearly all aspects of the health care system.

According to Title VI of the U.S. Civil Rights Act of 1964, health care institutions that receive federal funds are required to “take reasonable steps to ensure meaningful access to their programs and activities by LEP [limited English proficient] persons.” Additionally, in 2000, the HHS Office of Minority Health issued standards (including mandates, guidelines, and recommendations) called the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care.¹⁶ The CLAS standards, independent of the Department of Justice guidance, impose four significant mandates on recipients of federal funds. Health care organizations must: (1) offer and provide language assistance services at no cost to patients; (2) provide patients verbal offers and written notices informing them of their right to receive language assistance services; (3) assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff, with the rule that family and friends should not be used to provide interpretation services except by patient request; and (4) make available easily-understood patient-related materials and post signage in the

¹¹ American Institutes for Research, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations* (Sept, 2005), at 2, available at <http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf>.

¹² Jane Perkins, The Kaiser Commission on Medicaid and the Uninsured, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities* (Aug. 2003), at 3-4, available at <http://www.kff.org/uninsured/upload/Ensuring-Linguistic-Access-in-Health-Care-Settings-An-Overview-of-Current-Legal-Rights-and-Responsibilities-PDF.pdf>.

¹³ American Institutes of Research, *supra* note 11, at 2.

¹⁴ Perkins, *supra* note 12, at 4.

¹⁵ American Institutes of Research, *supra* note 11, at 3.

¹⁶ U.S. Department of Health and Human Services Office of Minority Health, *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care Final Report* (March 2001), available at <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf> (“CLAS Report”).

languages of the commonly encountered groups represented in the service area.¹⁷ The CLAS standards are specific to the health care setting and provide clear mandates to health care providers and significant protections to LEP persons.

Asian Americans face particular challenges to accessing health care because they are culturally, linguistically, and socioeconomically diverse and are historically understudied. One significant barrier to effective language assistance for LEP Asian Americans stems from the linguistic diversity of the population – Asian Americans speak several different Asian languages, making it more difficult to provide language access assistance for all LEP Asian Americans.¹⁸ As a result of this difficulty in obtaining language assistance, many LEP Asian Americans often rely on family members or friends to interpret for them in a medical setting. However, HHS discourages the use of family members or friends, in order to ensure complete, accurate, impartial, and confidential communication.¹⁹ These health mandates also state that minor children should never be used as interpreters, nor should they be allowed to interpret for their parents when the children themselves are the patients.²⁰

According to the HHS Office of Civil Rights' guidance: health care institutions should “consider special circumstances that may affect whether a family member or friend should serve as an interpreter, such as whether the situation is an emergency, and whether there are concerns over competency, confidentiality, privacy, or conflict of interest. Recipients cannot require LEP persons to use family members or friends as interpreters.”

A variety of problems can arise when an untrained interpreter is used, including:

- Loss of confidentiality
- Omissions
- Additions
- Mistranslations
- Misdiagnosis
- Wrong treatment

Although most survey respondents in this study reported not speaking English well, almost 90% were not offered an interpreter, and most relied upon their children, relatives, or friends to serve as interpreters for their health care encounters. This leads to the following concerns:

- Is there an undue burden placed on LEP Lao American patients to identify and obtain their own interpreters?
- Is the interpretation accurate? There do not seem to be mechanisms in place to assure that Lao interpreters are qualified, meaning that they are fully bilingual, are familiar with medical terminology, will maintain patient

¹⁷ *Id.* at 3 and 10-13

¹⁸ SEARAC Report, *supra* note 9, at 4.

¹⁹ CLAS Report, *supra* note 16, at 12.

²⁰ *Id.*

confidentiality, and can effectively manage the sensitive issues that often arise in health care encounters.

- What is the potential impact on quality of care received by Lao American patients, if patients are relying upon untested and untrained interpreters?

VI. Recommendations

As they age, Lao American seniors become more vulnerable in terms of their health status, and for many of them, limited English proficiency provides a significant barrier to care. For this population, it is especially critical to have effective linguistic access to health care.

Recommendations for hospitals

We recommend that metropolitan Chicago area hospitals utilize the below framework, provided by the federal government, for developing collaborative partnerships with the local Lao American community, and for training and deploying qualified health interpreters²¹:

1. Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

²¹ CLAS Report, *supra* note 16.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Recommendations for community-based organizations that serve Lao American clients

- ▶ Use the data from these studies.
- ▶ Gain deeper understanding of when language access is legally required.
- ▶ Engage community members in the process.
 - Arm seniors and other LEP clients with information about their rights.
 - Connect community members with interpretation training opportunities, such as through Cross-Cultural Interpreting Services, a program of Heartland Alliance.
- ▶ Build a cooperative relationship with key hospital staff and be a key resource for hospital.
 - Provide periodic feedback to the hospitals which might include both positive and negative feedback.
 - Offer assistance that includes data as well as shared understanding of cultural competency.

- Provide community resources and help hospitals conduct outreach to community members, including potential interpreters.
- Encourage hospitals to engage outside consultants to assist them with improving the effectiveness of pre-existing language access systems.
- ▶ Build a cooperative relationship with the HHS Office of Civil Rights and other agencies.
 - Report non-compliance to HHS:
<http://www.hhs.gov/ocr/office/file/index.html>
 - Report non-compliance to state and local agencies that implement the Illinois Language Assistance Service Act.
 - Keep abreast of applicable laws, regulations, and enforcement.
- ▶ Create and implement an advocacy plan with goals, strategies, and benchmarks that will lead to better outcomes for their constituents.
 - Articulate reasonable commitments to seek from health care providers and government agencies.
 - Strategize how to help them achieve these commitments.
 - Join forces with other communities facing similar barriers, such as the Korean community.

Recommendations for mainstream health advocacy organizations

- Include language access for Asian Americans as a priority advocacy issue.
- Develop cooperative relationships with Lao American community-based organizations to help them build advocacy capacity.

Recommendations for funders

- Provide funding support to assist Lao American and other Asian American organizations to build capacity for advocating on language access issues and building relationships with health care providers.

Appendix: Survey Instrument

Questionnaire for Lao Seniors seeking healthcare

- 1 Patient's zip code:
- 2 Name of Hospital or clinic: Sherman St. Joseph's Other (name):
- 3 Reason for visit: Chronic (describe) Emergency (describe) Check-up Other
- 4 Did hospital offer to provide interpreter?
- 5 English ability of patient: Not at all Not well Medium Well Excellent
- 6 Patient's public benefits: SSI? Medicaid? (Aged, Blind, or Disabled - please indicate) Medicare?
- 7 Patient's age: Patient's gender:
- 8 How many repeat visits in the past 12 months? Other places in last 12 months?
- 9 How often does patient see physician for nonemergency visits, past 12 months?
- 10 Patient's living condition: Alone With Spouse With Family Facility
- 11 Translator info: Volunteer Relative (relationship) Certified
- 12 Language(s) spoken at home:
- 13 Other types of treatment sought: Traditional healing practices
- 14 Patient's income (approx): Monthly Social Security payments (approx):
- 15 This visit -- How long did patient have to wait before seeing a medical practitioner?
- 16 Is patient receiving In Home Supportive Services (IHSS)?
- Other comments: