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SOCIAL WORKERS: A BRIDGE TO LANGUAGE ACCESS SERVICES

Introduction

The importance of assuring the people with limited English proficiency have access to health care and other services has long been supported. Title VI of the Civil Rights Act of 1964 prohibited discrimination based on race, color, or national origin by any organization that receives federal financial funding. In accordance with this law, entities and providers who receive federal funding cannot discriminate against persons based on linguistic and other diversities. In 2000, President Clinton issued an Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency.” This executive order secured that clients have a right to language access services. In 2009, the Children’s Health Insurance Program (CHIP) was expanded to include increased funding for language services. The CHIP reauthorization law of 2009 provides increased funding for states to cover interpretation and translation services in health care settings (Families USA, 2010). And, on March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act commonly referred to as Health Reform.

There are several language access-related provisions in the Act that are of interest to social workers. These provisions include:

- workforce training grants for health care providers;

- demonstration projects to address health professions workforce needs;
- improved data collection and reporting methods; and
- quality improvement requirement for the plans in the state health insurance exchanges asks that information about the plan be written in plain language that is culturally and linguistically appropriate.

The National Association of Social Workers (NASW) has been a leader in the struggle for the rights of all people regardless of their race, ethnicity, economic status, national origin, color, sex, sexual orientation, age, marital status, political beliefs, religion and mental and physical disability. NASW supports guiding principles for limited English proficiency policies in human service programs that includes work force diversity, cultural competency training, and the use of trained interpreters and translators (NASW, Social Work Speaks, 2009).

Demographic Shift

From 1990 to 2000, the three largest groups in the United States were of European descent—German, Irish and English. In 2000, these groups remained the largest European ancestries, yet each had decreased in size by at least 8 million and by more than 20 percent. The number

of people who reported African American minority descent increased by nearly 1.2 million or 4.9 percent between 1990 and 2000, making this group the third largest. During this period, there was a sizeable immigration of people to the U.S. from Latin America and Asia (U.S. Department of Education, 2001).

Overall, the number of immigrants in the United States is more than 30 million and accounts for approximately 11 percent of the total population (National Immigrant Law Center, 2004). It is projected that by 2050, 54 percent of the nation's population will comprise minority populations (U.S. Census Bureau, 2008). Thus, population demographics will reflect more ethnic and racial diversity.

Consequences of Language Barriers

In the United States, there are over 55 million people who speak a language other than English at home (U.S. Census Bureau, 2008). This number includes individuals with limited English proficiency (LEP) who have an insufficient ability to speak, read, write, or understand English (U.S. Dept. Health and Human Services, 2002). For individuals who speak a language other than English, the challenges to receiving health care, as well as other crucial services, can often be insurmountable.

Language barriers play a significant role in how health and mental health services are delivered, received and understood. Studies have shown that the absence of language services gives rise to barriers and reduces the quality of care for individuals with LEP, causing their medical treatment to be significantly compromised (Bancroft, 2007). For example, when researchers studied LEP patients, they found a higher incidence of medical errors and patient noncompliance, as well as decreasing trust and satisfaction with their health care providers (Families USA, 2010; *Hablamos Juntos*, Language Services Brief, 2005). In addition, individuals with LEP are less likely to have primary and preventative care visits, and more likely to use emergency rooms for their health care services (Chen 2007). In light of individuals with LEP experiences and their uncertainty of receiving needed health and mental health services, social workers can inform

and advocate for a linguistic and culturally competent approach that addresses the needs of this population. Cultural and language appropriate services address health disparity issues such as, access to healthcare; increased utilization of preventative, routine health and screening services; and, increased patient access to interpretation services. Appropriate language services may also increase patients' understanding of medication instructions, procedures, treatment, and adherence. In addition, these services facilitate appropriate discharge planning that addresses an LEP's individual linguistic and cultural care needs, resulting in improved outcomes, patient safety and satisfaction and enhanced services (*Hablamos Juntos, We Speak Together*, Language Service Issue Brief, 2005).

Support for Social Workers to Bridge the Gap

In recognition of the need to address and standardize care for LEP individuals and other patients, the Joint Commission revised hospital accreditation standards to improve patient-provider communication. As part of this revision, the Joint Commission developed new standards that emphasize cultural competency, communication and language. The new standards address the collection of race, ethnicity and language data; require the provision of language services and address qualifications for language interpreters and translators; and identify and address patient's communication needs. However, despite the adoption of these standards, health care organizations still face challenges to their implementation, such as the lack of federal and insurance funds to maintain interpretation and translation services, the need for culturally and linguistically appropriate translated patient materials, and cultural and language appropriate methods to collect patient satisfaction data.

With accreditation bodies such as the Joint Commission and the National Committee on Quality Assurance (NCQA), setting new standards that address cultural competence, communication and language for hospitals and insurance plans, there appears to be recognition that diversity factors are a component in the delivery of quality healthcare services and operations. Yet, with this challenge, is an opportunity for systems to evaluate and improve LEP services.

The Role of Social Workers

In health and mental health care settings, social workers provide a range of services for patients and their families. With the knowledge that culture and language influence the individual's belief systems as it relates to their health, healing and well being, social workers can be an asset in improving services for LEP individuals. Social workers provide direct services with the assistance of interpreters and in many health care settings social workers manage the professional interpretation services.

For LEP individuals who enter health settings, social work services are an essential resource for health care providers, patients and families. Often, because of the patient's language, communication and cultural differences, delivering health and mental health services to LEP individuals can be a challenge for both parties. Social workers can provide services when providers have concerns about the patient's and families, understanding and reactions to diagnosis and treatment.

Social workers who work in health service settings and provide direct practice for LEP patients may encounter many behavioral risk factors. These risk factors may jeopardize the patient's health. Some behavioral and cultural responses may include:

- a lack of attention or excessive attention to symptoms;
- a lack of conformance to intervention or treatment plans based on cultural factors;

- non-adherence with medical recommendations and treatment, such areas as diet, medications and treatment follow-up; and,
- the practice of non-tradition methods or alternative medicine, such as the practice folk medicine.

As part of a multi-disciplinary team or as primary providers, social workers can perform bio-psychosocial assessments and develop care plans that address the particular cultural and diversity needs of the LEP Patient.

In addition to direct practice interventions, social workers can advocate for macro interventions which address individuals with LEP needs. Particularly, social workers can advocate for culturally competent support services that include trained, qualified interpreters and LEP language services; translated materials that are written in a simple and culturally appropriate manner; and, federal funding for interpretative and translation services.

Resources

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The National Health Law Program and the Access Project. (2003). *Language services action kit: Interpreter services in healthcare settings for people with limited English proficiency* (revised 2004). Available at: www.healthlaw.org/index.php?option=com_content&view=article&id=119%3Alanguage-services-action-kit-interpreter-services-in-health-care-settings-for-people-with-limited-english-proficiency-revd-feb-04-&catid=40&Itemid=187.

In providing a cultural competent environment for the delivery of health and linguistic services, it is important for social works to understand the context in which these concepts operate and are defined:

'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (U.S. HHS Office of Minority Health, 2005).

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