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PUBLIC FORUM

PANEL I

(BY ANDREW STEWART)

CHAIRPERSON: (Inaudible) Late seventies, Sylvia had already been on the panel for some exciting times in years previous. I do want to recognize Sylvia. Also former member in the audience Eileen Finney. Who used to be a SAC member and is still extremely active in the community, particularly with issues of the Spanish speaking community. So welcome to all of you. Thanks particularly to Mayor Baines and the office of the City Clerk and David Scannell all of whom collaborated in making this wonderful space available to us. The old Merrimack Chambers. Also welcome to all the panelist and you'll be welcomed again, I'm sure, as

we go into the individual panels. The US Civil Rights Commission is created by legislation that gives it the responsibility of research and fact findings and monitoring of civil rights positions in the country. Each of the state's advisory committees of which there are fifty, plus the one in D.C., there are fifty-one that report to the Commission. With activity such as this one, to monitor situations that may require even closer scrutiny to make sure that no individuals or groups are excluded from the benefits of certain services. The New Hampshire SAC, that's the State Advisory Committee, and since we're federal we deal in acronyms, has been active for years. There's been investigations of the prisons, which Sylvia presided over some years ago. There was a two-day conference, a fact-finding session on

domestic abuse with the influence of the rural factor of New Hampshire and how that interfaced with law enforcement. We've looked at Spanish speaking communities in Manchester and Nashua and issues of housing, education and law enforcement. We've looked at the tracking of other language speaking kids into special ed. classes and today we are looking at access to healthcare. I, at this point, would like to particularly thank Lena Reese and Gray Gore and Maria Latoyia (inaudible) and Sheryl Pelham for their work on the subcommittee that created this wonderful array of panelist and the opportunity to be here today. Ah, Tony, got left out there. That's because I am really hostile to Tony. No, was really (inaudible) Manchester and has been a real asset too. So, having said I wasn't going to introduce

anybody I just introduce everyone. The format, the panel will each state each number, there will be an opportunity for questions thereafter. First from the SAC members, then from the audience. All questions, the only answer will be directed through the Chair of the panel. In this case that is Pat Gormley. I will be out there with a cordless mic, wireless, and hand it to you. To make things go a bit more smoothly. At this point, one of the factors in SAC management, I didn't mention, was that it is crucial to have liaison and support out of Washington and Angus (sic) St-Hilaire is our man and he does a huge amount work. And Angus why don't you take it from here.

AONGHAS ST-HILAIRE: Thank you Andy. I just want to say that that there is only one reg that I feel that I need to bring up. It's all SAC activities need have the fame and

great protections, that is just so that people, what that means is that when anybody speaks just focus on issues rather than personalities. Thank you.

CHAIRPERSON: At this point then, the first panel will be introduced by Pat Gormley our SAC member and we look forward to hearing from you.

PAT GORMLEY: Thank you. Welcome. Our first panel today is basically an orientation that is framing the kinds of issues we're talking about in terms of limitations on access to healthcare for communications issues. Which is not the proper name, it's just the way I think of it. And today we have on the first panel, four very distinguished panelists, and I am not going to read all their bio's because that would take up all their speaking time. And since

we've asked them to limit themselves to ten minutes so that we have time for questions from both the Advisory Committee and from people who are attending, we want to proceed as quickly as possible. Plus I have this hang-up, I started out in the Marine Corp and I had a tendency to march forward over people. So, if I do that I apologize right now in advance. So let me tell you who the panelists are and we will get started immediately. Our first panelist is Donna Gartelman, with the Equal Opportunity Specialists in the Office for Civil Rights, Region I, of the US Department of Health and Human Services, so she is providing very much our federal context on these issues. Next to her is Bill Walker, who is the Director of Minority Health Office of the New Hampshire Department of Health and Human Services bringing

our issues to our state scale. Susan Wolf-Downes, who is the Executive Director of Northeast Deaf and Hard of Hearing Services, Inc., bringing the prospective that we have a tendency to unfortunately forget to (inaudible) when we think of language barriers. Katharine Daly, to my immediate left, is the Executive Director of the New Hampshire Commission for Human Rights, I've had the great pleasure of working with her in my position at the University of New Hampshire. And again the special prospective of a civil rights compliance context. So, without further ado, we'll get started, Donna it's all yours.

DONNA GARTELMAN: Thank you. Good morning, as Pat explained I'm an Equal Opportunity Specialist with the US Department of Health and Human Services, Office for Civil Rights. And in that role we investigate complaints of discrimination as well as compliance with the federal civil rights laws that we enforce. Basically, some of the laws we enforce are Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color, and national origin. We also investigate Section 504 of the Rehabilitation Act of 1973 and that prohibits discrimination on the basis of disability. Both these are issues that we are kind of focusing on today. I have done a number of complaint investigations, not in the State of New Hampshire or anything, but regarding limited English proficiency and help --

, not --, the inability to communicate and to have access to benefits and services through state agencies and hospitals are the focus of a number of my complaints that I've investigated over the years. In 2002 our agency issued a Guidance to providers to help them to understand how they should be able to provide effective communication to limited English proficient patients or clients receiving benefits or services. This year in August of 2003 we reissued that Guidance because the Department of Justice has the overall coordination of Title VI compliance, so they, in response to, I think it was the OPM or OIT investigation realized that each federal agency has their own civil rights component. Like, Department of Education has their civil rights office. HUD has a civil rights office. Each federal agency has their

own federal component; so basically, the Department of Justice wanted to ensure that they were enforcing Title VI regulations equally across all federal agencies. So we reissued it, the Guidance, and copies are out in the lobby out there. Basically it's telling providers and giving them guidance on how to provide meaningful access to benefits and services for people with limited English proficiency. There are basically four steps that a provider should look into and do their own individual assessment as to whether they are providing effective communication. One of the steps is, the first step is to identify the number, or portion of the people that are eligible for services or benefits or the number of people that are likely to be effected by the program. That's step number one.

Number two is the frequency of contact with the limited English proficient person receiving benefits or services. Third one is nature and importance of the program. An emergency room should have some type of policies and procedures in place to get an interpreter or be able to translate information as opposed to --, that's a very important service and benefit that is needed to make sure that people understand. But, somebody that, you know, is walking in just for a brochure, the provider might not have to provide a translated document if they can translate it over a phone, like a telephone interpreter service. So that's a less important benefit or service that's provided. And basically the fourth one is cost and resources available. New Hampshire is more of a rural community as opposed to say,

Massachusetts and Boston. So what we would expect of Massachusetts might not be the same as the city of Boston, like their hospitals and services. A lot of times, you know, you have to do your own assessment as to whether you need to have bilingual employees, contracted employees in the community or even maybe even just a telephone interpreter service if the frequencies are on a less needed basis. So, I mean, each individual provided needs to assess their own needs in order to provide effective communication. Similarly Section 504 prohibits discrimination on basis of disability and one form of disability is not providing sign language interpreters for somebody who is deaf or hard of hearing. Again, most people kind of, you know, forget about the deaf community as opposed to somebody in a wheelchair or somebody

with another type of disability, but again, effective communication is the key to providing services and benefits in especially the healthcare arena. Some of the ways that you can provide effective communication for a sign language interpreter is providing a sign language interpreter (sic), using flash cards, using a computer assisted time transcription or card, or use of a telecommunication device. We don't, our agency will look at whether the service and the number of times it's needed when we do an investigation, has anything to do with the number of contacts an individual is at that facility (sic). In limited English proficiency we look to see that you have a policy and procedure in place. And one of the key features of having the policy and procedure in place is ensuring that all contact staff are

aware of the policies and procedures and how to get the services. Training is very, very crucial. All staff that has contact with somebody walking in, or you know, providing the service is critical. Because, one of --, I've got a number of complaints in the state of Maine and basically it's because they're not translating documents or their not providing an interpreter when needed. Well, the hospital will say, yes we have a policy and procedure in place but an individual comes in, speaking another language and they're not getting the services. They're not getting the treatment because they didn't contact an interpreter to provide for effective communication. I think I'll finish for now, and if anybody has questions later--

PAT GORMLEY: Thank you. I didn't realize -- are you sure I'm not cutting you off though?

DONNA GARTELMAN: No.

PAT GORMLEY: Okay great. Please hold your questions, as I said, till the end when we have all the panelists have a chance to speak. Then we'll take questions. Bill Walker, you're turn.

BILL WALKER: Great thanks. Good morning everybody. Donna did such a great job with setting me up for my few minutes of conversation. I feel like we've rehearsed this. I want to talk about some data that I've been looking at through our state offices as we analyze the need for additional language

assistance. But I want to back up before I get to the data and talk a little bit about New Hampshire from a historical prospective. From at least my prospective of our history. I bought my property here in 1973, coming out of Boston. Because I loved the mountains and because I love the open space and I like the population here. I think it's a great place to live. I think that in 1973 my family thought I was nuts because I moved to the mountains. And they said, "What's in the mountains for you?" And I said, open air, space and freedom. So I think that many of us have moved to this state for just those reasons. In addition to having a sense of freedom about our environment. The State of New Hampshire, many years ago, the turn of the last century was a very diverse state. If you've taken the time to

travel the state, as I have in my capacity as the Director of the Office of Minority Health, it looked at our culture, one of the things that I realized is that we have a very diverse state. We've had a very diverse state for many, many years. In the diversity we are talking about today the ethnic diversity, the (inaudible) diversity that we're talking about today is not new to New Hampshire. It is just different, and I want to come to that in a moment. And therefore we need to remind our citizens, this is not the first time that we've seen the state diversify its population. And the techniques that we use to incorporate and --, into bringing everybody into the quality of life here in New Hampshire are not new. They just need to be revisited and updated. And that's what I want to talk about. So

if you've not traveled to Berlin, you ought to do that, because the population in Berlin is very diverse and has been very diverse for four hundred years. Data. I want to talk about data. I've been crunching data at the state for the last few weeks in my preparation for presentations to the senior management as the state government looks at it's resources and reorganizes. So I'm going just share with you some fresh data that I've collected. I've collected data both on the issues of fiscal barriers, disabilities as a barrier to services in the state of New Hampshire. That is one of the areas that we've captured information on. And we've also looked at language as a barrier to receiving services by the Department of Health and Human Services and so Donna point about knowing your population, knowing

what the needs are of your population that you attempt to serve is very, very important. When we first started tracking data in November of 2000, I had asked --, I had traveled to district offices and asked the Departments to tell me about the population you serve. Can you tell me how many people with a physical disability your serving, how many people with hearing or sight or (inaudible) are you serving? You know, what about our access points, what about the distances the people have to travel? What about the pressure of the doors that our elderly and frail have to open? What are the issues of access to our services that never mind the knowledge and ability of our staff, and I'll come to that. So I started collecting data on who was using our services and back in November of 2000

we collected data on folks with vision issues, for lack of a better term, folks who were using close circuit TV, people with hearing loss, assisted listening devices. Physical disabilities and literacy are the categories that we captured data over the last three years. We had thirty-four people that fell into one of those categories in November of 2000 as we captured the data then. Over the next year, we rose to, in August of 2001 we had fifty folk that we were capturing across the twelve district offices and then as we push forward over the years, an equal of 2002 we had sixty-two people falling into those categories who were accessing our office and in August of 2002 we had 112 people in those categories accessing our services. It became --, this data allowed us to look, over the years,

look back and say, you know what our district offices needs to address these issues because our population is growing, the needs are growing and in fact, we can do a better job in servicing this population. And we've done a lot of work around those issues lately, and I'm pleased to say that, but the data helps to substantiate that when I'm standing in front of the twenty-five managers of your Department of Health and Human Services that I can argue intelligently for additional services and data allows us to do that. So please use data to help to arrive (inaudible). Let me talk about languages because they're even more dramatic by far. Back in November of 2000 we were tracking roughly seven languages in our twelve different district offices across the state. We track by (inaudible), we have 145

people who had, who's language other than English, prior language other than English was accessing our services as we identified them coming through our lobbies by our personnel, our intake personnel. That was November of 2000, so 145 people. If we skip ahead a few years, and I look at 2001, we were tracking in 2001; May of 2001 we were tracking twelve languages at that time, 162 people utilizing our services. We skip ahead a few more years, or a few more months actually, July of '01, we had sixteen languages, 214 people utilizing our services. Let me skip ahead a few more years, May of 2002 we had twenty-five languages we were tracking and 556 people in one month access our twelve district offices, but it doesn't stop there. Let me just push ahead a few years, about a year. December, no January of '03 we were

tracking thirty-seven languages now in our twelve district offices with a population of 835 people per month who's primary language other than English is accessing our services. This data has allowed me to stand there on Monday morning and challenge our department leadership around their ability to provide culturally linguistically competent services. This Department of Health and Human Services has done a lot since the creation of my office, thank you. And I'm pleased to be part of that; many of you have been responsible for creation for my office as I look around this room you've been part of what's helped driven this change in government. But there's still much work to be done. We have translated documents, we have put contracts in place for interpreters in our district offices, we have changed

our telephone access services, we've increased our ability to be accessed by folks with disabilities. We've done a lot of work. We've put in policies and about to implement a brand new policy in the next several weeks. We've done a lot of work and yet there is need for more work to be done. I don't want to throw out the baby with the bath water we had made lots of success as I look around this room the folks here have been instrumental in making a lot of changes and a lot of successful changes around these issues in the State of New Hampshire, particularly in state government. There's a lot of work to be done. And these stats show that. I'm just looking, two seconds, and show you a glimpse into the future. I did some crunching on Nashua school data. The 2000 census says that our ethnic populations are only 4% of the entire

states population, take a look at your Nashua's elementary school district, some of the elementary schools in Nashua, some of their population, their ethnic population is as high as 42%. The data is right here. So please know, as we push forward these issues aren't going to change. They're in fact going to get more significant and we need to address them now. Thank you.

PAT GORMLEY: Thank you very much Bill. Our next speaker is Susan Wolf-Downes.

SPEAKER: There is a hand held mic, there's an on and off button.

SUSAN WOLF-DOWNES: Can everyone hear me now? Everybody all set. Okay. One person nodded. Anybody else? Okay, great. I wanted to thank all of the members of the New Hampshire State Advisory Committee and also say good morning. My name is Susan Wolf-Downes. I am the Executive Director for Northeast Deaf and Hard of Hearing Services. Like Bill I moved to New Hampshire from Massachusetts. The reason for my move is actually because of a position open for this job as Executive Director. I used to work for Verizon in Massachusetts, but after a number of years in that position I felt it was time for a change and I felt that New Hampshire's deaf community really needed some assistance in their leadership. So I'm in my third year now, we've made a lot of progress, and there's a lot of improvements but just as Bill stated we have a long way to go

still. The legislature here in New Hampshire actually mandated that Northeast Deaf and Hard of Hearing Services be opened because of the number of complaints from the community about the lack of services that were accessible for people who were deaf or hard of hearing. I do want to clarify and make sure that everybody understand that we do not only serve people who are deaf, we serve people who are deaf, hard of hearing, any degree of hearing loss, and also people with hearing loss plus additional disabilities. We do a lot of referrals to other agencies, if we do not provide the services that people need. And in the past year, our statistics for interpreter referrals have increased 500%, and our information referral services the number of requests has increased 300% in the past year. You know, as a small

relatively new agency we are not able to take on all of the work that comes in, so we do a fair amount of referral to other agencies. I did want to share something that happened a couple of weeks ago. A fellow that we new died in his sleep at 8:00 am, his beloved, her name was Karen, went to wake him up in the morning and found that he had died in his sleep. They were both deaf. What she did was contact 911, she didn't use the TTY, you know, she was in such a panic she just dialed 911 and left the phone off the hook. And sure enough, you know, police, ambulance arrived and Karen requested an interpreter. And people indicated they were looking for interpreters for her and they came back and said, "Oh, we can't find one but we have a police officer from UNH who knows how to finger spell. The manual alphabet."

You know Karen has another disability, while she's not only deaf she has limited vision and she has CP and it makes it very difficult for to focus only on finger spelling. So that's not the best communication style for her, but you know at this point, she had shared her struggled with us and we're trying to figure out where to go from there. How to solve this kind of problem the next time it happens. We do have an emergency interpreter referral service running, and it's been very successful. We have a staff on-call so when a call comes in to 911 requesting an interpreter we have someone who is available twenty-four hours a day who can make calls and find an interpreter and to try to find someone who's close by, to get there as quickly as possible. It's interesting, because we did look in to whether or

not this police department had received training about how to request interpreters and how to serve the people with hearing loss. An there was an indication that there was some training, but obviously something fell through. We do have lots of work to do. We have a Health Advocate that works in our office, Doug McKinney, who's here with me today, who does a lot of outreach to the community to talk about peoples needs in medical situations when they have a hearing loss. You'd be surprised that in this day and age, 2003, you know this woman was failed by her town, by her police department. She was not able to communicate in this emergency situation. She is deaf and she has several other disabilities and how sad for her that she had to go through that without an interpreter. We recently

computed a needs assessment for the state of New Hampshire. It was completed June 30th of this past year. It took about a year and a half to collect all the information, to do focus groups throughout the state. We did hire someone under a contract to do focus groups with providers, with hard of hearing people, with deaf people, as many different types of groups as we could think of. And the results really show that there is a real lack of access to services for folks here in New Hampshire. I'm a real strong believer in collaboration. You know, we work very closely with Health and Human Services and we have a very good team relationship with them, so I think things will be improving. It's important for people to realize now, I don't know if anybody's aware but as of January 1st of this year interpreters

in the State of New Hampshire must have a license. And the way that they get licensed is through the Department of Vocational Rehabilitation. As Donna mentioned, she's responsible for Section 504 of the Rehabilitation Act, this is something that falls under that act. Folks with like disabilities obviously need to have that access to services and deaf and hard of hearing people are members of those groups. As for the number of people here in New Hampshire who have a hearing loss who are deaf and hard of hearing, it's very tough to get exact statistics. There is no census data collected on a national level about hearing loss. It would be wonderful if that were included, that people could check deaf or hard of hearing on their census forms. So we have been trying to track the numbers here in the state.

Culturally deaf and who are hard of hearing or have a lesser degree of hearing loss. And there's a lot of services, assisted listening devices that can be provided for people who are hard of hearing. Especially who are elderly and need to go into a hospital, you know there are Pocket-Talkers and other things that are available that are wonderful that are really available and should be more accessible. They should be in ambulances; they should be in emergency rooms. So I've been working with my staff and my team and trying to think of ways to create some solutions to these problems. How can we make some noise? How can we get some media attention and some awareness about the struggles that people with hearing loss are facing. Obviously like I said, we've made a great start, things are improving but we have a long

way to go and I'm anxious to hear people's questions so that I can address those later. Again if you have questions about the statistics or the Americans with Disabilities Act I'm also happy to answer those. One thing that we noticed in the community, that we see very often is family members being used as interpreters in medical situations. It's just not something that should be done. The average lay person, does not know the medical terminology, may not know the signs for that, may not know the way to express that in the way that a certified or a licensed interpreter would. A person who is interpreting a medical situation needs to understand the vocabulary, needs to know the meanings of the words and the (inaudible) so that that information can be interpreted correctly. I actually, in my own

experience, with my doctor had gone several times without an interpreter and at a recent appointment, finally did have an interpreter. My doctor mentioned how wonderful it was to have that in a situation, how much easier it was to communicate. And I felt great hearing that, because I think that's a really positive change in the medical community. Yeah, obviously it's not happening for everybody but it's starting. So I'm really pleased with that success. Thank you.

PAT GORMLEY: Thank you. Our last panel speaker is Katharine Daly.

KATHARINE DALY: Thank you Pat and good morning everyone, I'm very happy to be here. I see a lot of familiar faces in the group, but for those of you who are not familiar with our agency and what we do, let me just give you a brief picture of the Human Rights Commission here in New Hampshire. We are the state agency that enforces New Hampshire's statute against discrimination, RSA 354-A, in the areas of employment, housing and public accommodations. And for purposes of today's discussion let me just say right upfront that the definition in our statute of public accommodation does include, healthcare provider. It also includes any establishment which offers it's goods and services, goods or services to the general public. And I think that would resolve any, that

catch-all phrase would resolve any disputes over certain kinds of institutions and whether or not they fall into that category. So our public accommodation statute does apply in this situation. Both disability and a national origin, which includes ethnic background, language, are protected basis under New Hampshire's law against discrimination. Our agency consists of seven commissioners who are actually all volunteers, much like the task force here in New Hampshire. They are appointed by the Governor in Counsel and serve five-year terms each. They're staggered terms. But we also have a staff, I'm the Executive Director, we have an Assistant Director and an Office Manager who actually does just about everything. Also we have a staff of investigators. Right now we have five investigators, if we were

fully staffed we would have six. Their role is to take and investigate charges of discrimination, alleging a violation of our law. Every year we receive anywhere from 250 to 350 formal charges of discrimination, but we also receive hundreds and hundreds and hundreds of telephone calls, we try to refer people to the right agency if we're not the right agency for them to be in contact with. Sometimes we don't take a formal charge of discrimination, we try to actively intervene and resolve the problem. Where might we do that? We might do that where what was at stake really was something that couldn't wait for a charge to be drafted, to be sent to the charging party, they sign it under oath, get it back to us, we assign it to an investigator, we serve notice on the respondent, they file a written answer and so forth. And then

we start our investigation. If someone needs an interpreter, or someone needs access to healthcare or a person with a disability is being refused access to a movie theater because they are in a wheelchair, they really don't want to wait a year to go to a movie or see the doctor. Those might be appropriate cases where we would actually intervene before we took a formal charge. We also, in addition to our intervention and formal charge processing, have a mediation program that is available. We have a wonderful group of volunteer mediators, most of whom are lawyers in New Hampshire's legal community who are really specialists in this area of the law, discrimination law, who offer their services free of charge as a neutral to facilitate resolution in appropriate cases. It's an illegal practice under our statute, let me back

up, like many New Hampshire statutes, RSA 354-A is a very straightforward simple statute. Some people would laugh to hear me say that, but it's true. And basically all it says is, it defines unlawful discriminatory practices and it says that every individual in this state shall have the opportunity to have equal access to places of public accommodation without discrimination because of among other things, disability or national origin. And then the law defines what those unlawful practices are. It's fairly simple, it's refusing, withholding or denying any accommodations, advantages, facilities or privileges of a places of public accommodation because of a persons disability or national origin. Communicating orally or otherwise, through statements, advertisements, notices printed in newspapers, signs

and so forth that accommodations, advantages, facilities and privileges will be withheld or refused or denied to you because of a disability or your national origin. Or communicating a persons business, your trade, your custom is unwelcome at a particular establishment. We'd rather you went some place else because of your national origin or your disability. And that's all it says, it exempts religious organizations and enterprises run by religious organizations from giving preference based on religion. That's all it does. It doesn't exempt them from disability discrimination. And it exempts private clubs, where in much the same way that the American's with Disabilities Act Title III exempts clubs and religious organizations. Every year we do get charges in the area of public accommodation but

certainly not as many as we get in the area of employment. Employment is the largest category we get complaints in. And when Aonghas St-Hilaire called me and asked me to talk about cases that had been filed at the Commission, involving access, denial of access to healthcare because of either national origin, language issues or disability communication issues, I had to tell him there hadn't been any the last six years. What is concerning me, and why I'm so happy to be here, I'm always concerned that because we are a small agency, in a small state, that people are not coming to us and we're not getting complaints and charges. Not because there are not problems, but because people don't know where to turn, and so I'm glad to be here to share information but also to receive information and to learn from you as

participants in this forum if there is some issues that we need to be hearing about, and we're not, here I am. Okay, this is what I look like; I've got my card. Please let me know if there is a way we can help. We do have a charge filing process as I said. We do have an active intervention process. Some key differences between our statute and the American's with Disabilities Act, Title III or Title VI that Donna had talked about in terms of national origin discrimination are recipients of federal services is that lack of specifics in our statute. Our statute doesn't say, you must provide accommodations, you must modify your policies and practices and so forth. But our statute does say that everyone has the opportunity for equal access. It seems to me that if you are hearing impaired in a place of public

accommodation will not attempt to communicate with you in a manner that allows you to communicate effectively and receive services, that is a denial of equal access. So I would certainly welcome a complaint that tests what our law actually means. We have not had one yet. The ADA Title III is very clear in the area of disability when interpreters must be provided or auxiliary aids and services. Ours is very general. But I think that reasonable people looking at what equal access means for purposes of communication when folks have limited communication or different communication skills, I think it's got to mean some accommodation and I would love to have someone challenge that in our statute and have the Commission and the opportunity to make a determination, and give us some

guidance on that. So, even if, as we look at the remedies that are available under our different statutes, federal and state, you choose, or someone you know has a problem, chooses ultimately to work with the Justice Department or OCS that's fine with us. We are certainly happy to be a first stopping point for you to try to pick up the phone and get that problem resolved without that necessity of calling Boston or calling Washington or wherever. Most of the charges we are getting in the area of public accommodation and disability have to do with service animals for some reason. We're still getting a lot of reactions from folks to the idea that this animal is going to come into this establishment with this person and what this animal is going to do. There seems to be a lack of familiarity in

New Hampshire's community, retail establishment community, to what service animals are and so we try to do some education on those issues as well. And we've had some strange ones. (Inaudible) We've had a few wheelchair access issues, isles that are not wide enough. Cheryl Killam will probably talk more about some of those issues because her agency does deal with the access issues. The barriers to physical access. Again our statute is not strong on that issue and we have two other state statutes that deal with public accommodation. Physical barriers to access. I'd be happy to answer questions later, again I'm very happy to be here and hopefully I will hear from you as to what your needs are and how our agency can help.

PAT GORMLEY: Thank you. I think that our panel has very much framed the discussions of

these issues and our context in terms of compliance and data. So it's time for questions and we'll start with the Advisory Committee members.

CHAIRPERSON: Are there any questions?

GREG ORR: Actually my first question was for Bill. (inaudible) A lot of the conversations I've had in hospitals, and hospital associations, the issue sort of constantly comes up of reimbursement, specifically Medicaid reimbursement. Now And I understand you're in a different department, different office, but I was wondering whether or not you'd be willing to speak to that, the issue of reimbursement.

BILL WALKER: I don't know that I can give an intelligent response to that request. I know that there are activities, there is a category that allows New Hampshire's Medicaid program to

reimburse for medical interpretation. And last year's analysis which my information is certainly current showed that there is a number of utilization of those Medicaid reimbursement dollars. I also in conversations with the Medicaid personnel have added a lot of interpreters and a lot of reimbursements for those interpreters to their rules. So that that program is really expanded over the last year. Clearly it's probably not meeting the needs of the community, I think that Medicaid program, as a whole is a challenge from a statewide prospective. So I think that the Medicaid program is a small opportunity for reimbursement, it's certainly not going to be the mechanism by which we solve the reimbursement needs for interpretation in our healthcare professions in our provider's circuit.

But it is something that needs to be expanded and to be looked at.

GREG ORR: Actually I have a follow up and this is for Susan actually, and how does the reimbursement personified, which, your impressions of that?

SUSAN WOLF-DOWNES: Okay we have another interpreter coming in. So I just wanted to check in. Okay, let's see how to answer that question. Generally when a doctor sees a patient and uses an interpreter that doctor's office is directly responsible for the expense of the interpreter. Our agency generally does not get involved in that, but what our department does do is find interpreters to match each situation, to match (inaudible) consumer's communication needs. And make sure that interpreter has the appropriate training for that situation. That's what our referral

department does. If working with the Board (sic) of Health and Human Services, we do have a contract whereby we receive monies from them to pay interpreters who work for any of the offices for HHS. So interpreters bill our center and we use that money to pay them directly rather than going through the state. We also do have funding at our center for medical (inaudible), sponsored by (inaudible) for Health, who've been incredibly, incredibly supportive to our center. We definitely couldn't have done it without them. So if an emergency medical appointment comes up we have interpreters on-call available during the day. And our center bills the doctor or hospital for that, to reimburse that medical fund. So that's how that particular situation works. And we take care of the billing for

that. There is really no easy solution. It can be expense, doctor's offices are often resistant, many places are resistant, to the expense of hiring interpreters. But, the law requires that effective communication, so does that answer your question?

GREG ORR: More or less. I just had a --,

DONNA GARTELMAN: Greg, can I add something to that? I know that under CMS Center for Medicare and Medicaid that is both sign language and foreign language interpreters are reimbursable expenses under the administrative part of the plan. So I mean, if it's written into your state plan for Medicaid, particularly, it can be reimbursed through Medicaid with federal funds. I have worked with the state agency in Maine, and they worked with CMS to get reimbursement, more money allocated for interpreters services.

PAT GORMLEY: Someone else have a question?

TONY EPAPHRES: My name is Tony Epaphres. This question is for Katharine Daley. When you say (inaudible) foundation, the New Hampshire law (inaudible) is we have seen increasing number of immigrants coming to Manchester area, you know primarily because I live there, almost like sixty-three languages spoken. There are people from Sri Lanka, or India and other places, now do we expect all the agencies to provide interpretation, you know, facilities have access to all these immigrants coming for services? And if they don't do, because of their financial constraints, what kind of mechanism we have from the legislature from the state to help these agencies to provide these services?

KATHARINE DALY: Well I think, if I tried to answer that question, I'd have to look at what kind

of agency is it? As I said, New Hampshire's RSA 354-A doesn't have any explicit requirement in it that in the area of national origin, public accommodations, all public accommodations provide interpreters or translators. They just don't, it's just not in there.

TONY EPAPHRAS: For example, Jasmine (inaudible) minority out. The minority (inaudible) so many people are coming from different language group and minority, as an agency may not have enough funding to provide interpreters. Is there some other way the law provides some other mechanism that we can use or how do they get funding for minority health?

DONNA GARTELMAN: I think that issue is better --,

KATHARINE DALEY: The are some federal grants available to help provide the money for that. Yeah, that would be a Title VI issue if

it is a healthcare provider who is receiving any federal funding. Which most of them are in some form through Medicare reimbursements, Medicaid, and so forth. That why I think you have to separate who is the public accommodation, if it is a healthcare provider receiving federal financial assistance, it is going to have to provide that translator service. If it's Sears Roebuck, I'm not sure, obviously that's not a healthcare provider, but not all public accommodations are the same. And that's the first distinction that you have to make. But I think that the need is really a pressing one, as you say, then it's going to have to be taken up with the legislature, but I don't see them amending our state anti-discrimination statute to require all public accommodations to provide

translator services. I think that would probably be seen as fairly radical and burdensome. Unfortunately.

PAT GORMLEY: Yes, questions from --,

SYLVIA. CHAPLAIN: Yeah, I guess to the New Hampshire agencies specifically, how are your budgets? And in the current crunch, national, state wide, have you been cutback? Or are you holding your own? I won't even ask about increases.

BILL WALKER: Well that's kind. It's tough times in state government, as you know. It's tough time in many state government in many state government across the country right now. The budget is being reduced. It's the number one topic of discussion every day in our offices. We're charged to reduce our overall expenditures and that includes personnel and expenses. The Office of Minority Health, which is a small office, an office of three, is still in

existence as of this morning and I will be undergoing an institutional review on Monday morning that will basically get the organization somewhere or not as we go forward. Those announcements haven't been made. My assumption is we're holding our own, my assumption that the Department is committed to the issues that we're discussing here today. They have certainly not backed off, even as recently as, again, this past Monday. So there's no indication on the horizon that we're loosing ground around the issues of access and services and competency. So I'm optimistic from that prospective. But having been in New Hampshire government for eighteen years, I know enough to wait until the final statements, and the final budgets are put in place.

SYLVIA CHAPLAIN: I suggest that member of the audience, listen, I'm sure have listened

carefully and should, probably not suppose to say this, but I'm going to anyway, keep watch on what's going on with the budget for the things you care about. And make your voices heard.

KATHARINE DALEY: I don't know if you want The Commission for Human Rights to answer that question?

SYLVIA CHAPLAIN: Yes, I would.

KATHARINE DALEY: We're a fairly small drop in the state's bucket of budgeting, but we too cut our budget, meeting the Governor's guidelines of a budget that was no more than 95% of last years appropriation. And we have been able to do that. We have made the further 10% cut on top of that in Class Twenty which is general expenses and other classes, out of state travel, that was required. We've been very fortunate that we've been able to make those cuts. We have used some staff turnover to help us meet the

requirements. We are down one investigator, but holding our own. We actually are closing more charges than are filed and had a pending caseload right now that is manageable, 335 cases, five investigators to handle those. And looking to hiring in January, having had a position since last May, so we're holding our own.

SYLVIA CHAPLAIN: May I ask a follow up question?

PAT GORMLEY: Go ahead.

SYLVIA CHAPLAIN: It's related, sort of. As you know, the law against discrimination in New Hampshire was written and the public accommodation section was written before there was anything about disability. National origin was in there from the beginning, but not people with disabilities. Would it be helpful for clarifying amendments to the public accommodations law and is that feasible in the legislature? And

along with that, if it becomes better known, how would you be able to handle all these folks suddenly started bringing these complaints to the New Hampshire agency, would you be able to handle it?

KATHARINE DALEY: Well I can't speak for the legislature. I don't know what their reaction would be. I certainly would anticipate there would be some, if the purpose would be to incorporate, to revisit, and I think that's a good idea. Because your absolutely right Sylvia, the statute was written back in the sixties. Disability was added in '74 I believe. Long before the current statues, Title VI and the ADA came along, with I think a more sophisticated articulation of what the needs really are of folks who need to have equal access. Revisiting the statute might be a good idea. I

would suspect that the legislature would feel that it had to look at ways of addressing the issues of undue burden and so forth. Just as the ADA and I think Title VI do. But I think it might be a very realistic discussion to have, now that we have information from folks like Bill as to the very real needs out there. My sense as Director of our agency is that the people in New Hampshire would always rather deal with someone locally who can take an immediate practical approach to resolving this problem. I take a lot of pride in trying to keep our agency as unbureaucratic as possible and so I would certainly welcome that, and again I can't speak for the legislature. How would we handle it? As you know we do have a work share agreement with the EEOC, US Equal Employment Opportunity Commission

in the area of employment discrimination, where our statute is similar to federal laws prohibiting the same thing. We work with them and can take dual file charges. That is charges filed under federal and state law. Maybe it would be possible for us to work out some other kind of similar agreement with federal agencies. I have no idea, I'm not speaking for them, obviously, but I think it's worth looking into.

CHAIRPERSON: Katharine, can I butt in here? The next panel starts in about five minutes and yet I have no questions from the audience. I would like to open it up to you and also (inaudible) but to stay on schedule. Are there questions that you would like to address to the panel?

PAT GORMLEY: Could you please come up? Is this the mic Andy?

SPEAKER: It's the stand for it.

PAT GORMLEY: Okay.

GARY ROLFE: Hi, sure, I'm the Gary Rolfe, I'm the Chaplin at the VA Medical Center and Minority Health Coordinator. But I also volunteer with the Sudanese African Community here in Manchester, which is about 200 Sudanese African's in Manchester. About one hundred of them in Concord, total about three hundred. They're concerns are these, first of all, in New Hampshire we don't seem to distinguish between Arab-Arabic speakers and the African-Arabic speakers and this causes a great deal of confusion, especially in doctor's offices when there radically different cultural understandings as well as linguistic differences between the two and I guess my question to anyone on the panel is how could this be better addressed? The second thing is that they feel pretty much dropped. They're

brought here, sponsored from federal agencies, Medicaid goes for six months and they feel that they have not received information or resources nor have they been hooked up with primary healthcare at the end of that time. And I just want to know if Bill or someone could address that as well? Thank you.

BILL WALKER: Oh boy, I could talk for months on this issue. They're great questions. First of all Chaplin, it's nice to meet you. I look forward to doing more work with you. In our database, in our old database in the state of New Hampshire one our categories for language was Asian, that's a little scary, and so to be able to distinguish between Arabic dialects, countries and cultures is way more (inaudible) than perhaps our state is, is in some aspects, is prepared

for. So I think that there are training programs, certainly in the state offices, we have initiated training programs that look at those very issues around culture and language, and ethnicity and history and politics. Which are included and vary in those issues. So I think that's true. I do think that we bring folks here and get them some sort support for several months and then turn them loose. I think that in general is a true statement. I know that there are organizations sitting right here in the room that spend a lot of time trying not to let those balls be dropped. But, you know, given the magnitude of the issues and the limited resources those are just hard challenges. I think that's true. And I think that we can do a better job at constant support. Yesterday in a late afternoon

accidental conversation with a senior official I spoke about languages as a barrier and his philosophy still is, learn English. And it's really scary in 2003 that folks have that attitude but, again, New Hampshire is one of the three states in the United States that has a significant majority culture. And to bring the whole entire state and our relative administrators and legislators into a multi-cultural, multi-ethnic perspective is going to take a lot more work.

CHAIRPERSON: We have time for maybe three more questions and if you'll keep it to six seconds.

JAZMIN MIRANDA-SMITH: Good morning, my name is Jazmin Miranda-Smith and I work the New Hampshire Minority Health Coalition and I just wanted to say that for some of the questions from the Commission in

(inaudible). I'm going to be talking a little bit about Medicaid reimbursement and also about how the, what the Office for Civil Rights, the rule that really asks healthcare providers to provide (inaudible) due to national origin, and how that rule right now is being revised into my humble opinion it's just being (inaudible) worked down. So be talking a little bit about that too. In just one thing is that fighting for medical interpretation at the local, state or federal is not, the money is not there. Maybe it was a little, a couple years ago, but right now nobody wants to really money for medical interpretation. And we know that it's needed because it's not sustainable. And you know, it's not sustainable, it's never going to be sustainable but before just not willing to make that investment.

CHAIRPERSON: Thank you. I will say as I walk over, (inaudible), okay, that the (inaudible) will remain open and if you have statements that you would like to have included in the hearing, please submit them to Aonghas and we'll talk more about how to do that.

ANN SANDERSON: I just have a quick comment, I was gonna ask the question.

SPEAKER: (inaudible)

ANN SANDERSON: I'm sorry. Ann Sanderson, International Institute of New Hampshire. I'll hold my question for somebody individually later but I want to respond to something that Gregg Orr brought up and that was the reimbursement for medical interpreters or court or anything. I just want to be sure as we move forward with this that we don't stay focused on this low income group of people depending on Medicaid because I think this law, and

I would like to ask the question applies to anybody, average income or higher if they have the need of an interpreter. I believe that its still the provider's responsibility.

SPEAKER: It is.

ANN SANDERSON: And I just don't want us to forget that.

SPEAKER: Any provider that receives federal financial assistance has an obligation to provide effective communication. Whether they receive Medicare, Medicaid, a federal grant, they have to provide the, effective communication.

ANN SANDERSON: I just don't want us to loose that.

SPEAKER: Yeah, that's a good point.

CHAIRPERSON: I hope that the panelists will be available for a little bit more today. There will certainly be time after lunch to do nothing but get on record and get questions answered. I'm a little fearful that maybe people will

have to leave early and that's why I'm keeping this rolling here. Could you identify yourself?

DEB MCCANN: I'm Deb McCann from Northeast Deaf and Hard of Hearing Services. In just talking about any agency that has problems I know that this in terms of immigrants, individual immigrants that come into our state, I'm not sure about other places, but particularly in Manchester, that agencies or organizations have not been providing interpreters. INS specifically and they're from a federal level. So it seems very ironic that you have a federal agency that you have a federal agency that's mandated and not finding interpreters for people that they're mandated to serve. And I know that we also have a lot of work ahead of us to do. But in terms of just human rights

at the state level, I'm wondering what kind of enforcement opportunities are there so that state agencies become accountable, to make sure that they are providing access for individuals who need that type of language access. It's not just about us, that are trying to get the services but if there is somebody that can enforce the policies and laws that are already out there that would a help a great deal.

DONNA GARTELMAN: Well the Title VI was for federal recipients, who received federal financial assistance. It didn't apply to federal agencies, like INS. So unfortunately, federal agencies were not obligated to provide interpreters. There has been an executive order that was issued a couple years ago that addresses federal agencies responsibilities to also provide interpreters. But you would have to go

to INS and find out where their civil rights component would be to file a complaint against INS.

CHAIRPERSON: I apologize for this rushed program. Perhaps that is because the panelists are so rich in information and insight and we will continue recognizing that at the next panel.

PAT GORMLEY: I would like to thank our panelists and again as Andy said, hope that perhaps they can stay as long as their schedules permit so that people who have individual questions will be able to ask them. And thank you very much for being here.

[End Tape One, Panel I]

PANEL II

(BY ANDREW STEWART)

CHAIRPERSON: -- direction and suggestions, that remains to be seen in other corners of the room, that we start focusing on the next panel, please. I didn't mean to

scare you all off. So Lina Ruiz is the Chair of this panel and we'll take it from here.

(BY LINA RUIZ)

CHAIRPERSON: Thank you Andy and thank you everybody for joining us today for this forum on access to healthcare for individuals with limited English proficiency. And also that of hard of hearing. And this second panel is going to focus on health care providers prospective and I also have the finals from all of the centers, but I will not read them. They (inaudible) talk about your background and also your concerns, but I don't want to take your speaking time. But I do want to introduce first on my left, Michele Blanchard, Senior Care Manager for Hitchcock Memorial Hospital. To her right is Irene Proulx, Public Health Specialist, at the Manchester Health Department. To

her right, Dottie Gove, Director of Development and Community Relations for Visiting Nurse Association of Manchester and Southern New Hampshire. And then to my left Leslie Melby, Vice President for Government Relations, New Hampshire Hospital Association. Please begin.

MICHELE BLANCHARD: I would like to start with thanking Aonghas for the invitation here today. I feel like I'm here more to learn than to provide any information. Because this is clearly a challenge for us in Lebanon New Hampshire, which is the central part of the state. And we are far from being perfect in this era. I would like to say as an organization we have tried to provide deaf and foreign language interpretation to the

best of our ability over the years and I think we've done better with deaf and hard of hearing interpretation although that can continue to be a challenge. And until recently everything within our organization and I'm speaking for the Lebanon campus only, has been completely decentralized. So about two months ago we heard more about the reinstitution of the federal guidelines, we started to centralize all of this information for our organization, so we can have a better understanding of what our needs are. Which, they are very diverse. One of our challenges, one of many, has been finding primarily foreign language interpreters in emergent situations. We have historically used employee's who may or may not have medical background, we have not had relationships with outside agencies

providing foreign language interpretation because there have been very few and currently we're trying to locate people who don't have to travel two and a half hours to get to our organization to provide more emergent medical interpretation. So we have actually have used telephone interpretation service and two weeks ago we also acquired a video deaf and foreign language interpretation unit as well. Primarily for our emergency room, so we can meet those emergent needs of patients. But historically we've had on-call staff who have been trying their hardest to locate in a very quick manner, foreign and deaf interpreters for our patients who come, for our emergency room and then come for outpatient and inpatient visits. So our biggest challenge now is finding people now who can coordinate and

locate people who speak the variety of languages that we receive at our medical, at our tertiary medical center from all over the world essentially. So we are really struggling with this but completely understand the value of having, and the need to have someone there that speaks the appropriate language, knows the culture that are working with these patients that are under very stressful situations. Another struggle that we have is rather interesting because it's with our own providers. And as we've moved with used the telephone interpreter system and moving toward using our video interpreter system, our staff only want people. They want in-person interpreters, which is wonderful but the ability to find the variety of languages that we have for our patients is very challenging so as I said I'm

hear to learn and find out what the resources are within the state that come north of Manchester and Concord because there are very few, if any interpreters in the central and northern part of the state.

CHAIRPERSON: Thank you. Irene, please.

IRENE PROULX: My name is Irene Proulx, I'm Public Health Specialist with the Manchester Health Department and maybe our problems may be a little bit more unique than the private providers because we are public service agency. We serve clients from all nationalities, and we are not a third party biller. So we don't fall into

the Medicare reimbursement. So it can be a real challenge for us. And also the clients we serve. Maybe the highest percentage, is non-English speaking clients. We see many immigrants of course, but I also work very closely with the two resettlement agencies in the area. Lutheran Social Services and the International Institute of New Hampshire. And with those agencies, all refugees coming into the Manchester area are seen at the Health Department within two weeks of arrival for TB testing, brief health assessment and also provide the health orientation to the refugees. Needless to say they are coming from many different countries and I don't speak those languages, so I do have to work with an interpreter. The resettlement agencies have been excellent about providing an interpreter for me to work

with for the initial assessment. Providing, we don't have one. Now the health department based on, well, maybe the five years, we have grown as meeting this need. We do have four interpreters on staff now. Which are a wonderful blessing. But with the many languages that we are seeing now, we don't always have the language that we need. We do have a Bosnian interpreter who is with us full-time. Was hired back a couple years ago, when we were seeing a lot of Bosnians. And as the times change, the languages changed. I have a part-time Russian interpreter, part-time Vietnamese interpreter, and now we are seeing many people from Africa. And within Africa, it's not all just Sudanese, they're tribal languages within the African population, which adds many challenges.

Some of the services we see them for,

immunization clinics of course. They, immunization clinics are open to all children for free immunizations and also we are a designated (inaudible) surgeon for the immunization piece when refugees or foreign born apply for citizenship, green card. We give free immunizations to all adults for that. It's kind of a hardship when your giving a free service to have to hire an interpreter when we cannot bill for interpreter services. Our funding, many of our programs, are grant based. We write grants. We do get some grant funding for interpreters. It does not always meet the need as far as the cost to us to what we get, and it's always sometimes difficult. Within the last couple of years we've been using the interpreter bank for anybody who's been here any length of time and we don't have an interpreter. Once the

resettlement agencies have been with us for a while; they brought them for the initial visit, we follow many clients for up to a year of time. As I mentioned the TB program we do TB prevention and control. This, there are many home visits involved with that. I'll never forget when I was a staff person doing home visits, I went into a home, TB follow up, our first way of communication with these languages back a few years ago was pantomime. I was pantomiming with this individual for quite awhile only to realize that family moved out over the weekend and this was a new family. So it does have its challenges. We went from pantomime to what somebody else mentioned earlier, flash cards. We found that we asking many of the same questions in the home, so we made flash cards. That's the way we all learned

math, probably many years ago. So we put down the usual questions and have it translated into their language. Well, that only served for certain questions. We went from that to electronic translators, and I brought one with me if anybody doesn't know what they are, this afternoon we can look at it, that works occasionally. But if anybody has a visual problem they can't see what it says anyhow, so that wasn't the answer. Internet has translation services. But it's literal translation. Not grammatically correct. And we also are seeing clients that are illiterate, that's not going to help you there. So the best thing is trained interpreters. And like I say, now we have some of our own. We work with the translation bank. Our problems are a little bit unique. We do not have a physician

that sees clients and orders treatments. But in a physicians office when testing is very important, think of all of the money that could probably be saved if you could only communicate with the clients and just for an ethical practice without knowing exactly what this client is trying to tell you, the physician, in order to protect himself, orders all kinds of testing. Maybe expensive testing, that might not be necessary for something that probably is a very simple complaint. Also, if the physician were to know, have a better idea, a better explanation of exactly what the problem was preventative medicine is much less costly in treating the acute problem. Now I looked up a definition and I have it right here, I'll read it to you, as far as cultural competency and healthcare. Cultural competence in

healthcare as defined is, "The ability of individuals and systems to respond respectfully and effectively to people of all cultures. This consists of tailoring delivery to meet patients social, cultural and linguistic needs." It's not just language. If you work with a translator, they probably know the culture a lot better than that provider or individual who does not speak the language. So they serve as a cultural broker as well as a translator. If something were to be ordered that is against they're culture or belief that they do not believe in, many of them do not believe in our type of medicine. They're not going to follow that instruction. We have translated material in multiple languages. Our TB manual now is in nine different languages. Many times it's that tenth language you're looking

for. The same at the pharmacy, they'll go to get medication, we've seen many clients, when we go to see if they've taken their medicine, they pull the prescription out of their pocket, didn't know what this paper was for. They've never filled it. And going on with what Michele said, I have been working with Hitchcock lately. The physicians of the future have an interest in multi-cultural medicine. They are coming down to our clinics now. I had a call this morning, right before I left, they wanted book clinics to come down and see how we do deal with these many populations.

CHAIRPERSON: Thank you. And Dottie, please?

DOTTIE GOVE: We're in a very similar situation to

Irene. We do home visits here in Manchester and certainly are seeing many, many different languages and cultures. I think the cultures are as important as the language because we're going into the home. And again, who are we speaking with? Is it the husband; is it the wife? Do you take your shoes off; do you not take your shoes off? There are so many issues that are a little bit different in a hospital or environment where they're coming to. I did a lot of talking with staff over the past few days and really asked them, and I think I assumed things were set up a lot better than what I really (inaudible) was happening. I assumed that when we got the referral that we certainly new if there was a language barrier. And that an interpreter had already been set up, and that's really not what's happening.

Our staff our doing a lot, a lot of the leg work. We certainly try to start with bilingual staff and we do offer translators, in fact, we have quite a few clients on service now that were providing translation service for. But what we find works best and what the families like best, is their family and friends to be there. And that works well for us, because most of what we're doing in the home, is teaching. So we're teaching them how to do a wound dressing. A translator is not going to be able to do that for us. So that we need that family caregiver there anyway. Consistency something that we do well, and that's in providing the same staff. We find we do more of our visits after hours and on the weekend because that's when the husband, the friend, the family is home. Some of our challenges, we

talked about the referral sources aren't even, often, alerting us to we've got a language issue. The cost certainly is expense. We're paying about sixty dollars every visit, sometimes eighty-five sometimes a hundred dollars for the translation services. Which is more than we're getting reimbursed for the whole service anyway if we do have a reimbursement mechanism. We're finding that our staff are often working extra hours, I talked to a nurse yesterday who is bilingual, it was her day off, yet she was in working to be able to see her patients. Just a couple of examples, we got a referral the other day, it was a woman who was postpartum, we were given her address. The nurse went to where she assumed she would be, and it was a Chinese restaurant. She said I'm here to see Mrs. So-and-so,

and they're like, "Oh, follow me." And she said okay there must be an apartment attached to the restaurant. It was no apartment, she then got in her car, drove back across town, the woman had given the Chinese restaurant as her address knowing that there was somebody there who was bilingual, so we drove back across town and were able to do the visit there. We're finding that some of the things that we take for granted, some of the things as easy as, you could take Tylenol or Ibuprofen for your discomfort. They don't know what is Tylenol, what's Advil, what's Ibuprofen? So we're finding again if we write it down, they do tend to know, like where Brook's is, so they can go to their pharmacist. But it's very scary, and the whole prescription issue of I didn't know what to do with this. That's the basic stuff, we also have a

child care center and a parenting education program. We're doing a lot of things there trying to teach, again, English as a second language. We find it enriching for our staff but the things that we take for granted. The fire drills, the children from of the foreign countries are frightened to death of a fire drill. They'll hide immediately under a table when they hear that going off. They assume, thinking it could be a bomb scare. A nice funny story, we actually have a woman from Sudanese, that's one of our teachers at our childcare center and we have an infant room that she works in, and she loves the infants, and rocks them and nurtures them. We had one crying not that long ago, when she went to nurse the baby. Because again you talk about cultural differences, it's nothing to just pick up anyone's baby

and nurse them. And our staff went, "Oh no." It's enrichment.

CHAIRPERSON: Thank you Dottie. And Leslie, please?

LESLIE MELBY: Thank you. I'm Leslie Melby with the New Hampshire Hospital Association and I am very happy to be here. And like Michele I am eager to learn through the Minority Health Coalition and the Endowment for Health, over the past year, we have learned a lot, and oh, I don't want to leave out Northeast Deaf and Hard of Hearing, thank you Susan, for raising our consciousness and I would say that this is a real

consciousness-raising situation. The hospital said, I have talked to our varying levels of sophistication in terms of what their obligations are and what the resources are out there for them to meet the needs of the patients. And I will tell you, that in talking to people in the hospitals, because I am not in a clinical setting, and I need to go to them to find out what is going on, their number one concern is meeting the needs of the patient. Number one concern. And that is across the board. Always in terms of the healthcare and certainly with their increasing awareness about the language needs to communicate the appropriate information so that diagnosis and treatment of their condition is appropriate and that they are capable of going home and carrying out the instructions. This is critical. The

other overarching theme that has come across from my discussions is that of patient choice. An emphasis on patient choice. So for example, I have actually been told that the individual might not want to have his live interpreter because of confidentiality or cultural concerns and yet, I've hear the other side of it where, it's nearly impossible to convey such personal issues as your medical condition over a telephonic device. So there are so many varying situations and the social services patient and family services staff with whom I talk, have said, again they really want to meet the individual needs. Now having said that, we have tremendous geographic diversity in this state. And I will tell you certainly that in the Northern part of the state there has been historically less of a demand unless

you consider the French-Canadian population. I heard an interesting story, if you'll ah, allow me, I was up in Berlin at the Androskogin (sic) Valley Hospital about a month ago, meeting with the CEO and he said that they have recently been challenged with having to provide translation for medical services in Spanish because there's been a recent influx of Spanish speaking individuals from Massachusetts who have come to Berlin, of all places as you know, it's not a great place for employment these days, with the paper mills having shut down, and partially reopened. And they had heard about inexpensive housing. And so they came a very, very long way and again, speaking no English. What I've done is fielded quite a few questions recently and they seem to be increasing recently about providing interpreter services.

The hospitals, I had a call recently, as recent as yesterday with a very interesting question, which I'll tell you about later, but what I have been doing over the phone and which I would like to be able to do more sort of formally in the way of some specific guidance is to first let the hospitals know what the federal HHS guidance provides to them in the way, in the terms of the five elements of an effective language assistance plan and that is that the provider must be able to identify those individuals who need language assistance services. Determine what language assistant measures should be provided and I'll get into the measures that were identified through our survey last year. To have a process in place for training staff about interpreter policies and how to work with an

interpreter. Have a means to notify individuals of the available language services and have a process for monitoring and updating their plan. So, the best course of action for hospitals and certainly other providers would be to determine the extent of language assistance that should be provided using those five guidelines. And develop and implement a written plan and revisit that plan periodically to make arrangements for hiring and accessing interpreters and take necessary steps to ensure their competence. Because, though, there may be people out there who speak the languages or are competent in American Sign Language the medical interpretation is such a critical component. From my own experience I have difficulty understanding physician or when I go to a specialist in

particular using terms I've never heard. And having to ask questions and it wasn't to long ago that I was less likely to ask questions because of the all knowing physician and not wanting to appear ignorant. And there is a great need for people to understand that medical terminology and the treatment and diagnosis terminology. And finally identifying the final documents and determine what language they should be translated in. And so there's a lot of evaluation that needs to be made because of the geographic diversity of the state, what may be appropriate in Manchester or Nashua given the demographic diversity may not be feasible in Woodsville or Lancaster or even Berlin with their situation. Let me tell you a little bit about our survey that we conducted, it's now a year, so it's kind of old, because

things are changing so quickly. Hospitals, we wanted to know are hospitals providing language services, have they designated someone on staff as the language services coordinator, what type of interpreters do they use? Do they have interpreters on staff, do they contract for those services? Are they using language lines? What kind of community organizations are they accessing and finally a variety of languages spoken by patients who present themselves to the hospital. And about half reported that they have a language services coordinator on staff. So they have already --, then I would venture to say those hospitals would be the larger ones and those hospitals located from central New Hampshire on down. Not to be exclusitive (sic), Dartmouth-Hitchcock, however, in Lebanon given their unique

circumstances, and the services primarily involve contract services. And one --, I was asked to talk about this, practices. So here's an interesting description of what one hospital does. They have a very large Spanish and Portuguese population in their community who had so many questions about billing, so many questions about applying to the hospital for financial assistance for free care. Applying for Medicaid, that they designated two interpreters to staff an office every week, one day a week and more if necessary just to deal with those questions. And they have done that for the last three years and found it to be extremely helpful. The demand is increasing because word is out and people are coming in with many, many questions, not just dealing with the financial and billing issues. They

are certainly accessing community and statewide agencies such as Northeast Deaf and Hard of Hearing Services for identifying interpreters who can come in and provide medical interpretation. I learned about the Emergency Referral System that is available 24 hours a day seven days a week to access sign language interpreters. They do --; I would say probably all of them have either the ATT language line or Deaf Talk TV. This is relied upon when interpreters are not available or it may be the primary source for interpretation services because they don't know how to access live interpreter services or the time of day would make that nearly impossible or the geographic area just determine it's not available. What I've also have learned is the Deaf Talk TV provides language services. It was mentioned to

me up to 135 languages and I'm suppose to be done now. But let me just add that they have identified bilingual staff and that may or may not be appropriate based on who --, what their specialty is and there are issues that are related to that having to do with cultural issues and confidentiality. So we have a lot of work to do ahead of us, we have a lot to learn and I'm hear to learn from you as well to see how we can serve our patients better in New Hampshire's hospitals. Thank you.

CHAIRPERSON: Thank you Leslie. And the rest of the panelists. And now I'm going to ask the (inaudible) members if they have any questions (inaudible).

CHERYL KILLAM: Just a, I don't think this is working, just a quick question for Irene. You've listed, you said that you had four interpreters on staff is one of them an ASL interpreters. Sign

Language interpreter?

IRENE PROULX: Yes we do. We have four on staff, two part-time, and two full-time. We have full-time Spanish and Bosnian and part-time Russian and Vietnamese.

CHERYL KILLAM: Is any of those an ASL interpreter though is what I'm asking? A sign language interpreter?

IRENE PROULX: Oh, no. We do not have a sign language interpreter.

CHERYL KILLAM: Can I ask why?

IRENE PROULX: Um, well we have never run into the problem as having need for one. I'm sure if we did we would probably have to go through the sign language bank. But we have not had the occasion where we needed an interpreter for sign language.

CHERYL KILLAM: Thank you.

CHAIRPERSON: Greg?

GREG ORR: Yes, I recently just sort of as part of preparation for this meeting I had the opportunity of doing a visit with a Lebanese family, who's in the audience, and just sort of wanted to quickly sort of go over the (inaudible) one of my questions. This woman she was Latina and she only spoke Spanish, ah of Mexican decent. And she had a child, a one-year-old daughter who was born with a very severe congenital birth defect. In fact, very rare as well. She'd been receiving medical attention through Dartmouth-Hitchcock Medical Center here in Manchester and that attention she was getting was through a Spanish-speaking pediatrician. So she was, ah, you it's sort of working out pretty well. Unfortunately, she, her daughters needs were very severe and which were part of her (inaudible) specialist service. And since this

woman was on Medicare, ah Medicare sorry, she wasn't allowed to go down to Boston because they didn't accept her Medicaid. So the only within state, place for her to go was actually up to Lebanon to Mary Hitchcock Clinic, ah hospital. And she had actually at the time (inaudible) she had been, which is the November 14th; she'd actually been there on several occasions. And on each of the occasions she had not been provided an interpreter. The only instance which she had any sort of service when somebody from the cafeteria was brought up to interpret for her. And on this last occasion, on November 10th, this woman had been up to Lebanon and had spent the day and the night. And then had come back and we had met up with her I think it was three days after that and she still didn't know what had happened. She was

actually waiting for Dartmouth-Hitchcock Medical Center, her pediatrician here in Manchester to contact the doctor, the specialists in Lebanon to get the information and afterwards call her. And her concern was that if anything had happened, if there was any sort of change in direction in what she should be providing for her daughter, she wouldn't have known about that until at least a week later. I guess my question around that is more in terms of the system-wide approach, is that if your working, with for example, and I only take this example because that was my case, the Dartmouth-Hitchcock system how referrals take and how --, is there anyway to address the need for a referral, Dartmouth-Hitchcock here in Manchester to Lebanon office, in ensuring there are some interpreter

services?

MICHELE BLANCHARD: I assume that questions is directed towards me.

GREG ORR: Ah, yes. But as much as sort of a system issue as well.

MICHELE BLANCHARD: I mean, I would see that even though we're a Dartmouth-Hitchcock Clinic, we're functioning quite separately. So I would say any referral from any outside practice to the medical center would be similar of notifying people upfront of the need for the service. And I'm sorry that that happened. It sounds like a horrible situation. I'm somewhat familiar, I think, with the case that's occurring. And I don't want to make any excuses because certainly things can be vastly improved upon. One of the struggles we have, I think that Leslie mentioned, is ensuring the competency of our

interpreters. So when we talk about using someone from our dietary service there's a real question of, just because they speak the language, do they know the medical language? So we're trying to steer away from using employees who have not been deemed competent, and that's our next struggle. Is how do we deem people competent. What's our testing mechanism to ensure they are competent in the language? So the goal is to have the only safety net we have is the telephonic system in place to address that. So we are also looking at a way in our system to ask the question about, is English your first language or do you speak another language? So we can know in advance in our electronic system that someone does not speak English upfront and we're just starting to investigate that.

MARIE METOYER: I'm Marie Metoyer, and I have a question for Dottie. I'm fascinated by the use of the family for teaching procedures when we've heard so much about family not utilized because of confidentiality, lack of knowledge of the medical jargon, etcetera. Do you use something else besides pantomime? And my other question was do you ever encounter times when mental health problems are the issue in your meetings?

DOTTIE GOVE: I missed the end of the question about mental health, can you repeat the end?

MARIE METOYER: Yes, do you encounter occasions where mental health problems or questions are issues with your clients?

DOTTIE GOVE: First of all, when I talk about using the family, the family member or the friend that we're using is bilingual and will speak English with us. We've even been offered children. We don't

use children except for maybe demographic information, to confirm addresses and things like that. But we're never using children to interpret. So what we're finding is that family member or friend that we're using speaks English. So that part is not an issue. And I am a nurse by education, I have not been doing home health for quite a few years now, so as far as the mental health issues that are being encountered in the field, I really can't answer it.

ANDREW STEWART: Leslie mentioned you had done a survey and you had data on what hospitals are doing. Perhaps you could communicate to Aonghas that it is available so that we can make it a part of this.

LESLIE MELBY: I can make that available. I would just caution that it's a year old. And when I looked over the survey having learned what I have over the past year.

I think it's inadequate. The (inaudible) questions, and I am thinking about sending that out again with additional information, so I'm happy to share what we have now.

ANDREW STEWART: With that cautionary note.

LESLIE MELBY: Yes. Thank you.

ANDREW STEWART: Leslie, ah excuse me, Michele, you (inaudible) that Greg Orr raised it seems like something's wrong. That that situation could happen. And the efforts being made up in Lebanon to identify interpreters certainly necessary, necessary to comply with the law too, but presumably when this person was sent up there, there was no English language spoken. Do you have any suggestions now removing it from specifics and moving it to the hypothetical for communication that would prevent this from ever happening again?

MICHELE BLANCHARD: I'm not sure I understand your question. We are trying to work with agencies to identify how we can obtain in-person interpreters for situations. And we are not encountering many people who would like to travel two and a half hours to Lebanon one way.

ANDREW STEWART: So it's a real--

MICHELE BLANCHARD: As well as the cost of that incurred. So like I had said are using, the only alternative we have in most of our areas is the telephone interpreter system. So we are actually wanting to work more, we will be working with an agency in Southern New Hampshire who will be helping to educate and train in competency of staff, but not until 2004. They'll have their program up and running.

ANDREW STEWART: So, at this point, on Leslie's survey, Dartmouth-Hitchcock in Lebanon, would have a language coordinator?

MICHELE BLANCHARD: Yes, we have someone through our care management department who assists in locating people.

ANDREW STEWART: Huh.

LESLIE MELBY: I just wanted to add that perhaps in our capacity as an association would be, having heard this, is to somehow make healthcare providers both physicians and the clinics and hospitals aware that in, I'm assuming that medical information and medical records were sent from the Hitchcock Clinic down here up to the hospital, and that part of that record might have contained and perhaps it didn't contain, a statement about the need for language interpreter services. And so what I take away from that is working with folks and trying to find out how we can build that into the referral process, and maybe it already is, and was some kind of an oversight.

MICHELE BLANCHARD: Often times we do know when people need another language interpreter. It's just the ability to access someone to do that interpretation for us.

ANDREW STEWART: And probably buried in here also is that the difference between the urban needs and consciousness and rural perhaps even more it's a major medical center in the rural area. It's interesting.

GREG ORR: I actually have a question for Leslie. In terms of the Hospital Association, I mean, I know you mentioned a conversation with someone from Berlin, and your survey which you sent out, has the Hospital Association had sort of a formal discussion with the hospitals about how they organize their systems for medical interpreter access, would that be something that the Association would do?

LESLIE MELBY: It is something that we want to do, and in fact two weeks ago, I was able to get twenty copies of the language services action kit from Jazmin so that I could distribute them at a meeting of hospital compliance officers. There job primarily as compliance officers, is to make sure that in every aspect the hospital in which they work is meeting all its regulatory obligations both state and federal. And so though these, this is a wonderful publication and it had been distributed to all the hospitals by the Southern Area Health Education Center, ah, I wasn't sure it had gotten to the compliance folks and so we began to enlighten them about what it is that they are required to do. And I am now looking at developing a plan to educate and provide guidance to the hospitals. The Endowment for Health is very much involved along with

the (inaudible) Health Coalition and now certainly with Susan Wolf-Downes from Northeast Deaf and Hard of Hearing so that we can develop guidance and suggestions. I would like to see some of the hospitals policies and procedures and pull together some of the best of the best and send those out to the hospitals for them to consider using. And may involve training and maybe some of you will help me with that type of meeting.

GREG ORR: So you think you may have (inaudible) and maybe later when Rob will be willing to speak to this, but certainly the issue of the discrepancies in certain areas of the state and how medical interpreter issues are addressed. In a sense of trying to figure out (inaudible) Hospital Association will staring making their systems a little bit more uniform

throughout.

SPEAKER: No.

SPEAKER: I don't understand your question sir.

ANDREW STEWART: One quick question, if any of you have any (inaudible) encounters, unfortunate or otherwise with the English only law, that's here in legislation. I'm not even sure how it would surface, other than that of a misguided attempt to excuse behavior. But do I have a need to go into that? Good. So a number of questions from SAC members, we want to entertain the audience. When you obviously take the mic (inaudible) would you please tell us your name?

AUDIENCE: Hi I'm Claudia Nixon with Granite State Independent Living and Communication Access. I just wanted to attempt clarification with respect to spoken language or the Language Bank. Typically speaking, the Language Bank works with spoken language only. So

the Northeast Deaf and Hard of Hearing, Inc. are not invited there. However, as you heard, Northeast Deaf and Hard of Hearing Services, Inc. as well as Granite State Independent Living have an internal referral so those would be the agencies that you can connect. The Community House of Nashua also has a mental health referral. So that's another area that you can connect with. The other piece that I was going to talk about was a little bit around, when we're talking about understanding the language and understanding medical language, those two pieces, are very different than being able to interpret it. So I think that we also need to be mindful of the interpretation process.

AUDIENCE: I (inaudible), and thanks to the (inaudible) in working with the Access Project to look at assessment of interpretation needs and process in the

state. I wanted to ask a question in the issues of cultural broker came up earlier and I just wanted to, while we have this expert panel, have a little more conversation around that in the sense that there seem to be a real differences of opinion in our experience in the field in terms of who feels comfortable with an interpreter playing that role and who doesn't. And I wonder how we all have experienced that. Do you all view the cultural broker role as something that an interpreter should play or do you see the interpreter more being strictly in the communication of the language as opposed to the culture?

IRENE PROULX: Do you want me to answer that? I think it does take practice in working with an interpreter for one thing. Just the way that you position yourself in working with an interpreter, you want

to deal directly eye contact with the client and have the provider speak directly to the client and client to the provider. And have the interpreter in the background just as translating word for word. You want to make sure the translator is well briefed and that's what they are doing is translating. And they are not summarizing and giving their own opinion of the situation. And as far as the cultural broker, if you can have somebody who has actually been in that culture and knows the culture, that's an additional benefit. Because each culture has it's own unique belief's. And if you don't know the belief's that's an extra challenge. So if you can get both, the translation and the cultural broker, that's wonderful. But it also takes practice in just the language translation in working with

interpreters. And it should be a trained interpreter, not just somebody from dietary that might speak the language, especially medical interpretation.

ANDREW STEWART: Do you have another question here?

JAZMIN MIRANDA-SMITH: Ah, my name is Jazmin Miranda-Smith, I am with Minority Health Coalition and more than a question, what I wanted to do and I know there are going to be some people going before I have an opportunity to talk. And if I could be (inaudible) we have been meeting for two years. This is our last report for a grant that we initiated from the Minority Health Coalition in the Southern New Hampshire Area Communication Center. Two years ago, funding for the (inaudible) program and (inaudible) health and the (inaudible) program went away. The Endowment for

Health stepped in and (inaudible) school funding and just received it today. We are in our third year. We are engaging in a strategic plan to (inaudible), so that communication issues in New Hampshire that Greg Orr referred to that he is working on is another piece for this puzzle. So I practically beg everybody that is here to join us in this exciting and challenging initiative that we have been working on officially for two years. And unofficially for more than I sometimes want to remember. But I just want to say to all of us, I commend the Commission for this forum today but putting the past in the past. It is unfortunate, I can spend hours telling you horror stories, but what are we going to do after today? I humbly challenge you to join in and be part of the solution. Because the

problem is not just for those individuals that need language interpretation because they don't speak English or because they need sign language. It is essentially the whole community, the whole community is going to benefit from making sure that these individuals that are very vulnerable, get served. So please join us, if you need information, I have cards. Many people can know where to find me at the New Hampshire Minority Health Coalition. But, ah, thank you.

ANDREW STEWART: Thank you, and there is one more question.

AUDIENCE: Yes, my name is Ann Dancy (sic) and I'm with Lutheran Social Services and the Language Bank. I want to thank all the panelists for coming. Your good sports to be here as well as I think it's very important. But a lot of hard questions are being asked today. It really

concerns me that there are very few service providers in the audience and seems a little bit like we're preaching to the choir here. And I think a lot of these tend to feel like that. And I was wondering if you, as a medical provider, in the medical community have some ideas how we could encourage more people to win this dialogue. (Inaudible)

LESLIE MELBY: How I think that as a statewide organization we can do that with our members. I see that Janet Monahan from the New Hampshire Medical Society is here. And we can first and foremost identify what we need to communicate and educate our providers on, and we can certainly partner with the Homecare Association and with the New Hampshire Healthcare Association which represents nursing homes and identify those groups

and just develop a plan. Perhaps with the Endowment for Health helping us and Jazmin and Susan to put together some kind of a work plan to, I mentioned raising consciousness, and that varies around the state. They're calling me now with a number of questions saying we just don't know what we are required to do. So let's at least lay out those requirement of the law, get into the guidelines, find out what the Human Rights Commission, what your statute requires of the, ah, what the mandate is, and to move on from there. And I'd say this is a great beginning. I think we can engage providers, certainly if they don't understand their obligations, and we tell them what they are, they will step up to the plate. I really believe that they, as part, if you look at the recent, over the last few years just in terms of medical

errors which you've all heard about, well I can only imagine the kind of medical errors that might occur because of the lack of proper interpretation. And in terms of quality of care, I know providers are very concerned. This is one very important aspect of that and we can work with you.

CHAIRPERSON: Anybody else?

DOTTIE GOVE: I would say the same thing; I think the setting is intimidating. I think being in the Aldermatic (sic) Chambers, people, I mean even my boss said, "You're doing what? You're going before the Aldermatic Chambers? Is this, like, televised?" And so I think if we can do something to make it, take the fear factor out a little bit, and recognize that people are doing good things and sort of, in the invitation it talks about best practices and barriers but I think we've got to make

it a little bit easier and not just, you have to, your required to, to meet the standards of the law. It's not really that hard. And to make it just a little easier, and recognize the good that people are doing.

MICHELE BLANCHARD: And I would like to take that one step further and offer what resources there are in the state. We seem to have a fairly good understanding of what we're required to do and want to do that, but with the limited resources, I think being able to coordinate and pull more information together centrally, so we can make one phone call to find out what is available throughout the state would be extremely helpful.

AUDIENCE: My follow up question is, in terms of reimbursement. That seems like a big issue. Just finding the money to provide the services. I was wondering if you know if your agencies or the

institutions your representing are being proactive about locating funds so this wont be such a difficulty. Are you doing such things such as putting interpretation in the budget as a line item? Having a grant writer looking for funding opportunities or having your foundation or the fundraising arm of your organization locate funds to pay for this since Medicaid is not going to be the answer. Or working with private insurance companies to try and see if you can gain access to those funds?

IRENE PROULX: I can answer that for the Health Department. We do not fall, as I mentioned earlier, we don't fall into the Medicare or Medicaid funding but we're very grant driven. We do not have a grant writer that writes the grants for us, each program writes her own grants, so every year we are

constantly looking ahead to the following year and translation services are in our grant.

LESLIE MELBY: The sense that I get from the hospital is that they are bearing the costs of this. A number of them were unaware that Medicaid provides reimbursement and even then, it doesn't cover the cost of the care, however if they pay more than the cost of generating a bill, I'd have to say go-for-it and bill the Medicaid program. But that only represents a very small portion of total billing for hospitals in general as far as Medicaid is concerned. So I think they've just, ah, I'm sure that if they find over time that they are paying more and more of this, they obviously have to build it into their budget. And provide it as a free service if there's no recourse. I don't know whether they are building it

into their contracts with the health plans, that's certainly an area to make the contracting managers in the hospitals aware of if the need is increasing for those individuals who are (inaudible) plans.

ANDREW STEWART: Excuse me we have two more questions, which we need to get to. (Inaudible) You're next up.

AUDIENCE: My name is Ilene Finney (sic) and I work with Latin American Center and I have a question to ask. How do we clarify, or how do we ensure that this particular case for this woman who is going again for about three or four days with this child and decisions have to be made as to whether surgery is going to be necessary, how do we assure that there is a language coordinator there. Because we have tried, so this time, how do we assure there is one?

MICHELE BLANCHARD: We will do our best. We actually have

talked about identifying the possible nursing staff, who speak the language, and can be identified to take care of that child, but they only work certain shifts. So ensuring, I think the difficulty is ensuring 24-hour availability of interpreters for the patient. Which we will do our best with what we have available. If anyone has resources that they're aware of, that we could help with, that would be great.

ANDREW STEWART: One more question.

AUDIENCE: My name is Sue Wolf-Downes and I just a follow up on one question. You also need to think about providing access to family members who are deaf. Say for example if the patient themselves are not deaf but someone in their family is deaf. Say for example if you have a child who can hear but the parents are deaf, you need to also think about

providing access to the parents. It's not just providing access to the patient, so also think about that in terms of budget planning. Because that means a bigger pool of people you need to think about providing access for. And we have a small outreach program that we're doing some education with hospitals. And once again, the Endowment funds those blessed services, but as Debbie's been trying to contact hospitals trying to get this set up, they say, "Oh, well, we have someone on staff that can take care of that." And so we actually have to wait until something happens to actually (inaudible), the hospital understand that they're not equipped even though they think they are. And we've had situations where a person went into ICU for four days without any type of service. And actually I have a

question now, specifically for Irene, concerns --, you're with the Public Health Manchester, is that right?

IRENE PROULX: That is correct.

SUSAN WOLF-DOWNES: Thank you. Do you have deaf people that come into your office?

IRENE PROULX: We have not, that I am aware of. Now I'm sure, like any other medical facility the possibility is there. I have not encountered the situation.

SUSAN WOLF-DOWNES: Okay. I find that interesting, do you know why you think that that's not happening? And that's probably because deaf people know that traditionally you don't provide access, and so they go into Granite's Independent Living Center instead or they come to us instead. So the news is already out in the community that you don't provide service so that's why you don't see them. So it's very, very important to have someone collaborating you with us

for example to make sure that you do have access and that the community will know that you have access and again they'll be coming to you. So we have a presentation that we can provide in terms of education at no cost, we'll just be happy to come out and work with your agency on this.

IRENE PROULX: One reason why we probably do not see these clients, is a client with a hearing deficit, chances are has his own private physician. We mainly see clients who do not have their own provider. We do not take clients on as our patients, we try to refer them so they have own primary care provider.

ANDREW STEWART: There is one more question from a SAC member here.

CHERYL KILLAM: It's actually just a comment. Based on what Susan just said. In my job as the Accessibilities Specialist for the State of New Hampshire I often get,

well we don't have people in wheelchairs come in. Well that would be because that's because they have steps.

ANDREW STEWART: One more questions.

AUDIENCE: Thank you. My name is Linda Bills (sic). This will probably just show you what I don't know about something, but what's the likeliness of us having difficulty using sign language with people that speak foreign languages?

AUDIENCE: Ah, yes there, let me make sure that Sue can see my answer. I'm sorry, I'm just trying to make sure that everyone has access to my answer. Yes you will find that because individuals from other countries who are deaf also come here, so their first language is not English and it's not American Sign Language, they have, maybe they're first language is from their own country, their sign language or even a

spoken language other sign language. So that can be very challenging. And our services try to help them learn American Sign Language, but in terms of medical issues, the concepts are much more complicated. So we usually, the best solution we have found is to have a deaf person become an interpreter. So the interpreter's actually work as a team so you have a hearing interpreter and a deaf interpreter and the deaf interpreter is able to better communicate all of those -- that information to the deaf patient. So that does happen on occasion. And say for example, someone mentioned this morning talking about how much time is wasted from the doctor's prospective not being able to communicate with the patient an interpreter will certainly expedite those services.

ANDREW STEWART: We have gotten down to 11:30. The

other panel has just started. Let's take five minutes on break. I have a question for you though. The next panel will be about an hour, we'll be breaking around 12:30. Are there any of you that would like to talk with panelists, who'd like to get on record that cannot stay here, that cannot come back after lunch? My question I will ask after the next panel is, whether you'd like to go immediately into some discussion and recommendations or break for lunch. So those of you who are on restricted schedules may want to think about that. So five minutes. Strictly five minutes and we'll be back for the third panel.

[End of Tape Two, Panel II]

PANEL III

(BY ANDREW STEWART)

CHAIRPERSON: Now we are on the third panel. Thank you. This panel is Chaired by Cheryl

Killam who will introduce the panelists.

(BY CHERYL KILLAM)

CHAIRPERSON: Good morning. This is the Panel that is going to discuss consumer issues and I'm looking for some real experiences that people have had and know of and maybe in an instance where there was effective communication. First on our panel is Aida Cases, next is Jazmin Miranda-Smith, next is Mourad Lakhdari, and Claudia Nixon. And we're going to begin with Aida.

AIDA CASES: Ah, thank you. Thank you for giving me the opportunity to have a voice for the people I represent, which is a mental health. Again my name is Aida Cases. I'm a Project Coordinator with Bienestar Mental, a National Alliance for the Mentally Ill Project. It is a project that began with the New Hampshire Minority Health Coalition as part of their health education program. They had recontinued (sic) that program in Nashua; however, we began to program basically just focusing on mental health. We wanted to ensure that mental health access services were available to the Spanish speaking community that Latino Hispanic Community. Which by the way, has a lot of cultures, it is not just Latino Hispanic, it is also many, many different cultures of South America, Central America and the Caribbean, ah,

Dominican Republic, Cuba, Port Rican, Mexican, so we are not only dealing with a language but we are also dealing with a lot of cultural beliefs as well as education around mental health. One of the pieces of our program that we provide is advocacy and that's a very big piece that we provide in our program because of the access to mental health. Particularly access to mental health with communication. As you know there is no real guide technical or scientific basis that you can go and take an x-ray that you can determine what the mental health diagnosis will be. So communication is the utmost important piece. How do you communicate what your mood is, how do you communicate what your, been feeling. That is only done through the language. Through the verbal piece. So if you have a provider or you have

an intake process and this person does not speak the language, what is it you are going to get out of this process? Obviously, your not going to get very much, which brings up the piece of, ah, cost effectiveness. If the person comes in and is not understood, that person is going to return medication, diagnosis, treatment, everything that has to do with diagnosing a mental illness. Obviously it's not going to be available because the language is not understood. So one of the pieces that we do in our program is we provide advocacy. We also provide education to the families as well as to the providers about cultural pieces and the language pieces and how that piece is very important. As well as best practices. For example there may be a particular person who suffered from bipolar, what is the best practice for

this person who does not speak the language? Do we provide that same service that you're providing to your English culture to your Anglo-culture? So we want to ensure the outcome and best practice is part of the education that we provide for the providers. One of the things that we have found working with the families in Nashua, and as it turns out, our program now works, we stuck them in Manchester with the Minority Health Coalition as part of their education program and have developed it as a mental health program. One of the things we are finding, is we are getting calls from throughout the entire state of New Hampshire. So it is not just a piece of Nashua or a piece of Manchester, it is an issue that is affecting the entire state as we're seeing the demographics change. The Latino population, as

someone mentioned, ah, Berlin. Now you would think, why Berlin? Well actually we did a more cultural outreach out in Laconia in our Spanish speaking materials went like water. They were picked up. So obviously the families are moving throughout the state and if we are able to prepare rather than react to those changes then perhaps we can begin to address those issues. Now in terms of mental health as I was stating before, if person comes in, for example to an emergency room and does not know how to work with that emergency room person as to what they're feeling, what they're going through, what the manic is, what their problems are, how is that person going to be diagnosed? How is that person going to be treated? What medication is that person going to be receiving? Who's liability is it if that person is

sent home and that person is not given the appropriate mental health treatment that they require. That's number one. Number two, as we all know, mental health requires not only medication, which doesn't always require medication, let me just point that out, but also requires therapy sessions with someone who doesn't speak the language. Well tell me all about your problems? At end of session why would that person return to that therapist session that perhaps is needed. So that alone is a big issue for us. I work with the population in Nashua, as I said, as well as with the population throughout the state. And I've seen many, many, many cases where an individual has not had the appropriate interpreter come in. I'll give you an example, we had a person, a gentleman who had been suffering from severe depression and

went to one of the mental health centers with his daughter and the mental health center said we have no one at the moment to interpret, can your daughter interpret for you. You know, that alone should be a red flag for anybody, can your daughter interpret for you. This is a gentleman who's having severe depression and the child is being asked to interpret. That is one case of many. Another situation that we find is that the families are given materials to fill out, what is your health history. Well I have no health history because I don't know what your, you know, what this is all about. Unless they have someone, the health history is not going to be part of that intake or that process. So that's a real issue for us as well. Another piece, and without giving you statistics, another piece

that we're finding are medical interpreters, and Jazmin will speak a little more about that, um, the Endowment for Health has been really wonderful with our program. We've been able to get the information out to the community but one of the things we are finding is we needed medical interpreters for the mental health system. And we've been able to identify, because we have looked for the resources and we have worked with the existing organizations in the state who are putting together and working very hard to insure that medical interpreters are trained. That they have been given appropriate training because interpretation, medical interpretation is not so much learning the medical language, by the way, it's so much the dynamic of what your role is when your interpreting from someone

from another language. And in terms of confidentiality the issue is, well I don't want to use that person because of confidentiality. Someone who is appropriately trained who has, who you have as a resource, that is an issue that you can discuss. That you can have them sign prior to reacting to, oh we have someone here who speaks Spanish, let's use someone in the hospital who speaks that language. If you can appropriately identify the resources to which you have (inaudible) already been given that piece of confidentiality information and been trained in it, that would certainly not be an issue then you can do your own orientation. Doesn't mean you hire them forty hours a week, it just means that you've prepared for that person. And that's something that we are working with our mental health system

down in Nashua and throughout the state to ensure that when they hire someone that they have the appropriate training. For example we had someone that we interviewed because we are looking for a medical interpreter and my question to that person was, if the therapist says to you with the client seated next to you, what do you think that client is feeling, are they very depressed are they a little depressed, do they have manic depression and the interpreter says, well I will certainly answer and say well I feel that person is somewhat is depressed, that is not their role. That someone has not been appropriately trained, that is not something we advocate. The interpreter someone said is the venue, the communicator, the person who will get that important information, so that person with a mental health illness

will certainly be taken care of appropriately. Another thing that I need to mention, my time is up, but I want to mention this quickly is that we want to ensure that people do not go to emergency rooms unless they need to go to emergency rooms. And not use emergency rooms as clinics. (inaudible) So we want to make sure that everyone who is providing health services has an interpreter so that we can begin to look at that big cost that's happening in the state. Thank you.

CHAIRPERSON: Thank you Aida. Jazmin?

JAZMIN MIRANDA-SMITH: Good morning members of the Commission, friends and colleagues. I could talk for hours and try to do it slowly about this issue. Not only I've been working on issues related to interpretation for as long as I can remember that I have work in the United States. Which is almost like ten years. But also part of the mission of my organization it's my personal passion I am originally from Costa Rica. I came to this country almost thirteen years ago. I didn't speak any English when I came to this country (inaudible). My formal training is agricultural engineer. I work with cows and chickens and all that good stuff. So I knew some words in that field when I came to this country but that was not very useful. So I struggled a lot when I was, recently arrived to the U.S. because I didn't speak the language. People

treated me in discriminatory ways. You name it, from being stupid, to whatever. There was this person inside me screaming, you know like, you had no reason to treat me like that, but I couldn't do anything, I couldn't slap them. My mom taught me not to do that. It also helped me to motivate myself to learn the language, however, I was very lucky. I didn't have to work to provide for food and a roof for my family. I was working with my in-laws and they provided for me and they were the ones that encouraged me the most to learn English and to provide for me, so that I could learn this language as quickly as possible. But I don't forget. So that is kind of a wonderful, as you say, that is okay. I'm very proud of that. A couple of disclaimers that I want to make because sometimes some of the issues that I'm

going to be talking about, some people might know that I'm talking about you and yes I'm talking about you and I'm not going to say your name. So what is in the past, is in the past, as I said let's see what we are going to do as we move forward. I am not judging what it is, (inaudible) I am not judging you personally or your organization. I am just offering my help, our help in organization and all our colleagues that are really trying to work on this issue. However, I don't have any money. And I cannot solve the money problem, I am just part of the solution with all of you. And I am always creating these new love, hate relationships that I just, because of the work, it just comes with the territory. And I'm totally at --, I live with that. Having said all that stuff, I chose to talk a little bit

about the work that we're doing right now with American Interpretation, through the American Interpretation Advisory Board which as I said before it is the Board that advises the initiative that we are working on in collaboration with the Southern New Hampshire Area Health Education Center in funding from (inaudible) health. And I need to mention that some of the things that we find in the system, and again it's nothing personal, it is the system and we really need to look at and fix that. But this way we can as quickly as we can. But I'm sure there might be people sitting in the audience that once I mention some of the collaborators that we have, will be surprising who I didn't know. So it's the same, that happens that comes to the clinic, hospital, whatever trying to get interpretation, trying to get

services and they are sent back home. And when we call the organization finding out why this person was sent home I am told by the supervisor that there's a system in place, but the person that was the first contact they didn't know for one reason or another and things get greased a little bit and then the system functions. So some of the partners that we are working with are the Manchester Mental Health Center, Catholic Medical Center, Dartmouth-Hitchcock, Lutheran Community Services. I am, I definitely hate when I mention names because I am always leaving somebody behind. The New Hampshire Community Technical College, the Manchester Community Resource Center, and many, many, many others. What we're trying to do with the Advisory Board is that we've divided in different subcommittee's and the one

that I want to (inaudible) in the financial piece, it doesn't have any money attached to it, so don't, you know, don't get too happy about it. There is another committee for service delivery and there's another one for needs assessment. What we, when we started this project it was a very, it was just a training project. We were not going to solve the problem of medical interpretation in New Hampshire. Like, never thought about that piece. However, as we move forward, the training is not enough. Some things that I can tell you is that we have trained so far in the two years, eighty interpreters, they speak, we have like twenty-two languages. People from (inaudible) over in Manchester, Bedford, Nashua, Merrimack, oh I'm sorry, Merrimack, Hudson and Concord. We have also trained

professionals. The healthcare providers, I know that in year two the day was (inaudible) we train over a thousand professionals in New Hampshire. We have trained also the community members so that they understand what their rights are, however, even though we can do that work, and people get to the door and they are turned away, it doesn't matter how much people know about their rights and how many the people know or might not know about their obligation which doesn't mean that they didn't have obligation just because they pretend not to know it or they don't know it. And we have trained like also a thousand people in the community. As I said when we started this program, those were the components. We felt that we needed to train interpreters because there where people out there,

they were the dieticians, they were the cleaning people, they were the radiologists, there was whatever your name is they were bilingual and they were being used. So we wanted to make sure that at least those individuals that were used as interpreters had some basic training. There was one component's that we also needed to talk and work with the providers because they needed to know that they needed to provide these services and how to do it. And the other piece was to help the community understand so that they could help advocate for themselves and also let us know we can help them advocate for these issues. In the third year that we just initiated a new component. We still have those three component that I mentioned, the MIAB, that is the Medical Interpretation Advisory Board is another component of

the grant. And where we have, many, many people, many are sitting around these tables in, ah, and I'm also again inviting everybody that is here to become part of the MIAB that is a core component in now our new strategic planning piece. We just keep on going around and around and around. Very quickly, I know that they are going to pull me, they're pulling me. The Medicaid reimbursement issue, you know this is one more time that I say if I have talk about Medicaid again I'm going to jump off a tall building. Because the way that I see it and the way that I know how to deal with it, it's a model. So that way I can deal with continuing talking about these issues of Medicaid. But the money that Medicaid will help fix this problem is very small. And just very quickly, many of the people that we're talking

about, when we talk about spoken language access is, are, individuals that are uninsured. So no matter what, no matter what we do Medicaid is not going to pay for them. And or they are undocumented there's no way Medicaid is going to pay for this. If this is the larger piece, that hospital's, clinic's, everybody under the sun is dealing with so we need to use Medicaid as a model, so hopefully that will keep us in pieces of things that might work to help the insurance companies, to help the hospitals, to help many, many, many other people to look at where, how can we be creative? How can we be --,

CHAIRPERSON: Excuse me. Excuse me, your overtime.

JAZMIN MIRANDA-SMITH: Just put the interpretation line item in your budget and we're here to help resolve that problem. To be part of the solution. Thank you.

CHAIRPERSON: Thank you. Mourad?

MOURAD LAKHDARI: (inaudible) I wanted to just to say that in many countries their own cities they have a lot of languages spoken within the country. So they have these issues when their own population goes to the doctors. We have to provide them interpreters. I remember in my country while I was a medical student, always they called me, I go to (inaudible) floor to help with this issue. Later on I had to leave in foreign country as well as I practice medicine and, ah, in that country we had more than six different languages. I was amazed, it did work perfectly because the care of it, if someone

shows up, doesn't speak the language we just do everything we could before he sees the doctor. But he has someone to help out with interpretation. As foreign physician I had to use an interpreter for eighty percent of the patients I had seen in that country. So always it was basically perfect. I didn't run into any problem because I had always someone to help me out with. When I arrived to this country I spoke a few words of English, of course I never thought that I would have to speak English. I spoke some words, but the worst was to understand people talking to you. Think unfortunately for me first month when I arrived I had to go to the ER twice. Once for my daughter and once was for me. Thanks God the reason was so obvious, so no one can miss it, I had dislocated my shoulder so --, to take care of it to

find out what is it was easy. But I, no one was worried about just if I was getting it, and worst was when you leave and there is some orientation when they discharge you, you have to (inaudible) specialist, you have to do something or get medication. And no one makes sure that you get that. In my case, I didn't get that I had to see another doctor and I didn't know if my insurance was covering that visit and I missed what comes next. I did work in Lutheran Social Services for the last four years as (inaudible) as a Medical Case Manager so I tell you I spent all of my time running from hospital to hospital over the state. I was asked to come with some life stories but I don't know if you're ready for it. Again, I've seen a lot. Just while I'm taking care of our client being in the waiting room for awhile when the

doctors are running behind so you get chance to see a lot of things. From the most simple thing when someone shows up and doesn't speak the language, you just don't wait, saying we talk with doctor, there is no one who can help you here. Please bring your, an interpreter with you and rescheduled an appointment. This is very common. I have seen one of our clients while I was doing the medical case management, I was providing interpretation for the languages we had for free. But when we didn't speak the language of that person, when we go to the hospital if they speak some or they just don't care, or they never cared. I had patient family, a whole family who had shots twice. Same sets in like three days. They went back for some reason, miscommunication, they gave them same shots. I had, we had a case

who tried to commit suicide. Brought to the ER by friends or neighbors. I don't know how it went in because I didn't witness that, but I know that he was discharged without any care, any follow up, basically a few hours later he walked back home. Once I was helping our patient getting ready for surgery, right before the surgery I hear another people, something going on behind the curtain because everyone is covered. A nurse talking to patient, I get that he was Asian; I think he was Korean. She had the hardest time to just communicate with him or get from him very basic question, like are you allergic to any medication? And when they don't understand, it's funny how it gets loud. Because they repeat the same question louder and louder. Finally they get housekeeper from the hospital to help out. She wasn't able

to help or what she was saying, I think he understands what your saying. I had patient, I get call once from clinic, we had good relationship with, so I been working with them for four years. They call me in emergency situations saying can you get here, one of your clients is very sick? I said, "What do you mean can you get here?" He said, "Fifteen, twenty minutes can you send someone?" I said, "No. Unfortunately everyone is out and I'm busy and even if I drive straight, it would take for me forty-five minutes." He said, "Okay, we'll use the phone." A few weeks later, he told me who was the patient, so I knew who was the case. It happened that I met the patient few weeks later and so I was worried about him, said what happened to you? They called me and needed me right away, did they help you? What happened? He said

they referred me to surgery. I had surgery. I said what was wrong, he said, "I don't know." This was a girl, and she didn't know what was removed basically. I had some patient who used a family member who his English wasn't that good, again, it was an emergency he went to the ER referred to surgery. For a year, the lady thought that they removed her kidney. Which one-day went through her paperwork, found out that it was a gallbladder. And for the whole year, whenever she thought that she had just one kidney instead of what they removed really. Recently we received a call from teacher to our school liaison caseworker in the office. They were wondering why kid didn't show up to school system, to the class, sorry. And we try to find out, and the parents said oh, he's okay it's just his mom was sick, she's in the

hospital and the kid had to stay with her to interpret the whole days. And the kid was ten years old. Many hospitals also say or do use the phone lines in which I always liked because if someone shows up, no one can talk to these people at least we can get someone from phone. Oh, I have to speed up. But we don't take care of the before the appointment and after the session. I want to mention the very bad attitude when we have to advocate for our client. When I call I say, "Listen, I'm calling just to let you know this patient is coming and doesn't speak English." You don't want to hear what I get as answers. This is medical services, not interpretation services. Ah, this is ah, the best one was I got to tell you that. I called down to Nashua saying a patient is scheduled for surgery in two days he

doesn't speak any English. You said we don't offer interpreters or whatever; you didn't want to listen to me. I said if you need our service we will be there. They called me the day of surgery. We're struggling for two hours we have to get him in can you come down. I said, okay, it takes an hour for me to get there or send someone. When my interpreter gets down there the nurse comes out to him, and tells him, big smile, we fixed the problem we get someone through the phone for free. Thank you very much for your trip. That's the attitude we are getting from a lot of providers unfortunately. I'm sorry I can't go on for hours. Thank you.

CHAIRPERSON: Thank you very much, Claudia.

CLAUDIA NIXON: Claudia from Deaf Services at Granite State Independent Living, and since everybody has taken all of my time, no

I'm just kidding, I have to really, I can't stay --,

CHAIRPERSON: You're not getting out of it.

CLAUDIA NIXON: I'm kidding. I am Deaf Services Coordinator and Communication Access at Granite State Independent Living and for those of you who are not aware of Granite State, we are an independent living center who works with individuals with disabilities promoting life with independence. One of the programs within our organization is deaf services and that is a program that I am the Coordinator. You know, I feel like I am going to be reiterating many, many points that have already

been made. So I'm just going to kind of tag on a few things. Sue had mentioned earlier around licensure law in New Hampshire, which for deaf and hard of hearing folks is a bit of a safety net. The problem is we don't have an over abundance of the sign language interpreters in the state. One of pieces of work that I do is advocating for consumers when requested. And that advocation looks like, just sharing with both the consumers as well as the organizations around how to go about hiring interpreters. The push is really around the consumer. If there is an appointment being made making sure that they make the request for the interpreter at the time of the appointment, not to go into the doctors office on a given day and say, "Oh, I thought you'd, ah, I thought an

interpreter was going to be here." If a request hasn't been made, you can guarantee there won't be an interpreter there. Not only am I suggesting to the consumers that they need to make the requests, but also to follow up with the request a week before the appointment. And not, you know, it's important that they get the name of the interpreter. Because often times while they may have made a request, the organization or doctors office is not doing the follow up. They're not calling to make, to obtain the interpreter. So that's a big piece that I impress on my consumers. That, you know, get the name of the interpreter and if you don't have a name, that probably means that the doctors office has not obtained the interpreter. So that's a really, that's a big one. If in fact consumers

indicate to me that a there has not been an interpreter or they've been refused an interpreter then I make a phone call to an agency or an organization, and very nicely and politely, well, it's always not so nice actually, but just kind of, you know, share to folks what the law is in New Hampshire. And what the liability, if they're not hiring an interpreter, what that means to their agency. It's usually typically doctor's offices. When we're talking access to healthcare one are in deaf services I see, with Granite State Independent Living, working with folks with disabilities is dental care. And we haven't really talked about dental. That's a huge area that's not looked at, in terms of access. Typically dentist offices are not real accessible, especially in terms of physical access. So I'm just

going to drop that one out there for later discussion. With respect to some examples, I got a phone call yesterday, actually it wasn't a phone call it was a fax from an individual who informed me that through writing notes back and forth to a doctor, that their could've been a possible diagnosis of cancer. Which completely horrified me. And part of the problem with that is, when you are writing letters back and forth to second language learners, so I'm speaking of deaf folks in particular, it doesn't matter whether it's written or spoken very loudly or whispered. It's still English, and it's still a second language. So, you know, I'm wondering and part of not having an interpreter is that, you know, that miscommunication when this individual is reading this fax. It could have been that they have been being tested

for something that, you know, and I don't know if cancer was written on the paper or what, so I'm not sure, and part of again my work around advocacy is connecting with that consumer and reading the notes to figure out what in fact is the diagnosis, if any. Another example of lack of interpreter is an individual who, I mean we can go on around senior's, sort of looking at doctors and going, okay you know, whatever, because the doctor's know everything. Senior's typically won't speak up about their needs. But this particular individual who has diabetes and, you know, very many years of diabetes, very thin skin. One little bump can cause a huge ulcer. But what had happened was this individual did not have an interpreter with them for an appointment and was told to use paper tape as opposed to adhesive tape.

Well, you know paper tape, whatever, what does that mean? This individual went to the store and got adhesive tape, when he went to take off the tape, he took off a huge amount of skin. So, had an interpreter been there the message would've been facilitated appropriately and this probably could've been avoided. When we're talking about having family members interpret, another piece of advocacy I strongly recommend and tell organizations and doctor's offices on a daily basis, as I wear another hat in the office as Interpreter Referral Specialist, that having a family member interpret is not appropriate. Because A they're probably not certified and license and you need to be in the State of New Hampshire but they also might not relay the message faithfully. And when your looking at the code of

ethics, interpreters follow the code of ethics, you relay the message faithfully. Family members typically want to sugarcoat and, you know, they don't want to hurt the family member's feelings. They might not want to, you know they might feel like, okay that family member may have been; thank you, may have been really anxious about that particular appointment and didn't want to hear the news that the doctor is telling. So I really encourage doctor's and nurses, or whoever's doing the referral or trying to obtain the interpreter, to not allow family members to do that piece. And especially if they're children. So I think that I will wrap that up. Okay.

CHAIRPERSON: Good. You've got two more minutes.

CLAUDIA NIXON: Two more minutes? Well, um. You know. Oh, the other piece, I will add one more pieces, medical interpretation.

The emergency referral that Sue had mentioned that runs out of their shop, it is an emergency referral, it's not to be called for if you just didn't call an interpreter. It's not for prescheduled appointments, and Sue will I'm sure correct me if I'm wrong, an emergency would mean, an emergency medical, suicide, someone is in the hospital emergency room. So if doctor's offices had a prescheduled appointment and just failed to do their job in terms of obtaining an interpreter, the 911 or 800 number for interpreter referral emergency line is not the appropriate avenue to take. I'm all done, thank you.

CHAIRPERSON: Thank you very much. Question?

ANDREW STEWART: I'd like to ask a question. And this is both to members of the panel, particularly Dr. Lakhdari and Claudia. Both (inaudible). Given the

scenario's that you described and the responses that you have experienced and what one might term as egregious lapses, do you see any movement in the medical community, the larger community at this time or would you be advising people to contact Donna Gartelman and Katharine Daly, Human Rights commission and OCR universally to motivate rapid improvement?

CLAUDIA NIXON: Could I--.

ANDREW STEWART: Ah, no. Perhaps Dr. Lakhdari.

MOURAD LAKHDARI: Yes, I've seen a lot of improvement. With certain (inaudible) of course. Where the willing to use interpreters but there is no organization behind it. Just, you were talking about, just having someone you can rely on to take care of the interpretation issues. But that doesn't exist. Basically the clinics we work with, we do a lot of work for them, just to satisfy our

clients. We do the call initiate for them, without them knowing that it's coming.

ANDREW STEWART: So, then hand, perhaps the mic over to Donna and Katharine, if Katharine is still here. If these came through your door. How would you react?

SPEAKER: Phil Donahue at work.

DONNA GARTELMAN: Donna Gartelman with the Office of Civil Rights. If a complaint comes in our office we're obligated to investigate. We get the allegations, we look at the allegations that are presented to us. We contact the covered entity who did the discrimination to find out what actually happened. And make a determination on those basis. We do an investigation, so I mean, your free, anybody is free to file a complaint. Or even on behalf of somebody else (inaudible) to file a complaint.

CLAUDIA NIXON: Can I just add, that, to answer the question, there have been great improvements around deaf and hard of hearing services and there's great technology out there now. And I know that Nashua and out seacoast somewhere, can't remember what town, there is a system, a video relay system that is being used. And when you talk about reasonable accommodation, it works for some folks, not for all. So individuals with low vision cannot use that TV system, and hospitals sometimes have a difficult time with that because wait a minute, we have a TV. Well the TV might be on the fourth floor and folks are in the emergency. Or it might be in the emergency room in room six and they're in room one. There's a lot of situations that I, you know --

DONNA GARTELMAN: You have to investigate it on a case-by-case basis.

CLAUDIA NIXON: And I also, you know, self advocacy is always the key. Encouraging folks to make complaints I think is something that's important.

KATHARINE DALY: If someone calls us with an issue regarding the kinds of things that you've been talking about and we've heard a lot of different stories here. Obviously one of the questions is what is the specific issue. Is it, are we fighting over who's going to pay for a translator or are denying service all together. Clearly our agency can take a charge of denial service based on disability or national origin. As I said before, the murkier area for our statute in our agency is the lack of specific requirements in our statute to provide those services that are explicitly in, either the American's with Disabilities Act or Title VI. But we would certainly offer our services

to try to resolve that. How would we do that? Probably by active intervention even if we didn't have jurisdiction. We would offer to make that call to advice (inaudible). Our investigators know the law, both federal and state, even if we don't enforce that federal law. Do that intervention, make the call, advice the healthcare provider if they don't already know, remind them what they're obligations are and what could happen if they are not will to do what they are obligated to do. Clearly under federal law, possibly under state law, depending on the circumstances. In the appropriate case we would certainly take the charge right away.

ANDREW STEWART: Following up on what Katharine just said there is a person here from Legal Assistance that would like to (inaudible).

LYNN PARKER: Yes.

ANDREW STEWART: You can introduce yourself again.

LYNN PARKER: Hi. My name is Lynn Parker, I'm a Staff Attorney here in Manchester with New Hampshire Legal Assistance. Our office has been working for a number of years on this issue of access to non-English and limited English proficient persons. One of the things we're seeing right now in the area of access to medical services is the fact that we are finding that medical institutions, facilities and other agencies have plans instituted in which at least the upper management understands what the plan is suppose to be and what the (inaudible). But as it filters down to those folks that are actually in the front office, they are not familiar enough with the plan that does exist or they are not being encouraged or

trained at the level that they should be, so that when a person comes in, that front office person knows what to do. And one of the things we're finding right now is that people who are trying to access medical services may get in the door, but then their being told that they can't have their needs met right then or their being asked to use an interpreter who comes in with them. No effort is made to find out whether that interpreter actually is adequate and I think there is a real dichotomy that exists within medical institutions right now which is that the institutions understand that there is a very strong need for appropriate language. And appropriate interpretation. Yet there's also this belief that if they can't provide the interpreter from their staff that the way to remove themselves from liability

in that instance is to use somebody who is not connected to that institution, so that if there is a problem with communication, somehow they think it will fall back onto the interpreter that's providing. And I think that's accurate. And the challenge we face is how to overcome that misconception.

ANDREW STEWART: Thank you very much (inaudible). Okay there are some SAC members that, they have questions.

GREG ORR: I just have a quick question, this is more for Mourad. I understand that you are in a very unique position and that you are connected with the Refugee Resettlement Program and at the Language Bank at the same time. So you get to see how services are accessed is being done over a very wide region throughout the state. And I guess this is sort of a little bit on Andy's question is, do you see specific

regions which are having more difficulty than others?

MOURAD LAKHDARI: Yeah, of course. The worst place in where were operating is Laconia. This is very bad.

GREG ORR: Laconia.

CHAIRPERSON: Anybody else on the staff?

PAT GORMLEY: This may be a more general question even then for these panel members but for some of the folks who are on before. It seems to me that one of the issues in terms of availability is that we are not making it a priority to obtain the number of folks that we need who are going to be able to interpret languages other than English or to use sign language. And I guess it frustrates me, knowing we have a community college system, and I don't know what all languages are, but is this the kind of thinking that part of either encouraging people who are

already proficient at languages to be able to use them in settings such as this. And to be certified and to hear that there are problems at Mary Hitchcock up in the Dartmouth area when Dartmouth College has on of the finest language instructional programs of any college in the United States, particularly in Spanish, and so for them not to have some sort of community support kind of, gift, if you will, to the community and it's members to make this kind of thing more apt to happen. If we're looking even past the provision of services using, you know, getting the money to pay for interpreters and to get more people certified, how do we get it on the radars screen of coming from the University of New Hampshire to get the kind of educational systems and political attention to help solve this

issue, from many directions. And that's, I know, a very broad question and I don't know who would like to answer it, but I am sitting here so frustrated with it I could scream.

ANDREW STEWART: I thought perhaps you would want to respond.

MICHELE BLANCHARD: I'd be happy to answer. We are very fortunate to have Dartmouth College in our back yard. And we have used college students but the concern is the competency of those students. So we're actually hoping in March, to do the full training program and work with the college students on their competency.

ANDREW STEWART: Thank you. Ms. Cases.

AIDA CASES: One of the things that I wanted to mention in terms of getting the competent medical interpreters is again, paying the interpreters. The institutions are not willing to pay the interpreters. So you don't find

someone who can be hired full-time as an interpreter, just someone who's going to be called at the last minute as he stated. You know, can you come down here in an hour. And you come down here and nobody is going to pay you. Medicaid (inaudible) a second issue. So cost is a big issue. Right now we are looking to hire an interpreter for nine hours in the mental health center down where I am working and we've been fortunate to be able to get a pool of interpreters but we've got to offer the money so that that person could see it as a viable income to be able to interpret.

ANDREW STEWART: Next question, she's been waiting a long time here.

AUDIENCE: I want to mention just a few things that have been going on in my mind and

I will make this short. First of all, I know that Sue mentioned this morning that there's about 500% increase in interpreter requests. And that is good, but there's still so much more training that needs to happen. I mean there's a lot of staff turnover, there's new people that come on board that don't have the training and education. So just a continuing education piece is the thing that we're always chasing. And maybe the Human Rights Agency, they may get a lot of complaints and that may be a way to deal with that, in terms of just doing the investigation piece. The other thing, I'm tired of hearing people talk about the TV Talk. It kind of creeps me out. As a deaf person. Not as a professional, but as a deaf person, that sends chills down my spine. Because I know that there are few deaf

consumers that say that the hospital forces them to use that technology. That doesn't seem right to me. And often times staff don't know how to even set up the equipment so that it's even useable. And then, that just doesn't seem fair either. If the deaf person wants to use that, then the person is fine. But if the deaf person wants an interpreter actually there, you need to find someone. And statistics used to prove that. Most deaf people don't like using that particular piece of technology. In terms of spoken language, the interpretation over the phone, the Language Line works. But it certainly doesn't work with deaf people, even if they come from another country because sign language is such a visual language that it requires having that visual contact in order to make communication

happen. Someone who's speaking for you at the other end of the phone, that certainly is an option, but it's not always an option when you're working with deaf individuals. We talked about the (inaudible) interpreters. That certainly is true for sign language interpreters as well. It's very difficult that there are programs. Interpreter training programs in the state. We need to work with them to make sure, when those interpreters get out of those programs, they stay in the field, they stay in the state and I know there's a lot of issues around that. But we need to think about all of those things. One-way to encourage interpreters maybe is to set up a mentorship program. And so that we can have veteran interpreters working with new interpreters to keep them in the field. So those are the three things I

wanted to mention.

ANDREW STEWART: Thank you. Can I get a group count of other questions in the audience? One and the other is two. Jazmin you had something to say too, I think. Here is what we're thinking. We don't trust you basically you're going to go at lunch and you're not going to come back. So, what we're thinking of is extending a half an hour to make sure that everyone here has a chance to get on record, get your comments on the record, ask questions of either these panelists or panelists that have been generous enough of their time to stick around. Is there any problem that you see with doing it that way? Good, we'll do it that way. And, Jazmin if it's okay with you can I get these two questions and I'll come back to you? (Inaudible)

AUDIENCE: Actually this is quick, um, and I do

have to leave. But I wanted to make a point of clarification. I'm going to ask Jazmin to kind of respond to it for me. I think there's been a lot of talk about certification and licensing of interpreters and I just want to clarify and I think I'm correct, I think it's only for deaf interpreters. When were talking about, medical, legal, foreign language interpreters there is no process.

JAZMIN MIRANDA-SMITH: That was one of the comments that I was going to make. There is no certification for, do you want me to answer now, or wait?

ANDREW STEWART: Go on. Finish the sentence.

JAZMIN MIRANDA-SMITH: Massachusetts has been working has been working on certification for fifteen years. So we have a lot that we can copy from Massachusetts right now. But there is no real certification that exists or that is required from

interpreters.

AUDIENCE: I just wanted to be sure that--

JAZMIN MIRANDA-SMITH: Yes.

ANDREW STEWART: Thank you.

AUDIENCE: (Inaudible) This has been great. (Inaudible) quick comment and a question. The comment is to remind people that we do have real examples of what (inaudible) example. A study done, double blind top of the line research, looking into depression and looking at (inaudible) African American majority patients and proved, they (inaudible) they provided appropriate interpreter services and culture competence interventions it really made a difference to those patients. Six months, twelve months later in terms of their depression. That's a good side of the piece. (Inaudible) is still there. It also showed unfortunately that the people of color, did not get

better in terms of their employment where as whites did but it did show that there was a culturally competent intervention really had (inaudible). You don't just have these (inaudible). The other thing is there was a study done in pediatrics looking at the question how well did interpreters do and how often were there errors. What they found was we all know that many family members and so on, don't do well, also found that the many professional interpreters don't do as well as we might expect. Two-thirds of the error that happened had clinical consequences. So my question is how are folks doing assessments right now so that we know when someone comes in fact is skilled. Who can be actual literal interpretation and knows how to do (inaudible) intervention. What are people doing right now around

assessment?

ANDREW STEWART: Thank you.

AUDIENCE: My name is Gloria Abdar (sic) and I am working in New Hampshire under the (inaudible) program. And I think I can answer part of your question. And as a medical interpreter getting licensed pretty soon too, I find that I interpret with medical sessions for children and a lot of times we have the therapist asking us the interpreter our advice in what we think is going on. And we have to put a stop to that and says no, I can't say that, and just say let me interpret that to my client and let them answer. Let him or her answer. So, (inaudible) something that needs to be also addressed to the therapist and the provider so that they know that they're not to ask the interpreters to do that. So that's something that really, an educational

piece as well.

ANDREW STEWART: Another question?

SUSAN WOLF-DOWNES: Your comment just reminded me about services for mental health. In this state there is only one therapist that works in an agency. We have two licensed New Hampshire licensed female, one we have a male, who do mental health work. But there's no female that actually works for an agency at this point. So I'm wondering why, I mean, the CCN in Nashua would have that, and on the report documents, comments from the deaf community that they want a female therapist to talk about those intimate issues. Someone who can sign, someone who they can communicate with directly. So we need to recruit people from outside of the state to come in, that's certainly one solution. In terms of --, most deaf

and hard of hearing people say for example myself would prefer to have direct communication with a therapist. With an interpreter, I'd be happy to work with an interpreter in a medical facility, but when it comes to mental health or some of those other types of more personal intimate settings, I feel it's important to have one on one direct communication with a service provider. And so, we just need to figure out how do we coordinate the people that are interested in providing services with the ones that actually need the services.

ANDREW STEWART: Thank you. I forget if we've presented this before, but Aonghas if there are organizations or individuals who want to submit reports, commentary to you in Washington for inclusion in this report is that (inaudible).

AONGHAS ST-HILAIRE: Yeah, I give you business cards.

ANDREW STEWART: How long do we keep that open? Are you under some sort of a deadline, some sort of --?

AONGHAS ST-HILAIRE: Well the sooner the better, but certainly within a month we'll get started on writing the report.

ANDREW STEWART: Okay. Now we have as much time as you want to take. (Inaudible). Recommendations paths to further walk down and pursue, the floor is open.

JAZMIN MIRANDA-SMITH: I have a question, about we're having this forum and are you going to work on a plan? What is the outcome of the meeting? Are you going to come and make sure and check that, you know, in a year, that we have made some progress? That there are some things that we say, we're going to work on this and this and this and come and check us out?

ANDREW STEWART: A few years ago, I would've rolled my eyes and said, God knows. Now Aonghas

is working with us and things are happening. But Aonghas you have a better sense of reality and budget and timelines and legal reviews and all that (inaudible).

AONGHAS ST-HILAIRE: Yeah, the budget at the Commission has been flat for a number of years and so with inflation, what the Commission actually do, is reduce, as long as I'm with the Commission I'll do is advocate within the Commission to further the work of this Committee. Other Committee's have done follow up, public events and press releases, etcetera.

ANDREW STEWART: As a practical matter in looking back over the years, one of the main uses of reports that come out of here, have been for grant writing for bringing salience to the issue. We did not see any media here this time. That, the Union Leader or the other papers may not have articles for you to clip out

and use for that purpose. So there will be transcription of this and there will be usable data. How rapidly it goes through to a formal report remains to be seen. But there should at least a summary before, I don't know --,

SPEAKER: And impressively said.

ANDREW STEWART: And (inaudible) issue.

JAZMIN MIRANDA-SMITH: And just a note of caution, I have found with people that come to us complaining about something that has happened to them, when access healthcare, is that many people are (inaudible) or they don't really want to make waves because they are afraid of retaliation. Because bottom line, I have to go back to that doctor, that clinic, that hospital next month. And we have had some bad cases in people, we try to encourage them to talk to a Commission, go to OCR and people are just afraid that one, they are not

going to be able to get the services that they need in the future or two, they're going to put in jeopardy their family members. And we have offered to do it for them, but people are so afraid that we haven't even been able to fill out a complaint for them. And I could, you know, tell you stories.

KATHARINE DALY: I didn't go into great detail about the Commission process of law and all that, because that's not what we're really here for but in terms of the fear factor, one thing to be aware of is our statutes against discrimination does allow for Commission, Commissioner initiated charges where they can be the charging party. In a situation where a complaint party really feels that they wish to remain anonymous or where it's going to be obvious who is really being effected here, but they want the, I guess the weight of the Commissioner

coming forward making the complaint to help them out. Kind of like in a domestic violence situation, where it's no longer the victim filing the complaint, it's the police filing the complaint and prosecuting the person who's being violent. So keep that in mind. Our Attorney General can also file a charge on behalf of someone who is discriminated against.

DONNA GARTELMAN: Again with the Office for Civil Rights, wé're, I, --, not an individual complaint comes in --, but you can contact our office. We're at the discretion of having to do complaints reviews also. If we have the time and enough resources available, we can, you know, initiate our own complaints and (inaudible).

ANDREW STEWART: Thank you.

AUDIENCE: -- third group, and I wanted to thank you for this Forum today. I'm

wondering if you have considered having a deaf or hard of hearing member on your advisory committee? And who would be the right person to contact if that were to happen?

AONGHAS ST-HILAIRE: You can contact me. The Advisory Committee is not going to be rechartered again until February --,

ANDREW STEWART: Next year?

AONGHAS ST-HILAIRE: Yes, next year.

ANDREW STEWART: We all serve without compensation, we ah, a volunteer organization and ah, sounds like a good idea to me.

AUDIENCE: I am Gloria with Bienestar Mental. As my way of a recommendation from what I can see so far is that education for the providers as to how to work with an interpreter, more like a guideline of do's and don'ts. And also, the fear factor, one of the things that I've notices with the non-documented, the undocumented immigrants is that

providers ask the question, do you have insurance? Now when the patient says no, they ask why not. So that question should stop right there. They can give the patient basically information about Medicaid and Healthy Kids and that should stop right there and not try to instigate in the privacy of what their fearing. Because that is something that is huge. That's one of the ways that (inaudible) communication comes out. Immigrant status of illegal aliens does have that one person can find out that they're illegal and that is where the fear factor comes in. So if providers know this is the limit as to where you can ask the questions, then I think that that's something that would eliminate some of the fear factors in that respect.

CLAUDIA NIXON: Could I just add something around the education to providers. And Aonghas I

could probably send this card to you. There are many instances where deaf and hard of hearing folks are having, are meeting barriers around interpretation. And at our office I do have a card that is double sided, one side is how to hire an interpreter, the other side is how to use an interpreter. So I often give that to organizations and agencies to host. Which whether they do or not I'm not sure. But it is an offer, so that may be something that you guys may be interested in.

ANDREW STEWART: In fact the report that comes out, might have addresses for Human Rights Commission or all your organizations. Well there was a specific recommendation for education and another specific for membership on the SAC. Let's go around and see what else --

CHAIRPERSON: Questions in the back maybe?

ANDREW STEWART: Yes sir?

AUDIENCE: A couple of recommendation pieces to follow up. In terms of training providers and how we work with interpreter, there is an excellent video produced by the colleagues at the Cross-Cultural Healthcare Program out of Seattle around how to work with an interpreter. I've used it in trainings myself. Part of what I really like about it, it's relatively inexpensive, which helps everybody. And it's ninety minutes so it can be used in the regular training kind of session. It uses, three vignettes. It has the first time someone brought in this not a well-trained interpreter, it was a receptionist that is brought in to interpret and it showed everything basically that can go wrong in an

interpreted session. Leaves things out, adds her own opinion and so on and so forth. Then they bring in a qualified interpreter and shows everything that can go right in the sessions. You see how it's done well. The third time the first interpreter comes back in and now the clinician, in this case it's a physician, takes charge and helps that person do a better job. It's clear it's not (inaudible) from having a trained professional but it's the duty, as a clinician your institution has to help you do this. That's just one good tool I would like to put on the table. And the other thing the question of how you work with mental health issues in particular. I really can't believe having run (inaudible) social work, without saying it's really important that people understand that mental

health issues don't just happen in mental health settings, right. I used to run an emergency department and many of our patients had mental health issues as well as physical issues, so if you thinking about how to address those issues, that's across the whole spectrum. Very, very challenging as people had brought up, but it's fundamental to providing quality care. On the panel, I just wanted to emphasize this (inaudible).

RUIZ-MINGOTE: Andy, I do have something I want to say. Lena (sic) here. I think also in the report it could be added, and I don't know if it can, a section of resources available. And for that I'd ask especially the panelists for the experts in this matter to maybe provide a list of resources. So when providers get a hold of your report, they will have a list of resources that they can

access. Because we've been talking about, we need to educate the providers and the providers need to be educated and providers need to provide the services. But I think also it's our responsibility to offer them some tools that they can use to do their job in a better way.

ANDREW STEWART: To follow up on your comment. I know that Dartmouth Hitchcock in Lebanon right now is looking at spending substantial amounts money on simulation capabilities for training and mentoring of new nurses. This is part of their employee retention program. And maybe a cheap video might well be figured in the budget somewhere.

SPEAKER: I'm sure we could figure that one out.

ANDREW STEWART: Okay. Is there anyone here that has been waiting for this moment to draft issues, recommendation, comment, I don't want anybody going out of here

and saying I wish I had said something. Lena just had a shot so we'll go right here.

SUSAN WOLF-DOWNES: I do want to make a comment about the videotape. Were you talking about that for a mentoring situation? I don't know how that work, it just seems to me that a mentoring situation needs to be working with a person in a variety of different settings. Because I think that there's a lot of dialog that needs to happen. Not only before the assignment, during the assignment but also after the assignment. So I don't understand how a videotape might achieve all those things.

ANDREW STEWART: I was actually looking at education of the administrators and alerting them to the issues. But good point, not I'm not falling into that pit. Greg Orr.

GREG ORR: Thank you. I just, in terms of recommendations what kind of strikes me

is what Mourad was talking about in terms of the state of a whole. And that you had some pockets which are more competent that are working towards it that have made some progression, where as other parts that are really sort of having some challenges. I guess, one of my, my recommendation is one of the things that I'd like to see is some leadership within the organizations of hospitals. I am not specifically saying the Hospital Association necessarily, but some sort of system-wide movement. Just sort of unified, talk about these issues within the medical care area. And talk about some sort of communication we can sort of discuss, specific hospitals, what they're doing, what's working, from there it's (inaudible). I've been with Jazmin I guess for awhile and this whole thing, it's always felt to me

like, you know, the agencies and the people who are working with minorities are really kind of pushing the thing along and there's a lot of well-intentioned people in the hospitals who are trying to make an effort, but there needs to be a systemic change, a systemic change. Not only within the hospitals but within the state as a whole looking at how hospitals provide those services.

ANDREW STEWART: At this point --,

CHAIRPERSON: There's a lady.

AUDIENCE: This is not so much a recommendation as a request perhaps. Next October the Commission for Human Rights is sponsoring a leadership conference on diversity in New Hampshire in the 21st Century and they are not going to try to fight off every single protective category that our statute covers.

Because our statute is quite broad. But they have chosen at this point to focus on issues of national origin, race and color in New Hampshire and what do we want New Hampshire to look like, feel like and how are we going to welcome folks and make sure that this is the place that we want it to be. In terms of what we're talking about today I would invite further communication with many of the folks that are here today as possible presenters and leaders and communicators at that conference. And so I'm going to be contacting some folks and inviting you to continue this conversation in that forum. We are going --, our target audience is going to be healthcare providers, retail establishments, tourist industry and those kinds of areas in New Hampshire where English is a second language and so forth is a

real problem. Attracting people to our state in many different capacities as tourists, and citizens and so I will be contacting folks and inviting you to continue this education process there.

ANDREW STEWART: So we've come down to the end, unless someone has something they want to say. You really want to do this? Has everyone else had the opportunity they would like to speak?

AUDIENCE: Like the pathologist always wants the last word. I will send a resource list to, for inclusion. I want to mention three specific, four specific books, I just think are just so excellent. And I want to put them on record and have them exposed (inaudible). One is actually published up in Maine it's called, "Culture and the Clinically Encountered" it's a desensitizer to cross-cultural relationship including

language and other issues as well. Second and all specifically is called the "Latino Patient" by Nilda Chong (sic). A cultural guide for healthcare providers. Nilda Chong (sic) writes the institute for culturally competent care (inaudible) in California, one of the national leaders around this work. I just think it's an excellent resource. It talks about a lot of the issues we talked about here, including how much their diversity reached within their given population as well as across the population (inaudible) really important. The other two are not within healthcare and part of what I really appreciate hearing about the Civil Rights Commission piece is that we often don't learn enough from each other. There are a lot of things that folks in other fields have learned that they can teach us as well as

(inaudible) teach others. So I really appreciate having that broad audience. If I look at how Wal-Mart does, they have some real problems, but they also have some real things that we could learn from them. I think we ought to be learning from each other around what we do. So these two books are not specifically in healthcare. One is called "The Skin That We Speak, Thoughts On Language and Culture in the Classroom." The other is by Taylor Cox, "Cultural Diversity in Organizations. Theory, Research and Practice." and it's a lot about how do we take what we know in theory and put it in practice to benefit our patients (inaudible).

ANDREW STEWART: With the gratitude that we all feel and for the wonderful panelists, definitely now extends to all of you in the audience that have contributed very valuable information. Thank you.

There being no further comments, and just for bringing up again, you can submit written reports and opinion, commentary to Aonghas and (inaudible) from him. There being no further comment at the moment this forum is over. Thank you so much.

END OF HEARING

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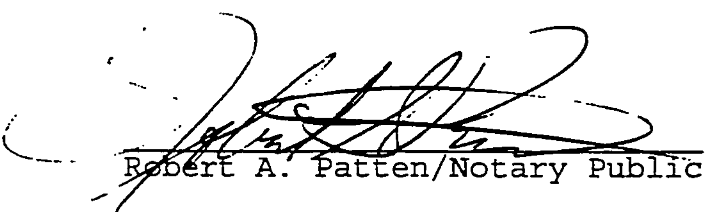
4 I, Robert A. Patten, do hereby certify that New Hampshire Deposition Services, 113 South State Street, Concord, New Hampshire 03301, transcribed from a tape recording, the foregoing pages and that the same is a true, full and correct transcript of all of the testimony at the hearing, to the best of my knowledge and belief.

I further certify that I am neither attorney nor counsel for, nor related to or employed by any of the parties to the action in which this hearing was taken, and further that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in this action.



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