

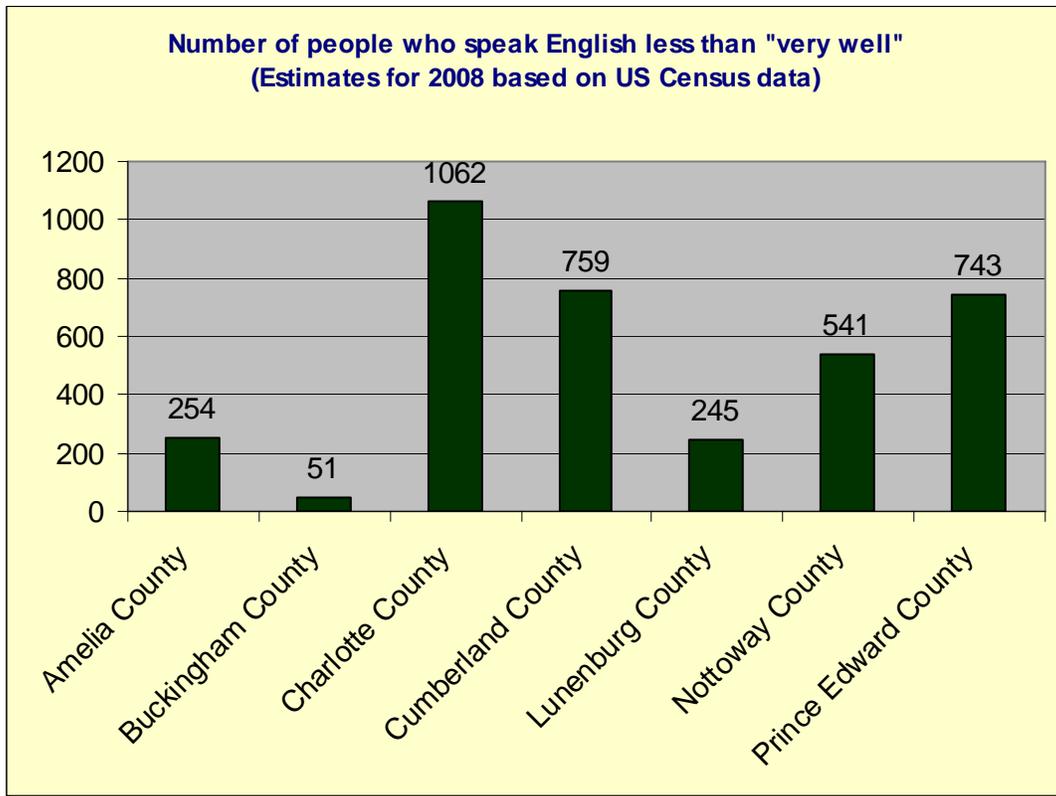
## 2010 LANGUAGE NEEDS ASSESSMENT: PIEDMONT HEALTH DISTRICT

(Areas covered: Amelia County, Buckingham County, Charlotte County, Cumberland County, Lunenburg County, Nottoway County, Prince Edward County)

### HOW DOES THE CLAS REQUIREMENTS IMPACT THE PIEDMONT HEALTH DISTRICT?

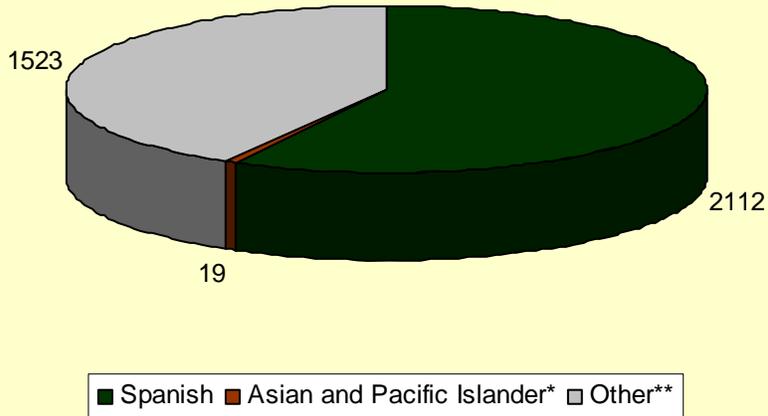
The obligation to provide meaningful access is fact-dependent and starts with an individualized assessment that balances the following four factors:

1. The number or proportion of limited English proficient (LEP)<sup>1</sup> persons within this district:



<sup>1</sup> Individuals are considered limited English proficient (LEP) if they “do not speak English as their primary language and...have a limited ability to read, speak, write or understand English.” (From [www.lep.gov](http://www.lep.gov).)

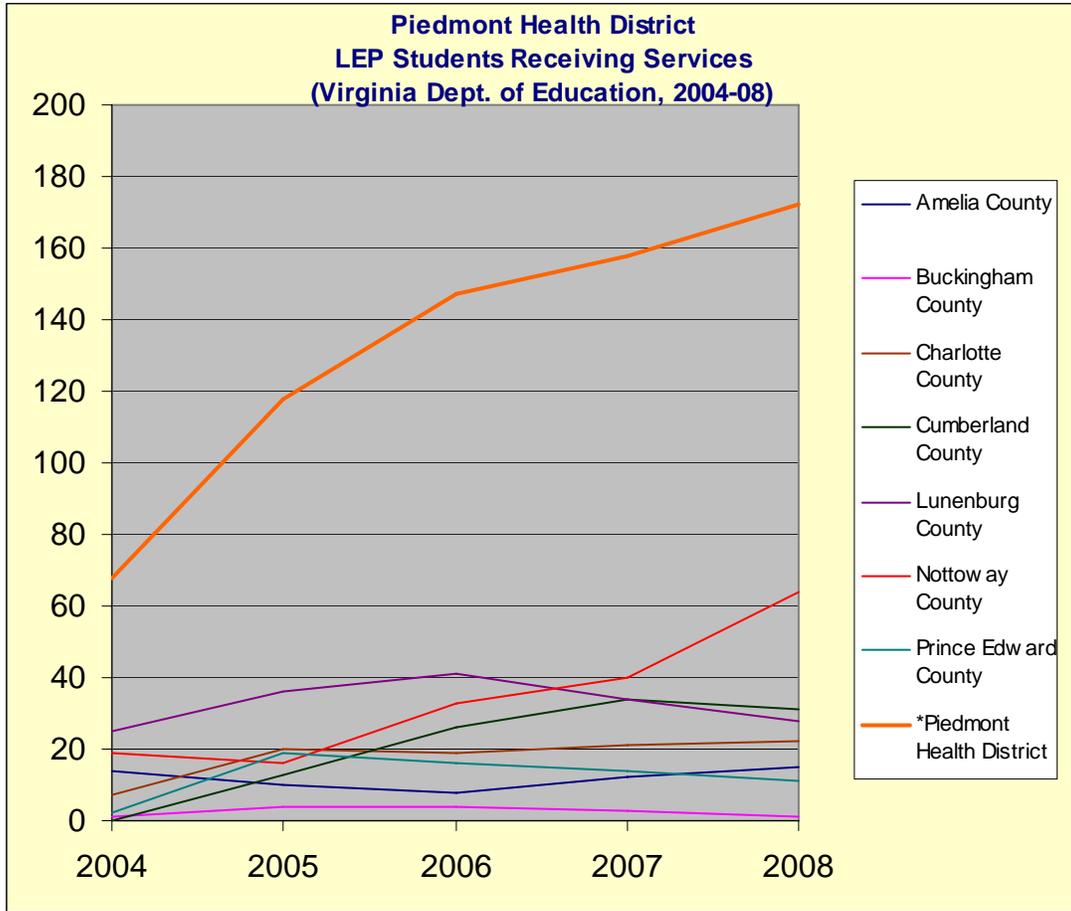
**Languages spoken by LEP individuals,  
Piedmont Health District  
(Estimates for 2008 based on US Census data)**



\*Based on US Census language designations. Asian and Pacific Islander languages include, but are not limited to: Burmese, Cambodian, Chinese, Indonesian, Japanese, Korean, Mongolian, Tagalog, Thai, Turkish and Vietnamese.

\*\*Based on US Census language designations. Other languages include, but are not limited to: Albanian, Amharic, Arabic, Bengali-Bengla, French, German, Hindi, Italian, Kurdish, Nepali, Persian, Portuguese, Russian, Somali, Sudanese, Tigrinya, Ukranian and Urdu.

Based on 2008 estimates from US Census data, 3,654 of the residents of Piedmont Health District are considered LEP. This proportion is significantly higher in Charlotte County (1,062 LEP individuals). Of the LEP residents in the Piedmont Health District, just over half (58%) speak Spanish as their primary language.



*\* The Health District total is the sum of all LEP Students within the cities and counties of the district.*

Based on data from the Virginia Department of Education, the number of LEP students receiving educational services in the Piedmont Health District is 2.5 times what it was five years ago but is still relatively small (172 students in 2008). The increase in LEP students indicates that the overall LEP population is small but growing.

**2. The frequency with which LEP individuals come into contact with the program:**

The following is patient level data for the Piedmont Health District as reported in the Virginia Department of Health's (VDH) Web Vision, January- December 2008\*:

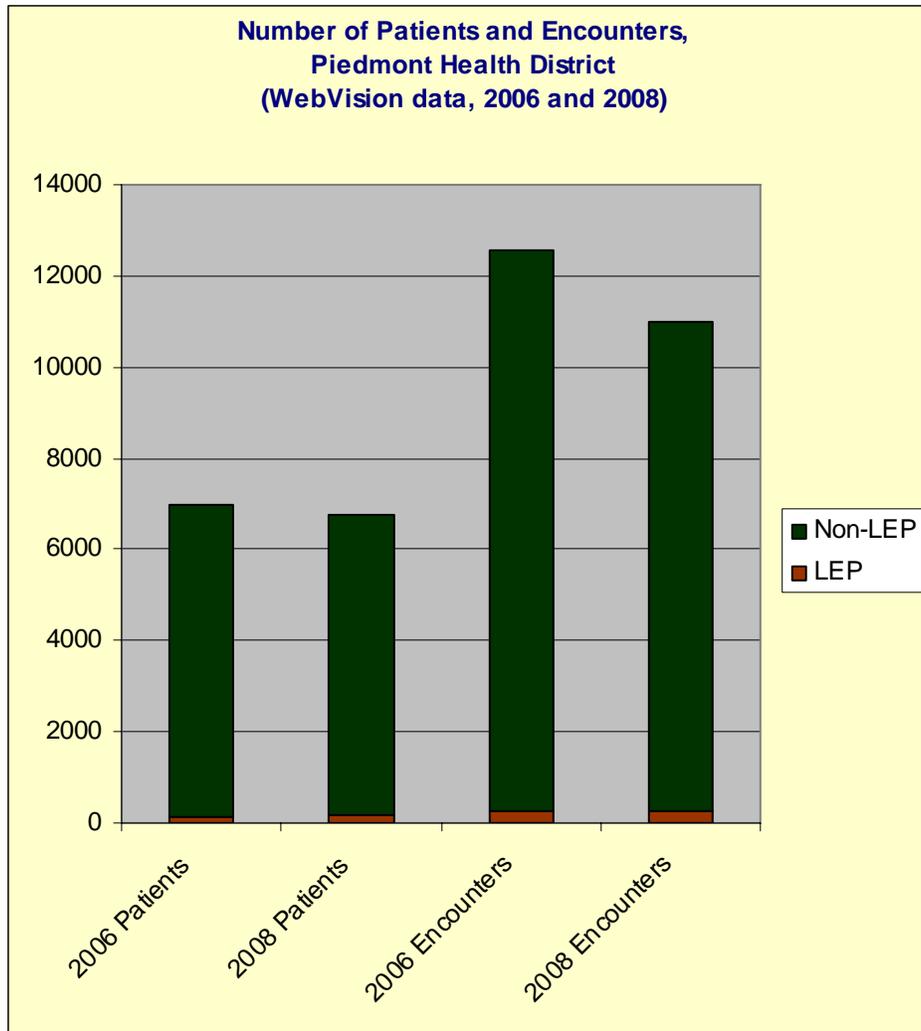
Primary Language**	Patients (unduplicated count)		Patient encounters	
	#	%	#	%
English	6,576	97.54%	10,694	97.24%
Spanish	148	2.20%	274	2.49%
Chinese	3	0.04%	4	0.04%
Somali	1	0.01%	1	0.01%
<b>Piedmont Health District</b>	<b>6,742</b>	<b>100.00%</b>	<b>10,997</b>	<b>100.00%</b>

\* The listed languages may not equal 100% because of the exclusion of rarely encountered languages and non-English speakers who are not Limited English Proficient.

\*\* By need for an interpreter (responses of "yes" & "unknown")

According to this data, for the Piedmont Health District:

- ◆ 2.27% of all patients are LEP
- ◆ 2.56% of all encounters involve LEP patients.



Since the most recent language needs assessment in 2007, there has been a slight increase in percentage of both LEP patients and encounters. The 2007 report showed that about 2% of all patients and encounters involved LEP patients. Compared to the data from the 2007 report, the number of LEP patients and encounters essentially stayed the same, while overall numbers decreased for Piedmont Health District.

**3. The nature and importance of the program, activity or service provided by the recipient (VDH) to its beneficiaries.**

The agency should consider the importance and urgency of its program, activity or service. If the activity is important and urgent, immediate language services are needed. If the activity is important but not urgent, language services are needed but can be delayed for a reasonable period of time. (See [Title VI federal guidelines](#) or the language needs assessment home page for more guidance on this matter.)

**4. The resources available to the grantee/recipient (VDH) and the costs of interpretation/translation services.**

Agencies should carefully explore the most cost-effective means of delivering competent and accurate language services due to resource concerns. In many cases it is more cost-effective

to hire staff or take other appropriate measures, thereby improving the quality of service. Resource limitations must be well-substantiated before using this factor as a reason to limit language assistance. (See [Title VI federal guidelines](#) or the language needs assessment home page for more guidance on this matter.)

**Based on the federal requirements, the following processes should be in place at the Piedmont Health District to ensure compliance:**

- **Notification of Rights:** Both verbal offers and written notices informing clients of their right to receive language assistance services at no cost to them. For this purpose, VDH has designed a language identification poster that informs patients in 32 languages of their rights to a trained interpreter at no cost. Copies of this poster should be displayed at all offices of the health district and as appropriate in multiple locations within offices. This poster is available online at <http://www.vdh.state.va.us/healthpolicy/healthequity/documents/8x11languagecard.pdf>.
- **Interpretation Services:** Interpretation services should be provided to all LEP patients at no cost and at all points of contact in a timely manner during all hours of operation. LEP persons cannot be required to bring their own interpreters nor should they use family members or friends as interpreters unless specifically requested by the patient/consumer after receiving notification of their rights to receive language assistance services at no cost to them.
- **Assurance of Competence:** have a mechanism for assuring the competence of the language assistance provided.
  - It is recommended that the Piedmont Health District utilize interpreters and translators (whether they are in-house, bilingual professional staff, or contract interpreters and translators) who:
    - have been screened and tested for proficiency in both English and the target language(s)
    - have received a minimum of 40 hours of training as professional medical/health care interpreters (the training should include, but not be limited to, the following topic areas: ethics and confidentiality, medical terminology, basic anatomy and physiology, roles, and cultural competence)
    - adhere to an interpreter and translator Code of Ethics, a statement of confidentiality, and are aware of and comply with HIPAA related privacy guidelines
    - participate in ongoing medical/healthcare interpreter and translator continuing education
    - have subject matter expertise in medical and health care and prior experience translating medical/health documents
    - are able to write at an appropriate reading level for the target audience

- have been screened and tested for proficiency in both written English and the target language(s) with affiliation/accreditation by the American Translators Association preferred
  - are able to act as a cultural bridge, providing VDH with feedback not only on grammatical and linguistic accuracy, but also on cultural appropriateness
  - do not rely on software-based translation programs
  - are covered by liability insurance
- ◆ **Translated Materials:** make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups, including written translations of vital documents for each eligible LEP language group that constitutes 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered.

In order to help health districts comply with the culturally and linguistically appropriate health care services (CLAS) requirements, VDH has contracted with Language Services Associates, a provider of telephonic interpretation and translation by trained and certified professionals. The following chart summarizes the 2008 calls.

Language	# of Calls	Minutes	Total Charge
Spanish	24	237	\$279.75
<b>Piedmont Health District</b>	<b>24</b>	<b>237</b>	<b>\$279.75</b>

### Summary

Culturally and linguistically appropriate health care services (CLAS) LAS requirements obligate each health district to provide suitable language access for all district services at no additional cost to the patient. The determination of the district's language needs is made based on data from the US Census, the Virginia Department of Education (DOE), the Virginia Department of Health (VDH), and Language Services Associates (LSA), the telephonic interpreting provider for VDH. According to 2008 estimates, 3,654 limited English proficient (LEP) individuals reside in the Piedmont Health District, comprising 3% of the total population in the district. 58% of the LEP population in Piedmont speaks Spanish as its primary language. DOE data indicates that the LEP population, while relatively small, is growing rapidly: the number of LEP students receiving services has more than doubled over the last five years.

In the Piedmont Health District about 2% of all patients and 3% of all encounters were LEP patients in 2008. This was a slight increase in the proportion of LEP patients served as compared to the 2007 language needs assessment.

This report makes no new compliance recommendations for the Piedmont Health District. As in 2007, all patients should be notified of their right to a trained interpreter at no cost; LSA telephonic interpretation should be utilized for this purpose. Note: Health service providers should note that the use of untrained medical interpreters, such as family and friends of the

patient, is unacceptable when a trained interpreting service (including telephonic interpreting) is available.

Health providers in the Piedmont Health District should be aware of the potential for rapid growth in the LEP population in the district. It may be that DOE data is not the proper indicator for potential growth of the LEP population within this district; however, they suggest that the LEP population in the Piedmont Health District has experienced significant growth over the last five years. Specifically focused outreach programs may be needed to reach any emergent LEP groups.

Such outreach programs may be already needed for non-Spanish speaking LEP populations in Piedmont Health District. There is a notable portion of non Spanish-speaking LEP individuals in Piedmont that comprise 42% of the LEP population in the district and their share of LEP patients and encounters in the district are only 3% of LEP patients and 2% of LEP encounters. This data suggests that non-Spanish speaking LEP populations are not utilizing health department programs. It may be that the census data have overestimated the LEP population or that this population is not in need of health department services. Nonetheless, non-Spanish speaking groups form a significant subset of the LEP population in Piedmont. It is recommended that Piedmont Health District identify specific LEP populations, particularly non-Spanish speakers, and target these groups for health department outreach. Doing so will help to assure that the district meets the needs of all potential LEP patients.