Healthy Communities

SAN MATEO COUNTY

LINGUISTIC ACCESS STUDY:

SUMMARY OF FINDINGS AND RECOMMENDATIONS

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A Community Health Improvement Initiative to Eliminate Health Disparities

Healthy Communities San Mateo County Linguistic Access Study: Summary of Findings and Recommendations

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BACKGROUND

The Linguistic Access Study emerged from a county-wide initiative to eliminate health disparities. San Mateo County community members and organizations recognized that health disparities, differences in incidence, prevalence, mortality, burden of diseases and other adverse health conditions among specific population groups, exist throughout many arenas of health care and health outcomes in the county. Community members and stakeholders came together in May 2004 at the first Healthy Communities Summit to identify local disparities and develop a plan of action to reduce them on a countywide level. Supervisor Rose Jacobs Gibson and the County Health Department have led follow-up work, in partnership with organizations and residents across the community.

After several follow-up meetings, community members and organizations involved in this process chose three directives on which to concentrate strategic planning efforts: Childhood Obesity Prevention; Alcohol, Tobacco, and Other Drug Prevention; and Linguistic Access to Health Care Services. The Healthy Communities San Mateo County: A Community Health Improvement Initiative to Eliminate Health Disparities prioritized these issue-specific areas because communities with high rates of obesity and substance use/abuse experience significant health disparities. Disparities in health outcomes have also been identified in populations that lack linguistic access to health care services and programs. Other recent planning and evaluation activities in San Mateo County, such as the Mental Health Services Act (Prop. 63) and the Latino Access Study also found that linguistic barriers prevent many individuals from receiving adequate access to health care.

The Health Department spearheaded the planning efforts around these three priority areas and determined that a baseline study of linguistic access to health care was a necessary first step in reducing cultural and linguistic barriers. Hospitals, clinics and programs have conducted assessments of their individual level of cultural and linguistic competence and used these findings to inform planning efforts on an organizational level. However, few counties, if any, have conducted countywide assessments of their level of linguistic access. A countywide study not only serves to identify high priority areas and strategies for improving linguistic access for the county's diverse regions and ethnic groups, but also provides policy-makers, community leaders, and individual health care organizations with a baseline against which to measure future improvement efforts. The goals of the study were to:

- Examine current services and determine the degree to which San Mateo County health care organizations render adequate language assistance services
- Identify service gaps
- Make recommendations to reduce linguistic barriers to care.

To guide this process, the Health Department formed a steering committee comprised of staff representatives from health programs with expertise on linguistic access and experience with immigrant communities. Gibson and Associates, an independent research and evaluation firm, was selected to conduct the Linguistic Access Study, in collaboration with the Health Department and steering committee. The findings and recommendations of this study are reported here. The results of this study can be used to inform strategic planning, policy-making, and improvement efforts across the county and at individual health care organizations and programs, with the ultimate goal of enhancing linguistic access in San Mateo County.

The key findings and recommendations are presented in this report. While data was collected on the practices and policies of many health care organizations and programs throughout the county, findings related to individual programs and organizations are not reported here given the community-wide scope of this study. The overall goal of the Linguistic Access Study was to assess the level of linguistic access available in San Mateo County as a whole.

EXECUTIVE SUMMARY

The purpose of the Linguistic Access Study was to assess the level of linguistic access available to Limited English Proficient (LEP) residents in San Mateo County. Both qualitative and quantitative methods were used to determine the overall level of linguistic access at health care organizations in San Mateo County. The findings and recommendations from this study are reported here.

The primary findings from the study are as follows:

The study found that the level of access available to LEP clients at health care organizations across the county varies significantly by organization or program type. A few organizations have high levels of linguistic access, whereas many have insufficient levels. Several large organizations are engaged in efforts to improve their overall level of linguistic access.

- Small to medium sized health care organizations that focus on the health care needs of a single ethnic group (primarily Latinos) have the highest levels of linguistic access.

- Access is highest in primary care settings and lower in specialty clinics, hospitals, and urgent care settings. Language assistance services are not consistently available or used at these settings.

- Health care organizations have better capacity to provide linguistically appropriate services to Spanish and Tagalog-speaking clients than to all other LEP groups. Interpreter services and written materials in Tongan, Chinese and Russian are not available at enough points of service. As a corollary, access is highest for Latino residents and lowest for Chinese and Tongan residents.

- Social and economic factors, as well as systemic barriers to care compound linguistic barriers. Lack of insurance, geographic accessibility of services, and negative experiences with some health care organizations represent additional barriers to care.

- Most health care organizations lack comprehensive policies and procedures regarding the provision of linguistically appropriate services. As a result, language assistance services are not consistently available and used at enough points of service.

- A few large health care organizations have recently created comprehensive policies and procedures on language assistance services and engaged in efforts to promote linguistic access.

The key recommendations are as follows:

1 Conduct a self-assessment at an organizational level and plan for language assistance services. Create standards, performance measures, and on-going evaluation activities to monitor the delivery of linguistically appropriate services.

Organizations should conduct a self-assessment of their level of linguistic access and develop a plan to improve the delivery of language assistance services. An integral part of this process is the creation of standards and performance indicators to measure and monitor the delivery of linguistically appropriate services. These tools can also me used to assess the level of linguistic competence, to guide programming and training, and measure improvement over time. Organizations should routinely conduct internal evaluation activities.

2 Create uniform policies and procedures regarding the provision of linguistically appropriate services to LEP clients.

Health care organizations should create uniform policies and procedures regarding the provision of linguistically appropriate services to LEP clients as soon as possible. Large health care organizations should ensure that divisions and programs adopt or modify these policies as appropriate to the services and programs they render. The policies should comply with legal mandates from the Office of Civil Rights and reflect the recommendations outlined in the Summary of Best Practices in Linguistic Access to Health Care. References for sample policies are included in that summary.

Upon creating policies, staff members need to be trained on them and practices established to monitor their implementation. All health care organizations should devote time to increasing staff's knowledge of language barriers, legal guidelines, and organizational policies and procedures related to language assistance services.

3 Expand the availability and use of oral language services and translation services to a wider range of settings and languages.

The study found that language assistance services are not consistently available or used at many health care organizations. LEP clients from all language groups frequently rely on family and friends to provide interpretation because staff members are unaware of the problems associated with this approach or

interpreter services are not available. Organizations should take steps to expand the availability and use of interpreter technologies at specialty clinics, hospitals, and emergency rooms. Efforts should be made to ensure that interpreter services and translated materials are available to LEP clients who speak Tongan, Chinese, and Russian, as well as other less commonly spoken languages.

4 Formalize the role of bilingual employees who provide language assistance services. Provide adequate time, training, and evaluation to perform these duties successfully.

The study found that interpretation and translation services are performed informally by bilingual staff at many health care organizations. At those organizations that rely heavily on bilingual administrative and support staff to perform interpretation, procedures on how to access and use an interpreter are lacking. As a result, the use of an interpreter hinges on individual provider judgment and is under-utilized in many settings. The study also found that the absence of training and on-going monitoring and support means that the quality of language assistance services rendered by bilingual staff is variable. To address these issues, organizations should formalize the role of bilingual staff that provides language assistance services.

5 Develop a plan to improve linguistic access for clients in the northern region of the County, as well as non-Spanish speaking LEP clients across the County.

The study found that linguistic access was lowest for clients residing in the northern region of the County, as well as non-Spanish speaking LEP clients. Systemic barriers, such as lack or insurance and geographic inaccessibility of services are particularly acute and compound linguistic barriers for LEP clients residing in the northern region of the County. The study found that linguistic barriers are especially high for Chinese, Russian, and Tongan clients, though each group responds differently to these barriers. Organizations should implement the following strategies to improve access:

- Conduct outreach and build relationships with community leaders in LEP communities.
- Increase the availability of written materials on health care services in Chinese, Tongan and Russian.
- Provide local and bilingual services. Additional services and/or human resources may be needed.
- Explore models of excellence in cultural and linguistic access and/or culturally targeted care to inform long term

METHODOLOGY

Multiple methods were used to to determine the overall level of linguistic access to health care in San Mateo County. Specifically, the study sought to determine:

- Barriers to care and level of access for different LEP communities across the county.
- Capacity to serve LEP communities across county and community health care programs.
- Policies, procedures, and practices of county and community-based health care organizations related to language assistance services.

Quantitative and qualitative data sources were used to obtain the perspectives of diverse stakeholders and allowed researchers to analyze data by language group, region, and organization type. Managers, staff, and clients from over fifty county and community-based health care organizations and programs from all regions of the County participated in the linguistic access study. More than 150 clients, residents, and advocates from six LEP communities in the county also shared their perspectives. The chart below outlines the methods used in the Linguistic Access Study.

METHOD	DATA SOURCE
Demographic review of LEP populations	Census Report 2000, Medi-Cal User information, California Department of Education reports on LEP Students
Best Practice Research Summary	Review and summary of guidance from the Office of Civil Rights, research from experts in linguistic access, and recommendations from leaders in immigrant health.
Program Manager Survey	Structured interviews with managers on policies, practices and procedures related to language assistance services. Forty county and community-based agencies participated.
Staff Survey	Survey of staff from county and community based agencies. Completed by 377 staff, including managers, providers, program, and administrative and support staff.
Community and Client Input	Key informant interviews with ten community leaders and advocates for immigrant health. Focus groups with predominant LEP communities in the county (150 participants).
Site Observations	Site observations at six county and community-based organizations in all regions of the county.

A summary of best practices in linguistic access to health care was conducted during the initial phases of the study and served as a rubric against which practices and procedures in place at health care organizations in San Mateo County were measured. The summary of best practices also outlines legal guidelines and recommendations for health care organizations and should be viewed as a companion guide to this report. Separate reports on findings from the Program Manager Survey, Staff Survey, and Community and Client Input are also available and provide more detailed findings and recommendations.

LIMITED ENGLISH PROFICIENT POPULATIONS IN SAN MATEO COUNTY

San Mateo is a culturally, linguistically, and geographically diverse county. Those individuals with limited English proficiency are more likely to experience linguistic barriers to health care services, and as a result, experience inferior health outcomes than those who speak English fluently. Limited English proficient refers to those residents who speak English "not well" or "not at all." According to census data (2000) 38% of the population speaks a language other than English and more than thirty languages are spoken in the county. However, this number is most likely higher as the census aggregates data on less commonly spoken languages and reports them as groups (i.e. Pacific Islander languages). Qualitative reports from community leaders also suggest that more than 45 languages are spoken in the County. While the majority of those who speak a language other than English are also fluent in English, the most recent census found that about a quarter are limited English Proficient (LEP). Spanish-speakers make up the majority of LEP individuals in the County, followed by Chinese and Tagalog speakers. Russian and Tongan speakers represent small percentages of the LEP population and reportedly experience linguistic barriers to care. The remaining LEP individuals speak a wide range of languages. A review of demographic data and input from program managers and community leaders identified the following communities as the predominant LEP groups in the County:

- Latinos (Spanish)
- Filipinos (Tagalog)
- Russians (Russian)
- Chinese (Cantonese and Mandarin)
- Tongans (Tongan)

The chart below outlines distribution of LEP individuals by language group:

LEP SPEAKERS BY LANGUAGE GROUP IN SAN MATEO COUNTY

	Total LEP Population	Spanish	Chinese	Tagalog	Russian	Pacific Islander*
Total LEP	53,465	35,425	7,355	2,740	830	745
% of total LEP	_	66%	14%	5%	2%	1%

Source: U.S. Department of Labor. 2000 Census special tabulation on Limited English Proficient Adults
*Census reports information on Pacific Islander languages as one group.

FINDINGS AND RECOMMENDATIONS: CAPACITY OF HEALTHCARE ORGANIZATIONS IN SAN MATEO COUNTY TO PROVIDE LINGUISTICALLY APPROPRIATE SERVICES

This study sought to determine the level of access, linguistic barriers, and the capacity of organizations to serve LEP clients from the predominant language groups across the County. The study also sought to identify the types of organizations that successfully provide LEP clients with access to health care and the factors that facilitate such access. The cultural and linguistic competence, as well as the overall culture of an organization can affect linguistic access to care. Researchers obtained input from managers, staff, providers, clients, and community leaders, and conducted site observations at county and community-based sites across regions of the County.

Key Finding #1: **While some health care organizations in the County have high levels of linguistic access, others have insufficient levels. Several organizations are actively engaged in efforts to improve their level of linguistic access.**

The study found that some organizations have high levels of linguistic access to health care, while others have insufficient levels. Several organizations are actively engaged in efforts to improve their level of linguistic access. Site observations, client feedback, and findings from the staff survey all indicated that non-profit HMOs, individual providers, and small, community-based clinics with relatively homogenous clienteles have the highest levels of linguistic access. Most possess high percentages of bilingual staff and providers, as well as an expressed commitment to serving LEP communities. At these organizations, bilingual staff and managers are aware of cultural and linguistic barriers and strive to create a welcoming environment for clients and staff. "Friendly," "willing to squeeze you in," "taking the time," and "bilingual" were words that clients used to describe these organizations. Many clients from all language groups interviewed reported high levels of linguistic access at individual provider offices. In these settings, small size seemed to facilitate personal and friendly interactions between clients and staff. Size did not always appear to be a factor, as many Filipino and Latino clients suggested that non-profit health plans in the county were very well equipped to handle the language needs of people in their community.

Findings from the community and client input phase, as well as the site observations indicate that the capacity of several large health care organizations and hospitals to meet the language needs of LEP clients is inadequate. The study found that linguistic access is highest in primary care settings and insufficiently

available in programs or organizations that provide specialty, hospital, or emergency services. At large organizations, interactions between clients and staff were more likely to be alienating and bureaucratic. In general, these organizations had a smaller proportion of bilingual employees, a greater demand for services than available appointments, a more linguistically diverse clientele and inconsistent use and availability of interpreters. Best practices related to linguistic access were not in place at most of these organizations. Policies and procedures for providing linguistically appropriate services were ad-hoc and informal. Staff and managers tended to rate their organization's level of cultural and linguistic competence highly. However, self-assessment of linguistic competence was not corroborated by client reports. Many clients and community leaders reported that language assistance services were not consistently available at larger health care organizations and hospitals, and as a result, characterized such organizations as "difficult to use," "confusing," and "unfriendly to people who don't speak English."

The challenges faced by larger health care organizations and hospitals in meeting the language needs of their clients include a more linguistically and culturally diverse clientele, a wider range of services, and at times a more complex organizational structure. This study found that despite these challenges, several have engaged in recent efforts to improve the level of linguistic access by updating or creating new policies on serving LEP clients, expanding interpreter services, providing additional trainings to enhance cultural and linguistic competence, expanding partnerships, and/or hiring more bilingual employees. Many staff and managers at larger health care organizations and hospitals felt that their organization's commitment to serving LEP clients was reflected in such initiatives. Some clients where highly satisfied with new interpreter technologies such as telephonic and remote video conferencing. As many initiatives to improve linguistic access are still in the formative phases or early stages of implementation, their benefits may have not been observed or experienced by clients during the timeframe of this study.

Key Finding #2: **Many health care organizations have the linguistic capacity to meet the language needs of Spanish and Tagalog-speaking clients, but are not adequately equipped to handle the language needs of LEP clients from the Chinese, Tongan, and Russian communities.**

The study found that health care organizations in the county have better capacity to provide language assistance services to Spanish speakers than to speakers of Asian and Pacific Islander languages, such as Tongan, Cantonese and Mandarin. Site observations, as well as reports from managers suggest that small to mid-size organizations are generally able to meet the language needs of Spanish-speaking clients internally. The client and community input phase, as well as findings from the staff and program manager surveys indicated that many organizations have significant numbers of Spanish-speaking staff and

providers who are able to meet the language needs of Latino clients, with several organizations reporting 100% bilingual staffing. In the staff survey, for example, 40% of staff members who participated identified themselves as Latino and over 50% said that they were fluent in Spanish.

Researchers also found that benefit information, health education materials, and medication instructions are widely available in Spanish. Spanish is the predominant language spoken by LEP residents in the county and the study found that linguistic access to health care was adequate in many of the Latino communities across the County. Many Latino clients and community members reported that while they had experienced other barriers to care such as transportation or high cost of services, they were generally able to get adequate primary health care services in their language. The study found that Spanish-speaking clients experienced some linguistic barriers at large health care organizations and programs, as well as those organizations located in the northern region of the County.

Filipinos in this study reported fewer linguistic and systemic barriers than all other groups. They also reportedly receive most of their care through private HMOs and medical groups. Interviews with community leaders and program managers indicated that Filipino clients are generally more proficient in English than other LEP clients and that several hospitals and HMOs in the North County are staffed by bilingual Tagalog speakers. Filipino clients who participated in the study were for the most part fluent in English, despite efforts to recruit LEP clients, and did not report many linguistic barriers to care. Several clients suggested that recent immigrants experience linguistic and systemic barriers to care, though this study was unable to capture their perspectives. Additional research may be needed on Filipino residents who receive public benefits, are Limited English Proficient, or lack documentation to determine their level of linguistic access to care.

Language assistance services were less available to speakers of smaller LEP communities in the county, especially to those who speak Tongan, Russian, Cantonese or Mandarin. The program manager and staff surveys indicated that health care organizations employ a small number of providers and staff who are fluent in these languages. Analysis of the client and community input corroborated this finding and also suggested that interpreter services are not available at enough points of service to meet the needs of non-Spanish speaking LEP individuals. Many LEP clients from these groups rely on a clinic or doctor's office with staff or providers fluent in their primary language for their primary care needs, but experience significant linguistic barriers when they are referred to a specialist, go to the hospital or seek emergency care.

Among those who participated, Chinese and Tongan clients reported the lowest levels of linguistic access. Both groups reported a lack of bilingual staff and providers, extensive reliance on family and friends for interpretation, and inadequate written information in their language. Among Chinese participants, lack of linguistic access caused them to seek care in San Francisco, rely on home or drugstore remedies, or delay treatment. Tongan clients, on the other hand, continued to seek care, but said that they frequently did not understand their diagnosis or treatment.

Key Finding #3: **Social and economic factors, as well as systemic barriers compound linguistic barriers to care in many communities.**

The study found that social and economic factors, as well as systemic barriers to care compound many linguistic barriers, especially among Latino and Tongan clients. Program managers, community leaders, and clients identified a myriad of factors that keep LEP clients from getting adequate health care. Lack of insurance and the high cost of care deter many from seeking care unless they are very ill. Obtaining insurance and going to a doctor or hospital can be a daunting and confusing process for recent or undocumented immigrants. The geographic accessibility of services, especially for those residing in the northern region of the county, and lack of transportation are additional barriers. Cultural factors and lack of understanding of non-Western concepts of health, illness, and treatment on the part of providers and staff prevent some LEP clients from seeking care. Finally, long wait-times, poor customer service, and alienating interactions with staff deter some LEP clients from returning for care. While many of these issues span beyond the arena of linguistic access, some may need to be addressed to improve the level of linguistic access available to LEP communities.

RECOMMENDATIONS

1 Large health care organizations that serve significant numbers of LEP clients from multiple LEP communities should conduct a self-assessment of their level of linguistic access and develop a plan to improve linguistic access.

Organizations that serve a wide range of language groups should conduct a self-assessment to determine the level and quality of language assistance services available to LEP clients from each language groups. The Summary of Best Practices in Linguistic Access to Health Care offers guidance and resources for individual organizations to use during assessment and planning phases. A review of census data, as well as

penetration rates can determine service gaps and needs for expanded services. A plan to improve access to care for a wider range of LEP communities and at more points of service should be developed by large healthcare organizations and programs.

2 Additional research is needed on the level of access available to LEP clients who speak Asian and Pacific Islander languages.

The study found that speakers of Tongan, Cantonese and Mandarin have lower levels of linguistic access than other groups. Recent immigrants and the uninsured also have low levels of linguistic access, especially in the northern region of the county. More information is needed on the proportion of the population that accesses care relative to the proportion represented in the general population for each of these groups (penetration rates). Additional information on the level of access available to recent Filipino immigrants and/or those who are LEP should also be collected to determine the extent to which they are served. Because of limitations in recruitment, researchers were unable to capture their perspectives and determine their level of access to care. Despite efforts to recruit LEP clients, most Filipino clients who participated were fluent in English.

3 Training and on-going monitoring should be implemented and/or expanded at an organizational level.

The study found that few organizations have a formal process for determining whether documents, programs, activities, or services need to be added, reduced, or modified to improve service to LEP clients. Organizations should establish on-going monitoring, performance measures, and evaluation activities to track their progress and identify evolving language assistance needs that accompany changes in demographics. Staff may need trainings to increase knowledge of linguistic barriers and to learn organizational policies and procedures. Systemic barriers to care should be addressed to improve the overall level of access for LEP communities.

KEY FINDINGS AND RECOMMENDATIONS: POLICIES ON THE PROVISION OF SERVICES TO LIMITED ENGLISH PROFICIENT CLIENTS

Policies can codify and reflect an organization's commitment to serving LEP clients and define on-the-ground practices related to language assistance. They are especially important to large health care organizations to ensure consistent provision of services over time. In the study, the researchers sought to determine the range of policies in place at health care organizations across the county. The study also examined the extent to which policies aligned with legal guidance from the Office of Civil Rights for health care organizations, as well as other recommendations from experts in linguistic access. Finally, the policy review also aimed to determine staff's knowledge of organizational policies, and how closely practice aligned with policy. In order to complete this assessment, researchers conducted structured interviews with program managers, a staff survey, and site observations. Written policies from a few participating organizations were also reviewed.

Key Finding #1: **Most organizations in the County lack written policies on the provision of services to LEP clients. Others are incomplete or require updating.**

In the review of policies the study found that most organizations and programs do not have formal, written policies on the provision of linguistically appropriate services to LEP clients. In interviews with program managers and the survey of staff, many reported that policies exist, but were unfamiliar with their contents. Within organizations or programs, there was little consistency in responses regarding the existence of policies and their provisions. For example, in a given program, three respondents of five interviewed indicated that policies did exist, and two said that they did not. Upon closer review, researchers found that the program lacked written policies.

Among those lacking policies, many had informal, unwritten policies and procedures related to language assistance services, though the study found that unwritten policies were implemented inconsistently. In the program manager and staff surveys, for example, a majority of respondents reported that LEP clients received written or oral notification of their right to interpreter services. However, written notification was only observed at one of six locations that researchers visited. Oral notification was not provided at any of those sites observed. The lack of formal policies and procedures can be a source of linguistic barriers. Clients may be turned away or not given appropriate language assistance services because procedures for securing such services are not in place.

Several organizations have policies on the provision of linguistically appropriate services to LEP clients or are in the process of creating them. During the course of this study, one large organization was in the process of updating its policies. Another had recently created comprehensive policies and procedures regarding interpreter services and translation. A health plan was in the process of sharing policy recommendations with providers in its contract provider network. Others, however, lacked key provisions regarding notification, training, and appropriate wait-time for an interpreter, as well as limitations on the use of family members, friends, and minors as interpreters.

Key Finding #2: **Policies, written or unwritten, are implemented inconsistently at many organizations.**

The study found that in many organizations, both written and unwritten policies are implemented inconsistently. This may be due to the lack of formal policies and procedures, inadequate training on those policies, or insufficient monitoring of language assistance services. An overwhelming majority of staff and program managers indicated that there was little oversight or monitoring of language assistance services. The use of family and friends as interpreters was one area where researchers heard inconsistent reports. While many staff and managers reported that their policy prohibited or limited this practice, in every focus group and site observation researchers heard that this practice was commonplace. At some site visits, researchers received disparate reports from staff members and managers regarding the use of family and friends to interpret. Some said that they were never used, whereas others disclosed that clients were told to return with their own interpreter. Even among those programs with up-to-date policies, client and community input, as well as the site observations revealed gaps between policy and practice.

RECOMMENDATIONS

1 Create or update policies on the provision of linguistically appropriate services, train staff on policies, and monitor their implementation.

It is critical that organizations or programs, regardless of size, that lack a policy on the provision of linguistically appropriate services undertake the creation of policies as soon as possible. Those organizations whose policies lack the key provisions outlined in the Summary of Best Practices in Linguistic Access to Health Care should update their policies to comply with legal mandates from the Office of Civil Rights and better reflect best practices in language assistance services. Upon creating or updating policies, staff members need to be given appropriate training and guidelines need to be established to monitor their implementation. Internal evaluation activities, such as standards of excellence in linguistic access, site observations, client focus groups, and a periodic review of services should be developed and implemented. All organizations, including those with up-to-date policies, should devote time to increasing staff's knowledge of language barriers, legal guidelines, and organizational policies and procedures on language assistance services.

KEY FINDINGS AND RECOMMENDATIONS: LANGUAGE ASSISTANCE SERVICES

Language assistance services refer to oral language services and translation, as well as any service or practice that facilitates client's linguistic access to health care services and programs. Oral language services include the use of bilingual staff and providers, as well as interpreter services to facilitate LEP client's access and use of health care services. Translation services refer to the provision of written materials in languages other than English. The study sought to determine the level, types, and quality of language assistance services available throughout the county. It also aimed to understand the extent to which practices aligned with legal guidance from the Office of Civil Rights for health care organizations and other recommendations from experts in linguistic access. In order to complete this assessment, researchers conducted structured interviews with program managers, a staff survey, client and community focus groups and interviews, and site observations. In addition to determining the overall availability and quality of services, researchers also sought to identify local practices and emerging efforts in the quest to provide linguistically appropriate care to LEP clients.

Key Finding #1: **While most language assistance services are delivered by bilingual staff, the study found shortages of bilingual pharmacists and licensed providers across the county.**

The study found that bilingual staff and providers are used to deliver language assistance services to LEP clients at most organizations in the county. As noted previously, most bilingual staff members speak Spanish and occupy administrative and support positions, followed by licensed provider positions. A few occupy management positions. The study found a need for additional bilingual pharmacists and providers across the county in most languages, including Spanish, Tagalog, Chinese, Tongan and Russian. A shortage of Spanish-speaking dieticians, pharmacists, mid-level practitioners, and doctors was also noted, with many health care organizations waiting months to fill a bilingual position.

Key Finding #2: **Family members and friends are frequently used to interpret during the medical visit.**

All data sources indicated that family and friends are frequently used to interpret during the medical visit at many health care organizations across the county. This practice was more evident at organizations serving speakers from a wide range of language groups or at larger organizations that offered multiple services and programs. While several managers were very aware of the problems associated with this

practice, many staff and managers reported that this practice was commonplace and were not aware of the potential issues associated with this approach. The reliance on family and friends to provide interpretation was especially high among Tongan, Chinese, and Russian clients and for many, limited their access to care. Many clients noted that bilingual family members tend to be employed and have limited availability to attend appointments during regular business hours. The study found that many clients delay seeking medical care until a family member or friend is available to interpret because they know that they will be unable to communicate with medical staff and providers. Delays in treatment can result in preventable medical complications and emergency room visits. Others reported that family and friends who perform interpretation are often LEP themselves and unable to provide adequate interpretation. The study found that when family and friends are used to interpret, LEP clients often leave the appointment with inadequate information on their diagnosis, treatment, medication, and/or the purpose of future appointments or referrals.

Key Finding #3: **Formal interpreter services are used infrequently at most health care organizations, though several organizations have developed new technologies and programs to expand the use and quality of interpreter services.**

The study found that organizations rely infrequently on interpreter services to meet the language needs of their clients. Many organizations rely solely on bilingual staff and providers to meet the needs of their primary language groups and family and friends for less commonly served languages. Others offer informal interpreter services, usually provided by bilingual staff from their own organization or borrowed from other agencies or programs. The study found that organizations that rely on bilingual administrative and support staff to interpret often lack procedures for obtaining an interpreter, as well as policies outlining the situations in which an interpreter is required. As a result, the use of an interpreter depends on the judgment of the individual provider, the availability of bilingual administrative and support staff, or the client's level of assertiveness. The program manager and staff surveys revealed that bilingual staff with informal interpretation and translation duties have not received adequate training in interpretation and may have difficulty leaving their regular duties to perform interpretation. Researchers found that a lack of policy and procedure regarding the role of bilingual staff means that interpretation is not sufficiently utilized in many settings.

The study found that even when procedures and services are reportedly in place, interpreter services are not used consistently for a variety of reasons. Clients noted provider and staff resistance to providing interpretation, long wait times, and inadequate interpretation. Staff and providers may not know the

procedures or feel that they have the time to arrange for an interpreter. If family and friends are readily available, they will be used instead of calling for an interpreter. If clients appear to speak adequate English, they may be told that an interpreter is unnecessary even though their level of comprehension of English may present a challenge. Monitoring efforts are not in place to ensure that interpreter services are used consistently at appropriate points of service.

A handful of organizations use in-person interpreter services, telephonic interpreter services, and other interpreter technologies. Several large health care organizations have implemented new technologies, such as remote video conferencing, interpreter trainings, and interpreter pools. One organization formed an interpreter pool of all its bilingual employees, created an interpreter phone book, provided interpreter trainings to bilingual employees and posted notices throughout their building highlighting the availability of interpreter services in almost twenty languages. While many clients reported inconsistent availability of interpreter services at large health care organizations, the benefits of these efforts were noted. Several clients had experienced the new technologies and were very satisfied with the results. In general, findings from the client and community input phase indicate higher client satisfaction with telephonic, remote video, and in-person interpreter services, than with services rendered by bilingual staff with other duties.

Key Finding #4: **Bilingual administrative and support staff play an important role in facilitating linguistic access to care and implementing key policies and procedures.**

While much of the research on linguistic access has focused on the importance of provider-client interactions during the medical visit, researchers also found that client interactions with bilingual administrative and support staff at reception, intake, and throughout the medical visit influence their level of linguistic access to care. Bilingual administrative and support staff are responsible for implementing key policies and procedures regarding linguistic access, such as securing an interpreter, providing interpretation, and offering notification of the right to free interpreter services. The majority of bilingual staff (especially Spanish and Tagalog speakers) occupy administrative or support positions, which means they are the first to identify a client as LEP during intake or when making an appointment. Researchers found that the quality of client-staff interactions can significantly impact the perception of a given health care organization within LEP communities, as well as the client's willingness to use services again. Bilingual administrative and support staff therefore play a crucial role in ensuring that LEP clients receive the language assistance services they need and must be considered as key players in reducing linguistic barriers to care.

In this study, researchers also found that the ability of bilingual administrative and support staff to deliver linguistically appropriate services was mixed. At several small clinics serving primarily Latino clients, the findings from site observations and client and community input indicated that bilingual staff facilitated linguistic access by taking a client-centered, rather than bureaucratic approach to their work. Staff members were friendly, personable and willing to accommodate clients. Clients commented on everyone's willingness to help and viewed these organizations as resources to their community. The study found that clear policies and procedures were in place for providing linguistically appropriate services to LEP clients at such sites. At other sites, administrative staff members were unfriendly and less flexible in their interactions with clients. Researchers heard several reports from Filipino, Latino, and Chinese clients indicating that some bilingual employees were unwilling to help them make an appointment, navigate the health care system, or accommodate an urgent care need in their language. Some clients reported that bilingual staff performed inadequate or hurried interpretations. In general, administrative and support staff members tended to rate their own level of linguistic and cultural competence more highly than clients and community members.

A confluence of factors is most likely responsible for differences between organizations in terms of the quality of interactions between staff and clients, including types of services provided, size, diversity of languages served, client volume, proportion of bilingual employees, competing job duties and responsibilities of bilingual staff, leadership, and the organization's level of cultural competence.

Key Finding #5: **A wide range of translated materials is available to Spanish speakers, but less frequently to speakers of other languages. Use of materials also varies by ethnic group.**

All data sources revealed that translated materials are widely available to Spanish speakers, indicating that health care organizations are providing an adequate level of translated materials in Spanish. Managers, staff and clients all reported sufficient availability of health education materials, benefit information, and for the most part, medication instructions in Spanish. Speakers of Tongan, Tagalog, Chinese and Russian all indicated that there were insufficient written materials available in their languages and wanted more written information in their language on insurance, medications, disease, and prevention. Some Latino clients, on the other hand, requested that information be shared through radio, TV, classes, and workshops.

At many sites, written signs, patient rights, and health education materials were available in Spanish and occasionally in Tagalog. However, written notification of a client's right to an interpreter was not observed in any language at most sites.

Key Finding #6: **Some translated materials were appropriate to the culture and literacy-level of the target audience, while many were not. Some organizations have implemented procedures to address the needs of low-literacy clients.**

Site observations and interviews with clients and program managers indicated that some translated materials were appropriate to clients' cultural background and literacy-level, while others were not. At one organization serving primarily Latino clients, the intake form was written in very simple, grammatically correct Spanish, in large print, with ample room to fill in answers. At other organizations, the translated forms were literal translations of the English versions, with certain items making little sense. Many health education materials were text heavy and contained images that may be deemed culturally inappropriate by some clients. For example, a sketch of a nude woman conducting a self-exam was included in a breast cancer prevention pamphlet in Spanish. Research has shown that nude images are taboo in many Latino cultures and that female clients may not read materials that contain such images. One pamphlet in Spanish on dental health was several pages long with paragraphs of text written in a small font, while another was a single page with single phrase tips written in large font. Research has also shown that LEP clients are more likely to read pamphlets if they include visual images, large font, and convey several concise messages, rather than long descriptions in medical jargon. The Summary of Best Practices in Linguistic Accesss includes additional guidance on translation services.

Clients reported that they were generally satisfied with most materials, but found certain materials difficult to read. Organizations have many sources of translated materials, suggesting that they sometimes do not control the content of the materials that they share with clients. Many rely extensively on bilingual staff to translate materials on an as-needed basis and occasionally on translation services. Training requirements and formal processes for completing translation were not in place at most organizations.

Despite these challenges, several organizations have implemented procedures to address the needs of low-literacy clients. Several large organizations use an oral, rather than written intake process. At others, front office staff routinely assists clients with the completion of forms. In one clinic, managers have worked to obtain medication instructions in Spanish with drawings and symbols instead of extensive written instructions.

RECOMMENDATIONS:

1 Assess, plan, and monitor organization's practice and policies related to Language Assistance Services.

Organizations should conduct an internal review of their practices and policies related to Language Assistance Services, create a plan to improve the quality and availability of services, and implement on-going monitoring activities. Organizations should determine their practices related to notification of the right to free interpreter services, the use of family and friends to provide interpretation, and provision of interpreter services, as outlined in the Summary of Best Practices in Linguistic Access to Healthcare. The study found that procedures for ensuring linguistically appropriate services to LEP clients, especially speakers of Asian and Pacific Islander languages, are lacking at many organizations. In general, there is little monitoring as to the consistency with which oral language services are provided or to the overall quality and availability of written materials. Organizations should develop such monitoring and quality improvement procedures. In regards to translation, organizations should develop procedures for completing translations and conduct a periodic review of translated materials to determine whether they are accurate and appropriate to the literacy-level and culture of the target audience.

Research has shown that organizations that integrate planning for language assistance services into their strategic and organization-wide planning efforts are most successful at implementing new practices and procedures. Experts in linguistic access caution that language assistance services may not be well integrated into existing services and programs when planning for them is conducted by an individual or separate program. Managers, staff and providers may view linguistic access as the coordinator's responsibility and not weigh such issues in their own planning and decision-making processes. While a coordinator of language assistance services to oversee such processes may be a useful addition to some organizations, steps must be taken to ensure that all members of an organization take responsibility for improving linguistic access and implementing new practices. Managers, providers, and staff need to participate in the planning process and should be afforded opportunities to learn new practices or additional duties. Organizations should develop procedures to monitor the quality and level of language assistance services and the consistency with which new policies and practices are implemented.

2 Expand interpreter services and availability of translated materials to a wider range of languages.

The study found that many LEP communities experience barriers to care because language assistance services are not consistently available to them. Organizations should determine the extent to which oral language services and translated materials are available to LEP clients from a range of language groups. Larger health care organizations, hospitals, and HMOs should insure that telephonic, remote video conferencing, or in-person interpretation options are available and consistently used at all points of service. By expanding interpreter services, organizations can significantly reduce the reliance on family and friends to provide interpretation and reduce language barriers associated with this practice. Tongan, Chinese, Tagalog, and Russian clients would also benefit from additional information in their language on benefits, medications, and prevention.

3 Provide training opportunities to increase knowledge of policies and procedures related to oral language services and awareness of linguistic barriers.

The study found that some staff and managers lack awareness of linguistic barriers and knowledge of policies and procedures related to oral language services. In many cases, this is due to the lack of formal policies and procedures. In addition to establishing such procedures, organizations should provide trainings on linguistic barriers to care and legal guidelines for health care organizations. Staff and managers should be provided with opportunities to learn procedures for ensuring adequate language assistance to all LEP clients. Some staff may need additional training on and monitoring of customer service skills and procedures for serving LEP clients.

4 Formalize role of bilingual staff members who perform interpretation and translation and provide appropriate training in these activities.

Organizations should formalize the role of bilingual staff members who provide interpretation and translation. The study found that informal arrangements with bilingual staff to provide language assistance services can reduce linguistic access to care. Organizations should continue to train bilingual staff in interpretation and consider offering bilingual staff courses in culturally and literacy-level appropriate translation and/or language courses. They should also ensure that job descriptions of bilingual employees include interpretation and translation responsibilities and that performance of these activities

is evaluated annually. Large organizations that share bilingual staff across agencies or programs should consider formalizing such arrangements by forming an interpreter pool, creating a directory, and providing interpreter trainings.

PROGRAM MANAGER AND STAKEHOLDER FEEDBACK ON FINDINGS AND RECOMMENDATIONS

The preliminary findings and recommendations of the study were shared with program managers and stakeholders to gain their input and help identify barriers to and strategies for improving linguistic access. Around 35 participants attended this meeting, in which researchers shared results, answered questions, and provided opportunities for feedback. Overall, participants strongly agreed with the findings and recommendations and felt that they accurately reflected their experience with and knowledge of linguistic access to health care. Many applauded the County for taking a proactive approach to addressing this important public health concern, noting that self-assessment is a necessary first step to reducing linguistic barriers. While a few participants had questions or wanted more information about a specific finding or recommendation, most felt that the study accurately portrayed the current level of linguistic access in the County. Participants noted several barriers to implementing the recommendations, including a lack of funds, difficulty recruiting bilingual staff from a wide range of language groups, and a lack of qualified trainers, as well as the need to address issues of cultural and linguistic competence simultaneously. Many participants were encouraged by the study, noting that there were many practical recommendations that health care organizations could begin implementing in the near future. The need for uniform and updated policies at large health care organizations was identified as a high priority next step. Others felt that human resources needed to be included in conversations about how to attract, train, and retain bilingual staff. Many echoed the need to professionalize the role of bilingual employees who perform translation and interpretation by providing them with appropriate training and support. Participants wanted to learn more about health care organizations with high levels of linguistic access and suggested interagency partnerships to work on expanding and improving language assistance services. Finally, participants felt that staff members from all levels and job types should participate in planning and training efforts to improve cultural and linguistic access.

CONCLUSIONS

Over 150 clients, residents and community leaders from immigrant communities and over 400 managers, providers and staff from county and community-based organizations and programs shared their perspectives and experiences in the Linguistic Access Study. Researchers found that linguistic access is generally higher for Spanish-speaking clients than for speakers of Asian and Pacific Islander languages. The study also found that many organizations lacked the capacity, policies, and procedures to meet the language needs of Asian and Pacific Islander clients. Language assistance services are more consistently available and used at small to mid-size healthcare organizations that serve primarily Latino or Filipino clients and at programs and organizations that provide primary care services. The study found that language assistance services are not sufficiently available when clients seek care from hospitals, emergency rooms, or specialists, though efforts to address these barriers were in place at several such organizations. Procedures to consistently deliver language assistance services to LEP clients were lacking at some organizations. Systemic barriers, such as a lack of insurance and long wait times, also compound linguistic barriers.

While researchers also found promising practices and models of excellence in linguistic access at several healthcare organizations in the county, they also identified several key areas on which to focus improvement efforts. Organizations need to improve the consistency with which language assistance services are provided, as well as their capacity to serve the language groups which represent smaller, but nonetheless significant segments of the LEP populations. While the work of improving linguistic access is an ongoing process, organizations can begin by conducting a self-assessment and developing a plan for action. The Summary of Best Practices in Linguistic Access offers many useful guidelines and recommendations for organizations working to enhance their level of linguistic competence. Organizations can also learn from local and national models of success and embark on the journey toward providing meaningful access to health care for all clients they serve.