San Mateo County Health Department

Linguistic Access Study: Summary of Model Programs & Promising Practices in Linguistic Access

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Summary of Best Practice Research

INTRODUCTION

Many local and statewide studies on the health of immigrant communities have shown that linguistic barriers contribute significantly to poor access, misdiagnosis, and health disparities among Limited English Proficient clients. In recent years, demographic shifts in immigrant populations, greater linguistic diversity among health plan members, lawsuits from the Office of Civil Rights, new state legislation, and recent findings from health disparities research have compelled many healthcare organizations to examine and address the level of access and quality of care available to Limited English Proficient clients. In many discussions on immigrant health, the issue of linguistic access has been identified by stakeholders as a primary barrier to improving the health of LEP clients. While many healthcare organizations are aware of the acute need to improve their level of linguistic access, they face a myriad of challenges, including ad-hoc policies and procedures on language assistance services, limited financial and human resources, and competing organizational priorities.

Despite these challenges, models of success exist in a wide range of healthcare organizations, from community-based clinics to public health departments in both rural and urban communities. A wealth of resources and publications documenting exemplary programs and practices in linguistic access is available from health policy organizations such as Diversity RX, The Commonwealth Fund, The California Endowment, The Health Law Program, and California Primary Care Associates, among many others. Publications and articles from these organizations and many others have been reviewed and summarized in this report. Because many excellent publications already exist for specific types of healthcare organizations seeking to improve their linguistic access, the scope of this report is broad, with the hope that the policies, practices, and guidelines outlined here will help healthcare organizations in San Mateo County better meet the language needs of their LEP clients.

This report addresses the following areas:

- **Reviews of guidelines from the Office of Civil Rights**
- **Policies on language assistance**
- **Translation**
- **Oral language services**
- **Program monitoring**

GUIDELINES FROM THE OFFICE OF CIVIL RIGHTS ON PROVIDING LANGUAGE SERVICES TO LEP INDIVIDUALS

WHY PROVIDE LANGUAGE ASSISTANCE SERVICES?

There are many benefits to providing language assistance services to LEP clients, including better health outcomes, higher patient satisfaction, fewer medical errors, and long term cost savings. The most powerful reason, however, is a legal and ethical one. Title VI of the Civil Rights Act and subsequent legislation mandate that federal fund recipients provide meaningful access to LEP clients seeking healthcare services. Failure to do so can mean lawsuits from LEP clients or the Office of Civil Rights and loss of funding. While the wording of the legislation allows a certain degree of flexibility, the message is clear—LEP individuals cannot be discriminated against on the basis of their linguistic background and are entitled to access to the same services as English-speaking clients.

A Note on Terminology

Translation refers to written materials only.

Interpretation refers to the oral process of converting a message in one language to another language.

Oral Language Services encompasses the use of resources such as bilingual employees and staff, as well as interpreter services.

THE OFFICE OF CIVIL RIGHTS GUIDELINES FOR HEALTHCARE ORGANIZATIONS

The Office of Civil Rights (OCR) issued guidelines to help health service organizations that receive federal funds comply with Title VI of the Civil Rights Act. These guidelines represent a framework for

organizations working to provide LEP clients with meaningful access to healthcare. With the hope that language assistance services reflect both community needs and individual organizational capacity, the OCR guidelines are both broad and flexible. The guidelines do not reflect additional legislation or obligations, but are intended instead to clarify existing ones.

The chart below outlines the legal requirements of Title VI and the recommended guidelines. Health care organizations have used these guidelines to fulfill the federal mandate through a wide range of policies and practices.

Note: Additional California state legislation applies to Medi-Cal health plans. See the Resource section, General Legal Guidance for more information.

PLANNING FOR LANGUAGE ASSISTANCE SERVICES

Organizations that engage in a formal assessment and planning process often experience a greater reduction in language barriers, than those who implement an ad-hoc or division-by-division approach. Many organizations integrate linguistic access into their planning efforts on cultural

THE LAW	RECOMMENDED GUIDELINES
Title VI mandates that recipients of federal funds provide LEP clients with meaningful access to healthcare. ✣ Title VI applies to all entities that receive federal funds. ✣ Organizations must provide free language assistance services to LEP clients. ✣ Recipients of federal funds cannot exclude or limit participation of LEP individuals. ✣ Failure to comply can result in loss of federal funding. *Source: www.lep.gov*	Health service organizations should: ✣ Assess the language needs of the population served ✣ Develop a comprehensive written LEP policy to address those needs ✣ Train staff on this policy ✣ Monitor compliance with this policy

competence or health disparities initiatives. A steering committee comprised of employees, stakeholders, community leaders, and clients may be convened to oversee the planning process. It is important to note, that organizations who successfully engage all employees in the planning process experience more significant and long-lasting changes. Many start by revisiting and revising their vision or mission to incorporate the goal of serving all clients, regardless of language or ethnic background. The next step is to identify high priority objectives for both the short and long term and appoint committees and/or sub-committees to oversee the implementation process. Community input from LEP communities and a review of best practices related to linguistic access should be integral parts of the priority-setting phase. As stated in the OCR guidance, organizations should include processes to both train staff on new practices and procedures and to monitor progress towards the goal of improved linguistic access. This may include an annual report, with opportunity for client and employee input, community meetings, and client and employee satisfaction surveys or focus groups.

Program Snapshot: Innovative Assessment and Planning at the County Level

In 2000, Contra Costa Health Services embarked on a planning process to reduce health disparities. Improved linguistic access was identified as a primary objective of this initiative. A Diversity Advisory Committee was formed and identified increased cultural and linguistic competence among Health Service employees as a top priority. The organization decided to use a cultural and linguistic competence self-assessment with all staff and employees. Led by a team of consultants, the county allocated time and resources to implement a multi-pronged approach, including:

1. Interviews and focus groups with clients, employees, and board members
2. A three-day Diversity Futures conferences to share the results of the assessment and attended by representatives from every division
3. A Walk of Silence to display and use self-assessment results
4. A process to elicit and use staff and senior management feedback in the strategic plan.

The county identified key objectives to reduce health disparities through a strategic planning process that involved staff, clients, and community members. In addition, the county has committed significant fiscal and human resources to this initiative.

POLICY

A clear and comprehensive written policy on serving Limited English Proficient clients prioritizes the goal of improved linguistic access within an organization and is often the first step in planning for language assistance services. If upon review organizations find that their policies are nonexistent or out-dated, the creation of such policies should be undertaken with urgency. There are many model policies available as a resource to hospitals, non-profit health plans, county agencies, and small family practices seeking to update or create new policies on serving LEP clients. (See the Resource Section at the end of this report.) The purpose of this section is to identify key areas to include in a policy on serving LEP clients.

POLICY RECOMMENDATION: ASSESSING THE LANGUAGE NEEDS IN THE SERVICE AREA

While many health care organizations have an informal sense of the language needs of non-English speaking clients in their community, the policy should outline procedures for identifying the language needs of LEP individuals. This information will be used to inform programming for language assistance services and help health care organizations comply with the state and federal legislation.

Use of Multiple Data Sources in Assessment: Organizations will need to analyze multiple sources of data to determine the percentage of individuals who are limited English proficient and not merely bilingual. Both user and population-level data should be reviewed, including:

- Census-level data
- Medi-Cal data
- Language line or telephonic interpreter usage data
- Internally generated user-level data
- Community informants

Because of the limitations of each of these data sources, it is important to use a variety of sources. While Census and Medi-Cal data are the primary population-level data sources, low penetration rates and a high number of invalid entries on the language item mean that some immigrant groups may be under-represented in the Medi-Cal data. In addition, the presence of small ethnic and linguistic enclaves often goes undetected in both data sources. Community informants from organizations and agencies with established relationships with immigrant communities may alert health care organizations to new demographic shifts and trends. When triangulated with other data, internally generated user data can reveal the level of penetration among Limited English Proficient communities.

Internal System to Track Language Background of all Clients: Few health care organizations have created procedures or systems to internally track the language background and abilities of their clients. As a result, clients, instead of health care organizations bear the brunt of securing language assistance. The creation of such information systems could go a long way towards ensuring that each client receives appropriate language assistance services, as well as informing quality improvement efforts. Procedures to collect data on ethnicity, primary language and level of proficiency in English of all clients should be outlined in the policy. The following recommendations should be included:

- Information should be collected via self-report and should follow the Census methodology of determining LEP status. The Census asks if the individual speaks a language other than English, then asks how well they speak English. If the response is other than "very well," the individual should be classified as Limited English Proficient. (See: **http://www.census.gov/prod/2003pubs/c2kbr-29.pdf** for Census questions on language ability.)

- Language background and ability should be recorded in the medical chart and stored in a system database. Some hospitals and clinics use color coding tabs on the medical chart to identify clients who need language assistance services.

POLICY RECOMMENDATION: RIGHT TO FREE INTERPRETER SERVICES

Federal fund recipients are required to provide free interpreter services to LEP clients. A commitment to fulfill this mandate should be outlined in the policy. As a corollary, organizations must also provide notification to LEP clients of this right. The policy should outline a variety of mechanisms in which notification may be given. Notification and availability of language assistance services should be provided at all points of entry and afforded to a client's representative or decision-maker in addition to the client, as necessary. Some ways of providing notification include:

- Signage in the primary language(s) of LEP clients in waiting rooms and/or exam rooms
- Translated forms, including applications, medical-intake forms, and health education materials
- Recorded greetings in the client's primary language
- Oral Notification by bilingual employees at reception or in the exam room

POLICY RECOMMENDATION: HEALTH CARE INTERPRETER GUIDELINES AND REQUIREMENTS

Many organizations have informal practices related to the provision of interpreter services, which can result in long wait times, inadequate interpretation, and over-reliance on interpreter services. The policy should offer guidelines for contracting with interpreters, including the acceptable methods of providing interpretation. The goal of building internal capacity through bilingual staff and in-house interpreters should be explicitly stated in the policy. The policy should outline the following:

- Types of acceptable interpreter arrangements, such as in-person contract interpreters, bilingual staff, and telephonic interpreting
- Certification, training, and language level assessment requirements for all bilingual staff and contractors who provide interpretation
- Prohibit the use of minors as interpreters during the medical visit
- Limit the use of family members as interpreters to emergency or non-medically related situations (such as reception)

- Outline interpreting options for rarely encountered languages
- Outline interpreting options for emergency or crisis situations, including a bilingual option on the crisis telephone line

Guidelines on Situations Requiring an Interpreter or Oral Language Services: In addition, the policy should outline the situations in which an interpreter or bilingual provider is required for LEP patients. Such situations include when obtaining consent, obtaining a medical history, providing medication instructions, and any other situations in which clear communication between provider and patient is deemed essential to the success of the visit.

Guidelines on an Acceptable Wait Time for an Interpreter: According to providers, unreasonable wait time is a primary barrier to the consistent use of interpreters during the medical visit. A commitment to reducing this barrier should be addressed in the policy, with a policy statement ensuring that clients and providers wait no more than 30 minutes for an interpreter. Because many organizations have contracts with telephonic interpreting services, this goal should be attainable. Many strategies for streamlining the logistics of working with an interpreter are also outlined in the Oral Language Services section.

POLICY RECOMMENDATION: TRANSLATION REQUIREMENTS AND GUIDELINES

The policy should outline the accreditation and certification requirements of those who provide written translation, as well as guidelines for determining which documents need to be translated into another language. The policy should specify the following:

- Language proficiency assessment through the human resources department or an external agency for all bilingual employees who provide translation
- A list of documents requiring translation
- Protocols for contracting with translators, including certification and training requirements
- Guidelines for complying with the Safe Harbor Limits on Written Translation (See next page)

Organizations may consider the adoption of **state-developed protocols** on translation. The California State Personnel Board and the Department of Health Services both have state adopted translation policies modeled after the Massachusetts Department of Public Health's policies, a model agency in serving LEP clients.

For model protocols, see: **www.spb.ca.gov/BILINGUAL/DOCUMENTS/transwrittendoc.pdf**

Safe Harbor Limits on Written Translation: Threshold and Concentration Languages:

The Office of Civil Right's guidance established the Safe Harbor limits for translation of written materials. Compliance with these guidelines represents a good faith effort to ensure linguistic access for LEP clients and could shield organizations from regulatory action from the OCR. The guidance states that organizations must identify the most frequently encountered languages in their service area, commonly referred to as the threshold and concentration languages. At a minimum, organizations should provide translation of written materials according to those guidelines, though many use this information to inform programming for

SAFE HARBOR LIMITS ON TRANSLATION OF WRITTEN MATERIALS			
LANGUAGE GROUP		GUIDELINES	EXAMPLES
Threshold	Each language group in the service area that constitutes 10% or 3,000 individuals, whichever is less.	✣ Written materials which are provided in English should be provided in the threshold language(s). ✣ Vital documents, important notices, and notification of right to language assistance services should be provided.	Client Instructions Consent forms Client rights and responsibilities Intake forms Health Education materials Medication instructions Signage
Concentration	Each LEP language group in the service area that constitutes 5% or 1,000 individuals, whichever is less	✣ Vital documents should be translated at a minimum and notification should be provided.	Consent forms Intake forms Medication Instructions Client instructions

Source: California Primary Care Association: Manual of Promising Practices

oral language services as well. The policy should include procedures for identifying the threshold and concentration languages and a requirement to comply with the OCR guidelines. (See the Translation section below for additional information.)

POLICY RECOMMENDATION: TRAINING EMPLOYEES ON SERVING LEP CLIENTS

Organizations that train staff on language assistance services and cultural and linguistic competence have better client satisfaction, as well as improved adherence to organizational policies. A commitment to training staff in the following areas should be outlined in the policy:

- Organizational policies on serving LEP clients.
- Legal requirements of Title VI of the Civil Rights Act and California legislation for state and local agencies
- How to access, use, and work with an interpreter
- Role of bilingual staff in translation and interpretation
- Cultural competence and cross-cultural communication with LEP clients

POLICY RECOMMENDATION: HUMAN RESOURCES

While there are many options for the provision of oral language services, the most desirable one for those with a large LEP clientele is to hire bilingual staff and providers. The policy should explicitly outline the priority of attracting and retaining bilingual providers and staff. Policies on recruitment, language testing, and pay differential for bilingual staff should also be included here.

The Role of Bilingual Staff: Many bilingual employees perform informal translation and interpretation, without appropriate training in these areas. Rarely are these duties included in the job description. The policy should formalize the role of bilingual staff by requiring that all translation and interpretation duties be included in their job descriptions. A commitment to provide appropriate training and time to fulfill these duties should be articulated as well.

POLICY RECOMMENDATION: PROGRAM MONITORING AND QUALITY IMPROVEMENT

In order for a language assistance program to be successful, organizations must implement systems that facilitate on-going planning and evaluation of programs and services. As outlined in the guidance from the Office of Civil Rights, organizations who adopt a system-wide, rather than ad-hoc approach to planning and evaluation have significantly reduced linguistic barriers to care. The policy should include the following:

- Identification of a point person, position, or committee responsible for coordinating and monitoring language assistance services.
- A range of procedures and practices for program monitoring, including an annual review, cost analysis, review of utilization and population-level data, client and provider satisfaction surveys and/or focus groups.

Assessing Need for Services: The policy should also outline procedures for determining the need for language assistance services in each program or service area.

The following criteria, drawn from the Office of Civil Right's guidance to health care organizations, should be used to make such determinations and included in the policy:

1. **Demographic Data:** Organizations should review this data and seek to provide language assistance services in languages that are most frequently spoken by LEP clients.

2. **Frequency of Encounter:** The higher the frequency of contact with LEP groups, the great the need for language assistance services. However, organizations should rule out low penetration rates in immigrant communities or other language barriers if a program or service has low utilization rates among LEP clients.

3. **Importance of Encounter:** The level of importance of the service or program being offered should be weighed when determining whether or not language assistance services are needed.

4. **Resources:** Organizations will want to know the language abilities of current

staff, available resources for language assistance services and cost of providing oral language services for a given service or program.

The results of each assessment can be used to inform hiring and programming efforts. For information see: **http://www.hhs.gov/ocr/lep/revisedlep.html**

Sources: "Providing Health Care to LEP Patients: A Manual of Promising Practices." California Primary Care Association. "Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency." Department of Health and Human Services. "Straight Talk: Model Hospital Policies and Procedures on Language Access," Safety Net Institute.

LANGUAGE ASSISTANCE SERVICES

Language assistance services include any mechanism which reduces language barriers and facilitates LEP client's access to health care. While language assistance has traditionally referred to translation and interpretation, signage, bilingual staff and employees, the availability of translated forms, proficient bilingual providers, and well qualified interpreters all affect the quality of the clinical encounter for the LEP client and should be considered as well. Leaders in serving LEP clients have noted that a holistic, rather than ad-hoc approach is more effectively reduces language barriers.

PROMISING PRACTICES IN TRANSLATION OF WRITTEN MATERIALS

While translation of written materials seems like the most straightforward component of a language assistance program, the quality of translated materials can sometimes prevent LEP clients from receiving adequate health care. Materials are often translated on an ad-hoc basis by bilingual staff whose written abilities in the target language have not been assessed. The written materials produced by translation services often fail to reflect the vernacular, dialect, and literacy level of the target audience. When materials are poorly translated, the original meaning may not be communicated, clients may complete forms inaccurately, and client education materials may go unread. Some health care organizations

have met these challenges by adopting more in-depth processes for translation so that the translated written materials consistently reflect the intended meaning, as well as the cultural, linguistic, and educational background of their LEP clients.

Policy on Translation: The first step to addressing ad-hoc translation of materials is to develop a comprehensive policy on the protocol for translating materials. The policy should include:

- A plan for translation of materials. Plan should include the identification of a person or position within the organization who is responsible for coordinating translation
- A method for identifying threshold and concentration languages
- A list of materials which require translation
- Credentialing or certification requirements of all translators
- Language-level assessment for bilingual staff who provide translations

Promising Practice: State and Local Standards for Translating Spanish Materials

In the last decade, the state of North Carolina has seen its Latino population increase by more than a third. In an effort to improve the quality of translated materials, the Department of Public Health developed standards for the translation of Spanish materials for local and state agencies. The importance of culturally appropriate and grammatically correct publications is clearly articulated in this guide. In addition, the publication is reader-friendly and accessible, with many useful examples and recommendations for improving the quality of written translation. The guide includes:

- Standards for creating culturally and literacy-level appropriate written materials in Spanish
- Steps for ensuring accurate and grammatically correct publications
- Guidelines for complying with state policies and legal mandates
- Tips on contracting with a translator, including a sample application and interview form

What to Translate: The OCR recommends the following guidelines:

- Organizations should translate most materials available in English into the threshold language(s) in their service area.
- Vital documents should be available in concentration languages and commonly encountered languages.

Use of Translators: While some health service agencies may have the internal capacity to translate materials, most contract with outside agencies. Unfortunately, no national or statewide standards exist for translators. Several organizations offer credentialing and certification for translators, including the American Translators Association and The Translators and Interpreters Guild. Diversity RX and the State of California Department of Personnel recommend that health service organizations follow these guidelines:

- Use a certified or credentialed translator with staff trained in medical translation.
- Use at least two translators to complete the translation
- Discuss the target audience and intended reading level with the translators.
- Incorporate back translation (i.e. retranslation of document into English by a separate translator) to ensure accurate communication of meaning.
- Pilot the translated forms with intended clientele in a structured focus group to ensure that meaning is well communicated. Use feedback to make revisions.

Culturally and Linguistically Competent Translation: Low literacy levels among some LEP clients can present an additional barrier to care, especially if materials are translated at an academic level. In addition to the recommendations above, Diversity RX suggests the following:

- If feasible, develop materials from scratch based on information from focus groups conducted in the native language of the target group. Cultural norms, dialects and vernacular terms are better reflected this way.
- Involve native speakers of the dialect of the target audience in the translation of materials. Incorporate cultural knowledge and norms into the materials.

- If the materials are translated directly from English to another language, literal translations should be avoided, with the level of detail and type of language reflective of the education and literacy backgrounds of the LEP client populations. In general, the reading level of translated materials should be at the fourth grade.

Source: Diversity RX: "Models and Practices: Written Materials in Other Languages." California State Personnel Board: "Recommendations and Resources for the Translation of Written Documents." Department of Health Services: "Translation of Written Informing Materials."

Program Snapshot: The Translation Room

One small community clinic serving a large number of Latino immigrants with low literacy levels noticed that intake and medical history forms were being completed inaccurately or left blank. A bilingual community worker was trained to help workers complete the forms. To minimize shame and protect privacy, the clinic instituted a "Translation Room" where the community worker helps clients fill out the forms.

Source: California Primary Care Association: Manual of Promising Practices

Program Snapshot: Introducing LEP Members to Healthcare Services

One non-profit HMO in Minnesota serving a large number of LEP clients with low literacy levels produced a video in multiple languages, with the purpose of orienting new members to the health plan. The video covers many topics that LEP clients may be unfamiliar with in regards to navigating managed care, including accessing care, medication, mental health, and preventive care. Peer educators facilitate groups where these videos are shown and help to answer any questions about managed care. In addition, many videos and tapes on health education and prevention have been produced as well.

Source: Lovelace Clinic Foundation: Providing Oral Linguistic Services: A Guide for Managed Care Plans

PROMISING PRACTICES IN ORAL LANGUAGE SERVICES

Oral language services include the use of bilingual staff and providers, as well as in-person and telephonic interpreters. They can be the most expensive and challenging component of a language assistance

program, as organizations contend with workforce shortages of bilingual staff and qualified interpreters. Insufficient or ad-hoc oral language services are often the source of misdiagnosis, incorrect treatment, and low penetration rates among LEP populations. In order to meet client needs, many health care organizations offer a range of oral language services. When developing or restructuring an oral language program, clinics and hospitals must carefully consider the needs of their LEP clients, as well as their own organizational capacity. The percentage of LEP clients in the service area, the human and fiscal resources available, and types of services provided all factor into the planning and programming of oral language services.

POLICIES ON ORAL LANGUAGE SERVICES

A well defined policy on the provision of oral language services is the first step to ensuring that a wide range of options are available to LEP clients. The policy should address the following areas:

- Identify a range of oral language services, including bilingual staff, in-person interpreters, and telephonic interpreters.
- Limit or prohibit use of minors and restrict the use of family members to emergencies or situations in which the client has declined an interpreter.
- Procedures for assessment of oral language ability. Delineate required certification/training of bilingual staff, providers, and interpreters.
- Address recruitment, training, and retention strategies for bilingual employees.
- Outline procedures for accessing and using an interpreter, including situations in which an interpreter is required and acceptable wait times.
- Require a bilingual option for crisis and emergency telephone lines.

TYPES OF ORAL LANGUAGE SERVICES

Organizations have several options in terms of providing oral language services to their clients. If organizations serve a large number of LEP clients, the use of bilingual providers and staff is the most desirable option, followed by in-person interpreters, and lastly, telephonic interpreters. Each of these options has its costs, benefits, and limitations. Most organizations use a combination of services to meet the language

needs of their LEP clients, including:

- **Bilingual Providers**
- **Bilingual Staff as Interpreters**
- **In-person Interpreter Services**
- **Telephonic Interpreters**
- **Family and Friends as Interpreters**

Bilingual Providers: The advantages of employing bilingual providers to provide oral language services are many, especially for clinics and programs serving high numbers of LEP clients. The clinical encounter is more seamless and the cost savings are significant. Though some smaller clinics require that all providers are bilingual, larger health care organizations face many challenges in attracting and retaining a significant number of bilingual providers, including:

- A workforce shortage of qualified, bilingual providers. Bilingual and bicultural candidates are under-represented in the health care field.
- Poor retention strategies- bilingual and bicultural staff may feel culturally alienated within the larger context of an organization, especially if a commitment to serving LEP clients hasn't been clearly articulated.
- Competition from other health care organizations for bilingual staff.
- No procedure for assessing language level of self-identified bilingual staff. Providers possess varying degrees of second language proficiency. Some have limited knowledge of medical terminology.
- Lack of cultural competence trainings for all employees.

Addressing the Workforce Shortage of Bilingual Providers: Despite these challenges, all health care organizations with an identified threshold language should make reasonable efforts to attract and retain a cadre of bilingual providers. With this goal in mind, many organizations have implemented the following strategies:

- **Partnerships:** organizations have partnered with medical and nursing schools to attract more bilingual and bicultural candidates to the health professions and have served as training sites for residencies and internships for nurses and doctors.

- **Assessment:** some organizations have implemented language proficiency testing to assess oral proficiency and knowledge of medical terminology.
- **Continuing Education:** for providers with a proficient level of second language competency, some organizations pay for courses in medical terminology. Others partner with universities to train bilingual entry-level employees as nurses or mid-level practitioners.
- **Mid-Level Practitioners:** organizations are increasingly hiring mid-level practitioners, such as nurse practitioners and physician assistants with bilingual abilities to provide direct care.
- **Trainings:** organizations have offered mandatory, all-staff cultural competence training to foster a more inclusive environment for bilingual and bicultural employees.
- **Financial Incentives:** many organizations offer a bilingual stipend, offered as an addition to the hourly rate or as a monthly stipend. Others offer a signing bonus for newly recruited staff.
- **Coordination:** some organizations implement scheduling systems to match LEP clients with bilingual providers.

Health plans may indicate language ability of providers in their plan directory so that LEP cients may better access bilingual providers.

Program Snapshot: Diversifying the Workforce

A non-profit HMO in Colorado is part of INROADS, a national program to encourage minorities to enter leadership positions in a variety of fields, including those in healthcare. The HMO employs students enrolled in pre-medicine, nursing, and administration during the summers while they are in college and helps them gain career skills. The program supports them in maintaining high academic standing, identifying career goals, and completing their education. The HMO hopes to employ them in the future.

Source: Providing Oral and Linguistic Services: A Guide for HMOs

Bilingual Staff: Bilingual staff (medical assistants, administrative support staff, etc.) can play an important role in the provision of effective oral language services, serving as outreach workers, patient navigators, or in-house interpreters. However, all too often, bilingual employees in many organizations find themselves serving as informal

interpreters, while juggling their regular job duties. Many health care organizations have begun to formalize the role of bilingual employees as interpreters, through new policies and trainings. In recent years, some have trained their bilingual staff as in-house interpreters or created new positions for them, resulting in significant fiscal savings and improved quality of care. Organizations have a couple of options for using bilingual employees to provide oral language services, including:

- **In-house Interpreters:** may be part--time or full-time employees whose sole responsibility is to provide interpretation. This is a more cost-effective measure than contracting with interpreter services if need is high.
- **Bilingual Employees with Interpreter Capacity:** the employee still maintains another position, such as outreach worker or patient navigator, but has time allocated to provide interpretation. This option can work if duties are clearly outlined and staff understands the role of this type of employee.

Important practices for working with bilingual staff include:

- **A clearly written job description,** with duties well outlined. This description should stipulate that bilingual staff may only serve as interpreters if they have received appropriate training or credentialing.
- **Language assessment** for bilingual staff providing interpretation. Individuals have varying levels of proficiency in a second language. Knowledge of medical terminology should be included, as it is is essential for those employees who provide medical interpretation.
- **Interpreter training** for all bilingual employees providing interpretation. Un-trained employees should not provide interpreter services. Training should address interpreting skills, medical terminology, and cross-cultural communication.
- **Whole staff training** on protocols and procedures for working with in-house interpreters.

Program Snapshot: Community Outreach Workers and Interpreters

In several clinics across the country, native speakers of target languages have been trained as outreach workers/interpreters by community organizations and/or community colleges. Such employees receive training in medical terminology, cross cultural communication, interpretation, and Western and non-western concepts in medicine. They may work half time doing outreach or health education and the other half providing interpretation during clinic appointments.
Source: California Primary Care Association: Manual of Promising Practices

Program Snapshot: Ensuring Competency among In-house Interpreters

Many hospitals and health plans, in an effort to cut costs and improve services have developed a corps of full or part-time employee interpreters. Many hospitals have used the Bridging the Gap curriculum to build the competency of their interpreters, providers, and administrators. Bridging the Gap was developed by the Cross Cultural Health Care Program (CCHCP) in Seattle, but has been used to train healthcare staff across the country in cultural competence and interpreting. The curriculum covers interpreting skills, the health care system, basic health concepts, culture, communication skills, and professional development. CCHCP has also developed a handbook for interpreters, with information about different cultural concepts of medicine, medical terms, and medications.
Source: The Commonwealth Fund: Providing Language Interpretation Services in Health Care Settings

CONTRACTING WITH INTERPRETER SERVICES

Ideally, organizations should strive to build the internal linguistic capacity of their staff. However, when bilingual providers and in-house interpreters are unable to meet the language needs of an organization, contract interpreters, be they from a language bank or community organization, are valuable resources. Telephonic interpreter services are another important option, serving as back up when in-person translation is unavailable or when serving clients who speak rare languages.

CHOOSING AN INTERPRETER

Ensuring high quality interpretation is a potential barrier to care. Organizations can choose from a variety of interpreter service arrangements including:

- **Free-lance interpreters:** interpreters who are usually self-employed and charge an hourly rate.
- **Interpreter services:** interpreters who work for a for-profit company. The company is usually responsible for training and verification of credentials.
- **Non-profit community organizations:** Interpreting services are offered at free, reduced or regular rates and coordinated through a non-profit language bank or other community organization. Such organizations can be of enormous benefit to large hospitals or health plans that encounter a wide range of languages.
- **Telephonic Interpreter Services:** Telephonic services are useful for rarely encountered languages, for large hospitals or health plans that serve clients from a wide range of language backgrounds, or for those facing a scarcity of bilingual providers and staff.

Organizations must weigh the costs and benefits of each of these different options, including the financial cost, level of additional support, interpreter capacity, and availability of interpreters. Organizations should also consider the following recommendations:

- **Plan:** develop a plan for interpreter services, which addresses projected needs, costs and logistical support. A review of utilization data from the past year can help organizations determine what types of services are appropriate.
- **Work with an Accredited Service:** Work with a contractor or language bank accredited by Language Line or CHIA.
- **Work with a Medical Interpreter:** Ensure that interpreters have a background in medical interpretation. Cross-cultural communication trainings are an added benefit.

The value of working with an interpreter service whose employees are trained in interpreting, as well as cultural responsiveness cannot be underestimated. The ability of an interpreter to understand, respect,

and communicate cross-cultural concepts of health is essential to the success of the medical visit.

STANDARDS FOR HEALTH CARE INTERPRETERS

This year, the National Council on Interpreting in Health Care (NCIHC) developed the first set of national standards for health care interpreters. In addition, the California Health care Interpreters Association (CHIA) recently created a set of standards on health care interpreting, which all of its member uphold. Clearly, familiarity and adherence to these standards should be the minimum criteria for selecting an interpreter service. The standards address the following areas:

- Confidentiality
- Impartiality
- Respect for individuals and their communities
- Professionalism and integrity
- Accuracy and completeness
- Cultural Responsiveness

For full description of CHIA standards see: ***http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_health care_interpreters.pdf)***

For NCIHC Standards, see: ***http://www.ncihc.org/NCIHC_PDF/National_Standards_of_Practice_for_Interpreters_in_Health_Care.pdf***

HOW TO MAKE INTERPRETER SERVICES WORK?

Health care organizations must carefully consider logistics and operations to ensure that an interpreter program runs smoothly and is well accessed. Studies show that even when interpreter services are available, they are often under-utilized because of lack of awareness, poor coordination, or long wait times. Organizations should consider the following recommendations to improve the quality and use of interpreter services.

Streamline the logistics: Interpreter service programs often run into logistical problems, which can discourage use and compromise quality.

- Health care organizations should implement systems to provide interpreter services at all points of contact for LEP clients.
- For non-emergency situations, administrative support staff should be respon-

sible for scheduling interpreters. Organizations may coordinate scheduling of appointments for LEP clients for select time slots when interpreters are available.

- Offer a variety of options for self-identification of language ability. Some health care organizations use "I Speak" cards in a number of languages for clients to choose from, which assists in arranging for an interpreter.
- Arrange for a variety of options for interpreter services. If in-person interpreters are unavailable, have a telephonic option for when an unexpected need arises. Telephones, instructions, and hands-free devices in the exam room can facilitate use.

Program Snapshot: New Technologies, Improved Interpreter Services

The state of Massachusetts has been at the forefront of providing effective language services in hospital settings, driven by statewide legislation focused on reducing linguistic barriers in healthcare. Hospitals across the state have added new technologies and services to streamline interpreter services. Some have computerized systems which allow for scheduling of provider and interpreter appointments simultaneously. Others have developed contracts with interpreter services and language banks to ensure that interpreters are available within 30 minutes of the request. A few programs have adopted remote simultaneous interpretation, a new technology using headsets, where interpretation is provided simultaneously to provider and client.

Source: Office of Minority Health, State of Massachusetts: Best Practice Recommendations for Hospital-Based Interpreter Services

Create Incentives: Organizations have increased usage of interpreter services through a variety of measures:

- Awareness campaigns and trainings on the legal requirements of Title VI
- A waiver requirement for LEP clients declining an interpreter
- Documentation of the use or decline of an interpreter on the medical record or in the system database.
- Financial incentives, such as stipends, for providers who use interpreters.

Program Snapshot: Provider Incentives

A non-profit health plan in California, serving a large number of LEP clients has implemented a stipend program for participating providers who contract with interpreters. It also pays for the cost of interpreter services. The health plan has a large number of providers in private practice. A provider survey revealed that very few offered oral language services, though they saw a large numbers of LEP clients. Most cited cost and logistics. The health plan works with a language bank and has implemented awareness campaigns among its providers to increase usage of interpreters.

Source: The Commonwealth Fund: Providing Language Interpretation Services in Health Care Settings: Examples from the Field

Provide Appropriate Training: Staff and providers need training on how to access and work effectively with interpreters. Ideally, training should be incorporated into pre-existing administrative structures or meetings. The areas to be addressed include:

- Organizational policies on serving LEP clients
- Health disparities research and the role of language barriers
- How to determine if an interpreter is needed during a clinical encounter. Share a list of situations in which an interpreter is required.
- How to access, arrange, and work effectively with an interpreter
- Role of bilingual staff in interpretation
- Cross-cultural communication and cultural competence training

FAMILY AND FRIENDS AS INTERPRETERS

Many LEP clients rely on family and friends to serve as interpreters. The Office of Civil Rights, however, strongly discourages this practice during clinical encounters. Family and friends have no formal training as interpreters, may have limited knowledge of medical terminology, and may provide incomplete interpretation. In addition, family dynamics may prevent a client from communicating sensitive information to their family member. Many complications can arise from the use of untrained interpreters, including uninformed consent, misdiagnosis, inappropriate treatment, and poor health outcomes. While some clients may insist on using their family and friends

as interpreters, organizations should use the following guidelines:

- Always inform clients of their right to receive free interpreter services and inform them of the importance of using a trained interpreter.
- Allow family or friends to be present during the visit if the client prefers this arrangement.
- Have clients sign a waiver if they choose to use a family member or friend.
- Make prior arrangements for an interpreter to be present during clinical encounter to ensure accuracy of interpretation.
- Maintain a policy prohibiting or limiting the use of minors to emergency situations.

By having other systems in place to provide oral language services, health care organizations can greatly reduce the reliance on family and friends as interpreters.

PROGRAM MONITORING AND QUALITY ASSURANCE FOR LANGUAGE ASSISTANCE SERVICES

A process for monitoring quality and evaluating effectiveness is an important piece of any language assistance program and is usually led by a committee or individual. An annual or bi-annual review should be part of routine operating procedures, with data collected across all programs on utilization rates, language backgrounds, use of interpreter services, and employee language abilities. Organizations will want to know:

- Client, Provider and Interpreter Satisfaction
- Effectiveness of Current Programming and Service Gaps
- Funding Language Assistance Services

Client, Provider and Interpreter Satisfaction: It is important to gather perspectives from clients, providers, bilingual staff, and interpreters when assessing language assistance services. What may work for providers may not work well for clients. It is useful to understand satisfaction levels

among interpreters as well, if they are used. Low levels of satisfaction, for example, may indicate the need for more provider trainings. Surveys and focus groups are useful ways of assessing the quality of language services from multiple perspectives.

Culturally Competent Evaluation:
Organizations should make efforts to incorporate qualitative methods into their evaluation plan. Research has shown that some cultural groups are reluctant to express negative opinions on a survey and that a focus group format elicits more honest opinions. In addition, the survey format has low levels of reliability among clients with low-literacy levels. In addition, hospitals and HMOs may consider developing a formal grievance process for LEP clients, which should be adequately publicized and frequently reviewed.

Assessment of Current Programming:
Programs will want to develop a process for determining whether documents, programs, activities, or services need to be added, reduced, or modified to improve service to LEP clients. When assessing the level of language assistance services or programs, organizations should consider the frequency of encounters with LEP clients, the importance or nature of the activity, staff training needs, and potential resources or partnerships to meet the need. Periodically, organizations should review census and utilization data and/or meet with community leaders to assess any demographic changes in the LEP population in the service area and to determine whether or not linguistic access has improved. If, for example, a review of census and utilization data shows a significant LEP population in the service area, but low penetration rates, an organization may need to address barriers to access more aggressively.

Program Snapshot: Community Needs Assessment

A community-health collaborative in Oakland wanted more information about the uninsured and under-served residents, especially immigrants in Alameda county. The collaborative conducted a randomized telephone survey in seven languages, including English, Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Dari. The results of the

survey will help inform estimates for statewide programs, guide countywide health priorities, and identify target groups for outreach efforts.
Source: California Primary Care Association: Manual of Promising Practices

FUNDING LANGUAGE ASSISTANCE SERVICES

A primary challenge for large healthcare organizations seeking to reduce language barriers is the cost of language assistance services, particularly the cost of interpreter services. The mandate of providing written and oral language services has been called an unfunded mandate by health care administrators and policy advocates alike. The cost of interpreter services can range anywhere from $25–$130 an hour, with many services, such as Language Line requiring a one hour minimum. Hospitals, health departments, and clinics often pay for these costs out of their operating budget or through public and private grants. Despite recent legislation in several states to reimburse providers and hospitals for the cost of interpreter services, the majority of health care organizations must still grapple with funding issues at an organizational level. Issues of funding have been addressed in a variety of ways, influenced in part by the individual organization's size and budget, as well as the language background(s) of LEP clients. While policy changes at the state and federal levels could significantly reduce funding barriers, at an organizational level there are few short-term solutions. Instead, organizations must focus on long-term, system-wide and cost-effective strategies to improve the level of access and quality of care available to non-English speaking clients. The following recommendations are based on the practices of health care organizations who have met this challenge:

Plan for Language Assistance Service:

Many experts in linguistic access to health care have noted that organizations experience greater financial costs when services and programs are designed without a consideration of the needs of LEP clients. Competing priorities, lack of time, and lack of awareness of linguistic barriers are often the source of ad-hoc practices, where expensive, short-term solutions are used to compensate for system deficiencies.

Extensive reliance on telephonic interpreting is one such example. Many hospitals and large healthcare organizations have used Language Line to meet the majority of oral language needs of their clients. Telephonic interpreting is very expensive and is considered by many experts in linguistic access to be best used as a back-up system for rarely encountered languages or emergency situations. When healthcare organizations engage in system-wide planning efforts for linguistic access, programming is often better informed, more coordinated across divisions, and better aligned with client needs and preferences. While the upfront costs of planning may require a commitment of funds and time, the long term benefits and cost savings of improving linguistic access have been well documented. When it comes to planning, organizations may engage in an independent linguistic access planning effort or integrate it with cultural competence planning, strategic planning, county planning or health disparities reduction initiatives.

Conduct a Cost Analysis: Programs looking to reduce funding barriers will want to assess the cost effectiveness of current language assistance services. A review of usage levels and costs of in-person and telephonic interpreter services can provide valuable information about the allocation of resources, especially when viewed in conjunction with population-level data. For example, if an organization spends a great deal on contract interpreters for services provided to speakers of their threshold language, they may want to consider alternatives. Hiring and training bilingual staff to provide interpretation is often more cost effective than working with a contract interpreter. In regards to translation, many libraries of translated materials exist, where documents are available at low or no cost. A centralized system to store and share documents can also result in fiscal savings. Organizations that strategize around maximizing their use of technology, community resources, and internal human resources can successfully reduce costs.

Build Internal Capacity: Small community-based clinics have modeled the benefits of building internal capacity to meet the language needs of non-English speaking clients for decades. Many small clinics

require that all staff are bilingual and undergo a language proficiency assessment prior to employment, resulting in a significant reduction or elimination of language barriers. Their ability to meet the language needs of their clients has elevated the level of client trust, as well as the overall health of the communities they serve. In recent years, larger organizations, such as Kaiser Permanente, have sought to emulate the model of the small community-based clinic, through clinics geared to the cultural and linguistic needs of specific ethnic communities (see below). Kaiser's Centers of Excellence represent a responsive, rather than reactive approach to meeting the cultural and linguistic needs of their non-English speaking members. Building internal capacity is holistic in nature, focusing on long-term strategies to meet client needs, rather than on short-term remedies. Hiring bilingual and bicultural staff is central to this type of effort, but not without initiatives to address the shortage of bilingual healthcare workers and the creation of programming that is culturally and linguistically responsive.

Program Snapshot: Kaiser Permanente's Centers of Excellence, Building Internal Capacity

Many large healthcare organizations located in urban areas face the challenge of serving members from a wide range of cultural and linguistic backgrounds. Kaiser's Institute for Culturally Competent Care, created to better address the needs of its diverse clientele, developed an innovative solution to this barrier. Building on the model of community-based clinics, which have a long tradition of providing culturally and linguistically competent care, Kaiser has developed six centers of culturally targeted care in communities across the country. In San Francisco, Kaiser's Center of Excellence focuses on the specific cultural, linguistic, and healthcare needs of Latino and Asian members. The Center is staffed by a multidisciplinary team of doctors, case managers, and health educators who are proficient in the languages and cultures of Latino and Asian clients. All staff receives training in cultural and linguistic competence. Providers receive a culturally specific provider handbook, in which they receive extensive training. The centers are currently being evaluated for

evidence of improved health outcomes and client satisfaction among the members they serve.
Source: "Kaiser Permanente's Centers of Excellence."
www.ckp.kp.org

Build Partnerships: Many healthcare organizations have developed cost-saving solutions by partnering with other health care organizations, colleges and universities, immigrant health advocacy organizations, and community-based organizations. Such efforts are often mutually beneficial and creatively solve funding barriers and build internal capacity. Partnerships between hospitals and colleges or universities have focused on addressing work-force shortages of licensed bilingual staff and qualified interpreters. In Southern California, one hospital worked with a state university to recruit bilingual and bicultural support staff to participate in nursing training programs. Another worked with admissions staff of nursing, dietician, and medical programs to strategize around recruiting and retaining bilingual and bicultural candidates for licensed medical professions. Other organizations have partnered with community colleges or national experts on cultural and linguistic competence to train bilingual staff as interpreters or to serve as pipelines for recruiting interpreters. Recently, hospitals have begun to form interpreter pools and implement new video technology to improve their capacity, cut costs, and provide more client and provider-friendly interpreter services.

Program Snapshot: Remote Video/Voice Medical Interpreter Bank Project San Joaquin General Hospital

Consortiums of hospitals in New York, Boston, and cities in the Midwest have formed interpreter pools with other hospitals in their communities, where each consortium pays, trains, and shares interpreters to meet the language needs of their clients. In Northern California a group of rural and urban hospitals have formed a healthcare interpreter network using remote video/voice medical interpreting technologies (RVVMI), instead of traditional telephonic interpreting. The RVVMI directs calls through a call center to an interpreter in a room equipped with video-conferencing technology. Interpreters can be located

at any network hospital and can provide health care interpreting within five minutes to any of the participating hospitals. Interpreters cover a wide range of languages and participate in an interpreter training course. The technology has been implemented at San Joaquin General Hospital and is being rolled out at other network hospitals this year, including the San Mateo County Medical Center. The benefits of the RVVMI project are many, including:

- Reduced wait time
- Improved client and provider satisfaction (through video-conferencing)
- Expanded capacity to handle multiple languages, including rarely encountered languages.
- Significant cost savings (interpreters are in-house healthcare interpreters and/or trained bilingual employees)
- Uniform standards for healthcare interpreting, training, pricing and governance.

Source: "The RVVMI Project" by Melinda Paras

Creating language assistance services that are responsive to the needs of non-English speaking clients takes planning, collaboration, and time, as well as a commitment of funds. Initiatives like the RVVMI were made possible through the collaboration of Northern California hospitals and through grants from federal agencies, counties and private foundations. While some organizations draw from their own operating budget, many have accessed external resources to finance their planning and programming efforts.

CONCLUSION

While the work of improving access to health care for LEP individuals can seem daunting, the costs of language assistance programs are offset by many long term gains- an overall reduction in unnecessary tests and procedures, more accurate medical diagnosis, appropriate levels of treatment, a reduction in health disparities, and better penetration rates among historically underserved communities. By conducting a self-assessment, developing a plan, and learning from the successes of others, organizations can embark on the journey toward providing meaningful access to health care for all clients they serve.

RESOURCES

HEALTH CARE ORGANIZATIONS:

The California Endowment: Funds programs and research on multicultural health and has produced many publications on linguistic access. Publications are available on its website. www.calendow.org

California Healthcare Interpreters Association: An interpreter's association in California with published standards for healthcare interpreters. Advocates for cultural and linguistic competence in healthcare. www.chia.ws

The Commonwealth Fund: Funds research on multicultural health, with many publications addressing issues of linguistic access and immigrant health. Publications are available online. www.cmwf.org

Diversity RX: An online resource with many articles on cultural competence, linguistic access and multicultural health. www.diversityrx.org

LEP.gov: An online resource sponsored by the federal government with planning tools and guidance on how to comply with Title VI of the Civil Rights Act. www.lep.gov

National Council on Interpreting in Healthcare: A national interpreter's association, which recently published the first national standards on medical interpreting. www.ncihc.org

National Health Law Program: A national program with many publications and articles on immigrant health and the legal requirements of Title VI of the Civil Rights Act. This organization also publishes a newsletter called NHelp, addressing these issues. www.healthlaw.org and www.nhelp.org

Office of Minority Health, State of California: The Office of Minority health maintains a list of many resources to help healthcare organizations improve their linguistic access, including planning guides and model policies. www.dhs.ca.gov/director/omh/html/language.htm

PLANNING RESOURCES:

General Legal Guidance

"Guidance on the Prohibition against National Origin Discrimination as it Affects Persons with Limited English Proficiency." Department of Health and Human Services.

"Health Care Providers' Language Assistance Responsibilities: Major Federal and California Requirements." UCSF Center for the Health Professions.

"Checklist for Developing a Limited English Proficiency (LEP) Plan." National Association of State Workforce Agencies.

TRANSLATION

"California State Personnel Board: Recommendations and Resources for the Translation of Written Documents." California State Personnel Board.

"Developing, Translating and Reviewing Spanish Materials: Recommended Standards for State and Local Agencies." Suzanna Aguirre Young, State of North Carolina, Department of Health and Human Services.

Community Clinics

"Providing Language Services in Small Health Care Provider Settings: Examples from the Field." The Commonwealth Fund.

"Providing Health Care to Limited English Proficient Patients: A Manual of Promising Practices." California Primary Care Assocaition.

Hospitals

"Best Practice Recommendations for Hospital-based Interpreter Services." Brunilda Torres, Office of Minority Health.

"Straight Talk: Model Hospital Policies and Procedures on Language Access." Melinda Paras, Safety Net Institute.

Health Plans and Managed Care

"Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and their Staff Members." California Academy of Family Physicians.

"Providing Oral Linguistic Services: A Guide for Managed Care Plans." by Kathryn Paez, Lovelace Clinic Foundation.

"Providing Language Interpretation Services in Health Care Settings: Examples from the Field." By Mara Youdelman and Jane Perkins, National Health Law Program.

"Limited English Proficient Enrollee's Access to Health Plan Grievance Systems." California Pan Ethnic Health Network.

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