



Improving Language Access in California Hospitals

A Report of the California Health Workforce Tracking Collaborative

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Highlights of Findings

Many California hospitals have recognized the value of providing linguistically appropriate care for their patients and are making strides in addressing the needs of their limited English proficient (LEP) patients. In late 2006 and early 2007, 30 leaders at 20 California hospitals were interviewed for their perspectives and thoughts on making health care available to every individual in a language he or she understands.

All 20 hospitals selected for this study had implemented programs designed to facilitate communications between health care providers and LEP patients. Hospitals generally used a combination of telephonic and face-to-face interpreter services to meet their patients' needs. In-person interpreters included:

- dedicated staff interpreters
- outside vendor or independent interpreters
- bilingual staff

In addition, several hospitals have implemented interpreter services by video.

Representatives from the selected hospitals spoke to the benefits and challenges – including relative costs – of the various modes of language services. A summary can be found on pages 6-7. Key to determining the combination of language services that best suits each hospital is being able to track patient needs, language service usage and costs. Respondents also addressed procedural issues, including adopting language access policies, collecting information about patient language needs,

establishing language access programs and assessing the impacts of such programs.

The individuals contacted for this study were generous in sharing the information they had and lessons learned about improving language access in California hospitals. At the same time, they were all very interested in finding out what others were doing and in building on successful models already in place elsewhere.

This issue brief is a step toward meeting that mutual interest in sharing perspectives, challenges, models and best practices.

Background

The period from early 2006 through mid-2007 witnessed an exponential increase in attention on improving access to health care services for LEP patients in the United States. A sampling of the developments – from academic research to legal requirements – includes the following:

- **Research** – Studies include a summary of the benefits of professional interpreters on communication, utilization, clinical outcomes, and satisfaction with care,ⁱ a national review of the challenges to and approaches taken by hospitals to provide care to linguistically diverse populations,ⁱⁱ and findings that language barriers increase risks to patient safety.ⁱⁱⁱ
- **Policy** – Policy making bodies, including The Joint Commission, which accredits the nation's hospitals and health organizations, and the California Office of the Patient Advocate, which informs consumers about their rights as HMO enrollees, have continued to develop and fine-tune their standards and reporting requirements regarding language assistance services.
- **Recommendations** – Findings from the research have led observers to call for

ongoing and improved efforts to provide language services. Areas worthy of particular attention include: the role of executive leadership; quality improvement; identifying need (including collecting and using data); workforce development and training; patient safety and provision of care; developing and using model programs and approaches; and engaging the community.^{iv}

- **Information** – Dozens of organizations, websites and publications now offer resources, models, and technical advice on writing hospital policies, collecting language information, and securing interpreters^v (see resources section on pages 15-16).
- **Laws and Regulations** – Building on a base of longstanding federal and state laws that assign responsibility to hospitals and health care providers for ensuring patients are offered care in a language they understand, “California continues to have more laws addressing language access in health settings than any other state.”^{vi}

A synthesis of these developments would highlight the realities that health care providers do not always speak languages their patients understand, that miscommunications are associated with risk of harm to patients, that many hospitals and providers are making efforts to improve language access programs, that challenges exist to such efforts, and that an increasing number of resources are available to health care providers seeking information and help in this arena.

To complement the wealth of information already available, the Health Workforce Tracking Collaborative undertook a study of select California hospitals’ efforts to improve language access for LEP patients. The study was designed to identify and interview representatives from a limited number of hospitals within the state that were identified prior to being interviewed as having made significant efforts to address the needs of their LEP patients. Staff conducted telephone interviews of Chief Executive Officers (CEOs), Chief Financial Officers (CFOs), and language services directors from these hospitals in late 2006 and early 2007. These key informants were queried on the non-English language services they provided, the

systems and institutional organization established to support those services, the costs associated with their language services, and any outcomes data regarding the impact of their interpreter and translation efforts.

2006-07 Key Language Access Publications

Divi, C., et al. (2007). **Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study.**

Hasnain-Wynia, R., et al. (2006). **Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey.**

Karliner, L.S., et al. (2007). **Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature.**

Roat, C.E. (2006). **Certification of Health Care Interpreters in the United States: A Primer, a Status Report and Considerations for National Certification.**

Wilson-Stonks, A., & Galvez, E. (2007). **Hospitals, Language, and Culture: A Snapshot of the Nation.**

Highlighted Legal Responsibilities

U.S. Title VI of the Civil Rights Act of 1964

Any program or activity (including hospitals and physicians) that receives federal funding (including payment for Medicare and Medicaid enrollees) must take reasonable steps to ensure meaningful access to their programs by persons with limited English proficiency.

California Health & Safety Code § 1259

California general acute care hospitals must provide language assistance services 24 hours a day for language groups that comprise 5% or more of the facility’s geographic service area or actual patient population.

What’s Being Done?

For this study, we intentionally focused on California hospitals that were known among their peers and policymakers to be making significant efforts to provide services in the languages of their patients. While not an exhaustive list, the 20 hospitals selected for this study were considered to be among those that were implementing ways to better meet the needs of their LEP patients. Table 1 below describes the basic characteristics of the selected hospitals. It is not surprising that all of them reported processes and activities in place designed to improve language access. The range of activities being pursued, however, and the extent to which they are being implemented, is quite broad. First we take a look at the services being offered; we subsequently shed some light on the processes and infrastructure hospitals have set up to handle language access activities.

Table 1: Characteristics of Interview Hospitals

Location	Northern CA			Southern CA		
	14			6		
Type	Non-Profit	City/County		District		
	12	7		1		
Teaching	Number of Teaching Hospitals					
	9					
Rural	Number of Rural Hospitals					
	1					
# of Beds	1-49	50-149	150-199	200-299	300-499	500+
	1	0	2	2	5	10

Activities & Services

Telephonic Interpreter Services

All of the hospitals in this study offered some form of interpreter services for their patients who needed it. The most common mode of interpreting for these hospitals was telephonic. Representatives from all of the hospitals that participated in this study reported that their LEP patients could have access to an interpreter by telephone, under contracts arranged between the hospital and one or more telephonic interpreting companies. Several vendors are doing business in California and most respondents estimated

approximately 100 languages being available. Some informants mentioned using multiple outside vendors to ensure they could have the coverage when needed. A couple of respondents also noted that this strategy helped to keep prices down because the services would compete with each other. One hospital reported having an on-call language bank that was staffed after hours with community members, staff from the interpreter services department, and other bilingual employees, which together offered coverage in 35 languages.

Telephonic services are relatively easy to use and generally meet patient and clinician needs in a timely manner. However, respondents noted the limited control they had over the quality of interpretation and continuity of interpreters over time. Costs can be reasonable if telephonic interpreter services are used for the relatively rare languages or emergency situations. On the other hand, telephonic interpreter costs can rise steeply if used too frequently to cover language needs that could more effectively be met with other options such as dedicated staff interpreters, bilingual clinicians, dual role bilingual staff, or networked video services.

Face-to-Face Scheduled or by Request

All of the hospitals reported that in-person interpreters could be available to patients on a scheduled or on-request basis, but the list of languages covered was often very limited and coverage was usually limited to business hours. Spanish was offered at all hospitals. Mandarin and Russian were offered at most. Vietnamese, Cambodian, Cantonese and Hmong could be found at approximately five or six hospitals. A few hospitals offered the following languages: Lao, Arabic, Farsi, French, Japanese, Korean, Urdu, Tgrinia, Amharic, and Ukrainian. In addition, Mien, Punjabi, Bosnian, Hindi, Pestu, Toya, Italian, Tagalog, Thai, Portuguese, and Eritrean could each be found at one hospital.

About six hospitals reported that they offered 24-hour face-to-face interpreters. Not surprisingly, the list of languages covered during this expanded time period was even more limited than those available during business hours. Spanish was offered at all of the hospitals reporting this coverage. Individual

hospitals also offered Mandarin, Vietnamese, Russian, or Hmong 24 hours a day.

In-person interpreters were provided through several mechanisms. About half of the hospitals interviewed reported having dedicated in-house interpreters on staff. Among these hospitals, the number of staff interpreters on payroll ranged from one to forty-six, with an approximately equal range of full-time equivalent budgeted positions. All but two hospitals reported using bilingual staff (ranging in number from less than 20 to 140) that either had “dual role” job descriptions or stepped in to interpret on an as-needed basis. Additional face-to-face interpreter services were secured through contracts with outside vendors, independent contract interpreters, or “on-call” employees who were part of a hospital’s call bank. While most hospitals reported that the language skills of their dedicated staff interpreters were assessed and certified in some way, only about half of the hospitals reported training, certifying or testing their bilingual staff in language competency and/or interpretation skills. A minority of the hospitals using bilingual staff as interpreters reported offering monetary premiums for interpreting; these premiums ranged from small amounts to significant bonuses. One hospital reported offering non-monetary rewards, such as food and movie vouchers for interpreting. Base salaries may or may not include recognition of bilingual skills.

Some hospitals’ policies included attention to the challenges of bilingual staff acting as interpreters. For example, if a priority ranking of language services has been stated, rarely if ever is bilingual staff listed as primary. One hospital specified that their bilingual staff complete a 40-hour training course but they are only to use their bilingual skills within their own department when necessary; they are not meant to “float” to other departments.

About five of the twenty hospitals interviewed noted that they employed bilingual clinicians. Policies varied as to whether such clinicians needed to pass competence testing before they could provide their own care in a targeted language without calling on a medical interpreter. Policies also varied as to where on a prioritized list of

interpreting modalities bilingual clinician services were located.

Many respondents reported using patients’ family members and friends to act as interpreters. Where policies had been written regarding language access services, family – particularly children – and friends were usually considered to be interpreters of last resort. However, patient preferences were also considered. It was generally acknowledged that, absent established policies in place, family members and friends were often relied upon by clinicians for interpreter needs.

Most participant hospitals noted the perceived superiority of face-to-face interpreter services relative to telephonic services. However, given the impossibly high costs of having “24/7” in-person interpreter coverage for all potentially needed languages, hospitals usually tried to strike a balance between the two. Critical information needed to determine the proper balance included good data on patient needs, service usage and reliable tracking mechanisms for costs associated with the services.

Many informants emphasized that the biggest challenge of using in-person interpreters was ensuring that they met patient and clinician needs without significant delays. Considerable time was spent traversing from one department, office or clinic to another on large hospital campuses or in waiting for clinicians or test results before interpretation could continue. “Down time” for contracted or vendor interpreters could be particularly expensive.

Video Interpreter Services

The recent introduction of video technology has changed the landscape for interpreter services at several California hospitals. More than half of the hospitals interviewed reported having participated in some testing of video interpreter services, five reported now using video interpreter services as a key component of their language access services (an additional two hospitals reported using video interpretation exclusively for American Sign Language interpretation at the time of the interviews) and several reported interest in bringing video interpreting technology to their sites in the future. Of the hospitals that are using video

interpreting technology, two are using internal systems and three are networked together within the Health Care Interpreter Network.^{vii}

With video interpretation, a video and sound monitor brings an interpreter's face and voice into the room where the clinician and patient are meeting. The interpreter may be down the hall, across the hospital campus, or – for networked systems – in another California hospital. Using a remote control device, the clinician accesses the virtual call center, which locates and connects an interpreter. If no available interpreter is located immediately, the system rolls the request over to a contracted telephonic service.

The hospitals involved in video interpretation report high satisfaction rates among clinicians and patients due to the significantly reduced wait times for interpreters. While some clinicians and patients still prefer in-person interpreters when available, all prefer the video system over telephonic only. Some even prefer it over all in-person interpreters because of a slightly increased level of privacy compared to having an interpreter in the room. To manage costs and coverage, hospitals usually hire a limited number of interpreters to be on staff for the most commonly demanded languages at that site and then rely on the networked interpreters for the other languages. Ongoing information technology maintenance costs are expected to be low. For networked systems, billing is based on usage of interpreters in the network less credits of a hospital's own interpreters used by others in the system. For many hospitals in queue to join the network, the costs of installing video systems are reportedly limited to minimal hardware purchases as the technology development costs have already been covered by research and piloting grants. However, some hospitals may find hardware costs significant and installation efforts, including working with existing technology systems and firewalls, challenging.

Several respondents expressed optimism about the increased productivity of interpreters using video technology. In addition, the languages and hours covered can be very broad when networked with other hospitals. The possibility of networking with

institutions in different time zones could dramatically increase coverage.

Translated Materials

Most of the hospitals contacted for this study reported offering translated written materials to their patients who spoke languages other than English. Usually, the list of languages in which translated materials was offered was very limited. Spanish was by far the most common; some hospitals also reported Chinese or one or two other languages. Hospitals reported various means by which translation was done. Sometimes such services were done in-house by staff who knew the target language. Other times, requests were sent to outside agents for translation. A few hospitals have translated some of their website pages into Spanish or other targeted languages depending on their patient demographics.

The table on the following pages summarizes the benefits and challenges of the various approaches to language services.

Table 2: Benefits and Challenges of Various Approaches to Language Services

Language Service	Benefits	Challenges
All Language Services	<ul style="list-style-type: none"> Improved quality of care Higher levels of safety Increased satisfaction rates among patients, clinicians and hospital staff 	<ul style="list-style-type: none"> Costs can be significant Difficult to match all patient needs with language service availability Clinicians and staff may not know benefits of language services or how to use them Assessing quality of language services can be challenging
Telephonic		
	<ul style="list-style-type: none"> Costs can be lower than for in-person interpreter services Costs can be easily tracked Quality and usage of this mode of interpretation is known and tested Wait time is minimal How-to-use training is minimal Number of languages covered is high Easy to access 	<ul style="list-style-type: none"> Physical presence of interpreter is lacking – possible loss of non-verbal cues and body language Limited hospital control over quality of interpretation Continuity of interpreters is limited Extra investment costs can include phone lines, dual handsets and speakerphone capability
In-Person		
All In-Person Language Services	<ul style="list-style-type: none"> Physical presence of interpreter - higher potential for non-verbal cues and body language to be captured Quality and usage of this mode of interpretation is known and tested 	<ul style="list-style-type: none"> Assessing language proficiency
Dedicated & Tested Staff Interpreters	<ul style="list-style-type: none"> Costs can be lower than using contract or vendor Costs can be easily tracked Quality of interpreters can be known Continuity of interpreters can be better ensured Institutional control over training, education and continued assessment Institutional authority over standards, policies, quality, and procedures 	<ul style="list-style-type: none"> Costs can be significant, particularly for 24-hour coverage, high demand or multiple languages Training needs for staff can be moderate to significant Coverage can be challenging for languages requiring less than 100% full-time equivalent staff position. Initial assessment and continued testing of interpreters needed Locating available interpreter more difficult than telephonic services; wait time can be significant
Contract or Vendor Interpreters	<ul style="list-style-type: none"> Costs can be lower than employing dedicated staff interpreters Costs can be controlled by negotiating with multiple vendors 	<ul style="list-style-type: none"> Costs including “down time” and mileage reimbursement can be high Limited hospital control over quality of interpretation

Language Service	Benefits	Challenges
	<ul style="list-style-type: none"> • Costs can be easily tracked • Language coverage can be expanded with multiple vendor contracts • Outsourcing simplifies testing needs 	<ul style="list-style-type: none"> • Continuity of interpreters is limited • Locating available interpreter more difficult than telephonic services; wait time can be significant • Training needs for staff can be moderate to significant
Bilingual Clinicians	<ul style="list-style-type: none"> • Additional costs limited to testing and training • More privacy without a third party • No wait time • Less chance for miscommunication 	<ul style="list-style-type: none"> • Costs might not be easy to track • Knowledge of medical terminology in requested language may be poor • Must assess language proficiency
Bilingual Staff (non-clinician)	<ul style="list-style-type: none"> • Costs can be lower than employing dedicated staff interpreters • Additional costs may be limited to testing, training, and premiums • Wait time is limited 	<ul style="list-style-type: none"> • Costs can be significant considering lost productivity in home department • Training clinical staff how to use may be moderate to significant • Knowledge of medical terminology in requested language may be poor • Must assess language proficiency
Friends and Family	<ul style="list-style-type: none"> • No costs • Physical presence of interpreter – Level of comfort and trust may improve compliance • No wait time 	<ul style="list-style-type: none"> • Knowledge of medical terminology in requested language may be poor • High risk of communication and medical errors, particularly with interpreters who are children • Issues being discussed may be inappropriate in front of some parties, particularly children • Possible interpreter bias • Training clinical staff how to use may be moderate to significant • Possible lack of proficiency in English and/or patient’s language
Video		
	<ul style="list-style-type: none"> • Costs can be low if networked • Higher potential to capture non-verbal cues and more personal than telephonic • Early positive feedback on quality and ease of use • Higher quality control & interpreter continuity than with contract services • Wait time is limited • Coverage of languages can be high • Mobile, non-intrusive equipment 	<ul style="list-style-type: none"> • Costs can be significant for initial investment of hardware & equipment • More impersonal than in-person • Training needs for staff can be moderate to significant • New mechanism has not been studied extensively for quality or safety • For networks, must develop contracts or join existing system

Process & Infrastructure

Four categories of process activities associated with language services were identified by study respondents: adopting policies, collecting information about patient language needs, establishing language access programs, and assessing the impacts of language access programs.

Adopting Policies

Some of the hospitals queried had adopted policies regarding their efforts to provide language-appropriate care to their patients. Most of these hospitals had at least some of their current policies under revision at the time we spoke with them. Others said that policies were being considered or that they felt the general hospital policies for safety and access to services already covered those patients who might require language services. The goals of such policies appear to try to clarify for clinicians and patients what types of language services are available and how they can be accessed. When more than one type of service is available, hospital policies often establish the priority order. For example, if available, in-person interpreters are often noted to be preferred to telephonic services. Policies might also note prohibitions. For example, some hospitals specifically state that clinicians should not attempt to communicate with their patients in languages other than English unless the clinicians have documented successfully passing hospital-approved examinations in the second language. Others specifically state that it is against hospital policy for patients' relatives, particularly minors, to interpret in cases other than emergency.

Collecting Language Needs Information

Most hospitals that participated in this study reported that information about patients' primary languages was collected at registration, reception, or intake. Most respondents indicated that identification of patients with limited English proficiency who needed interpreters was a combination of staff determining that the patient needed an interpreter and the patient asking for one.

All hospitals that reported collecting information about patient language needs also reported that the information was entered into databases that were accessible to clinicians treating the patient, including at future visits. Various computer programs were used to track the information. The information was also reportedly added to the patient's file or chart; some hospital representatives reported putting a special sticker or mark on the patient's chart indicating interpreter need. A few used wrist bands, particularly if the patient may undergo anesthesia.

Establishing Language Access Programs

All of the hospitals that were selected for this study had gone beyond the planning stages to enacting viable programs to provide language services to their LEP patients. Almost as varied as the range of languages and modes of language services found in California's hospitals, which are described above, was the range of organizational commitment and choices regarding authority and responsibility for language programs.

Every hospital that we talked to has an individual person who coordinates scheduling and delivery of interpreter services. Some of these individuals have job titles reflecting this coordination and focus exclusively on interpreter services, sometimes including education and staff training in addition to interpreter management. Others are in positions where interpreter coordination is only one of multiple job responsibilities, many of which stretch beyond interpreter services. Some of these individuals appear to drive the programs, almost single-handedly, while others are carrying out the designs of the executive administration.

Among this study's respondents, language and interpreter services could be found in a variety of departments (see list below). While managers of some of these departments directly reported to executive leadership (CEO, COO, Executive Director), others had several layers of management between the language services and executive administration.

- Customer Service

- Patient Relations
- Nursing Administration
- Government and Community Relations
- Social Services
- Quality Control
- Social Work & Diversity
- Ambulatory Services
- Interpreter Services Department
- Health Disparities

Despite not always having direct access to top hospital leadership, some of the language services administrators reported advocating for their programs to their supervisors or senior administration. About six non-CEO respondents indicated that this was an area their leadership was very aware of and very supportive of. Several of the CEOs interviewed reported that their own involvement and leadership in the area of language services were critical to the success of such programs. However, several non-CEOs reported their impression that while hospital leadership views interpreter services as important, other priorities come first and that hospital leadership is not necessarily committed to continuing or expanding services.

Most of the hospital representatives interviewed reported that language services were well integrated within their organizations. Several noted that such services are often pursued collectively with efforts to address cultural competence or health disparities and at least one participant explained that interpreter services are named as part of the hospital's strategic plan to increase cultural competency. Of the respondents who felt that language services were well-integrated throughout their respective hospitals, several noted that such integration had been evolving from earlier auxiliary departments and improving in recent years. A number of study participants commented on the current stability and low turnover rates in interpreter departments as indicative of strong integration with the larger institution. Respondents from at least three hospitals thought language services were specifically aligned with their organizational missions and at least a handful of hospitals thought

their language services would be expanded in the near future.

On the other hand, many of the program coordinators noted that competition for resources for language services continued to be a challenge. Several felt that language services were always under threat of being cut due to budget constraints. In particular, hospital plans to retrofit or expand facilities were specifically named as endeavors that appear to be taking focus and resources away from language service programs.

Assessing Impact and Outcomes

Hospitals were also queried on their efforts to track the impacts of their language services. Interviewers used prompts regarding clinical outcomes and satisfaction rates among patients and clinicians. No hospital reported in-house evaluations of language services having an impact on clinical outcomes although several individuals noted the presumed link between language concordance and service excellence or safety. About a third of the respondent hospitals reported that no evaluations of their language services had been conducted but several within this group mentioned that they would follow up on any complaints received. Another third of the respondent hospitals reported that no tracking of impacts or outcomes had been conducted but that plans were underway or they would like to collect such information. A final third of respondent hospitals reported conducting patient surveys (either general patient satisfaction surveys or surveys specific to interpreter services) and/or staff or clinician satisfaction surveys. One hospital reported conducting pre- and post-interpretation surveys as their video interpretation program was rolled out. One hospital reported contracting with an outside agency to conduct the surveys and that unfavorable response information is shared with departments to encourage better education of staff on how to use the interpreters.

Hospitals that had information on patient and clinician satisfaction did not share the data with the interviewers. However, from their perspective, there

was general consensus that the work they were doing was satisfactory to their patients although several noted room for improvement or expansion of their programs. Interestingly, even among the hospitals that did not conduct patient surveys, most respondents reported that their patients were satisfied with the services offered. At least some of this sense may be due to informal reports of gratefulness or appreciation shared by patients with the interpreters, who in turn shared the information with program directors. A handful of hospitals reported collecting quantitative data on interpreter utilization rates by language and wait times. Results from these data reports are often used for planning purposes and/or shared with staff to further educate and inform.

Costs

As part of the research, staff attempted to contact CFOs at the selected hospitals to ask them about the costs of language access services. Representatives from only about one-third of the 20 participating hospitals made financial information available and some of this was incomplete. However, based on this information, a few observations can be made.

Of the six hospitals for which we have relatively complete financial data, estimated total annual costs associated with language services (including contracts with telephonic vendors, video interpretation, salary premiums for bilingual (dual role) staff, salaries and benefits for dedicated staff interpreters, contracts with independent interpreters and interpreter vendors, and other associated administrative costs) ranged from less than \$100,000 to over \$3 million. As a percentage of overall hospital operating budgets, these amounts represented a range from 0.06% to 0.78%. For most of the hospitals in this limited sample, the vast majority of costs are associated with salaries and benefits of staff interpreters. Some hospitals spend considerable amounts of money on premiums for bilingual staff while others offer minimal or token signs of appreciation. Representatives from hospitals that are using video interpretation, particularly on a network plan, noted that they

believed their costs were considerably lower than what they would be spending if they were using staff interpreters and/or telephonic service rather than video interpretation to meet the needs of their patients. We note that these numbers should be viewed with caution as there was no attempt to audit reported costs or collect data on patients' language needs, utilization rates, wait times, or quality of the interpretation.

When asked about financial return on investment, none of the six hospitals reported having looked at or seen a financial return on the costs of providing interpreter services. Rather, respondents noted that anecdotal evidence can be persuasive, that language services is the right or proper thing to do, that providing such services is a part of the hospital's mission, that the hospital hopes to prevent lawsuits and increase LEP patient compliance and engagement in their own care, or that providing such services is about safety, patient satisfaction and quality of care.

None of the hospitals that we spoke to reported being able to secure reimbursement from a third party payer for interpreter costs. However, as noted elsewhere in this report, several hospitals reported having received grant funding to support aspects of language services. Several non-CFO respondents mentioned the sense that language services were an "unfunded mandate" that the hospitals were burdened with and that should be reimbursed by governmental or other sources.

Seen as both a way to initiate or develop language services and to defray some of the costs associated with medical interpreting, many hospitals had participated in pilot or demonstration programs often funded by foundation grants. Over half had participated in or considered participating in video interpretation projects. Most of these were for foreign language programs but some were for American Sign Language. Other projects included research (such as examining satisfaction and outcomes of trained versus untrained interpreters), education and testing (assessing cultural competence, training bilingual employees to serve in dual roles including interpreter, developing tools

to assess clinician linguistic proficiency) and equipment or information technology (setting up multi-language kiosks, buying dual handsets to facilitate telephonic interpretation). At least six hospitals reported not having participated in pilot or demonstration programs, although at least one reported having been denied grant funding to research how LEP patient outcomes compare with non-LEP patients.

How Efforts Began

Many of the study respondents commented on the impetus to begin or expand their language service programs. For some hospitals, interpreter services have been an integral component of care for decades due to patient demand or hospital mission. For others, the awareness of need and development of programs have evolved over time or very recently. More than once, awareness of patient need was spurred by a task force or committee organized to look at issues of patient racial and ethnic diversity, patient language preferences, or clinician cultural competence.

For some hospitals, a sentinel event, including a visit by The Joint Commission that emphasized compliance with new guidelines on language assistance services or legal action at another hospital triggered the implementation of interpreter services. For others, an unanticipated opportunity, such as an invitation from another hospital CEO to participate in the testing of video interpretation snowballed into sophisticated programs.

Respondents from several hospitals noted the positive role grants played in this arena. Although no hospital has been able to secure full funding or reimbursement for all language services, quite a few hospitals have used grant funds to test systems, improve the delivery of culturally appropriate care generally, or cover research and development costs of new technology.

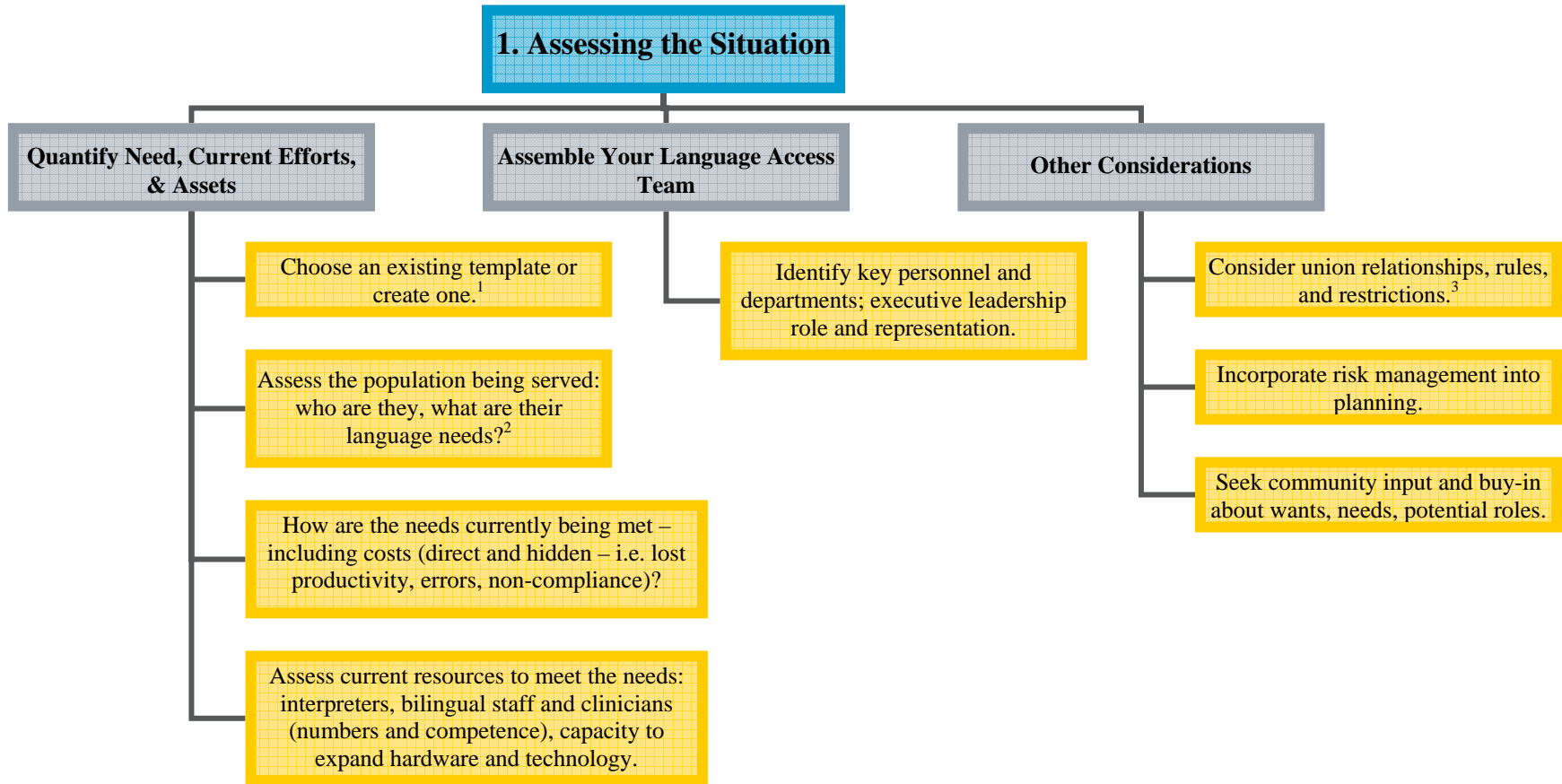
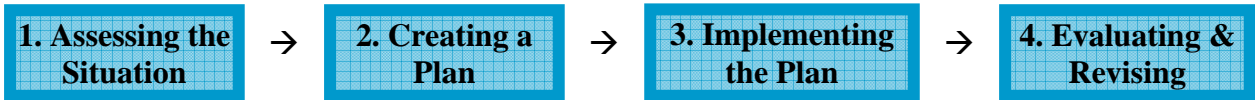
Finally, the majority of informants who commented on how language service programs began drew attention to the importance of leadership. CEOs or Vice Presidents were often named as individuals

who brought the question of language services to the forefront of hospital care by forging appropriate partnerships, authorizing needed funding, naming committees, creating departments and choosing effective individuals to direct language service programs. In addition, many of the departmental managers or coordinators of programs were applauded by their colleagues as the people who made things happen. Their strategic efforts covered many areas: budgets, staffing, testing interpreters, training clinicians how to work with interpreters, and developing useful policies and guidelines. Leadership within the executive suite or in another part of the hospital – someone with vision, the right network of people and resources, and the willingness to take that extra step – was critical to moving language access services from an auxiliary office to a fully respected and funded department capable of meeting the needs of LEP patients.

Putting it All Together: Steps to Take

The flow charts on the following pages illustrate the steps hospitals might take in considering and expanding language services for LEP patients. This four-part approach is a composite plan developed from analyses of the programs and recommendations of the study hospitals.

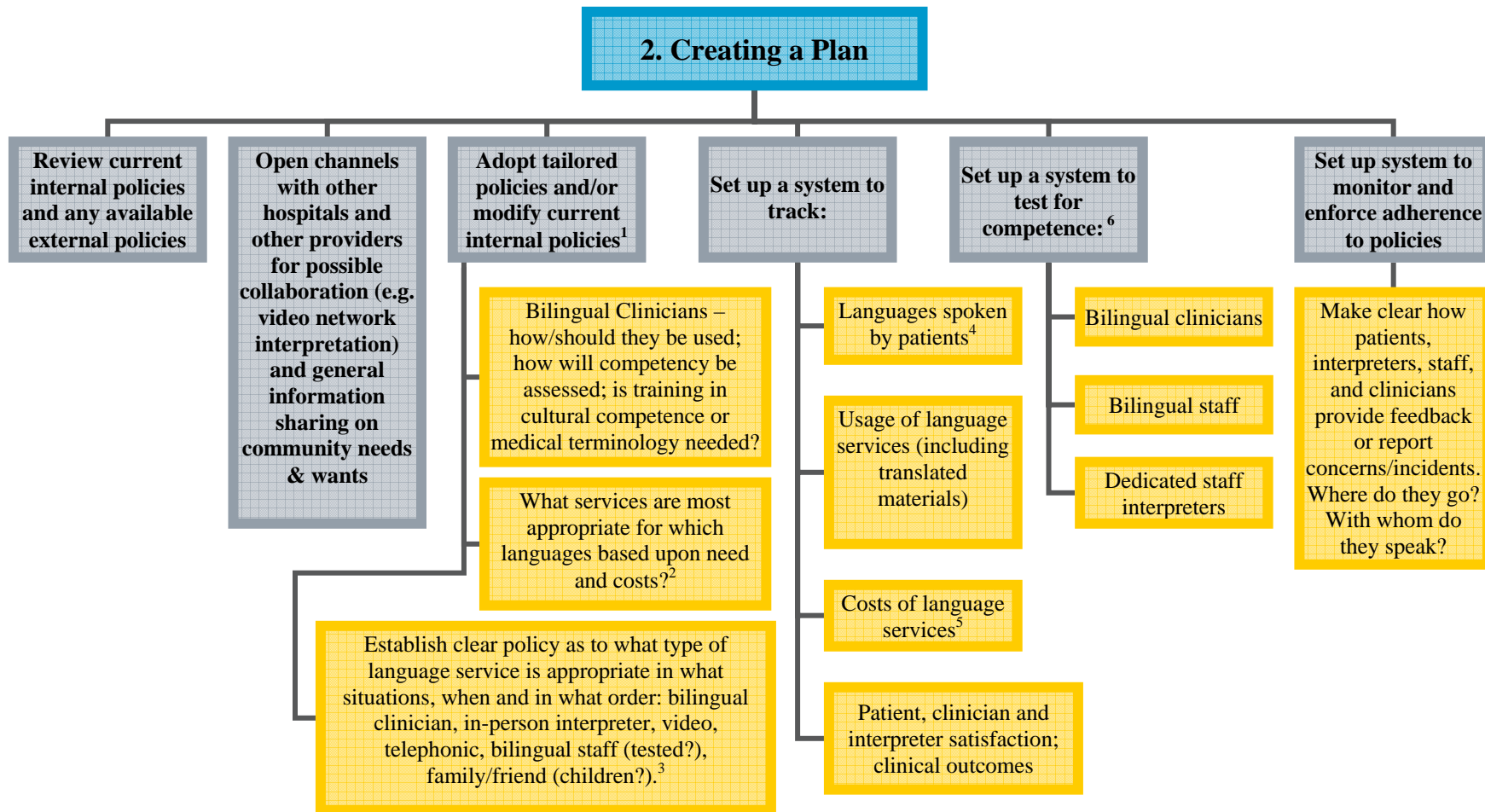
Putting it All Together: Steps to Take



¹ Several models and templates are available.^{viii}

² Data sources include U.S. Census and actual patient population.

³ Both dedicated/staff interpreter positions and increased utilization of dual role interpreters may require amendments to labor agreements.



¹ Consider existing model policies,^{ix} The Joint Commission requirements, as well as federal,^x state, and local laws.

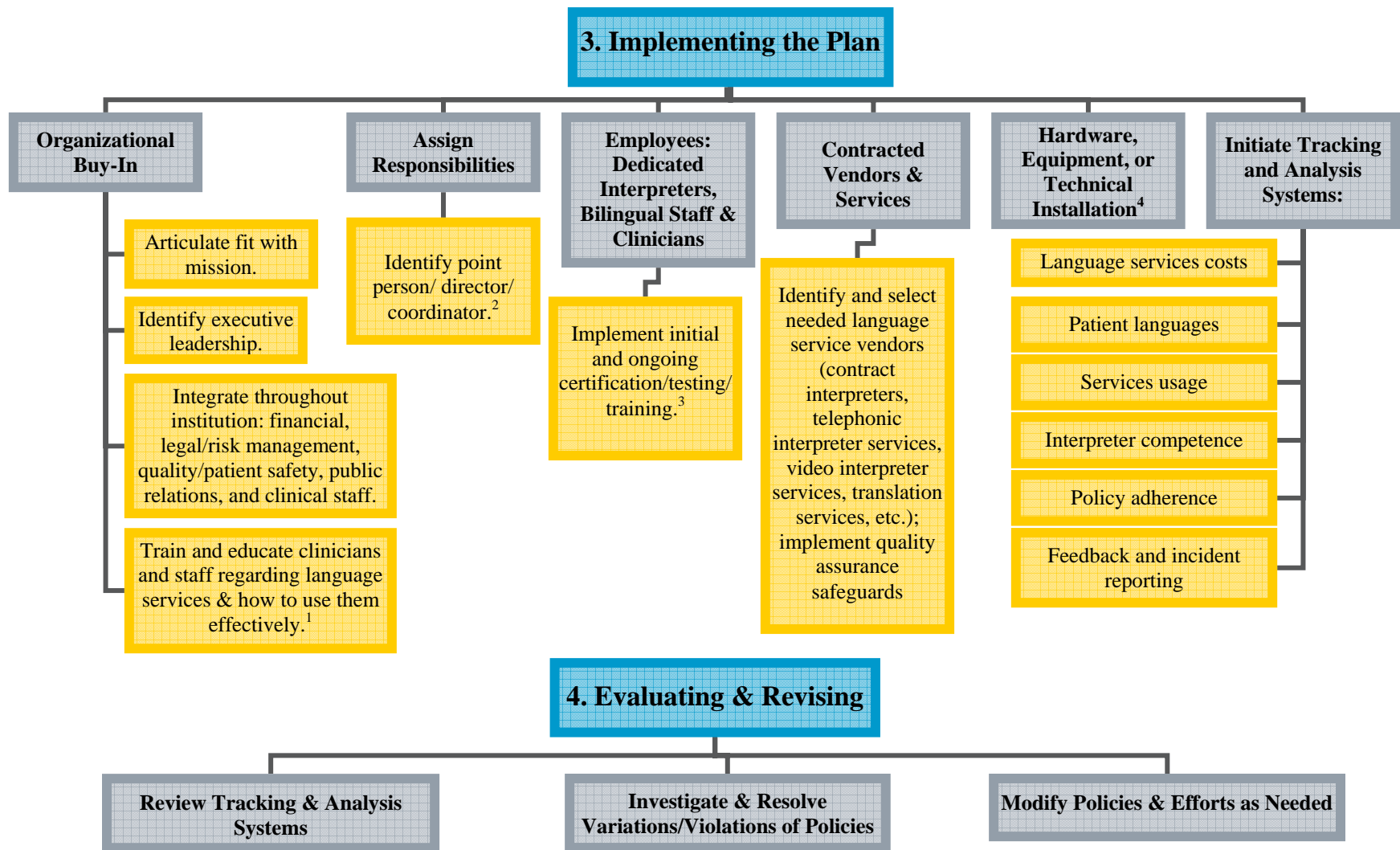
² Governing law may dictate decision making on factors, including costs.

³ With some exceptions, patient choice should be considered; the use of children interpreters is increasingly seen as inappropriate and highly risky.

⁴ See for example, Health Research & Educational Trust. A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients.^{xi}

⁵ Interpreters, premium pay, vendors, equipment, translations (including web site), staff testing/training/education, tracking & analysis (ROI, cost/benefit), signage.

⁶ Consider using published standards^{xii} to test for competence (including medical terminology, ethics, and how to serve as an interpreter).



¹ Consider using multiple opportunities to educate staff (e.g. staff meetings, grand rounds).

² This should be a person’s primary, if not sole, position, with meaningful access to executive leadership & other departments as needed.

³ Individuals may be designated competent at multiple fluency levels. Bilingual staff need to be clear on what role they are playing and when.

⁴ Consider secure wireless telephone services; software to bridge in-house video to telephonic services; online interpreter scheduling programs; and online patient language data collection and management systems.

Conclusion

This report offers a snapshot of some promising practices, policies and efforts that are being made at a number of California hospitals to improve the care being delivered to patients with limited English proficiency. Hospitals are generally finding the need to tailor language services to their patient population by offering a combination of language service options. Key to finding the right balance of options is having good information and data, an approach that is integrated throughout the institution, and dedicated leadership from the executive offices as well as from front line language program directors. Considerable work has been done in this area and the examples and information contained in this report are offered as models for others to integrate into their own institutions.

In the long run interpretive services must become an integrated part of the overall strategic direction of any hospital or care delivery unit as it delivers appropriate service to patients and customers. For this change to occur the executive leadership must recognize the value of these services in providing high quality, cost effective and consumer responsive care. Those responsible for the financing of the institutions must be able to see that programs that provide language access create a set of services that are cost effective in the aggregate. Clinicians of all types will need to recognize the contribution that these services make to patient care outcomes.

Those who lead language access efforts will need to articulately make the case for each of these key leadership constituencies if programs are to receive the necessary support and be successful.

Methodology

Project staff conducted 30 interviews. Individuals responsible for interpreter programs were interviewed at all sites; in addition, Chief Executive Officers (or equivalent) were interviewed at seven sites and financial information was gathered from six sites through interviews with Chief Financial Officers and others. All interviews were conducted

in accordance with UCSF Committee on Human Research standards.

Sites were selected based on published materials, online information or recommendations from key informants (including foundation representatives and hospital leaders) that policies, programs or services were in place at these sites to meet the needs of LEP patients.

Twenty institutions were included in the interviews. The majority of institutions were single setting acute-care hospitals. However, several hospitals had more than one campus and/or had affiliated ambulatory clinics that accessed interpreter services. Two institutions were hospital systems, each of which had two or more hospitals that relied on standard policies and services. Most of the institutions with which interviews were conducted were large (300+ beds), non-profit institutions in Northern California.

Resources

The following websites are a few examples of the many online resources available regarding language access. For more information, see:

<http://futurehealth.ucsf.edu/hwtc/languageaccess.html>.

General Resource Lists

California Healthcare Interpreting Association (CHIA): Links
<http://www.cms.chiaonline.org/content/view/21/76/>

California Health Care Safety Net Institute (SNI):
http://www.safetynetinstitute.org/programs/languageaccess_resources.html

Publication Lists

Robert Wood Johnson Foundation (RWJF):
<http://www.rwjf.org/pr/topic.jsp?topicid=1044>

The California Endowment (TCE):
http://www.calendow.org/Collection_Publications.aspx?coll_id=22&ItemID=312

Tools/Guides/Training

HHS Office of Minority Health (OMH): A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations

<http://www.omhrc.gov/templates/content.aspx?ID=4375&lvl=2&lvlID=107>

National Center for Cultural Competence (NCCC): Tools & Processes for Self-Assessment
<http://www11.georgetown.edu/research/gucchd/nccc/foundations/assessment.html>

Policies/Standards

California Healthcare Interpreting Association (CHIA):
California & National Standards for Healthcare Interpreters
<http://www.cms.chiaonline.org/content/view/42/100/>
California Safety Net Institute (SNI): Straight Talk: Model
Hospital Policies and Procedures on Language Access
<http://www.safetynetinstitute.org/publications/documents/StraightTalkFinal.pdf>

Regulations/Legislation

HHS Office of Minority Health (OMH):
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=14>
National Health Law Program (NHeLP):
<http://www.healthlaw.org/library.cfm?fa=detail&appView=folder&id=56882>

Data/Statistics

California Office of Multicultural Health (OMH):
<http://www.dhs.ca.gov/director/omh/html/publicat.htm>
HHS Office of Minority Health (OMH):
<http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=2>

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References

- ⁱ Karliner, L., Jacobs, E., Chen, A., & Mutha, S. (2007). Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Services Research*, 42(2), 727-754.
- ⁱⁱ Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, Language, and Culture: A Snapshot of the Nation*. The Joint Commission and The California Endowment.
- ⁱⁱⁱ Divi, C., Koss, R., Schmaltz, S., Loeb, J. (2007). Language proficiency and adverse events in US hospitals: a pilot study. *International J. for Quality in Health Care*. 19(2), 60-67.
- ^{iv} Hasnain-Wynia, R., Yonek, J., Pierce, D., Kang, R., Hedges Greising, C. (2006). *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*. Chicago, IL: Health Research and Educational Trust/AHA; Wilson-Stronks, A., *supra* note ii.
- ^v Roat, C.E. (2006). *Certification of Health Care Interpreters in the United States: A Primer, a Status Report and Considerations for National Certification*. The California Endowment.
- ^{vi} Perkins, J. (2006). *Summary of State Law Requirements Addressing Language Needs in Health Care*. National Health Law Program.
- ^{vii} Health Care Interpreter Network website: www.hcin.org.
- ^{viii} Paras, M. (2005). *Straight Talk: Model Hospital Policies and Procedures on Language Access*. California Health Care Safety Net Institute. Roat, C. E. (2005). *Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members*. California Academy of Family Physicians.
- ^{ix} *Ibid.*
- ^x See, for example, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. (2006). <http://www.hhs.gov/ocr/lep/revisedlep.html>
- ^{xi} Health Research & Educational Trust. *A Toolkit for Collecting Race, Ethnicity and Primary Language Information from Patients*. Retrieved February 18, 2005 from <http://www.hretdisparities.org/hretdisparities/html/makingthechange.html>.
- ^{xiii} U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services [CLAS] in Health Care. Final Report*. Washington, DC: DHHS; National Council on Interpreting in Health Care. (2005). *National Standards of Practice for Interpreters in Health Care*. Santa Rosa, CA; California Healthcare Interpreters Association. (2002). *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention*. Sacramento, CA.