

**Cross-Cultural Communication in Health Care:
Building Organizational Capacity**

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Introduction

[Broadcast opens with a dramatization. The scene is a health center examining room. The patient is seen by a nurse and physician. Neither recognizes that she does not speak English (she speaks Estonian). The scene ends with a frustrated patient who is given a prescription to treat an allergy when the reason for her visit is to get new eyeglasses.]

JOYCE ST. GEORGE: Serving the array of cultures within our communities can be daunting. We're a country that celebrates our differences. But as much as they enrich this country, cultural differences also bring challenges in, as you just observed, communication.

Health care agencies have pioneered ways to bridge differences to address community needs while strengthening services. They've learned that improved language access can provide opportunities, such as a larger customer base, increased quality care and patient satisfaction. But, as that scenario showed, difficulties with language can lead to miscommunication, misuse of resources and, at worse, medical errors.

Hello, and welcome to this broadcast on Cross-Cultural Communication in Health Care: Building Organizational Capacity. This broadcast is sponsored by HRSA, the Health Resources and Services Administration, Center for Health Services Financing and Managed Care, and the Department of Health and Human Services, Office of Minority Health, Office of Public Health and Science.

I'm Joyce St. George and I will be serving as moderator for the broadcast. With us today are: Shani Dowd, Director of Clinical Cultural Competency Training at Harvard Pilgrim Health Care; and Dr. Robert C. Like, Associate Professor and Director of the Center for Healthy Families and Cultural Diversity at the Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School. Also with us are experts with experience in promoting linguistic access and services in health care.

During this broadcast, we'll focus on specific interests of organizations just like yours. We'll discuss the rationale and need for language access and then focus on specific planning steps you can use to increase linguistic competence. Before we begin our presentation, we're pleased to hear from Dr. Elizabeth Duke, the Administrator of HRSA and Dr. Nathan Stinson, Deputy Assistant Secretary for the HHS Office of Minority Health.

ELIZABETH DUKE: Welcome to this broadcast on cross-cultural communication in health care. I am delighted that so many of you have taken the time to join us to learn more about this most important topic.

We are proud to bring you quality technical assistance programs like this one. Through the efforts of our Center for Health Services Financing and Managed Care, and in cooperation with the HHS Office of Minority Health, this broadcast is designed to help you reduce language barriers and improve access to vital health care services.

Why is there this focus on language? The answer is that there is increasing evidence that language plays a critical role in increasing access, improving quality, and reducing health care disparities for the diverse people we serve in communities across the country. This is especially so for the communication between the health care provider and the patient.

We know that you are all searching for ways to be more effective in communicating with patients who have varying language needs. And this program helps answer that challenge.

The broadcast faculty are not only clinicians and academic leaders in their fields. They are also managers - responsible for programs just like yours. From them, you will learn about some of the nation's best practices in developing culturally and linguistically appropriate programs that enhance clinical care and improve patient satisfaction. In the end, we hope you can adapt these real-world models to make a difference in your own organizations and communities.

Again, I thank you for joining us for this worthwhile learning experience. And now I'd like to welcome our partner, Dr. Nathan Stinson, Director of the HHS Office of Minority Health.

NATHAN STINSON: Thank you Dr. Duke and HRSA for spearheading this event and for inviting OMH to be a partner. I want to add my welcome and thank you for your dedication to serving the needs of culturally and linguistically diverse communities.

The mission of OMH is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs geared at eliminating health disparities. Today's effort is a priority of OMH and is directly in line with other initiatives to address cultural and linguistic competence such as the development of OMH's Center for Linguistic and Cultural Competence in Health Care. OMH recognizes that it is vital to:

- take an active role in addressing the health barriers and disparate health outcomes that result from inadequate attention to communication issues; and
- build organizational capacity and enhance the clinical skills of health care providers.

Forty-four million people in the U.S. speak a language other than English. Language diversity to this magnitude shows the need to break down cultural and language barriers that undeniably exist in regard to the provision of health care services.

I want to thank the faculty and experts for dedicating their time to this endeavor. The information to be conveyed during this broadcast will be useful and practical for the work that you all do in meeting the health care needs of diverse populations. Please enjoy the broadcast!

JOYCE ST. GEORGE: Thank you. We're fortunate to have Shani Dowd and Bob Like with us today. Shani is a nationally renowned trainer in cultural diversity, as well as an experienced clinician in a managed care setting. Bob Like is a practicing family physician and educator who's pioneered cultural and linguistic competence in the medical field.

SHANI DOWD: The growing number of individuals with limited English proficiency arriving at our doors can strain organizational resources, skills and even long-held beliefs about patient care. Managers confront these challenges daily, but are not always certain as to the effectiveness of their efforts.

Questions are constantly raised about the value of providing language services.

- What are the opportunities for agencies that provide language access?
- What are the potential pitfalls, best practices, and keys to success?

Think about the dramatization we just observed. How do you think the patient, the physician, and the nurse experienced that interaction, and what did that encounter say about the ability of that organization to provide quality care? These are just a few of the questions that we are going to address during this broadcast.

BOB LIKE: We developed this broadcast to be realistic. As the opening illustrated, dramas and video clips will be woven throughout the presentation to show real-world implications and recommendations. We'll give you specific resources and practical tips, and additional information will be available on the web site, www.hrsa.gov/financeMC/broadcast.

We understand that it's impossible to address issues around linguistic access without taking into consideration cross-cultural variations. Building effective language programs must be embedded in a broader vision and effort, which requires the organization to increase its knowledge and to respond effectively to a range of cultures. Culture will be referred to in this broadcast, but due to time constraints, we are focusing primarily on language and its implications for health care.

Rationale for Linguistic Services

JOYCE ST. GEORGE: Shani and Bob, can you tell us why linguistic access and services are so essential today?

SHANI DOWD: During the past two decades, national studies have revealed alarming trends of racial and ethnic disparities in care, treatment and prevention services. These disparities have costs, both in lives and in dollars. Our increasing recognition of these issues has stimulated interest in developing more culturally and linguistically appropriate services.

Also during this time period, immigration patterns shifted. America opened its borders to people from Southeast Asia, Korea, Hong Kong, the Indian sub-continent, Eastern Europe, and the former Soviet republics. There also has been a large influx of Central Americans. Besides immigrants, refugees fled war-torn areas in numbers not seen in this country since the arrival of Holocaust survivors. And unlike previous groups of ethnic immigrants who settled primarily in

urban areas, many new immigrants are creating their own communities in suburban and rural areas.

But this is a country founded by Native peoples and by immigrants, and an abundance of languages have always been spoken here. According to the 2000 Census, the most common foreign languages spoken in the U.S. are: Spanish, Chinese, French, German, Tagalog, Italian, and Vietnamese. [Slide # 2] The number of Spanish speaking people, such as those from Mexico, Central and South America, and the Caribbean is greater than all other language groups combined.

BOB LIKE: Most of us learned English as a primary language. For others, it became an adopted language. But, millions of Americans are not proficient in English, and more than 10% of the population in each of 5 states - California, New York, Texas, New Mexico, and Hawaii - have limited English skills.

Less than adequate functional literacy is also a concern. The 1992 National Assessment of Adult Literacy Survey found that 21% of adult Americans perform at the lowest skill level of English language proficiency.

It's against this backdrop that health care organizations function daily. To the extent that we fail to address language barriers and assist communication between patients and clinicians, language mismatches will continue to be fertile sources of racial and ethnic disparities in care.

This is why language access is so important. It allows the provider to construct an accurate medical and social history and assess the patient's beliefs about health and illness. And, language is an important tool for clinicians to establish an empathic connection and reach agreement with patients on treatment decisions and prescribed courses of action.

The failure to communicate effectively may result in misunderstandings of patients' concerns, misdiagnosis, or unnecessary testing. It can also result in poor patient satisfaction and misunderstanding of medical instructions. Studies indicate that a physician who understands the language of patients produces better patient self-reported physical functioning, psychological well-being, health perceptions, and less pain. [Slide 3]

Many organizations don't connect language access to quality, but experienced interpreters know that quality care involves more than words. Listen to an interpreter speak to this point from the training video, "Community Voices." [Community Voices video- Language/Interpretation section. Isabel Pontifranco telling the story about a daughter and mother at a clinic. The daughter was interpreting for the mother until Isabel arrived. "The story that the doctor got from me was different from the daughter. Details, medications got lost in the translation."] As this example shows, errors in medical interpretation can have significant clinical consequences. In fact, a recent study revealed that untrained interpreters:

- omitted questions about drug allergies;
- omitted instructions on the dose, frequency, and duration of antibiotics and rehydration fluids;

- and instructed a mother not to answer personal questions. [Slide # 4]

Accurate interpretation can contribute to clinical quality by reducing medical errors and increasing patient safety. It can also increase patient compliance and satisfaction, and improve primary care utilization. [Slide # 5]

JOYCE ST. GEORGE: There are convincing business reasons as well. Kelvin Quan is the Chief Financial Officer of the Alameda Alliance for Health in California, a managed care plan. The Alliance is nationally recognized for its efforts to increase language access and services in health care. Kelvin, would you talk about the business case for linguistic competence?

KELVIN QUAN: The Alameda Alliance for Health has been heavily vested in culturally and linguistically competent care from our origins in 1996. Initially the reasons were two-fold. One, there were minimum standards required by our State contract for our Medicaid population. And two, our membership was clearly diverse. 90% came from minority communities and 45% of our members spoke a primary language that was not English. [Slide # 6]

As time passed, our commitment and activities expanded and matured. The relationship between the commitment and the business case for it became kind of a chicken and egg relationship. Sometimes we did things even before we had a business reason and sometimes we had a business reason first. Sometimes, they were concurrent.

There was a really helpful article written by Roger Martin in the March 2002 issue of the Harvard Business Review, in which he presented what he called the Virtue Matrix. [Slide # 7] This is a model for how corporations generally decide to fulfill their corporate responsibilities to contribute to a greater societal role in areas such as worker safety, protecting the environment, and supporting philanthropic causes. I submit here that the promotion of cultural competency and language access can be readily added to the list.

The Virtue Matrix is made up of four quadrants. Let's begin with the two lower ones called "civil foundation" - it's the accumulation of customs, norms, laws and regulations. The lower left quadrant is "Choice". A health plan or a doctor could choose to promote, support and invest in language access because it's the industry norm. Unfortunately, that's not the case today and it's a large part of why we have this satellite broadcast.

The next quadrant, in the lower right, is labeled "Compliance." Perhaps the most discussion in language access focuses on laws, regulations and, occasionally, contracts, which require that a health care organization or provider provide language access. There are problems with this approach. In many ways, the promotion of language access through Compliance can be a race to the bottom in which the players seek to do the minimum, if that. Still, for many providers or payers, Compliance is the most effective way to initiate change and to establish at least a minimum definition of language access.

The top two quadrants are the "frontier" which encompasses activities which have intrinsic value that translates into profit, or owner equity. The top right quadrant is called "Structural" and speaks to "Social Justice" or "Public Interest". One may typically find such commitment in an organization's mission statement, or embedded in a doctor's Hippocratic Oath or personal values. As a public agency, this is certainly a strong motivation for the Alliance in serving the public good.

The last quadrant in the upper left hand corner is called "Strategic", because the motivation here is that language access can provide an inherent value to the organization or the doctor. This quadrant encompasses all the work being done in cost-benefit analyses and evidence-based studies to prove that language access can improve the value of the hospital or HMO and the profit-making ability of the doctor or clinic.

Organizations are learning that linguistic competence can help: increase market share, maximize retention rates, avoid or reduce costs related to medical errors, heighten primary and preventive care, improve patient satisfaction and adherence to treatment. It also helps to decrease unnecessary emergency room use, admissions, and diagnostic testing. [Slide # 8 and # 9] While this is exciting work to tackle, the health care industry - as a whole - is still in the mindset of "Prove it, before I invest in it, before I support it."

Taking all four quadrants as a whole, many organizations and doctors are still trying to find their way to a business case for language access. At the Alliance, we've found strong reasons to promote language access. In the context of the Virtue Matrix - It's the law. It's for public interest and for social justice. It improves quality that may lead to lower costs, better utilization. But most important of all, language access is better for the patient. It's the right thing to do and hopefully, one day, it will become the norm, the expectation.

JOYCE ST. GEORGE: Thank you, Kelvin. Let's focus for a few minutes on legal issues. I'd like to introduce Deanna Jang, Senior Civil Rights Analyst for the Office for Civil Rights, US Department of Health and Human Services. Deanna, can you help us?

DEEANA JANG: Federal requirements come from Title Six of the Civil Rights Act of 1964 which prohibits discrimination based on race, color or national origin. The HHS regulations implementing Title VI require recipients of federal financial assistance to provide meaningful access to their programs, services and activities for persons with limited English proficiency or LEP persons. Individuals who don't speak English as their primary language, and who have a limited ability to read, write, speak, or understand English, may be limited English proficient or "LEP."

The Department of Justice published its Final Guidance regarding this obligation in June 2002 and directed all agencies providing federal financial assistance to review their Title VI LEP policy guidances in light of the DOJ Final guidance. The purpose of this guidance is to assist recipients in fulfilling their responsibilities to provide meaningful access to LEP persons under existing law.

The HHS Policy Guidance is being updated in light of DOJ guidance. HHS recipients have considerable flexibility in determining what steps they need to take to fulfill the obligation of providing meaningful access to their programs. What a recipient should do is flexible and fact-specific. The guidance clarifies existing requirements by providing a description of the factors recipients should consider in fulfilling their responsibilities. A four-factor analysis is used to determine how meaningful access can be provided by different kinds and sizes of organizations in different geographic locations. [Slide # 10]

The first factor is the number or proportion of LEP individuals served or encountered in your service area who are eligible to receive your services. If your organization serves children, also consider the numbers of LEP parents. You should also consider language minority populations that may be underserved because of existing language barriers.

The second factor to consider is the frequency of contact you have with LEP individuals. The more frequent the contact, the more likely that enhanced language services are needed. The steps that are reasonable for an organization that serves an LEP person on a one-time basis will be very different than those expected from an agency that serves LEP persons daily.

The third factor to consider is the nature and importance of your activities. The more important and urgent they are, the more likely language services are needed. You should determine whether denial or delay of access to services or information could have serious or even life-threatening implications.

The fourth and final factor is resources available to you and the costs. Smaller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets. However, you should carefully consider cost-effective ways to provide competent language assistance. These could include use of technology and sharing of materials and services with other providers, community and faith based organizations, and federal, state and local governments.

After you consider these four factors, you can then decide what types of language assistance you will provide. For example, a hospital emergency room in a city with a significant Hmong population may need interpreters to be immediately available and may consider hiring competent bilingual Hmong staff. On the other hand, a small physician practice which encounters one Hmong patient per month may have more limited obligations.

In addition to what Title VI requires, there may be other federal, state, or local requirements. Medicaid managed care regulations require states to provide language assistance and translated materials for enrollees in certain circumstances. And health care accreditation standards, various state laws and regulations and managed care contracts may also include specific language access requirements. Additionally, community health centers, Hill Burton facilities and others have requirements to serve the community including LEP persons.

There are many resources out there to assist you. In collaboration with all federal agencies including HHS, the Department of Justice has created an Interagency LEP web page,

www.LEP.gov. The site provides updates on agency specific guidance, links to resources for interpreter and translation services, outreach materials, language identification or "I speak" cards, and assessment tools. I encourage you to visit the site often for updated information and to access public and private resources. In addition, the Office for Civil Rights is available to provide technical assistance to individual recipients and refer you to resources.

Definitions

JOYCE ST. GEORGE: It's important that we all share a similar understanding of the terms cultural competence and linguistic competence. Can we define them?

SHANI DOWD: Let me start with the term cultural competence. Cultural competence is defined as: a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework. [Slide # 11]

BOB LIKE: Linguistic competence refers specifically to language capabilities and is defined as: providing readily available, culturally appropriate oral and written language services to Limited English Proficiency (LEP) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators. [Slide # 12]

JOYCE ST. GEORGE: I understand there are guidelines related to language access.

SHANI DOWD: Yes, there are the CLAS Standards, which refer to National Standards for Culturally and Linguistically Appropriate Services. These were developed by the Office of Minority Health, in HHS based on a review of laws, regulations, contracts, and standards used by Federal and State agencies and national organizations, as well as input from a national advisory committee. Their aim is to "contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans." They are directed primarily to health care organizations, but individual providers are encouraged to use them - as well as purchasers, advocates and educators. The 14 recommended standards are meant to be used as guidelines to promote culturally and linguistically appropriate services in health care. They do not represent a mandate for health care organizations; but they can be useful for an organization looking to improve its services to diverse populations.

BOB LIKE: Four of the recommended standards deal directly with language access services - standards 4, 5, 6, and 7

Number four involves offering and providing language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English

proficiency - at all points of contact, in a timely manner during all hours of operation. [Slide # 13]

Number five deals with providing to patients/consumers, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services. [Slide # 14]

Number six addresses the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. It notes that family and friends should not be used to provide interpretation services except on request by the patient/consumer. [Slide # 15]

And finally, number seven involves making available easily understood patient-related materials and posting signage in the languages of the commonly encountered groups and/or groups represented in the service area. [Slide # 16]

A System Approach to Planning

JOYCE ST. GEORGE: How do organizations establish language access? More than likely, the process starts when a need arises. An influx of Spanish-speaking migrant workers in a community may cause a center to hire more Spanish-speaking employees. Advocates from a new immigrant group may encourage an organization to add bilingual signage.

As much as these efforts are needed, they're often sporadic rather than systematic. But to attain competence, organizations need a systemic and integrated approach. A place to start is by preparing a linguistic assessment and establishing a planning team.

SHANI DOWD: It's true that many organizations respond to situations as they occur. We pull bilingual staff to help physicians or sometimes we may inappropriately use family members and children as interpreters without realizing the potential medical, legal, and psychological risks. What we've learned is that these kinds of sporadic interventions may address the immediate need, but don't support other parts of the organization. Also, they're often not connected to other efforts such as quality improvement. In addition, they may inadvertently support stereotyped views of ethnic communities.

As a result, these efforts have only limited effectiveness, and may be costing the organization more than they're giving back in value. Here's an example of this.

[Dramatization: "Senior Staff Meeting". Scene is a conference room; present are the health care organization's chief financial officer, medical director, director of nursing, and director of human resources. They discuss how outside utilization costs are "getting out of hand", customer complaints are increasing, and surveyors may cite them for not having sufficient interpreters

available. They decide they need to develop a plan to improve their interpretation and translation services.]

SHANI DOWD: How many of us have been to those meetings? This is an example of managers trying to respond to demographic shifts in their patient and client base. As admirable as their efforts are, this team illustrates the struggles leaders face to either react to isolated concerns or create a systemic response. In this case, these leaders made a choice to be strategic instead of reactive.

We all know that change can occur in an agency by chance or by design. Often, concerns about the care act as catalysts for change. Patients and community members may place pressure through complaint processes and political forums. Negative treatment experiences can galvanize both clinicians and patients to mobilize for change. And cost factors associated with over or underutilization can motivate an organization's leaders to explore creative options for change.

In some cases, change comes when individuals in key positions champion a specific cause and move an entire organization. These changes may be effective and even rapid, but they may be vulnerable to reversal if the champion leaves and the changes aren't institutionalized.

BOB LIKE: Shani, what you're saying is that no change occurs in isolation. There needs to be support from the social, political and economic environment. We need to consider that geographic regions of the nation and local communities have different values and styles of interaction. And also think about the economic health of a community and how that reflects its willingness and ability to take risks. And last, we need to look at communities that have different cultures, languages, ages and abilities represented. [*Slide # 17*]

JOYCE ST. GEORGE: Let's hear from an organization that is already addressing these challenges strategically. Dinah Surh has joined us. She is Vice President of Sunset Park Family Health Center, part of Lutheran Medical Center, in Brooklyn.

DINAH SURH: As you know, Brooklyn is home to more than 36% of all new immigrants living in New York. With the growing waves of medically underserved and uninsured we found many challenges as well as good opportunities to engage our community leaders, patients and staff to increase linguistic access.

How did we start? Nearly 10 years ago, we created a new vision in a comprehensive strategic planning process called Vision Quest. We engaged all levels of staff and the community board to set our priorities, and to "Do the right thing in the right direction" to respond to change and competition. Our mission statement reads: to improve the overall health and well-being of the communities served by delivering high quality, culturally competent primary care and related services within community-based settings. [*Slide # 18*]

Without buy-in from the top of our organization, it would not have been possible to establish a formal direction and also embed the concept of cultural competence in everything we do.

We then created goals that would help us realize our mission. They are:

- increase patient satisfaction;
- increase staff satisfaction;
- provide staff training;
- create a managerial infrastructure; and
- reduce cost and increase efficiency. [*Slide # 19*]

We developed specific action plans based upon these goals and created objectives so that all levels of staff would be clear on expectations and held accountable for performance. And as we implemented our strategic plan, we didn't keep it a secret. We communicated and celebrated our successes.

SHANI DOWD: Thank you. So, what Dinah is emphasizing is that strategic planning is essential.

The first step critical to success is to engage the organization's leaders. The more closely the planning is aligned with the organization's goals, the more likely it is to receive support and to gain access to resources. Engaging appropriate consultants to provide a high-level executive briefing may be helpful to senior leadership and provide them with updated information on needs and opportunities for change.

To facilitate change, there needs to be a support base that is as wide as possible. Ethnic communities should be involved as early as possible. Likewise, all levels of the organization need to be represented to elicit internal support. Connections to communities, clinical groups and advocates help define jointly desired goals and provide broad based input in problem solving. These same networks can be helpful in learning how to develop effective communication with different groups.

BOB LIKE: In order to create strategic change, an effective approach is to designate a Planning Team, a group that will oversee the planning, implementation and monitoring of linguistic services. Let's talk about building a planning team. Some key questions are:

- Who decides on the selection of members?
- What criteria will be used to select them?
- Where in the organization will the team be based?
- How will the team function and report its recommendations?

SHANI DOWD: Planning teams established to develop linguistic services often begin as workforce diversity teams. But, please don't assume that they will automatically be effective in building linguistic competency. The skills and knowledge base are quite different. While the issues are certainly related, they are not identical.

There are several things to consider when forming a planning team:

- For example, the availability of rewards is often an issue for minority staff who may be asked to sit on several project teams.
- Sometimes unions need to be involved in the selection of committee members, as this work usually falls outside of a staff person's job description.
- Managers and supervisors need to be supported in dealing with workplace tensions that may result from a change of job description.

And the planning team should represent as many agency functions as possible.

Another point is that smaller organizations may need to partner with others to access the kind of expertise needed for success. This can result in a synergy of effort and generate new strategies and solutions.

JOYCE ST. GEORGE: I'd like to bring in someone else to talk about this issue. Catalina Sol is the HIV/AIDS Program Director at La Clinica Del Pueblo in Washington DC. La Clinica is a free community clinic serving uninsured Latino immigrants, primarily from Central America. She is also a member of the faculty for the medical interpretation program of the Northern Virginia Area Health Education Center.

CATALINA SOL: Thank you. As a well-known Latino service provider, La Clinica has been called on frequently over the years to assist other sister organizations with their planning processes. From these experiences, it is clear that small community-based organizations, or CBOs, may perceive developing linguistic competence as a huge challenge in the context of their insufficient resources. On the other hand, many CBOs have missions that are consistent with the principles of equal access, reductions of health disparities due to ethnic or racial differences. In short, the buy-in is there on principle.

Planning is just as key for smaller, front-line organizations, but unfortunately, it may not be where we start. Many of our organizations have few staff and deal with crisis continuously. And we come from organizational cultures of "fixing" problems quickly. But, taking the time upfront to plan is a truly worthwhile effort.

An issue to keep in mind is your relationship with your sister agencies. Many of us are very interested in sharing our expertise about our communities, and will frequently do so for free, or inexpensively. At the same time, please keep in mind that we are also small, overburdened organizations that have been historically excluded or ignored. When some of us have been invited to the table, it's not to listen but to find out if we can do your translations or send interpreters to your events. We feel much more respected if you involve us early on, acknowledge our expertise in any way you can, and ask us how we can help. Frankly it's also more productive to ask for help and ideas before you come up with your plan.

JOYCE ST. GEORGE: Thanks, Catalina. Dinah, it would be interesting to hear your perspective as well.

DINAH SURH: To start a planning process, you may want to begin with one group of patients. It may get too overwhelming to plan for more than one group at a time. You also want to allow time to learn from your mistakes, to avoid repeating them for the next group. In our center, we had a lot of experience in providing linguistic services to Latinos and had historically formulated relationships with a variety of clergy and with Hispanic organizations. Patient demand kept growing through word of mouth. This planning strategy worked, so we extended this concept to develop services for new Chinese immigrants.

We didn't want to reinvent the wheel, so we partnered with the Chinatown Health Clinic in Manhattan. They helped us recruit bilingual staff, translate materials and put some cultural knowledge into them. For example, nutritional guidance would not talk about cottage cheese, but rather bean curd, and included Chinese vegetable names. We formed a planning team consisting of key stakeholders: administrator, nursing, medical director, social services and community partners to meet and discuss strategies for our Asian Initiative. We engaged this group in designing our Family Physician Health Center in the mid 1990s. A similar planning group was formed to plan for the new Brooklyn-Chinese Family Health Center, which opened in December.

We have since used this type of planning group model to develop Mexican, Caribbean-American, Arabic and Russian Initiatives. Keys to some of our success have been to focus on a common goal and defer to community experts. Most often they have experience in how to provide the best linguistic solutions. Some ethnic groups can generate volunteers for your organization to translate. Other groups are set up to help translate written materials or engage in outreach efforts to help you recruit bilingual staff.

BOB LIKE: The comments from both Catalina and Dinah demonstrate how important it is to hear and respond to the voices of patients, families, and communities. For example, linguistic competence is especially relevant for children with special health care needs, and their families, as their care is complex and communication is vital. Too often, organizations work hard to develop their plan, but forget to reach out to community members who use - or don't use - the service.

In other words, we need to learn from communities in order to provide them with quality service. To do that, we need to have, as my colleagues Drs. Melanie Tervalon and Jann Murray-Garcia say, "cultural humility," that is, the willingness to address power issues and let go of our own ideas about communities, so that we can truly discover their needs, beliefs and strengths around health care.

JOYCE ST. GEORGE: Kelvin, we know that your organization in San Francisco's East Bay is also very diverse. How did you develop relationships with the various communities you serve and engage them in the planning process?

KELVIN QUAN: Even before many of our senior executives joined the Alameda Alliance, they had a history of working actively with our communities. We all continue our involvement on community boards. We maintain an Alliance presence in the community through our staff, programs, members and providers. We don't just talk about our values or about the problems of the uninsured. Our communities are not our "target audience" but rather our partners.

Over the past 4-5 years, we've donated nearly \$5 million to health care projects that benefit all County residents. We contributed \$50,000 in a detailed countywide survey to better understand the scope and needs of the uninsured. It told us that we have 140,000 uninsured adults under 65 and 12,000 uninsured children in spite of the various public programs. With this information, the Alameda Alliance created our Family Care coverage program that specifically reaches out to our immigrant communities. Many of them are limited English speaking.

We keep looking for input from our communities in a variety of venues. Our quarterly community advisory committee advises us on our language and cultural programs. Our member committee and surveys provide us input on whether our programs and materials will be effective or practical. We're also very deliberate to run our focus groups in non-English languages and offer interpreters for all of our community and member meetings. In one of our outreach programs called "Member to Member", we hired our members to call other members to tell them about their benefits. We also have active members of our health plan who serve as full Board members and participate in the governance and policy making of our health plan.

BOB LIKE: Meeting with members of underserved communities on their own ground is a powerful message of respect. People who have felt marginalized or excluded from services, however, may need to take the opportunity to express intense feelings of hurt, frustration and anger. Listen to the health care encounters of community members as told in the video, Community Voices.

[Clip from Community Voices: Language, Interpretation and Communication Styles. (1) Maude Guerier: "When patients go to the provider, the clinic, they know they don't speak the language. They already feel insecure; they feel so bad they can't communicate with people. (2) Majdek Rohani: "A lot of patients complain that doctors don't look at them. They look at the interpreter."]

We have to be open, and to connect not only to the person, but the community. This can do a great deal to increase our credibility and places organizations on the road to developing partnerships.

Trust is essential, especially in terms of involving, working with and collaborating with ethnic communities. We need to become more cognizant about the history that some communities have had with health care organizations and governmental programs. Listen to these concerns from the video Community Voices, and think about how these statements would influence an assessment.

[Clip from *Community Voices: From Social and Economic Inequalities, Hope White* - African American woman - "There's a definite historical link to black people not trusting the health system." In *Newcomer, Immigrant, and Refugee Health Issues*, Sanmiuth Koam, a Cambodian man who speaks about the issue of trust and mistrust and its effect on help-seeking behaviors and provider-patient interaction.]

Many ethnic communities have been over-studied in ways, and by institutions, that do not necessarily have their best interests at heart. The legacies of racist medical practices linger in the memories of many groups leaving residual mistrust. Many immigrants and refugees have also had painful or humiliating experiences during the migration process, sometimes with medical organizations or in refugee camps. For those of us who've never had to face that kind of degradation, we can only imagine the impact it would have on the ability of a person to trust the medical world.

JOYCE ST. GEORGE: Thanks, Bob. Fortunately, we're openly discussing these issues today, and taking actions to build greater credibility within health care.

Now, let's examine specific steps in planning and managing linguistic services. Shani, can you get us started?

Six Steps in Planning and Managing Linguistic Services

SHANI DOWD: Let's talk about a framework for planning and managing linguistic services. There are six steps we're going to use. They were developed by the Centers for Medicare and Medicaid Services, and the Agency for Health Care Research and Quality, in a document called: [Providing Oral Linguistic Services](#). [Slide # 20]

It's a step-by-step planning process that can be connected to the continuous quality improvement efforts of the agency. Even though it was originally developed for managed care plans, it can be adapted to fit different types and sizes of organizations. Information about how to obtain the document is on the broadcast website - www.hrsa.gov/financeMC/broadcast.

The essential steps are:

1. examine linguistic needs of the membership or patient populations;
2. assess the capabilities of the organization;
3. identify points of contact for members or patients receiving care;
4. consider different language strategies;
5. assemble a linguistic services plan; and
6. monitor what you have put in place. [Slide # 21]

JOYCE ST. GEORGE: Shani, you're talking about an undertaking that could be seen as overwhelming. How should this effort be approached?

SHANI DOWD: This six-step plan needs to be viewed as an incremental process, an ongoing, developmental journey that is taking place in a complex system. It's intended to be ongoing, so that lessons learned along the way can be incorporated into the plan as you go along.

It's helpful to keep in mind three guiding principles at each of the six steps. First, build reporting and refinement into each phase of planning and implementation. This provides a quality improvement approach to all aspects of the planning team's work. It also insures that evaluation is considered at each phase. Second, study mistakes and setbacks carefully to learn from them. And third, celebrate successes, small and large. [Slide # 22]

Step One: Identify Needs of Members and Patients

BOB LIKE: Let's get started with Step One, which asks organizations to identify the needs of members and patients. This means examining the number and percentage of actual and prospective patients who have limited English proficiency and also determining the preferred languages spoken. Census, public school district and local planning district data are helpful for assessment purposes, as well as member or patient population-level data. [Slide # 23] Organizations also can use surveys, focus groups and self-assessments to assess the linguistic needs of members.

Surveys are easier to analyze and allow sampling over time to track the results of intervention. [Slide # 24] They are popular and less expensive to deliver, but there are drawbacks to using them. They may be less effective in communities of color due to trust issues. Many communities resist responding to surveys. Linguistic concepts may be harder to capture. And nuances are lost. [Slide # 25] In addition, literacy issues, especially in combination with less fluency in the English language, may compromise the effort to collect accurate data.

On the other hand, focus groups allow participants to share impressions, emotional responses and values. They often reveal new information, and allow greater sensitivity in understanding issues of meaning. [Slide # 26] But as with surveys, focus groups have drawbacks as well. A focus group sample is not necessarily representative of a community. You lose the heterogeneity of the cultural group and can't compare results quantitatively or generalize to the total population. [Slide # 27]

Self-assessments can also be useful. They allow participants to add in-depth, qualitative comments, and can be useful in raising awareness. [Slide # 28]

Kelvin, what have you found to be useful?

KELVIN QUAN: The Alliance has been fortunate to have accurate data on the race, ethnicity and language of all our members, dating back to our beginning in 1996. Note that this is special - most health plans don't have this, especially for commercial members. This data informs us a

great deal about our communities. It's captured upon enrollment and it allows us to begin our communications with members in their own language. We can identify threshold languages for the translation of documents and monitor and maintain the language capacity of our physician and provider network.

Data on the language skills of doctors are equally important. Like most other health plans, we started off asking doctors to self-report the languages supported in their practices. However, this information did not indicate proficiency or who spoke the non-English language. About a year ago, we began conducting a detailed survey of our provider network. We learned what language skills they had and their level of proficiency. As a proxy, we asked whether they grew up speaking that language, or they used that language in a foreign medical school, or they were relying on the two years of Spanish they took in high school.

There are a lot of ways to expand our data and its use. Here are three examples.

- The first is that we can expand on member data by differentiating between written and spoken language preferences. Even if a woman is bilingual, she may prefer her native language when discussing medical matters.
- A second project is to aggressively promote the use of qualified interpreters by identifying those patient visits that had language barriers. We can then focus our communications to modify the behaviors of those physician practices and to empower those members by increasing their expectations.
- In a third project, we are working with others to identify proficiency standards for providers. We hope to then use these standards to develop a verbal assessment of proficiency, so that we're not just relying on self-reports or proxies. Then, we'll offer practical alternatives for the doctors, so they won't be compelled to use their limited language skills.

Step Two: Assess Organizational Capabilities

SHANI DOWD: This is a great discussion and so important to the overall quality of the planning process. Now let's move to Step Two which requires an assessment of the capabilities of the organization. This assessment focuses on attitudes, policies and procedures. It should also concentrate on the context within which the organization operates. I wonder, Dinah, if you would talk about this.

DINAH SURH: When you have diverse patients and staff, misunderstandings and conflicting priorities may arise. To me, a working definition of cultural and linguistic competence in a health center must include the concept of patient focused care. Unfortunately, I attended one meeting where a staff member stated, "Why are we spending so much time developing interpreter services? Our patients should be able to speak English in America." If we recognize the importance of our new immigrants as new customers, providing linguistic services is simply a part of delivering patient focused care. If the right thing to do is to maximize patient satisfaction you will provide services on a timely basis, in a friendly and personal manner, no matter how difficult the cultural and language barriers.

One of the types of surveys we conducted was an "Assessment of Staff Knowledge, Skills and Attitudes in Caring for a Culturally and Linguistically Diverse Patient Population." We asked employees who had frequent patient contact to complete a written survey. Some key results are that 55 % of staff were very interested in the cultures and traditions of others. 78% said they needed more culturally related information to do their job well, and 77% wanted cross-cultural training. [Slide # 29]

Other findings were that interpreters were not available for our newest growing immigrant groups. There was a high level of dissatisfaction with the language bank. Cultural diversity was a source of stress for a third or half of the staff.

Based on these findings, the Cultural Task Force recommended that more bilingual staff should be hired; training on medical interpretation skills should be provided for frontline staff; and training should be available for providers on how to use interpreters. [Slide # 30]

SHANI DOWD: Your experiences tell us that planning must take into account the values and norms of the larger community. I think that's important. In your case Dinah, attending to staff stress gave you a way to configure your response, and improve services for both patients and staff. An agency that contracted out for services probably would need a different approach. Just as important, the assessment should take into account administrative style.

JOYCE ST. GEORGE: So, what I'm hearing is that it's not enough to just examine data. The assessment needs to be contextual, taking into account a whole range of dynamics.

SHANI DOWD: That's right. And, in terms of assessing organizational policies and practices, the planning team should assess the agency's present readiness by exploring these questions:

- To what degree do members of ethnic communities have access to services or to decision-making?
- And, have practitioners been permitted and encouraged to adapt services to meet the needs of local populations?

JOYCE ST. GEORGE: We also have to assess decision-making capabilities within the organization. The planning team will become "agents of change", and to be effective, it must understand how the organization sets priorities, addresses challenges and determines goals.

As agents of change, the planning team also needs to consider its sphere of influence on key decision-makers. Kelvin, how were you able to influence key decision-makers?

KELVIN QUAN: At the Alliance, we feel the key decision-makers are the doctors, so we focused on the doctor-patient encounter. Here, we began connecting with providers on their

challenges by first standing in their shoes. We considered the possible scenarios when a patient doesn't speak English. Then, we made a list of possible reasons for why a doctor wouldn't use a qualified interpreter. This list of reasons was broken into four categories - Financial, Knowledge or Awareness, Attitudes, and Operations. [Slide # 31] We stepped back and asked, "How can the Alliance truly help the doctor or clinic?"

For the Financial reasons, the Alliance I think, effectively removed those barriers. We not only pay for the full cost of interpreters, but also pay doctors each time they call in a qualified interpreter. This payment recognizes the doctor's additional skills and time that comes with it.

In Awareness and Knowledge, we've repeatedly informed doctors of our payment and of the benefits of using qualified interpreters. Informing them how medical errors can be reduced is intended to appeal to the doctor as a scientist. As much as we've done this, we need to continue - especially to better articulate the cost-benefit and evidence-based arguments.

In Attitudes, quite frankly, I'm not sure what we can do to change attitudes. Our real goal is to change behaviors and we may be better able to do that by focusing on the other three categories.

The final category includes all the Operational Issues - recognizing the administrative hassles and all the rules and procedures that doctors' offices have to juggle. Here the Alliance has tried to take as much of the load off the doctors by making all the arrangements directly and even requiring interpreters to call the patients ahead of time to minimize the no-shows.

JOYCE ST. GEORGE: It's also essential to build support from within the community. Dinah, how did you do that?

DINAH SURH: One of the ways we began to have a direct dialogue between frontline staff and the community was to hold cultural diversity meetings. We invited community experts to gather with staff to generate a better understanding of various ethnic groups. For example, it isn't enough to learn to interpret accurately. It's also important to avoid non-verbal mistakes, such as offering the left hand to some Arabic patients, or touching some Asians during conversation and making too much direct eye contact. Staff expressed more confidence in dealing with patients and each other after these sessions.

Another visible way we develop community support is getting out of the center and attending community events - health fairs and ethnic celebrations - and partnering with community organizations on special events. One terrific example of mobilizing the community is through a coalition formed by our center called the Brooklyn Alliance to Strengthen the Safety Net, funded through HRSA's Community Access Program. A bilingual website in English/Spanish called momsandkids.org was created, There were a variety of partners, including all key safety net providers, working to improve the health of a target population.

Here's a sample of the home page, which is bilingual in Spanish. [Views of www.momsandkids.org website] We have website sections on finding faith-based and community-based organizations, finding health care services, learning about health problems

such as asthma and prenatal care and learning about health insurance. We are now planning to translate the website in other major languages in the coming year.

JOYCE ST. GEORGE: Catalina, what are your experiences in getting support from your community?

CATALINA SOL: In our case, the issue has been getting support from service providers that also serve our clients. This dialogue frequently begins as a result of someone's complaint. So, we're starting from a place where emotions are already frayed. What we have done is to have a discussion about the specific problem, followed up with an invitation to have a comprehensive training on culture and language issues.

The first key element in building support for linguistic access is developing an understanding about the immigrant communities themselves. Frequently, the stress of having to deliver services leads to negative attitudes, such as “why did immigrants come to the U.S. if they didn't intend to learn the language” and other very painful comments. We have found that when providers understand the historical reasons for migration, particularly when we are talking about communities who have been uprooted suddenly and have fled persecution or upheaval, it is much easier to obtain buy-in.

The second element in obtaining buy-in is to understand certain realities about language acquisition. It is very difficult for adults, particularly those with low literacy levels, to learn English at sufficiently proficient levels. There are liability issues when linguistic access is not provided. And not all bilingual persons possess interpretation and translation skills.

It's also helpful to refocus agencies on their mission. I remember once that a health department nurse shared with me that, even though she had access to interpreters, she never took them on home visits with her, because this would discourage her patients from ever learning English. I asked her if promoting language acquisition was a part of the mission of her health department. Of course it was not. And she was able to see that the priority should be providing the services to her clients in a way that would produce the desired outcome-in this case, an accurate assessment of the family and home.

JOYCE ST. GEORGE: Thanks, Catalina. Another aspect that needs to be examined is how we can link the work on improving linguistic services to continuous quality improvement. Kelvin, how does the Alliance do that?

KELVIN QUAN: There is an increasing body of literature that recognizes that race, ethnicity and language are key factors in health disparities and quality improvement. The Institute of Medicine came out with two seminal pieces in this area - Unequal Treatment and Crossing the Quality Chasm. The IOM recognized that cognitive complexity, time pressures and cost containments have an especially adverse effect on minority populations. The reports highlighted

the importance of equity in providing care that doesn't vary in quality because of personal characteristics, which can include language, ethnicity, and socioeconomic status.

A study by Dr. Glenn Flores from Wisconsin showed that inadequately trained interpreters made an average of 31 mistakes per doctor-patient visit, of which two-thirds of those mistakes could have negative consequences for the patient. [Slide # 32]

Another study by Dr. Louis Hampers from Colorado reported that patients with language barriers on average were in the Emergency Room 28 minutes longer, more likely to be admitted to the hospital and receive IV fluids, and were billed charges an average of 39% more. [Slide # 33] This suggests that less efficient care in the form of over-utilization is related to language barriers.

The Alliance itself is wrapping up a two-year study with UCLA to look at the correlation between doctor and patient of language and ethnicity in women getting cervical cancer screenings. This is most relevant for Vietnamese women whose rate of cervical cancer is five times that of the general population and for Latinas whose rate is two times as great. We also have the data available to see whether the health disparities are present in our own membership. If they are, then we can develop interventions specifically designed for our members' race, ethnicity, language, economic and living conditions.

JOYCE ST. GEORGE: Thanks Kelvin. You've mentioned some great resources. Remember to go the web site - www.hrsa.gov/financeMC/broadcast.

We will return in 10 minutes. Please enjoy our many announcements during the break.

Break

Step Three: Identify Points of Contact

JOYCE ST. GEORGE: Welcome back. Now, we'd like to move on to the third step of the planning process. How to identify points of contact.

When and where are linguistic services needed? Let's look at an example of a patient at a particular episode of care.

[Dramatization: *"The Pharmacy"*. The scene takes place in a pharmacy and shows an interaction between the patient, a Spanish - speaking woman, and the pharmacist who gamely tries to communicate with her, using the few words of Spanish he knows. In their halting communication he discovers she thinks the dosage is eleven tablets a day when it is one a day. After receiving her medication, she asks him to help her with the stand the stack of papers she has been given at the clinic, all of which are in English and she cannot read.]

JOYCE ST. GEORGE: Here's an example of a point of contact, where the pharmacist not only demonstrated good customer service, but also averted a potential misuse of drugs due to language barriers. It also highlighted points of contact that were not effective. Identifying points of contact, or, where patients interact with the organization, is a separate step in the planning process.

BOB LIKE: The clinical encounter between a patient and a physician is the obvious point of contact and a critical one. In most health care systems, family medicine, internal medicine, pediatrics, obstetrics and gynecology, emergency services - as well as nurse practitioners and physician assistants - manage the highest volume of visits. A planning team would also have to examine how the clinical staff is organized and what clinical specialties and disciplines are represented.

During this phase, an organization should extend its assessment beyond its own walls. Points of contact may include vendors and referral sources, like radiology. And services, such as mental health, HIV/AIDS related programs, sub-specialists for children with disabilities and other special needs, or dental care. There are also the contacts the patient has with the health plan, as well as formalized complaint or appeals processes.

SHANI DOWD: And, remember, oral contacts are both face-to-face or by telephone.

Points of contact also include written communication. Sometimes it occurs concurrently with oral communications, such as receipts for services, appointment slips and enrollment forms. Other times it happens when the patient has no direct contact with the person who generates written materials, such as benefit information, medical records, claims and billings. [Slide 34]

JOYCE ST. GEORGE: This would be a good time to talk a little bit about translation of written materials. Catalina, can you help us with that?

CATALINA SOL: The first thing to emphasize is that translation is a professional skill. Not everyone who speaks Spanish, for example, can write with the same proficiency, is knowledgeable of technical vocabulary, or is familiar with the process of translation. This process usually involves a first translation into the desired language - example English to Spanish - and then a translation from the first document back into English by another translator. This is a control that allows you to determine how faithful the translation is to the original. There is also a level of review to determine if the language is appropriate for the cultural group that will receive the document and if the literacy level is correct.

It is important to determine what documents in your organization need to be strict translations of the original, and which ones can be more flexible. For example, your consent forms, patient rights and responsibilities, patient instructions are legal documents. These translations need to be

extremely faithful renditions. On the other hand, educational materials really should be done from the beginning in the language of the targeted group by bilingual staff who have expertise in the area. But if this is not possible, there should be at least a process of testing and adaptation of the material so that it is culturally as well as linguistically appropriate. If you can't afford professional translation services, it is important to, at a very minimum, assess the writing and translation skills of the persons you rely on.

Some don'ts: [Slide # 35]

- Don't use computer programs that do automatic translations. It is more work to correct them than to work from them.
- Do not overburden your bilingual staff with all the translations that your organization needs unless this is explicitly a part of their job description, you are compensating them for this additional work, and they have the skills to do them.
- Don't rely on interpreters to "sight translate" your key documents - that is, hand them an English-language document and expect them to orally translate the document to the client. Because this leads to many variations in what is communicated, it may open you up to liability issues if important information is communicated incorrectly.

And finally, don't send materials to your sister immigrant agencies and ask them to translate them for our language groups. We will be happy to review for quality, but not doing the translation yourself just communicates that you are really not interested in reaching our clients.

JOYCE ST. GEORGE: Thanks, Catalina. I'd like to go back to points of contact other than translated materials. I'm wondering how an organization will know if it has identified every point of contact. Are there some that are overlooked?

SHANI DOWD: It's hard to identify every one and not feel something is missing. For example, some years ago here at Harvard Pilgrim, we had successfully recruited bilingual, behavioral health staff, and insured that the psychiatric hospital that was our preferred referral also had bilingual staff in two target languages and cultures. However, to our dismay we found that we had neglected to have directions to the hospital translated into our target languages. We routinely provided these to English speaking patients and their families. At first, we tried to dismiss this as a minor matter, until we heard from several patients that their families were prevented from visiting them immediately after their admission. They had to wait until a bilingual staff person could be available to give directions. It turned out to be an oversight that made family members feel that we did not want them to visit their loved ones at the hospital, and raised questions in their minds about what kind of care we were really delivering. It was incredibly important when the admission was not a voluntary one. In at least one case, it resulted in premature discharge of the patient, because the family felt excluded from the treatment and feared for their loved one. We just didn't think of directions to the hospital as important to quality of care, but we learned.

Some common points of contact that are overlooked are:

- preparations for diagnostic procedures;
- informed consent forms; side effects information; and
- medication bottle labels. [Slide # 36]

This third step of the planning process asks organizations to be specific about its points of contact and what linguistic supports are needed. This assessment can be done in a number of ways. You can conduct surveys of members, providers and staff or use focus groups. Medical claims information and billing records can also provide valuable information. [Slide # 37] Also, engaging each department broadens the involvement of staff across the organization.

JOYCE ST. GEORGE: Dinah, what are your thoughts about determining points of contact?

DINAH SURH: If we look at these issues from a patient perspective, it may be easier to cover all the bases. The best source, of course, is through direct patient feedback through focus groups and member visit surveys. We survey both our current patients and community residents who are not our patients.

One way to get started is to walk through your center as a new patient. Look at signage and the types of paperwork patients need to fill out. Identify any translation needs. Think about making referrals for diagnostics - or making referrals to outside organizations. And what about recalling patients for testing and follow up? We also must be mindful of patient rights, confidentiality, and patient safety issues and be able to communicate these concepts and procedures to our patients.

Step Four: Consider Different Strategies

SHANI DOWD:

The fourth step in the planning process asks organizations to consider different strategies and services that will enable them to address linguistic needs. The planning team must now narrow its focus. To do this, it must:

- establish a decision-making process that the team will use to evaluate the options and prioritize and select the ones to be implemented; and
- consider how the leadership will accept and implement the recommendations.

As a team considers different strategies and services that will have the greatest impact, here are possible criteria that can be used to evaluate and choose among the options. [Slide # 38] For example, which strategies would be:

- most important to patient and community groups;
- do-able in a close timeline, say one-year;
- justified and supported because of their alignment with overall organizational business goals;
- accomplished with local or affordable resources;
- supported by the staff.

Selecting initiatives that are do-able in a shorter timeline may be important to gain organizational momentum. Many of the most critical ones may take more than a year to implement. Adding shorter projects will provide opportunities for success and recognition as the team moves forward to more complex issues.

BOB LIKE: Once initiatives have been selected, they should be framed horizontally as well as vertically - in other words, implemented across the organization and at differing levels. Also, consider multiple strategies that interlock to support patient access to high quality clinical services. The selected initiative should have action steps that engage all business units and all points of patient contact.

Using an integrated approach means that staff will be involved in discussions of language and its relevance to their work and to patient care. It helps raise awareness of issues and begins to create an internal network of staff who will become increasingly well educated about these issues.

It's clear there is no one answer. And no one organizational response can answer the language needs across all divisions of the organization.

Catalina, what strategies did you choose?

CATALINA SOL: To support the development of linguistic capacity within our community, La Clinica has employed a number of strategies. [*Slides # 39 and # 40*] The most important is the development of a community-wide bank of trained medical interpreters and translators. Through a variety of funding sources, the program provides interpretation and translation services free to the clients of non-profit community-based agencies, including Ryan White service providers.

Other strategies include: training of medical interpreters as well as medical providers on how to use medical interpreters; and partnering with other interpreter banks to cover multiple language needs.

In this case La Clinica partners with the Northern Virginia AHEC, which has an interpreter bank. Through our partnership, we are able to cover the range of languages spoken in the Greater Washington area, share the training burden, keep interpreters busy, and therefore retain them at higher levels.

We also link training on immigrant cultures and backgrounds to linguistic access training. And develop systematic advocacy and education efforts to obtain buy-in and support for developing linguistic access plans.

The last strategy - using language access cards - was developed by our own interpreter program, and consists of providing clients with cards identifying their language and requesting an interpreter. This has been particularly important for clients when an interpreter may not be available, such as in an Emergency Room, or in a really small agency with limited staff. My

colleagues have developed this card in Spanish and French, and are working on additional language groups.

Within our own agency, we hire bilingual staff, most of whom are from the same community that we serve. And importantly, we interview them in both English and Spanish. It is important to assess the language skills of staff who state they are fluent, as sometimes those skills are not at the level required by the job.

DINAH SURH: In selecting strategies, you may want to consider which ones will make the greatest impact and take the least amount of time and cost.

Signage is a very visible way you convey to communities that you speak their language. We had a challenge to find a sign maker who could come up with signs in five languages. But we did it. Here's an example of a multilingual sign, which has slots for English, Spanish, Chinese, Arabic and Russian. [*Video clip showing signs in five languages.*]

But, signs can lead to some mistakes. For instance, when we put up one of the signs the slot for one of the languages got turned upside down and the meaning of the location changed to an embarrassing word. Whenever you have signs translated, please have them double-checked for accuracy!

Another approach is to consider the amount of staff interaction with patients. How many folks do patients have to deal with in order to navigate your systems? You may want to look at redesign and reengineering to facilitate patient communication and reduce the number of people patients need to see. This cuts down on the need for multiple interpreters and perhaps some unnecessary contacts and errors. We found that interpreters were being called continuously. This led us to convert some clerical lines to patient relations representatives, which did not cost additional dollars but improved efficiency.

And there is the telephone system. Can you measure how often patients abandon their calls from waiting too long or having to use a complicated system? If you ask patients to call the center for open access appointments, triage or other information, is your technology set up to address their language needs? Do you have a way of getting calls to the staff who speak the needed language?

When we register patients, we note their preferred language and if they need medical interpretation. When we make appointments, we try to book patients with providers who fit their language and cultural needs. Over the years we have gone from 40% of patients requiring medical interpretation to 28%. We attribute this decrease to hiring multilingual staff who interact directly with these patients.

KELVIN QUAN: It's easier to talk about and to make promises about promoting language access when it's only about the staff, or the Board, or the written policies and procedures of the Alliance. From early on, we realized that the focus has to be on each point of contact between

our patients and the doctors, hospitals, and clinics. This is the face-to-face moment that brings all the discussions of language access together.

We really have two distinct groups - administrative staff and medical providers. The first one is internal - they're staff on our payroll and their policies and practices are in the direct control of our health plan. We can readily affect change through internal supervision, direction, education or policy and procedure.

The other group, the providers, is external and we relate to them through contracts. The vehicles we can use to effect change are a combination of contract requirements, incentives, disincentives, education, negotiation, monitoring and cajoling. This is a constant work in progress. Our providers are diverse and they're motivated differently. Some are well intentioned but extremely busy. Some are not knowledgeable about the risks of not having clear communications. We are currently conducting a series of physician trainings on language and culture. We don't require doctors to participate, but instead entice them with expert faculty, CME, dinner, tickets to a jazz performance and a stipend.

With our members, we try to increase their expectation of language access and encourage and empower them to ask for interpreters. We're currently working on a program of "I Speak" cards, which members can use to show to their doctors to tell them their particular language need and how to access our systems to provide that service.

SHANI DOWD: These are important insights because they point out how different parts of the health care system have different needs and opportunities. And, different kinds and sizes of organizations choose different strategies.

JOYCE ST GEORGE: I have a question. Many organizations use bilingual staff as interpreters. After all, many of them know the communities being served. But complex issues are embedded in using bilingual staff. Would you speak a little on how to address this?

BOB LIKE: This is a big issue for many health care and managed care organizations. Bilingual staff need to be appropriately trained and compensated for assisting in clinical encounters. Many bilingual staff may have insufficient vocabulary in medical terminology, or anatomical knowledge. Others may have limited fluency and may not be able to understand the totality of an interaction. Still others may be proficient in certain languages but may not understand the cultural context.

I'd like to talk a little more about working with interpreters. When a health care provider is caring for a patient with limited English proficiency, it is extremely important to have a brief pre-session with the interpreter. Here's an example with a professionally trained interpreter helping to educate a physician about the interpretation process. This is from the Seattle Cross Cultural Health Care Program's videotape [Communicating Effectively Through an Interpreter](#).

[Clip from Seattle videotape. Cambodian interpreter educating the doctor on the interpretation process.]

When professional interpreters are not available, this type of pre-session should still be held to help optimize the communication process.

JOYCE ST. GEORGE: Catalina, it looks like you have something to add.

CATALINA SOL: One important issue to define institutionally is the role that you want interpreters to play, and then to make that clear to everyone. For example, at La Clinica we chose to adopt a training curriculum for medical interpreters that includes a level of advocacy for the client. In our experience, community members who interpret within medical settings have always played a role helping the client navigate the system, understand their rights, and defend the client from unintended or intended discrimination. The problem is that this role has often been played in an inappropriate manner, or has jeopardized the communication. Our current curriculum was attractive to us precisely because it acknowledged this important role, but trained interpreters on how to do it appropriately.

Once we defined that our interpreters were not going to be just "translation boxes", it was important to let everyone know that this was going to be the case. We also trained our bilingual staff on this curriculum, so that they understand the principles and also follow these guidelines when they were called upon to interpret.

To sum up, no matter what role you decide you want from your interpreters, training of medical providers on the roles and use of them is key. It really is up to the institution to clarify what is expected and not expected of interpreters, particularly in the absence of a national certification for interpreters.

JOYCE ST. GEORGE: Dinah, I know Sunset Park has an incredibly diverse staff, many of whom serve as interpreters. Would you talk about criteria you use to select in-house interpreters and the kind of training and support you provide?

DINAH SURH: Since we are located in a diverse community, our instinct was to hire staff who speak those languages. We also asked patients to bring someone to interpret if we knew we didn't have staff available in that language. Although we instituted a traditional language bank, it was cumbersome; and other language line services were expensive and not easy to use. We soon discovered the various levels of language, dialects, and the lack of familiarity of the frontline staff in utilizing medical terminology. We had an opportunity to work with the NY Task Force on Immigrant Health and the Office of Minority Health to start a medical interpretation skills training program. The focus was twofold: first, provide frontline staff the required medical terminology and training on how to serve as an interpreter; second, build the confidence in the

staff to be comfortable in a role as interpreter and legitimize this role as part of one's job responsibility.

We asked clerical and nursing staff who already worked closely with providers if they wanted to be trained as medical interpreters. Staff were excited about the training, particularly since it was being given as part of their work time. We started our first medical interpretation training for Spanish with a one-day session, once a week for 6 weeks, a total of 48 hours. We successfully graduated about 25 staff. We didn't pay them more once the training was completed. They are on union scale. But, we were able to conduct a nice graduation celebration with senior staff. We then held an evaluation session to get feedback about the training, and later on about their perception of their skills. We have completed other sessions for Arabic, Chinese and Russian and trained over 150 staff.

CATALINA SOL: At the beginning, we used anybody who was bilingual just like everybody else. In 1998, through the Northern Virginia AHEC we obtained training on the Bridging the Gap curriculum from the Cross Cultural Health Care Program in Seattle, and established that curriculum as our training guide. Current requirements for joining our interpreter pool are passing a language competency test in English and the language in which the interpreter will work, and completing the 40 hour Bridging the Gap training. The training includes medical vocabulary building, anatomy and physiology, and other such technical needs. But it also deals at great length with the different roles interpreters may play and how to do so appropriately, as I discussed earlier in terms of the advocate role. Our interpreters also have to be comfortable dealing with a whole host of issues, including family planning, sexually transmitted diseases, and sexual identity issues.

In our organization, we have a separate interpreter program which handles recruitment, training, scheduling, troubleshooting, and evaluating the work. Our staff meets regularly with our interpreters to evaluate their training needs, and we compensate them for their services and travel.

Training our full-time bilingual staff on this 40-hour curriculum did require some internal negotiation and buy-in. As anyone who has worked in a non-profit knows, finding five days for someone to be absent from direct services in training is a huge challenge. The way that we resolved this internally was by training one or two staff people at a time over the course of one year, rather than cutting back on the training time. So, even in an organization as committed to language access as we are, it does take planning, negotiation, and some sacrifice to make it happen.

SHANI DOWD: You're all bringing up great points, because there are considerations involving ethics and privacy if you're going to use bilingual employees as interpreters. Ethical concerns come up when the staff is a part of the community, especially an ethnic community, which often can be tightly knit. Privacy and confidentiality issues must be managed. This has been an important issue in those service agencies that provide care to individuals with HIV/AIDS, where social stigma is greatly feared.

JOYCE ST GEORGE: Catalina, we know you manage a HIV/AIDS program for a Spanish speaking population and that you also work with other organizations in your community. Could you share your experiences?

CATALINA SOL: The primary concern of many individuals living with HIV is that their confidentiality will be broken, especially in many of our communities where the stigma of HIV is still extremely high. In some language groups that are relatively small, clients may refuse an interpreter because they prefer to muddle on through rather than be exposed by someone they know.

There are no easy answers to this concern. This issue really brings home the need for training and support of interpreters. The highly specific terminology of HIV needs special attention. For example, many bilingual staff get basic HIV training in English, and then are at a loss on how to translate words such as "risk reduction" and "viral load." It helps to have interpreters assigned as much as possible to the same clients, so they do not feel they are disclosing their status over and over again.

Having bilingual staff versus a pool of rotating interpreters is a huge advantage. This is true not only because of the confidentiality issues, but also because so much of HIV involves very delicate issues in terms of an individual's sexuality. We do not use interpreters during an HIV prevention counseling session, for example. The need for the provider to pick up on subtle cultural nuances is very important.

Finally, I will say that the world of HIV also offers some unique opportunities to build language access. For those organizations that are in areas with Ryan White funding, the community planning process does offer an avenue to identify unmet needs and a way to get them funded. In our locality, Limited English Speakers who are living with HIV have access to interpreter services through any Ryan White service provider, because the local planning process made this a funded priority.

BOB LIKE: There are some situations where an interpreter who is not from that community may actually be more effective. But ethics is an important consideration. There are models of codes of ethics that can be adopted by organizations, including those developed by the National Council on Interpreting in Health Care, and interpreter associations in California, Massachusetts and Minnesota.

SHANI DOWD: I'd like to get specific about interpretation models and highlight three different methods: consecutive, simultaneous and telephonic interpretation. [*Slide # 41*]

Right now, most interpreters are being trained to manage face-to-face encounters using consecutive interpretation. However, there are a number of other technologies available that may be less widely known.

Consecutive interpretation is what most people are familiar with: a person speaks, and when they've finished their thought, the interpreter repeats the statement in the target language. Consecutive interpretation is easier for beginning interpreters to learn.

Simultaneous interpretation means that the interpreter has to interpret the message at the same time that the person is speaking. United Nations interpreters, for example, use simultaneous interpretation. It requires a lot of skill, experience and concentration. When it's well done, it shortens the time required for the encounter and gives a more natural feel to the conversation. Many clinicians find it initially distracting and can't "tune-out" the other voice. Patients don't have the same problem. They listen to the language they understand.

Catalina, I know you have experience with simultaneous interpretation.

CATALINA SOL: It is important to have access to simultaneous interpretation for a variety of reasons. We do not use it during medical visits, because we find it can be confusing for the client and provider-everybody's speaking at once, you feel as if the interpreter may be interrupting you or vice versa. However, simultaneous interpretation works well in groups. For example, a health education class is the perfect setting for it, as having consecutive interpreting would double the length of the class. This is also true for patient conferences, workshops, focus groups and other forums in which you want to hear from your patients. In all of these cases, it is a worthwhile investment to obtain the equipment - which is basically a radio system, in which the interpreter speaks into a microphone and the participants tune in to a frequency in which they can hear the person's voice through an earphone. It's relatively inexpensive, and you can rent more receivers for large events. Of course, you have to have a skilled interpreter to actually make this work.

BOB LIKE: Thanks, Catalina. There are also a variety of telephonic methods emerging. There are the language telephone lines that we're familiar with, and some newer variations. These methods are helpful when there is an urgent need, when interpreters are not available, or when caring for a patient who may speak a less common language.

This reminds me of a patient I cared for several years ago in one of our hospitals. She was a 60-ish year old Hmong woman admitted with pancreatitis, diabetes mellitus, and kidney failure who was very sick. She did not speak English and there were no Hmong communities in our area or Hmong-speaking staff or interpreters in the hospital. The patient's family offered to interpret, but it soon became clear that the quality of communication was inadequate, and everyone was frustrated. Fortunately we were able to access telephonic interpreter services at the bedside for a language that is uncommon in Central New Jersey. You could really see the positive difference this made in improving mutual understanding, the quality of care provided, patient, family, and health professional satisfaction, and most importantly, the clinical outcomes.

Some organizations are experimenting with remote interpretation by placing the interpreter in a room located centrally, and using telephone headsets to connect the patient and provider through a conferenced telephone link. In this kind of encounter, the provider and patient can face each other. Both wear headsets and hear only the voice of the interpreter through the headset. While there are some limitations, this technology has potential for eliminating the travel time to get an interpreter from one place to another, and holds promise for specialty services that rarely have on-site interpretation available.

Computer aided interpretation technologies are being developed as well. These allow the provider to be in one place, the patient in another and the interpreter in a third, using computers connected to a digital camera. With further study, systems like these may help smaller organizations maximize scarce resources and help agencies in rural areas bring effective interpretation services to a larger number of people.

Step Five: Assemble A Linguistic Services Plan

JOYCE ST. GEORGE: These newer methods of interpretation are really interesting. I'm glad you told us a bit about them.

Now, let's move to step five, assembling a linguistic services plan. A big question for most of us involves the financial implications. What were the challenges in these areas?

KELVIN QUAN: This past year, our costs for language interpreters ran on average \$0.14 per member per month. The total costs will vary with more or less patients and members. That cost increased by five times from the year before, but it's probably not as much as it should be if all language needs were truly met. Much of that increase was not caused by more need, but rather a greater awareness of how to meet the current need. In spite of the increase, the Alliance is committed to language access, and we don't shy away from stepping up its promotion for budgetary reasons.

The cost of translating a standard 70-page document into 3 languages costs us about \$9,000. The total annual cost of translation for all of our operational, legal and marketing needs runs about \$300,000. But remember, that's for five programs and 90,000 members. Note that the cost of translation doesn't increase with membership. Then, there are also the costs of staffing our services in supporting all of this work.

While some of the debate around language access includes cost-benefits studies, I believe that it must encompass a larger vision. It can't be reduced to a marginal analysis of the short-term savings from the use of one interpreter at a cost of \$92. While none of our revenue sources earmark dollars for language access, that can't be used as a reason for not making the investment. Our role as a health plan is to make the decisions to spend our dollars in the areas that we think will provide the best health care benefit to our members.

DINAH SURH: We've learned that there are good ways to share resources and help defer some of these costs. We're using about 15 Americorps and Vista members to help us with medical interpretation and patient outreach activities. We pay a stipend for their service with us for a year and are able to recruit multilingual members. Partnerships with local colleges and graduate programs are also effective.

Regarding the costs for translated materials we currently pay about 12 - 20 cents per translated English word and on average \$30-\$50 dollars per project. Our materials are translated by staff in Spanish, Arabic, Cantonese, Russian and French-Creole. They are reviewed by others for accuracy. We partner with other health centers to share translated materials.

One way to obtain some funding is by seeking grants to provide health education and outreach, or expand primary care services, and then fold in requests for staffing and materials for your linguistic services. You can join with other safety net providers to submit a coalition grant for funding. And sometimes unions are willing to partner as well.

JOYCE ST. GEORGE: These are really useful ideas. But I'm sure there are common pitfalls. Kelvin, can you talk about some?

KELVIN QUAN: When we began to implement a language access plan seven years ago, we took the usual approach of looking for the industry standards and researching best practices. We realized fairly soon that this aspect of health care doesn't have much history or best practice. However, we were fortunate to have the Language Cooperative in our own County as a valuable and reliable source of qualified interpreters.

We realized that we had to think out of the box. And we had to have the confidence and flexibility to experiment, to invest in a particular approach and to change it when our assessment shows it could be done a better way. For example, we had a lot of problems finding a single vendor that could serve all of our translation needs. This was even after looking at translation companies all over the country. They couldn't handle our volume, or they couldn't meet our turnaround times. Others couldn't work with the computer formats that our printers used. Others used politically incorrect terms, the wrong terms or literacy levels. In the end, we cobbled together a network of translators that gave us the quality we needed, with the trade-off that we'd have to spend more time managing them.

Another struggle was the use of internal staff for our organizational language needs. We're really fortunate that our Manager of Member Services has a graduate degree in linguistics and speaks seven languages. We also have other staff in key positions with bilingual or multi-lingual skills. We struggle with asking them to sign-off on the translations done by our outside vendors. And we constantly have to balance having staff do their regular functions while helping out ad hoc with our language needs.

JOYCE ST. GEORGE: Thanks, Kelvin. Let's talk about how a plan helps to avoid common pitfalls. Bob?

BOB LIKE: There are advantages in developing a formal written plan. The process makes us carefully think through and affirm each of the steps, creates a map to follow during implementation, and provides the documentation. [Slide # 42]

The components of a sound plan would include: the business case, linguistic needs, current linguistic capabilities, points of contact, gaps in linguistic services, proposed strategies and services, budget for implementation, appeals and grievances, monitoring and maintenance, and summary. [Slides # 43 and # 44]

SHANI DOWD: In the publication mentioned earlier, Providing Oral Linguistic Services, there are checklists to ensure that all key areas are addressed. Some questions related to the content of the plan include:

- Are rare languages covered?
- Is there after-hours coverage where needed?
- Are back-up services planned?

Other questions relate to the implementation process, such as:

- Who will have accountability for implementation?
- What is the timeline?
- What resources are required and who's going to develop the budget?
- What training will there be and for whom?

We hope you will take a look at those checklists and use them in your planning.

JOYCE ST. GEORGE: Catalina, are there specific issues interpreters raise about their involvement in helping patients?

CATALINA SOL: There are a few issues that are tricky. On some occasions providers insist on practicing their not-so-fluent Spanish or other language even when an interpreter is present. This is a very awkward position for an interpreter to negotiate, and really requires that the institution make its guidelines very clear to providers.

Another common complaint is that the provider may be confused as to the role of interpreters in the patient follow-up care plan. For example, the provider may tell the interpreter to give a patient instructions for a urine sample, as if the interpreter is a health educator or a nurse. They should not be given the responsibility of providing patient instructions, because even slight variations may be important. Again, this is a case for institutional guidelines.

Finally, community interpreters frequently find themselves in conflict with institutional guidelines regarding their relationship with clients. Over time, clients may develop a strong level of trust with interpreters. Guidelines relating to driving patients in your car, giving them your home number, or accepting small gifts are frequently at odds with common cultural practices. Rather than reprimanding your interpreters, talk to them to find out how they feel about these issues, and what ideas they may have to feel more supported.

Step 6: Monitor Services and Strategies

BOB LIKE: Finally, Step Six involves the process of building evaluation and continuous improvements of strategies and services into the plan. Monitoring lets you know whether the plan was implemented as expected, and if it meets the needs of members, patients and staff. When and how you are going to monitor must be considered in advance of program implementation, so that the appropriate data can be collected. Objectives that are established for the plan should drive the monitoring and evaluation process. You want to see if you are accomplishing what you said you wanted to achieve.

An example of an objective that can be monitored is: "to successfully fill a request for interpreter services 95% of the time".

Since it is unrealistic to assume that everything of interest can be monitored, the organization needs to select the most important items that can make a difference in continually improving the quality of the service.

JOYCE ST. GEORGE: Dinah, can you tell us about the monitoring and evaluation efforts at Sunset?

DINAH SURH: One of the ways we measure our progress is through the use of a report card. Based on our vision, we set benchmark targets and measure our performance in terms of service, quality of care, quality of worklife, and cost. [Slides # 45 and # 46]

- For quality of service, our patient satisfaction increased from 80% to 93%.
- For quality of care, there was a 56% reduction in pediatric admissions and an increase from 82% to 97% in the use of appropriate asthma medications.
- In terms of quality of worklife, staff satisfaction increased from 80% to 94%.

We think that cultural and linguistic initiatives influenced these positive results. For example, in our chronic disease management program we translated asthma materials at the appropriate literacy levels, and created an asthma raider comic book character similar to Hispanic folk heroes. We also use bilingual peer counselors to encourage pediatric patient compliance. A mother recently told us that her daughter used to spend every holiday in the ER. She now spends her holidays at home with her family.

To assess patient satisfaction, our survey covers five different languages and is analyzed by site, network and language. We also monitor changes in customer needs by periodically conducting focus groups of patients and community members who are not patients. To monitor staff performance, we build performance expectations around customer service and cultural competence into job descriptions and performance appraisal processes.

We have a Quality Council that reviews report card dashboard trends, incident reports and patient safety initiatives. We share our report card with frontline staff and also our community partners.

KELVIN QUAN: At the Alliance, we recently measured our performance with an extensive 3-4 month organizational self-assessment. Through a series of meetings and exercises with staff, we measured our performance against benchmarks. We examined our past performance, our current plans and charted future projects through a gap analysis. Instead of meeting as individual departments, we set up the reviews by inter-departmental functional areas like Medical Services, Organizational Infrastructure, Communications, Relationship Building, and Policy Advocacy. I expect that this will become an ongoing process.

Last year, the Alliance was selected by the HHS Office of Minority Health as the one health plan for study of the implementation the CLAS guidelines. During this process, we were really struck at the profound effect of our approach to push the responsibility out to each department, rather than to have it reside with a single department. The coordination is done by our three dedicated staff and myself. But as an organization, the real work takes place by all the rest of our staff, and of course, our doctors and other providers. From our approach, we've gotten tremendous commitment and suggestions on how to be more responsive to our members' language needs.

SHANI DOWD: These were really helpful examples of ways that different organizations monitor and evaluate their initiatives.

Here are five additional areas that you might consider in your monitoring and improvement efforts. [Slide # 47]

- Determining the competency of the interpreter
- Screening and training practices
- Accountability for assessing and documenting competency
- Developing a code of ethics, and
- Determining the competency of the bilingual staff who will be used as interpreters

BOB LIKE: Shani, you make a good point. Just monitoring whether services are provided is not enough. The plan must have a system in place to monitor the quality of the service provided.

Possible ways to monitor service quality include examining:

- utilization statistics;
- compliance with requirements;

- complaints data;
- member and patient satisfaction surveys;
- staff and provider satisfaction surveys;
- satisfaction surveys of bilingual staff as interpreters; and
- clinical outcomes and impact. [*Slides # 48 and # 49*]

By incorporating evaluation in your plan, you can identify areas for expansion and opportunities for improvement. These efforts will help your organization continuously improve as it learns to build on its strengths and take steps that are within reach.

Closing

JOYCE ST. GEORGE: Thank you, Bob and Shani and our group of experts for walking us through the six steps for planning linguistic services in such a thorough and practical way.

We have come to the end of this broadcast. Would each of you like to share a few closing thoughts?

BOB LIKE: One of the key take-home messages is that we need to see the development of cultural and linguistic competence as being a journey and something that doesn't happen overnight. It may be useful to think about improving cross-cultural communication as a type of innovation. In a recent JAMA article entitled, "Disseminating Innovations in Health Care", Dr. Donald Berwick, President and CEO of the Institute for Healthcare Improvement, offers the following seven recommendations about accelerating the rate of diffusion of innovations within health care organizations: "find sound innovations; find and support 'innovators'; invest in 'early adopters'; make early adopter activity observable; trust and enable reinvention; create slack for change; and lead by example." This is sound advice worth following. I'm certain that today's broadcast will help us all move forward in providing more culturally and linguistically appropriate care.

SHANI DOWD: In this broadcast we have offered an outline to use in enhancing linguistic services in your organizations. We have given you a map that is essentially linear in nature. Please keep in mind the examples you heard from Dinah Surh, Catalina Sol and Kelvin Quan. These examples demonstrate that each agency or program must decide what parts of this outline are relevant to them, where to begin their efforts, and how to use these essential strategies. The outlines that you create will of necessity be less linear and will be individualized to your particular circumstances.

While this work can feel overwhelming and complicated, it is also true that it is endlessly fascinating and exciting. I hope that each of you will take advantage of the incredibly rich opportunities for both personal and professional growth that you will encounter along the journey.

JOYCE ST. GEORGE: We know you're already doing many things to build linguistic competence into your organizations and hope points covered during this broadcast will help you to further your efforts.

Remember to take advantage of the resources on the website, www.hrsa.gov/financeMC/broadcast.

We'd like to thank Shani Dowd and Bob Like for guiding us through this journey. We'd also like to thank our other faculty, Deanna Jang, Kelvin Quan, Catalina Sol, and Dinah Surh, who shared with us their best practices and experiences.

Most importantly, we'd like to thank you for attending this broadcast. It reflects the commitment you have to this important topic.

[Broadcast ends with a replay of the scene from the beginning of the program. This time, however, the nurse identifies that the patient speaks Estonian and arranges for telephone interpretation. Through the interpreter the physician learns that she has come to see him because she has difficulty seeing and needs glasses. He notes that planning is beginning in the organization for improved language services.]

Credits.

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APPENDIX A

RESOURCE GUIDE

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Video sequences in this presentation are from the video "Community Voices" by Jennie Greene, MS, and Kim Newell, MD for the Harvard Center for Cancer Prevention. For information, or to obtain a copy of "Community Voices" contact: Fanlight Productions, 4196 Washington Street, Boston, Massachusetts 02131, (800) 937-4113, www.fanlight.com. Portions of this broadcast are protected by copyright, and may not be videotaped, copied or duplicated without permission of the copyright holder.

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U.S. Department of Health and Human Services, Office for Civil Rights. www.hhs.gov/ocr/lep

U.S. Department of Justice, Let Everyone Participate - Interagency Working Group on Limited English Proficiency. www.lep.gov

"Communicating Effectively Through an Interpreter", produced by The Cross Cultural Health Care Program, PacMed Clinics. For information contact The Cross Cultural Health Care Program, PacMed Clinics, 1200 12th Avenue S, Seattle, WA 98144, (206) 621-4161, www.xculture.org. Portions of the broadcast are protected by copyright and may not be videotaped, copied or duplicated without permission of the copyright holder.

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Massachusetts Medical Interpreters Association. <http://www.mmia.org/>
Minnesota Medical Association. <http://www.lep.gov/statetrans.html>

U.S. Department of Health and Human Services, Office of Minority Health. www.omhrc.gov

Medical Interpreter Training Programs and Materials from The Cross Cultural Health Care Programs - For information contact The Cross Cultural Health Care Program, PacMed Clinics, 1200 12th Avenue S, Seattle, WA 98144, (206) 621-4161, www.xculture.org.

Checklist of Key Areas - "Providing Oral Linguistic Services: A Guide for Managed Care Plans". U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services under contract to the Agency for Healthcare Research and Quality. Pages 76-77. www.cms.gov/healthplans/quality/project03.asp

Checklist of Implementation Issues - "Providing Oral Linguistic Services: A Guide for Managed Care Plans". U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services under contract to the Agency for Healthcare Research and Quality. Page 78. www.cms.gov/healthplans/quality/project03.asp

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Additional Resources

The resources below are a sampling the assistance and information available on this topic and is not intended as a complete listing.

Need For Language Access And Services

U.S. Census Bureau Minority Links. <http://www.census.gov/pubinfo/www/hotlinks.html>

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U.S. Census Bureau Minority Links - <http://www.census.gov/pubinfo/www/hotlinks.html>

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Interpreter Practice Standards

"Bridging the Language Gap: How to Meet the Need for Interpreters in Minnesota". Working Group of the Minnesota Interpreter Standards Advisory Committee. <http://cla.umn.edu/pti>

"Medical Interpreters Standards of Practice", Massachusetts Medical Interpreters Association. Send check to MMIA, c/o NEMC, Box 271, 800 Washington Street, Boston MA 02111.

"Standards for Healthcare Interpreters" (draft). California Healthcare Interpreters Association. <http://www.chia.ws>

Interpreter Code of Ethics

"Code of Ethics, Cross Cultural Health Care Program". <http://www.xculture.org/index.cfm>

"Code of Ethics, National Council on Interpretation in Health Care" (under development). <http://www.ncihc.org>

Code of Ethics, Massachusetts Medical Interpreters Association. <http://www.mmia.org>

Assessment of Interpreters

ATLA Language Services. <http://www.altalang.com/testing.htm>

"Guide to the Initial Assessment of Interpreter Qualifications". The National Council on Interpreting in Healthcare Working Papers Series, 2001. <http://www.ncihc.org>

Language Testing International. <http://www.languagetesting.com>

Useful Web Sites

U.S. Department of Health and Human Services, Office for Civil Rights. www.hhs.gov/ocr/lep

U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services. <http://www.cms.gov/healthplans/quality/project03.asp>

U.S. Department of Health and Human Services, Agency for Healthcare Quality and Research (AHRQ). <http://www.ahrq.gov/about/cods/cultcomp.htm>

U.S. Department of Health and Human Services, Health Resources and Services Administration, Center for Health Services Financing and Managed Care. <http://www.hrsa.gov/financeMC/bridging-cultures/default.htm>

The Managed Care and Health Services Financing Technical Assistance Center (MCTAC). www.jsi.com/hrsamctac. A program of the U.S. Department of Health and Human Services, Health Resources and Services Administration, Center for Health Services Financing and Managed Care.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. <http://bphc.hrsa.gov/quality>

National Council on Interpreting in Healthcare. www.ncihc.org

Cross Cultural Health Care Program. www.xculture.org

Hablamos Juntos. <http://www.hablamosjuntos.org/index/>

DiversityRX. www.diversityrx.org

The Access Project. www.accessproject.org

National Center for Cultural Competence, Georgetown University. <http://www.georgetown.edu/research/gucdc/nccc/>

Health Disparities Collaboratives. www.healthdisparities.net

U.S. Department of Justice, Let Everyone Participate - Interagency Working Group on Limited English Proficiency. www.lep.gov

Center for Multicultural and Multilingual Mental Health Services. www.mc-mlmhs.org

The Providers Guide to Quality and Culture. <http://erc.msh.org/quality&culture>

Institute for Culturally Competent Care, Kaiser Permanente, One Kaiser Plaza, Oakland, California 94612. 510-271-2315. E-mail address: nilda.chong@kp.org

The California Workforce Initiative, "Health Interpreters in California". <http://futurehealth.ucsf.edu>

"A Practical Guide to Culturally and Linguistically Appropriate Services in Medicare+Choice Organizations". Regional workshops sponsored by the University of North Carolina, North Carolina Institute for Public Health. <http://www.sph.unc.edu/oce/2003courses/cms.htm>

The resources listed below provide patient education materials translated to a variety of languages. Some material may be copyrighted and may have to be purchased. Prior to use, organizations should assess the materials and their translations for suitability with local needs and requirements.

Immunize.org. Immunization Action Coalition. <http://www.immunize.org/catg.d/noneng.htm>.

Spencer S. Eccles Health Sciences Library, University of Utah, Health Sciences Center.
<http://medstat.med.utah.edu/library/refdesk/24lang.html>.

Ethnomed Patient Education Resources, University of Washington, Harborview Medical Center.
<http://ethnomed.org>

Massachusetts Health Promotion Clearinghouse, a project of The Medical Foundation,
<http://www.macleavinghouse.com/Catalog.htm>

Multilingual-Health-Education.net, A non-profit alliance of Canadian health agencies,
administered by Providence Health Care. www.multilingual-health-education.net

APPENDIX B

SLIDES USED IN BROADCAST

(PowerPoint file available on the broadcast web site: www.hrsa.gov/financeMC/broadcast)

Cross-Cultural Communication in Health Care: Building Organizational Capacity

Satellite Broadcast
June 4, 2003

Sponsored by the HRSA Center for Health Services Financing and Managed Care and the Office of Minority Health, DHHS

Common Foreign Languages in US

- Spanish
- Chinese
- French
- German
- Tagalog
- Italian
- Vietnamese

Source: 2000 Census

Understanding the Language

A physician who understands the language of patients produces better patient self-reported physical functioning, psychological well-being, health perceptions, and less pain.

Source: Perez-Stable EJ et al. Medical Care, 1997.

Untrained Interpreters

- Omitted questions about drug allergies
- Omitted instructions on the dose, frequency, and duration of antibiotics and rehydration fluids
- Instructed a mother not to answer personal questions

Source: Flores G et al. Pediatrics, 2003.

Accurate Interpretation = Clinical Quality

- Reduces medical errors and increase patient safety
- Increases patient compliance
- Increases patient satisfaction
- Improves primary care utilization

Alameda Alliance for Health

Membership by Language

Total Population: 85,348

- | | |
|------------|--------------------------|
| <u>55%</u> | <u>45%</u> |
| • English | • Chinese |
| | • Cambodian |
| | • Vietnamese |
| | • Spanish |
| | • Asian/Pacific Islander |
| | • Farsi |
| | • Other |



- Linguistic Competence:
Business Value**
- Increase market share
 - Maximize retention rates
 - Avoid or reduce costs
 - Reduce medical errors
 - Increase primary and preventive care
 - Increase patient satisfaction
 - Increase compliance

- Linguistic Competence:
Business Value**
(continued)
- Reduce ER use
 - Reduce unnecessary admissions
 - Decrease costs for diagnostic testing

- LEP Policy Guidance**
- Four Factor Analysis**
- Number of LEP individuals
 - Frequency of contact
 - Nature and importance of the activities
 - Resources available

**Cultural Competence
Definition**

A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.

**Linguistic Competence
Definition**

Providing readily available, culturally appropriate oral and written language services to Limited English Proficiency (LEP) members through such means as bilingual and bicultural staff, trained medical interpreters, and qualified translators.

CLAS: # 4

... offering and providing language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with Limited English Proficiency at all points of contact, in a timely manner during all hours of operation.

Source: National Standards for Culturally and Linguistically Appropriate Services

CLAS: # 5

... providing to patients/consumers, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.

Source: National Standards for Culturally and Linguistically Appropriate Services

CLAS: # 6

... assuring the competence of language assistance provided to Limited English Proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services except on request by the patient/consumer.

Source: National Standards for Culturally and Linguistically Appropriate Services

CLAS: # 7

... making available easily understood patient-related materials and posting signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Source: National Standards for Culturally and Linguistically Appropriate Services

Planning Language Services: Social, Political and Economic Factors

- Different geographic/community values and styles of interaction
- Willingness and ability to take risks
- Communities contain various cultures, languages, ages and abilities

Sunset Park Family Health Center Network

Mission Statement

... to improve the overall health and well-being of the communities served by delivering high quality, culturally competent primary care and related services within community-based settings.

Sunset Park Family Health Center Network

Strategic Goals

- Increase patient satisfaction
- Increase staff satisfaction
- Provide staff training
- Create a managerial infrastructure
- Reduce cost and increase efficiency

Providing Oral Linguistic Services: A Guide for Managed Care Plans

Published by the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality

Planning Language Services Six Steps

- Examine linguistic needs
- Assess organizational capabilities
- Identify points of contact
- Consider different language strategies
- Assemble linguistic services plan
- Monitor linguistic services and strategies

Planning Language Services Three Guiding Principles

- Build reporting and refinement into each step
- Learn from your mistakes
- Celebrate successes, small and large

Sources of Language Data

- Population-level language data
- Census, school or local planning district data
- Member or patient population-level language data

Surveys

- Easy to analyze
- Can track results
- Less expensive

Drawbacks to Surveys

- Trust is an issue for communities of color
- May have poor response due to resistance
- Difficult to translate linguistically
- Nuances are lost

Focus Groups

- Allow sharing of impressions, emotions and values
- Surfaces new information
- Promotes sensitivity and understanding of issues

Drawbacks to Focus Groups

- Not representative
- Heterogeneity of community is lost
- Cannot measure results quantitatively or generalize

Self-Assessments

- In-depth, qualitative comments are added
- Teams can work together
- Raises awareness

Sunset Park Family Health Center Network

Staff Cultural Competency Survey Findings

- 55% Very interested in cultures and traditions of others
- 78% Needed more culturally related information
- 77% Were interested in cross-cultural training

Sunset Park Family Health Center Network

Task Force Recommendations and Action Plan

- More bilingual staff should be hired
- Training on medical interpretation skills
- Training for providers on how to use interpreters

Alameda Alliance for Health

Reasons Given for Not Using a Qualified Interpreter

- Financial
- Awareness and Knowledge
- Attitudes
- Operations

Mistakes by Inadequately Trained Interpreters

- An average of 31 mistakes per doctor-patient visit
- Two-thirds could have negative consequences for patients

Source: Flores G et al. Pediatrics. 2003.

Consequences for Patients with Language Barriers

- In the emergency room 28 minutes longer
- More likely to be admitted to the hospital
- More likely to receive IV fluids
- Billed charges an average of 39% more

Source: Hampers L. Pediatrics. 1999.

Written Points of Contact Unconnected to Oral Communication

- Benefits information
- Medical Records
- Claims and billing

Translation "Don'ts"

- Don't use computer programs with automatic translations
- Don't overburden your bilingual staff
- Don't rely on interpreters to "sight translate"

Overlooked Written Points of Contact

- Preparations for diagnostic procedures
- Informed consent forms
- Side effects information
- Medication bottle labels

How to Assess for Points of Contact

- Member visit surveys
- Provider and staff surveys
- Focus groups
- Medical claims information
- Billing records

Possible Criteria for Selecting Language Strategies

- Most important to patient and community groups
- Achievable in close time line
- Aligned with overall organizational business goals
- Accomplished with local resources or acquirable resources
- Supported by staff groups

La Clinica del Pueblo

Strategies

- Develop community language bank
- Train medical interpreters
- Train medical providers on how to use medical interpreters
- Partner with other Interpreter banks to cover multiple language needs

La Clinica del Pueblo

Strategies (continued)

- Link training on immigrant culture and background to linguistic access training
- Advocate and educate to obtain buy-in and support for linguistic access plans
- Use language access cards identifying language and requesting an interpreter

Methods of Interpretation

- Consecutive
- Simultaneous
- Telephonic (remote vs. local)

Value in Developing a Written Plan

- Assists in thinking through and affirming steps
- Provides a map
- Provides documentation

Components of Plan

- The business case
- Linguistic needs
- Current linguistic capabilities
- Points of contact
- Gaps in linguistic services

Components of Plan (continued)

- Proposed strategies and services
- Implementation of strategies and services
- Budget for implementation
- Appeals and grievances
- Monitoring and maintenance
- Summary

Sunset Family Health Center Network

Ambulatory Care Report Card 1996 - 2002

- Quality of Service
80% to 93% overall patient satisfaction
- Quality of Care
 - 56% decrease in pediatric asthma admissions
 - 82% to 97% increase in use of appropriate asthma medications

Sunset Family Health Center Network

Ambulatory Care Report Card

- Quality of Worklife
80% to 94% overall staff satisfaction

Five Key Areas of Monitoring

- Competency of the interpreter
- Adequate screening and training practices
- Accountability for assessing and documenting competency
- Code of ethics
- Competency of bilingual staff used as interpreters

Monitoring Methods

- Utilization statistics
- Compliance with requirements
- Complaints data
- Member and patient satisfaction surveys

Monitoring Methods (continued)

- Staff and provider satisfaction surveys
- Satisfaction surveys of bilingual staff used as interpreters
- Clinical outcomes and impact