



HEALTH EQUITY *and* LANGUAGE ACCESS

How Language Access Issues Affect Patients, Policymakers and Health Care Providers

Prepared for The Colorado Trust by Erica Baruch, JD; Sherry Freeland Walker, editor

» ABSTRACT

The provision of accessible and meaningful language services to individuals with limited English proficiency (LEP) is a key component of health equity. For the growing hundreds of thousands of Coloradans who struggle with language barriers, the obstacles to obtaining good medical care can be overwhelming and the cost of inadequate language services huge. Efforts to improve language access make up a critical part of the work needed to reduce existing health disparities.

This paper looks at how language access issues affect patients, policymakers and health care providers. Specifically, the paper:

Examines the importance of language access in health care. Language barriers compromise quality of care and patient safety. They affect patient satisfaction and whether or not patients will return to a particular health care institution. They can result in higher health care costs from inefficiencies such as unnecessary testing of patients with whom providers can't communicate. They can frustrate providers who want to serve all patients equally and to the best of their abilities.

Provides policymakers with an overview of existing legal requirements and additional policy opportunities for consideration. The federal Patient Protection and Affordable Care Act (ACA) expands requirements and offers opportunities for further improvement of language access. Colorado is eligible to receive a 50 percent match from the federal government for offering language services to Medicaid patients. Programs such as financial assistance for bilingual students entering the health care field can provide other opportunities for policymakers to address language access issues.

Offers health care providers approaches to improve language access. Strategies such as creating a language access policy have been found to help organizations avoid pitfalls and standardize quality of care. The process for assessing needs and improving services can be undertaken one step at a time, beginning with collecting data on patients' language preferences and the local LEP population.

Additionally, case studies detail how some Colorado organizations have made strides in improving language access. These examples, provided by grantees of The Colorado Trust's Equality in Health initiative, illustrate how strategies tailored to an organization's unique context, resources and needs can result in significant advances.

Health service organizations and policymakers can use the information in this paper to guide future efforts and assure all Coloradans receive quality, equitable health care.

» INTRODUCTION

Health service organizations know that effective communication between patient and the staff is essential for achieving positive health outcomes. Patients must be able to make appointments. Providers must be able to obtain a medical history and discuss symptoms. Health educators must be able to explain the nature of disease and prevention. Patients and their families must be able to understand diagnosed medical conditions and recommended courses of treatment. The rise in language diversity in the United States brings with it several challenges to ensuring effective communication. Organizations that work to address these challenges, however, can realize their goal of providing high-quality care to all patients.

The following stories, detailing actual events, demonstrate the importance of linguistically appropriate services. The stories also exemplify how language barriers can be overcome and how a health care delivery system with an understanding of the importance of language access can modify its services and change both staff and community perceptions relatively quickly.

In 2005, Maria Ortiz,* a young mother in her mid-20s, arrived at the emergency room (ER) of a Colorado hospital in excruciating pain. Her 9-year-old son, husband and other family members accompanied her. No one in the ER spoke Spanish and neither Maria nor her adult relatives spoke English. For two hours, the ER physician tried to determine the source of her abdominal pain. With no one else available, he relied on Maria's son to interpret, who, upset by the provider's increasing vehement questions and his mother's screams, started to cry. Many tests were performed. Family members became angry, crying. The staff became more and more frustrated and could make no conclusive diagnosis.

Finally, a member of the physical therapy department was called in to help interpret, and hospital staff determined Maria had a ruptured appendix. Emergency surgery was performed, but the severity of the case and continuing communication difficulties led to Maria's remaining hospitalized for several days. During

* Names have been changed to protect patient confidentiality.

this time, bilingual housekeeping staff with minimal formal education and no medical knowledge were called upon to interpret. When Maria's family eventually left the hospital, word spread throughout the Hispanic neighborhoods surrounding the hospital that the facility was unwelcoming to their community and provided poor quality care. Moreover, more than a few of the hospital staff blamed Maria and her family for the poor care they received, believing the family had a responsibility to learn English.

Seven years later, Lupe Gomez came to the same hospital for delivery of her fourth child. With the help of the hospital's on-site full-time trained interpreter, Lupe filled out the consent forms, and the hospital team, including the interpreter, prepared for delivery. Everything went smoothly as Lupe's labor proceeded. Toward the end of the delivery, however, the obstetrician observed some problems with the baby as well as some unusual bleeding that indicated a more urgent delivery was needed. The doctor quickly alerted the nursing staff and, through the interpreter, related to Lupe's husband the severity of the situation. He and Lupe were informed of every risk and decision as the physician addressed the clinical issues. Speaking through the interpreter, the doctor reassured the couple he was taking care of the situation and that Lupe and the baby would be fine.

The hospital's interpreter not only facilitated communication, but also, through her presence and her role as patient educator, helped keep the mother oriented as to what was taking place and allowed the father to make decisions needed immediately. The availability of several dual-role interpreters (bilingual staff members working in other positions who agree to serve as interpreters when needed) also made it possible for the staff interpreter to take a short break and recover from the emotional intensity of the previous several hours. Afterward, the staff interpreter returned to the obstetrics unit and stayed until Lupe and her baby were resting comfortably. She assured them that the nurses could call for her at any time. The family expressed their gratitude and appreciation to both the interpreter and the physician for their care.

Organizations that work to address language diversity challenges can realize their goal of providing high-quality care to all patients.

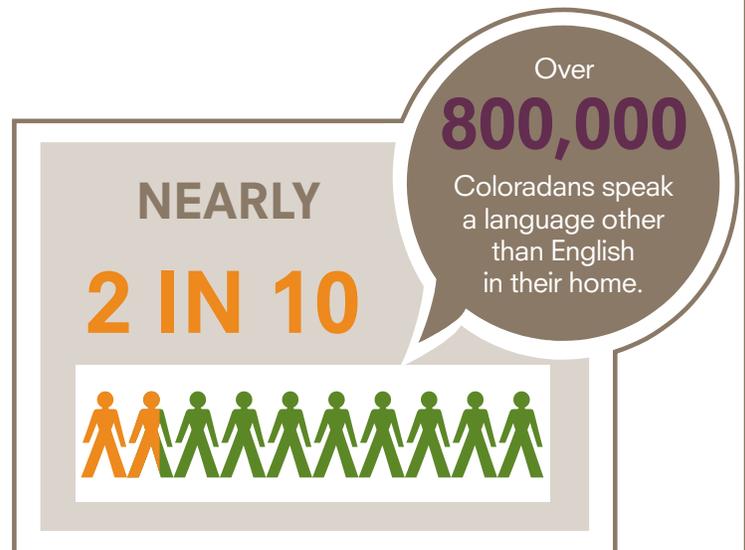
» THE IMPORTANCE OF LANGUAGE ACCESS IN HEALTH CARE

The 2010 U.S. Census shows that more than 800,000 Coloradans (roughly 17 percent of the population) speak a language other than English in their home, and 7 percent of Colorado's population (nearly 328,000 individuals over the age of 5) are considered "limited English proficient (LEP)"¹ – defined as speaking English less than "very well." Between 2000 and 2010, the number of Coloradans who spoke a language other than English at home grew by more than 200,000 (a 33 percent increase), and the number with limited English proficiency grew by 60,000 (a 23 percent increase).²

After English, Spanish is the most common language spoken at home in Colorado, followed by Vietnamese, German, French, Chinese, African languages, Korean, Russian and Arabic. Rates of the LEP population vary by language.² Where French or German are spoken at home, the rates of LEP individuals are relatively low (14 percent and 11 percent, respectively).² Sixty-four percent of those who speak Vietnamese at home, 50 percent of people who speak Chinese and 47 percent of those who speak Korean are LEP.² Among households where Spanish is the primary language spoken at home, 42 percent of the population is LEP.²

At the same time, a relatively small number of Colorado providers are fluent in a language other than English, and often it is providers with less training and authority who have additional language skills. For example, the Colorado Health Institute reports that 28 percent of certified nursing aides are fluent in a language other than English, compared to only 12 percent of registered nurses.³ Even if a patient's provider is fluent in the patient's preferred language, that patient may still face challenges in communicating with others throughout the medical system (e.g., front desk staff, medical/dental assistants, health educators, staff who help enroll patients in benefit programs, pharmacists).

Evidence indicates language barriers compromise quality of care and patient safety. Patients who face language barriers are less likely to have a usual source of medical care, they receive preventive services at reduced rates, and they have an increased risk of nonadherence to medication.⁴ Language barriers expose LEP patients to danger or risk by reducing their



understanding of diagnosis, treatment instructions and recommended follow-up care.⁵ Inadequate communication also can cause physical harm. A 2007 study reported that 52 percent of adverse events that occurred to LEP patients in U.S. hospitals were likely the result of communication errors and that nearly half of these events involved some physical harm.⁶

Other consequences of language barriers include low patient satisfaction, which can determine whether a patient will return to a particular institution for care, and higher health care costs as a result of increased inefficiencies such as unnecessary testing.⁷ Both factors can influence an organization's financial well-being and result in avoidable expenditures across systems.

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Interpretation vs. Translation

Interpretation: The verbal rendering of information from one language into another. The act of interpretation occurs in instances of oral communication, such as medical exams, therapy sessions, wellness groups, health education classes, etc.

Translation: The written rendering of information from one language into another. The act of translation occurs when written text, such as policies, consent forms, patient education materials, prescription instructions, etc., are converted into another language.

Both interpretation and translation, when done well, accurately capture the meaning of the original message. Specific words, phrases or expressions may be modified to adjust for the cultural context of the intended audience.

» HEALTH POLICIES

Legal Requirements and Opportunities

Title VI

In addition to the safety, quality control, ethical and fiscal motivations for instituting language access programs, legal requirements exist. Title VI of the 1964 Civil Rights Act prohibits “any program or activity receiving federal financial assistance” from discriminating based on national origin, which the U.S. Supreme Court has interpreted to include discrimination based on language. Thus, health service organizations receiving reimbursement through Medicaid, the State Children’s Health Insurance Program or Medicare, any type of federal grant or other federal funding must provide language services to LEP individuals. In August 2000, President Clinton issued Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*. The same year,

the U.S. Department of Health and Human Services (HHS) issued initial guidance to assist health care providers in meeting their obligations to LEP patients.

In the years following Clinton’s executive order, it became clear that many health care providers were not aware of their responsibility, did not consider language access as a priority and were not held accountable through consistent enforcement of the law.⁸ In 2011, the U.S. Attorney General issued a memorandum renewing the federal government’s commitment to language access, and the Department of Justice issued the *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs*. This document and many other published resources at LEP.gov aim to assist organizations in meeting the law’s requirements.

Health service organizations receiving federal funding must provide language services to LEP individuals.



National Standards for Culturally and Linguistically Appropriate Services

Following Executive Order 13166, the federal Office of Minority Health issued a set of standards for Culturally and Linguistically Appropriate Services (CLAS) in health care. Defined broadly as care and services that are sensitive to the cultural and language needs of all individuals, these standards are often used by organizations as a basis for crafting their own policies. Of the 14 CLAS Standards, standards 4-7 deal specifically with language access:

- **Standard 4:** Health care organizations must offer and provide 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.
- **Standard 5:** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- **Standard 6:** Health care organizations must assure 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).
- **Standard 7:** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Affordable Care Act

The ACA elaborates the need for language access services within the health care setting. Most of the act's requirements for improved language access relate to the health insurance exchanges and the "qualified health plans" certified by the exchanges. The requirements, however, extend to any organization or entity with which an exchange or qualified health plan subcontracts to provide services.

Nondiscrimination

Section 1557 of the ACA extends the civil rights protections of Title VI to any health program or activity receiving federal financial assistance, to any program or activity administered by an executive agency and to any state exchange.⁹ Thus, the health insurance exchanges, and any entity receiving federal funds through them, cannot discriminate on the basis of national origin. Regulations on the nondiscrimination provision will be forthcoming.

Summary of Benefits and Coverage, Appeals and Plain Language

Under Section 1001 of the ACA, any group health plan or health insurance issuer must provide a summary of benefits and coverage, and notify enrollees of available internal and external appeals processes, in a culturally and linguistically appropriate manner.¹⁰ Section 1331 calls for health plans seeking certification under the exchanges to provide information "in language that the intended audience, including individuals with limited English proficiency, can easily read and understand."¹⁰ This includes such information as claims payment policies and enrollee and participant rights. The National Health Law Program (NHeLP), which advocates for health rights for low-income and underserved individuals, notes that regulations following passage of the ACA require translation and oral communication of the summary of benefits and coverage and any appeals or notices when 10 percent of a county is LEP.

Quality Incentives

Section 1311 describes a payment structure for exchange plans that provides increased reimbursement or other incentives for activities to reduce health care disparities, including language services.¹⁰ Guidelines for receiving incentives are being developed.

Patient Navigators

The ACA authorizes funding to establish patient navigators to provide fair, accurate and impartial information related to the exchanges. Navigators – trained health care workers who guide patients through the complexities of the health care system – must provide information in a manner that is culturally and linguistically appropriate to the needs of the population served by the exchange.¹⁰

Data Collection

Section 4302 requires HHS to develop standards for collecting language data. These data must be reported for quality measurement under any ongoing or federally conducted or supported health care or public health program, activity or survey. HHS also must develop standards for managing and analyzing data collected to detect and monitor trends in health disparities at federal and state levels.¹⁰

While the ACA offers many opportunities to improve language access, much is left to the federal administration to determine as part of implementation. More explicit requirements for language services are likely to come in the regulations and/or subregulatory guidance from the relevant agencies. NHeLP makes the following recommendations for the exchanges and qualified health plans:

- *Translations* – Completely translate all vital documents and notices for each LEP language group that constitutes 5 percent or 5,000, whichever is less, of the applicants/enrollees in a service area.



- *Taglines* – Include in at least 15 languages a line that alerts LEP individuals to the importance of a particular document on all notices, vital documents and websites.
- *Oral assistance* – Provide competent interpreters or bilingual staff in all languages (including American Sign Language) at all points of contact.
- *Outreach and education* – Conduct all activities in a culturally and linguistically appropriate manner.
- *Navigators* – Ensure navigators have appropriate language services in place and that navigator training addresses assisting LEP individuals.
- *Data analysis* – Require exchanges and navigators to analyze quality and performance indicators by demographic data, including language, to identify and address any disparities in access to care.

Colorado Laws

Colorado has enacted several statutes and regulations that also support the importance of language access in health care. For example, Colo. Rev. Stat. 10-16-704(9)(e) requires all managed care plans to have an access plan that includes efforts to address the needs of covered LEP individuals. Colo. Rev. Stat. 12-38.1-202(2)(b) aims to improve outreach to individuals whose native language is not English to attract them into the health care profession.¹¹ A number of regulations focus

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on the entitlement of individuals with mental illness or developmental disabilities to receive in their native language an explanation of rules and information regarding dispute procedures. Colorado regulations also require notification in the applicant's native language of decisions regarding Medicaid and the Child Health Plan Plus Program (CHP+).¹¹

» HEALTH PRACTICES

Language Access Services

Despite legal requirements and evidence showing that unaddressed language barriers have a negative impact on patient care, progress in improving language services can be difficult. In a recent study, cost and

Considerations for Colorado Policymakers

Colorado policymakers might consider several different opportunities to promote language access. Perhaps most important is offering financial assistance to health care providers since the cost of providing language services often limits providers' willingness to do so. The federal government supplies matching funds to states for services provided to Medicaid and CHP+ enrollees, and these funds then can be distributed to providers and hospitals that serve a disproportionate share of Medicaid and uninsured patients. The funds also can be used to assist with administrative program costs.

Fourteen states directly reimburse providers for language services offered to Medicaid and CHP+ recipients. Were Colorado to add language services to its Medicaid state plan, the state would receive a 50 percent match from the federal government for covered services, including written translation and interpretation, whether provided by staff interpreters, contract interpreters or through telephone service.^{12,13} Though Colorado faces a tight budget, making it difficult to find funds to meet the federal match, the gains realized from allocating money for this program could be significant. Reimbursement of providers would provide an incentive for hospitals and safety-net clinics to increase their efforts to address the needs of LEP patients.

Policymakers also have the opportunity to address language access through Colorado's implementation of the ACA. Much can be done at the state level to influence what types of language access services will be required by the Colorado Health Benefit Exchange (COHBE) or in its qualified health plans. If policymakers consider the needs of LEP individuals and the NHeLP recommendations outlined on page 6 as they establish rules and regulations for ACA implementation, they can help expand language access and improve quality of care for the state's LEP population.

Finally, Colorado lawmakers have the opportunity to consider educational and student financial assistance programs that promote diversification of the health care workforce and support bilingual individuals in pursuing careers in health. Programs that create an educational pathway to health careers, from elementary school through higher education, and that encourage participation of students of color can help diversify the health care workforce. Loan repayment programs that provide special incentives for bilingual individuals to work in health fields and/or in geographic areas where their linguistic abilities are needed could also be a means to increase language access.

lack of insurance reimbursement for interpreter services were identified as the biggest challenges hospitals face in providing adequate language services for LEP patients.¹⁴ Similarly, two-thirds of internal medicine physicians working in practices with LEP patients felt that payment or reimbursement would increase their practices' ability to provide language services.¹⁵ Many organizations report it is difficult to find staff with the desired linguistic competency and diversity.¹⁶

National and state studies have found insufficient access to interpreter services, multilingual signage and written translation services, as well as low levels of patient understanding regarding their rights to these services. A 2010 study of 135 hospitals across the United States showed that hospitals are not meeting federal regulations. Seventy-eight percent of hospitals reported being able to provide language access services for their most common language in the ER within 15 minutes during business hours, but only 48 percent could provide interpreters in that time for their third most common language.¹⁴

Most hospitals required that staff (79 percent) and contract or agency (63 percent) interpreters undergo interpreter training, but ad-hoc interpreters, such as volunteers, dual-role interpreters and bilingual staff, were not held to the same standard. Additionally, 62 percent of hospitals reported that family members or friends were used as interpreters, even though 70 percent of these hospitals had a policy prohibiting this practice. Only half the hospitals surveyed had bilingual signage, and less than one-third had important documents, such as advance directives, patients' rights, discharge instructions and informed consent, available in two or more non-English languages. Only 17 percent of hospitals could provide all these forms in their most common non-English language.¹⁴

A 2004-2006 study of Colorado hospitals found similar struggles in providing high-quality language services.

Cost and lack of insurance reimbursement for interpreter services were identified as the biggest challenges hospitals face in providing adequate language services for LEP patients.

Public health agencies want to establish language services but lack infrastructure and knowledge about how to begin.

Although many of the hospitals reviewed had taken incremental steps to improve their services, the study showed that more work remained. Four of 10 Colorado hospitals surveyed had established institutional guidelines for interpretation, but some still struggled to train staff on the use of available resources and on existing policies. The study also found that the use of family, friends and/or staff lacking any formal training was widespread.¹⁷

LEP patients interviewed for the report described difficulty making appointments, including multiple phone transfers and frequent disconnections. They indicated that the lack of qualified interpreters made them fearful of accessing care and prevented them from seeking the treatment they needed. Additional patient complaints included difficulties in attaining accurate and timely information related to medication, accessing preventive care and having to take children out of school to interpret for their parents at medical visits.¹⁷

According to Colorado's Office of Minority Health and the state's language access coordinator, local public health agencies also are grappling with language access challenges. Public health agencies want to establish language services but lack infrastructure and knowledge about how to begin. While the Colorado Department of Public Health and Environment is working to centralize interpretation and translation services, these efforts do not yet extend to local health agencies.

» CASE STUDIES

Despite the challenges, some organizations in Colorado have made tremendous strides in improving language access in the last five to 10 years. The Colorado Trust's Equality in Health initiative focused on reducing racial and ethnic health disparities through improved organizational cultural competency, and nearly all of the 26 nonprofit service organizations and education institutions that participated took steps

to improve their language access services. Case studies from four of these organizations demonstrate there is no “one-size-fits-all” approach to improving language services, but rather that organizations can and should tailor strategies to fit the needs of their populations, their unique context and the resources available to them. Brief descriptions follow; please see Appendix A for the full case studies and Appendix B for explanations of various methods and modes of providing language access.

Prowers Medical Center

Prowers Medical Center (PMC) includes a 25-bed critical care access hospital in Lamar, Colorado, a Veterans Administration clinic and several outpatient services. Although Hispanic persons make up 36 percent of the Prowers County population,¹⁸ the organization did not have a formal language program prior to 2005, and patients were asked to bring their own interpreter. With the LEP population continuing to grow, the center hired a full-time language coordinator/staff interpreter. She conducted an education campaign throughout the system and used an assessment tool (LEP.gov) to measure language services and identify gaps.

Since then, the center has trained bilingual staff as dual-role interpreters (staff who work in other positions but who can serve as interpreters when needed); formed an Interpreters Committee to monitor progress, resolve issues or complaints, and ascertain where extra training may be needed for staff or interpreters; and taken other steps to stay on top of language access needs. PMC staff believe these changes have improved the clinic’s quality of care for LEP patients, its understanding of and support for language access services, and its relationship with the Hispanic community.

Summit Community Care Clinic

Summit Community Care Clinic (Care Clinic) offers primary care, oral health, behavioral health, physical therapy and reproductive health services to the medically underserved in Summit County. Prior to 2006, it relied on two Spanish-speaking staff as ad-hoc interpreters and allowed volunteer providers with basic Spanish skills to communicate directly with Spanish-speaking patients. As the clinic grew, emphasis was placed on culturally and linguistically appropriate services for its patients. The hiring of bilingual and bicultural staff was key with a candidate’s fluency in a

language other than English often given extra weight in hiring decisions. Bilingual staff were trained to serve as interpreters, and staff from other countries were hired who could relate to immigrant patients’ experiences and act not only as interpreters, but also as cultural liaisons.

Today, most of Care Clinic’s staff is bilingual and Spanish fluency is required for health educators, clinic and dental assistants, and eligibility specialists. The results of Care Clinic’s commitment to creating a multicultural and welcoming environment are evident in staff and patient surveys which show loyal, committed staff and patients who consider Care Clinic their medical home.

Marillac Clinic

Marillac Clinic provides integrated physical and mental health care to thousands of uninsured or underinsured Mesa County residents each year. When Marillac lost its bilingual counselor in 2006, a gap in service for LEP patients became apparent. Marillac understood the importance of having linguistically accessible mental health services for its Spanish-speaking patients, including both individual counseling and group sessions to help patients cope with stress and depression caused by chronic disease. Marillac invested in additional training and support for its two



dual-role interpreters, skilled and experienced in both consecutive and simultaneous interpreting necessary in mental health sessions (see Appendix B).

Because mental health sessions can be emotionally and mentally exhausting for interpreters, the clinic provides time for them to “process” with the mental health provider following a session and to discuss any cultural nuances that arose. Discussions between mental health interpreters and providers help interpreters handle the impact of conveying traumatic experiences. While interpreting in mental health is more complex than interpretation in other situations, Marillac’s commitment to both the patient and the interpreter has allowed the clinic to continue to provide integrated care services to its LEP patients.

Family Medicine Center

Several years ago, Poudre Valley Health System’s Family Medicine Center (FMC) recognized it had a problem with communication between residents and patients. Residents who lacked Spanish fluency often communicated directly with Spanish-speaking LEP patients, resulting in errors and miscommunication. Patients complained they did not understand their diagnosis, treatment options or medication

instructions. Some residents refused to use the staff interpreter, relying instead on family members, even children.

Recognizing the difficulty this posed in providing quality care, FMC crafted a new policy indicating what to do in various scenarios with LEP patients. During their orientation, residents are trained on that policy, the importance of appropriate language services and how to work with an interpreter. The staff interpreter/cultural care coordinator also conducts one-on-one teaching sessions using LEP patient cases to discuss language and cultural issues. Residents who have some Spanish fluency but lack confidence or skills can complete a two-week rotation with the interpreter to improve their vocabulary, grammar, pronunciation and understanding of cultural nuances so they can speak directly with patients, although an interpreter remains present for assistance. FMC staff believe that educating and training residents and staff on language access has led to improved efficiency and quality of care.

» STRATEGIES FOR IMPROVING LANGUAGE ACCESS

Organizations can and should take various paths to provide language access services for the populations they serve. Certain practices, however, are central to providing linguistically appropriate care but do not need to be implemented at once. Most organizations build their language access programs over a period of years. Each organization likely will want to assess its current efforts and resources and decide what to address immediately. For example, an organization may already have a basic policy in place but may not be implementing it properly. In this case, the organization may decide to provide training for staff on the policy and how to work with interpreters.

Another organization may observe that patients communicating in their native language with bilingual providers often return with lots of questions and fail to understand their diagnosis or treatment plan. This organization may want to institute an assessment for staff wanting to communicate in more than one language. Though organizations will implement strategies as time and resources allow, they can avoid common pitfalls and standardize quality of care by being familiar with the following practices.





- **Leadership support and development of organizational buy-in.** Language access efforts often start with concerns from front-line staff (providers and support staff), but leadership support ultimately is needed for long-term success. Leaders can demonstrate commitment to language access by promoting policies and procedures and by supporting staff interpreters and dual-role interpreters who may be encountering challenges. These challenges can range from provider resistance to using interpreters in the exam room to complaints from colleagues who feel dual-role interpreters are not keeping up with their regular duties. Leaders can participate on committees addressing issues of language access and cultural competency and encourage buy-in by articulating how language access is tied to providing high-quality health care.
- **Creation of a language access policy.** Policies and procedures that systemically support efforts to meet the needs of an organization's LEP patients help prioritize the issue and drive changes in practice. Policies typically include discussion of both oral (interpretation) and written (translation) services and specific procedures staff need to follow, including what language services are

available (e.g., on-site interpreters, telephone-based interpretation, etc.), how to access the services and what to do if a patient refuses services. Policy statements that prohibit the use of minors and family members as interpreters, except in cases of emergency or when the patient refuses an interpreter, establish expectations regarding this highly discouraged practice. Providing training to staff on policies and procedures at orientation and regularly thereafter helps to ensure proper implementation. While detailed procedures do not need to be shared externally, the public should be notified of the policy, in preferred language(s), through on-site postings, the organization's website and other mechanisms to promote community understanding of the organization's commitment to language access.

- **Assessment and certification of interpreters.** Assessing both the linguistic and interpreting skills of all individuals used to interpret is important to ensure quality interpretation. (Contract interpreters may be assessed by an agency, but it is worthwhile for organizations to verify such testing.) Linguistic skill testing includes oral and written components and incorporates medical terminology. Assessment of interpreting skills usually comprises verifying the interpreter's understanding and adherence to ethical and professional practice standards, as well as his or her ability to conduct both consecutive and simultaneous interpretation. Interpreters skilled in only consecutive interpretation will generally not be able to effectively interpret mental health care services. Certification of interpreters through recognized programs, such as Bridging the Gap or the National Board of Certification for Medical Interpreters, also helps ensure high-quality interpretation.
- **Assessment of staff wishing to communicate in more than one language.** For staff who wish to communicate directly with patients in more than one language, completion of a standardized oral and written assessment in their non-native language helps to ensure effective communication. Such testing is also important for staff whose first language is not English. Standardized assessments allow organizations to be confident in the abilities of staff who pass the assessment, while staff who do not pass may be offered training and/or an opportunity to take the assessment again later.

Many organizations have found that offering a pay incentive to staff members who pass a language proficiency test helps retain bilingual staff who may be sought after by other agencies.

- **Training for staff, providers and patients on the role of the interpreter and working with interpreters.** Successful interpretation involves at least three individuals who clearly understand the interpreter's role. Training for staff and providers on the practice and ethics of interpreting and the various roles an interpreter might play (e.g., conduit, cultural liaison, advocate) improves understanding and performance. Likewise, prior to the start of any session, patients should be informed of how the interpreter will function throughout the encounter.
- **Ongoing training and support for interpreters.** As the field of medical interpreting continues to evolve and because interpreting can be an isolating and difficult experience, interpreters benefit from receiving ongoing training and support. Regular meetings where interpreters can share new information and terminology and discuss challenges they have experienced have proved helpful in organizations where multiple individuals serve as interpreters. Interpreters, particularly those in mental health, may also need support services to help maintain their own well-being and prevent the effects of vicarious trauma. Opportunities to improve knowledge and skills, either through conferences or workshops or observation and feedback of more experienced interpreters, can also help interpreters improve their practice.
- **Review of all translated materials for accuracy, cultural appropriateness and suitable literacy levels.** Reviewing all translated documents to make certain the translation is grammatically correct and reflects the idiomatic characteristics of the target population ensures readability. As part of the review process, translating converted materials back to English can help guarantee the accuracy of the information being conveyed. Additionally, ensuring information is presented in a culturally appropriate manner and at an appropriate reading level for the target audience enhances each document's utility. Quality controls may include using patient focus groups, patient advisory boards or community representatives to review materials and provide feedback.

- **Collection and utilization of data to improve services.** Collecting language preference data at the first encounter with any patient and recording these data in the patient's record improves an organization's ability to plan for patient needs. Further, language preference data along with community-level data can be used to guide language service development. Data regarding health outcomes and LEP patient satisfaction can be analyzed to identify and monitor health disparities. Such data then can be used in short- and long-term organizational planning to improve services and reduce any disparities.



» PRACTICE CONSIDERATIONS:

What Health Service Organizations Can Do to Improve Language Access

Health care clinics, hospitals and other health service organizations can take steps to begin providing language access for their patients or improve what they are already doing. Those steps include:

1. **Conduct a needs analysis.**

To determine how best to meet the needs of their LEP population, a health care organization will want first to understand who is in their service area and who is or is not visiting the organization for care. Many organizations collect information on language preference in addition to race, ethnicity and other demographic data. Organizations that do not collect such data can begin to do so by asking all patients to indicate their preferred language at intake. Examining this data will allow organizations to understand the language groups they serve and each group's percentage of their patient population. If the system allows, it is also helpful to examine the return rates of a particular language group and what health services that group accesses.

Health care organizations can examine population data for their service area to see how those data compare with their patient data and if any significant language groups are missing. If an organization targets a specific race or ethnicity, it may also want to determine if particular cultural or language sub-groups are not represented among the patient population.

Organizations will also want to review the methods they use to meet both oral and written language needs. Does the health care organization ever use children or family members as interpreters? Does it use ad-hoc interpreters, including untrained bilingual staff? In how many languages are the most commonly used materials available? Are documents translated through a systematized process that checks for accuracy, cultural appropriateness and suitable literacy levels?

As part of this review, it is important to look at organizational challenges and successes. If an organization recently hired a bilingual provider or a full-time staff interpreter, how has that affected the organization's ability to meet the patients' language needs? Has the organization attracted more patients of a specific language? How have the organization's efforts influenced efficiency and/or patient satisfaction? Challenges might be noted by looking at such issues as dropped calls on an appointment line, wait times for LEP patients compared to English-speaking patients, additional testing for LEP patients or provider concerns about follow-up rates for LEP patients compared with other patients.

Finally, organizations will want to note where gaps in service exist. Examination of all points of contact between a patient and the organization helps determine where appropriate language services exist and where they are needed. This includes first points of contact (e.g., the organization's website, outreach services, appointment line and front desk/reception) through all potential aspects of a visit (e.g., intake, eligibility, medical history, exam, patient education) to all components of follow-up care (e.g., medication instructions, referrals to specialty clinics or testing, lab results, reminder appointments).

2. **Select the appropriate approach for the organization's culture and resources.**

Any organization is unlikely to be able to jump from its current state of language access to its ideal state, even with the most committed staff and leadership. Developing high-quality language access services takes time and a long-term plan. Once an organization understands its current strengths and resources, it can build upon them.

For example, if an organization primarily sees LEP individuals from one language group and employs bilingual staff who speak that language but are not trained as interpreters, the organization might send all bilingual staff to a comprehensive training course or ask one individual to become a trainer and then train others in-house. If an organization regularly sees patients from several language groups, it may want to consider a "language line" or telephone-based interpretation, where services usually include more than 150 languages. If

an organization only occasionally sees patients who do not speak English and usually knows the times of their visits in advance, it might investigate using a contract interpreter.

Most organizations are likely to need a combination of approaches. As each approach is introduced, it is important to train staff and make sure they are utilizing the service effectively. It is also important to remember that staff members need training and practice to become comfortable with new services.

As an organization assesses resources and options, leaders and staff may want to keep in mind community partners and potential collaborations. It may be possible to share an interpreter, collectively purchase a reduced rate for telephone-based interpretation or pool resources to pay for a local interpreter training. If an organization has limited resources, it might explore the use of volunteer interpreters, though it will want to make certain volunteers are trained, have appropriate linguistic and interpreting skills, and, especially in the case of small language communities, will not compromise a patient's confidentiality. Sharing translated educational materials and looking for translated documents from reputable sources can reduce costs, though each organization should assess the appropriateness of these materials for its own population.

3. Craft, disseminate and implement an organizational language access policy.

Regardless of what approach an organization takes, a policy around language access is essential to ensure that staff members recognize the importance of linguistically appropriate care to the organization and to its patients. Successful organizational policies articulate to staff the "dos" and "don'ts" procedures for responding to different situations and the staff's role in upholding the organization's linguistic accessibility. Many examples exist for organizational language access policies so no organization will need to start from scratch. Each organization, however, will want to craft a policy that fits its context and that its staff can easily understand. Some organizations find it helpful to have key staff or a committee review the policy and provide feedback as part of the development process. Often staff can note procedural challenges that need to be sorted out prior to the policy being finalized.

Once a policy is approved, the next step is dissemination. This might include opportunities for staff questions and answers and careful review of all procedures. Staff will also need to understand how the policy will be enforced. Finally, it is important for organizations to share the policy with their patients and with the broader community.

For a policy to be implemented successfully, staff may need training on the new procedures. They may need to practice such tasks as connecting to and using a telephone-based service or working with an interpreter. Role-plays or simulated situations incorporated into trainings can help improve practice. Further, if certain services are not used frequently, staff may need to be retrained periodically to maintain a comfort level with the services. Also, discussion of and practice with new translation policies can aid staff who assist with translations. Staff who assisted with translation under old procedures may feel offended by having their translations questioned and reviewed, but training on why such procedures are necessary for quality patient care and safety usually helps resolve these issues.

4. Evaluate and review language access policy and procedures.

Periodic evaluation and review of an organization's language access policy and procedures help to identify implementation challenges and any modifications that may be needed. Organizations can conduct evaluation through a variety of methods, including staff surveys, client surveys, client focus groups, key informant interviews and community forums. Each of these methods allows affected individuals to provide feedback on what is working and what is not regarding the organization's language access services.

Another method of evaluation uses trained bilingual staff or outsiders to conduct "secret shopper" calls or visits. This type of evaluation can provide more objective data on a number of items, for example, how many times calls are dropped or properly transferred to a bilingual individual, how often information is relayed correctly, how well employees use a telephone-based means of interpretation, or how well staff or dual-role interpreters are performing. Targeted sites or individuals can then receive additional training as needed.

Even when procedures work well, conducting a periodic review of services and trends in the field can prove useful. Such a review might consider new demographic trends, new interpretation technology and any changes within an organization's procedures or structure (e.g., new physical construction, use of electronic health records, new health services) that may affect the organization's ability to provide high-quality language access to all LEP patients.

5. Plan for scaling up.

Improving language access typically involves a series of steps and incremental changes. Organizations that plan for improved services even as they are implementing initial changes realize greater achievements more quickly. Such planning involves considerations of future patient and staff needs and the budget necessary to meet those needs. Including funds for language access services in an organization's annual budget and in grant applications helps secure needed resources.

Constructing a language access plan with strategies, timelines, resource needs and individuals responsible for strategy implementation can guide an organization through the language access improvement process. Integrating the language access plan into an organization's overall strategic planning and quality improvement efforts can further success.

» CONCLUSION

Numerous reasons exist for health service organizations to improve language access. Linguistically appropriate services can help reduce health disparities and improve the quality and efficiency of health care services. As federal and state laws require provision of language services to LEP individuals, enhancing services lowers liability risks. Moreover, when language access is high and services are consistent, patients, family members, providers, staff and administrators benefit.

Policy decisions at the state and organizational levels can influence the future direction of language access in Colorado. State policymakers have demonstrated their support for language services through a variety of regulations. With implementation of the ACA and the creation of the Colorado Health Benefits Exchange, new opportunities for furthering language access exist. Additionally, policymakers may want to apply for a federal matching grant for language services and fund targeted educational opportunities for the state's many bilingual students. At the organizational level, a language access policy can become the foundation upon which subsequent efforts are built.

Different organizations will inevitably have different language access needs as well as different resources for and challenges in meeting those needs. A careful assessment of both language service needs and internal assets is the first step in improving language access. Once the needs are understood, selecting and implementing specific strategies for meeting many of those needs can result in immediate benefits for the organization and its patients. Organizations also will want to develop a long-term plan for continuing to provide high-quality language services. Likewise, regular assessment is necessary to ensure that standards are maintained and to determine whether new needs have arisen.

Despite the many difficulties health care organizations face in meeting the linguistic needs of their patients, a number of organizations demonstrate that major improvements in language access are possible. While continued commitment, prioritization and long-term planning are needed, organizations can pace their efforts to devote resources toward specific strategies. Even organizations with limited resources can make critical strides simply by refusing to let children act as interpreters. Ultimately, providing high-quality language access can help to increase organizational efficiency, lower liability and improve health.

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» APPENDIX A – CASE STUDIES

In the past five to 10 years, some Colorado health care organizations have made much progress in improving how they provide language access services. Nearly all of the 26 nonprofit service organizations and education institutions that participated in The Colorado Trust’s Equality in Health initiative took steps to improve their language access services. Case studies from four of these organizations show there is no “one-size-fits-all” approach to improving language services, but rather that organizations can and should tailor strategies to fit the needs of their populations, their unique context and the resources available to them.

Prowers Medical Center

Hiring a full-time language coordinator/staff interpreter and training bilingual staff as dual-role interpreters.

Prowers Medical Center (PMC) is a 25-bed critical care access hospital in Lamar, Colorado. PMC also operates a Veterans Administration clinic and several outpatient services ranging from rehabilitation to home health to maternal and child health services. Hispanic persons make up 36 percent of the Prowers County population, and 25 percent of the population speaks a language other than English at home.¹⁸ In 2005, PMC established a formal language program. Previously, patients who could not communicate in English were asked to bring their own interpreters, resulting in children and family members often interpreting in the emergency room and throughout the hospital. When they were available, bilingual staff with no formal training were called upon to interpret, but LEP patients expressed concern that the interpretation was inaccurate.

LEP patients who did not bring their own interpreter experienced long waits as the hospital scrambled to find someone to help the patient and providers became increasingly frustrated because they could not communicate with their patients. While some staff members believed the hospital had no obligation to aid patients who couldn’t speak English, others believed that patient care could be compromised when patients couldn’t communicate well with providers and when vital documents such as consent forms for surgery or ER procedures were not translated correctly.

With the LEP population continuing to grow, PMC in 2005 posted a position for a “translator.” While hospital officials understood the need to improve services, at the time they did not fully understand the concept of medical interpreting or the role of an interpreter. Fortunately, the person they hired did. Over the next several years, the new language coordinator/staff interpreter/translator conducted an education campaign throughout the system, including the hospital’s leadership, regarding all aspects of language access. She used an assessment tool (LEP.gov) to measure services and identify gaps and, in 2007, formed an Interpreter’s Committee of 13 bilingual staff, which discussed the assessment and determined needed steps.

The following strategies allowed for enormous change in service quality and in staff understanding of language access services and LEP needs:

- The language coordinator participated in Bridging the Gap, a 40-hour medical interpreters training, allowing her to further understand the roles of an interpreter, improve her medical terminology and share her knowledge with the Interpreters Committee.
- She provided an overview of language services and her role for hospital staff and trained providers how to work with interpreters.
- The language coordinator worked to craft a language access policy, adopted by the PMC board in July 2011, and trained staff on the new policy.
- All signs indicating the need for LEP patients to bring their own interpreter were removed and replaced by signs indicating that interpreters were available.
- Vital documents, including consent forms, advance directives and health care proxies, were translated into Spanish by the Translating Committee using a three-step review process to ensure accuracy, appropriate literacy level and cultural sensitivity.
- Language identification cards were printed, allowing patients to point to the language and services they needed.

- Dual-role interpreters were trained and began to wear badges that said, “I speak [language(s)].” (Dual-role interpreters are bilingual staff members working in other positions who agree to serve as interpreters when needed.)
- Telephone-based interpretation services were purchased and utilized when the language coordinator/staff interpreter or bilingual dual-role interpreters were not available or when interpretation for a language other than Spanish was needed. The language coordinator became a certified Bridging the Gap trainer and trains members of the Interpreters Committee. Only individuals who have participated in the training are allowed to interpret in medical encounters.

The Interpreters Committee, which includes individuals from every department, meets quarterly to determine where needs still exist within the medical center. The committee monitors progress, discusses how to resolve issues or complaints, and ascertains where extra training may be needed for staff or interpreters.

The language coordinator also shadows the interpreters, providing feedback and helping them improve their skills. In addition, she conducts “spot checks” in PMC’s various departments to ensure compliance with the language access policy. A survey of patients on interpreter services and a survey of providers on the experience of working with interpreters allow PMC to evaluate its language access services and note areas for improvement. Finally, to help ensure PMC is meeting the needs of the entire community, the language coordinator tracks U.S. Census data and works with community groups to identify demographic changes and LEP population trends.

As a result of these efforts, PMC staff believes the clinic’s quality of care for LEP patients, its understanding of and support for language access services, and its relationship with the Hispanic community have improved. The investment in language access has brought returns in both increased efficiency and more patients coming to the hospital.

Please contact Elia Trujillo for more information on Prowers Medical Center’s language access policy and procedures: 719.336.7150 or elia.trujillo@prowersmedical.com.

Summit Community Care Clinic

Diversifying staff and creating a culturally inclusive culture.

Summit Community Care Clinic (Care Clinic) offers primary care, oral health, behavioral health, physical therapy and reproductive health services to the medically underserved in Summit County. Established in 1993 as a one-night-a-week walk-in clinic staffed by volunteers and managed by Summit County Public Health, Care Clinic became an independent nonprofit in 2006, now employing more than 50 staff and open six days a week.

Care Clinic’s approach to improving language access focused on building staff diversity as the organization grew. Prior to 2006, Care Clinic relied on two Spanish-speaking staff as ad-hoc interpreters as well as volunteer health care providers with basic Spanish skills to communicate directly with LEP Spanish-speaking patients. Some providers assumed they spoke Spanish well enough to explain everything adequately and that patients understood them. But the clinic found that following their exam patients would approach the Spanish-speaking staff with unanswered questions. Often, when an LEP patient came to the clinic, he/she would be asked to wait until one of the Spanish-speaking staff was available. If no one was available, the patient might have an extensive wait or leave. Children would interpret for their parents or other relatives, and no policy was in place regarding any type of interpretation or translation services.

While Summit County Public Health cared about the needs of the LEP population, it lacked adequate resources to address those needs. When the clinic became an independent nonprofit, it acquired a larger space with room for more staff and received support from Summit County. In the same year, the clinic became eligible for the state’s Primary Care Fund, resulting in an influx of resources. While these resources could have been allocated for several purposes, the newly hired executive director placed a strong emphasis on culturally and linguistically appropriate services that ultimately changed the clinic’s culture.

As the only safety-net provider in Summit County, Care Clinic sees about 2,200 LEP patients per year, representing more than 40 percent of Care Clinic’s patient population. Clinic leaders realized the best way for the clinic to meet

the needs of these patients was to hire bilingual and bicultural staff. A candidate's fluency in a language other than English was given considerable weight in the hiring process. Because the clinic had the ability to develop candidates' health care skills, it often hired bilingual candidates with less health care experience over those with more experience but an inability to speak directly with many of the patients.

The clinic also focused on hiring staff from other countries who could relate to their immigrant patients' experiences and act not only as interpreters, but also as cultural liaisons. Care Clinic paid for English classes for staff who had some difficulty in written communication and nurtured an environment where they could speak in their native language throughout the day. Moreover, Care Clinic worked to develop the professional skills of entry-level staff so they could be promoted and diversity could spread throughout all departments and levels.

For staff who felt a sense of cultural isolation in the resort communities of Summit County, Care Clinic became a community home and a place where diverse staff felt valued and supported. In the most recent employee satisfaction survey, more than 90 percent of respondents said they felt loyal to the clinic, respected and enjoyed their co-workers, and believed clinic leaders took staff well-being into account when making decisions.

Most of Care Clinic's staff today is bilingual, and Spanish fluency is a requirement for all health educators, clinic and dental assistants, and eligibility specialists who help patients enroll in programs such as Medicaid or Child Health Plan Plus. Care Clinic employs French speakers to work with the growing West African population and an eligibility specialist from Senegal who speaks French, Spanish and two African dialects. Unlike other primary care providers across the state, Care Clinic does not struggle to find bilingual staff. In fact, its reputation for having a warm and encouraging environment for diverse staff has brought in many bilingual/bicultural people as volunteers, hoping a job will open up. As Chief Executive Officer Sarah Vaine said, "There is an investment that needs to be made to find the right people to meet the needs of our patients, but it definitely pays off."

That "pay off" rests not just with the staff but also with the patients. Whereas eight years ago, Spanish-speaking patients came to Care Clinic because they had few other options, now they come because it is truly their medical home, a place where they know they will receive high-quality care in their native language. A March 2012 patient satisfaction survey found that 97 percent of patients considered the clinic their "regular source of care" and would refer the clinic to their friends and families. Nearly as many (93 percent) rated the treatment and advice they received as good or great and gave high scores to providers' willingness to listen and spend adequate time with patients.

Although most of Care Clinic's staff are bilingual, several volunteer providers and in-house providers are not. Furthermore, like most clinics and hospitals, the clinic sees a small patient population with diverse language needs. Therefore, in addition to building staff diversity and language capacity, Care Clinic implemented the following strategies:

- Trained all staff on the CLAS standards and Care Clinic's language access policy
- Trained all bilingual staff serving as interpreters through the Bridging the Gap program
- Trained providers in how to work with interpreters
- Purchased telephone-based interpretation services for languages other than Spanish and made sure a language line was available in every room
- Employed contract interpreters for languages of lesser diffusion, including but not limited to Russian, Polish and American Sign Language.

Care Clinic leaders are aware that their patient population is continually changing. They regularly monitor the language access needs of the community and listen to their patients' concerns. They inquire about language access in patient satisfaction surveys, patient forums and through the Patient Advisory Committee in an ongoing effort to make their services more effective and welcoming.

Please contact Jenniffer Gonzalez for more information on Summit County Care Clinic's language access policy and procedures: 970.668.4057 or jgonzalez@summitclinic.org.

Marillac Clinic

Interpreting in mental health.

Marillac Clinic is a community clinic providing health care to thousands of uninsured or underinsured Mesa County residents each year. An early adopter (1999) of integrated health care, Marillac's mental health services have served as a model for numerous clinics across the state and the nation.

Like many other grantees of the Equality in Health initiative, Marillac devoted significant efforts to improving language access services so it could offer better care to Mesa County's LEP population – both full-time residents and migratory workers. With its mission of serving the underserved, Marillac draws patients with complex and chronic illnesses, requiring both physical and mental health care.

When Marillac lost its bilingual counselor in 2006, a gap in service for LEP patients became apparent, and Marillac had to develop its capacity for interpretation in mental health. Marillac employs several trained dual-role interpreters, but limits mental health interpreting to two highly skilled and experienced individuals with the ability to use multiple interpreting approaches, including simultaneous – speaking at almost the same time as the patient -- and consecutive – speaking after the patient (see Appendix B). Group sessions, such as Mind, Body and Spirit, designed to treat the stress and anxiety that often accompany chronic conditions, and Diabetes Fast Track, which deals with the stress and depression experienced by many of Marillac's diabetic patients, require simultaneous, as opposed to consecutive, interpretation (see Appendix B). Additionally, mental health providers often will ask for a shift from consecutive to simultaneous interpretation during an individual session to allow for the interpretation to more closely track a patient's tone and demeanor.

Along with additional linguistic skills, mental health interpreters must possess personal and psychological strengths, including the ability to remain calm and professional in highly charged settings. Mental health sessions can be mentally and emotionally exhausting for the interpreter. Sessions usually last an hour, twice as long as typical interpreting times in physical or dental health. Moreover, the interpreter must often relay the patient's traumatic experiences while keeping his or her judgments or sentiments at bay. Before they recognized the unique skills required for mental health interpreting, interpreters would sometimes cry with the patient. As Marillac's staff interpreter and cultural competency coordinator relates, "You hear difficult things You carry it with you."

To adjust for these challenges, Marillac offers time for the interpreter to "process" with the mental health provider following a session. This also allows the mental health interpreter, who is bicultural, and the provider to discuss any cultural nuances that arose. Additionally, Marillac has arranged for group discussions with interpreters and mental health providers to help support the interpreters who experience difficult conversations. While interpreting in mental health is more complex than interpretation in other situations, Marillac's commitment to care for both the patient and the interpreter has allowed the clinic to continue to provide integrated care services to its LEP patients.

Please contact Karla McCann for more information on Marillac Clinic's language access procedures: 970-244-2573 or karla.mccann@stmaryj.org.

Family Medicine Center

Training family practice residents.

Several years ago, Poudre Valley Health System's Family Medicine Center (FMC) recognized that it had a problem with communication between residents and patients. Residents who lacked fluency often communicated with Spanish-speaking LEP patients without the use of an interpreter, resulting in errors, miscommunication and patient frustration. Patients would complain that they did not understand their diagnosis, their treatment options or medication instructions. Certain residents would refuse to use the staff interpreter. Often, after the resident left the room, the patient would ask the interpreter to repeat everything that had been said because he or she had not understood the resident's Spanish and had been too embarrassed to tell the resident. Residents would also rely on family members, including children of a young age, to interpret during medical exams. Residents with oral proficiency, but lacking sufficient written abilities, would sometimes translate outgoing letters to patients. In one case, this practice resulted in a patient's upsetting belief that she had cervical cancer despite the fact that lab results indicated the opposite.

As part of its work to improve language access, FMC devoted time and effort to educating its residents on the importance of using the staff interpreter. The staff interpreter/cultural care coordinator, with support from FMC's leaders also crafted a comprehensive policy and procedure document indicating what to do in various scenarios with LEP patients. FMC now provides a training session on that policy, the need for appropriate language access services and information on how to work with an interpreter during the residents' orientation week. In addition, the staff interpreter/cultural care coordinator conducts one-on-one teaching sessions using LEP patient cases to discuss both language and cultural issues. Further, residents who have some Spanish fluency but lack confidence or skills can complete a two-week rotation with FMC's staff interpreter/cultural care coordinator. The session is designed to improve their vocabulary, grammar and pronunciation, as well as their understanding of cultural nuances and/or health beliefs. These residents can then communicate directly with their LEP patients, although the interpreter remains in the room for backup assistance.

Staff believe FMC's commitment to educating and training staff, faculty and residents on the importance and use of language access services has resulted in influential and lasting change. Five years ago, residents, faculty and senior management resisted the arrival of a grant-funded staff interpreter/cultural care coordinator. By the end of the grant, however, all understood the dangers of operating without an interpreter and the benefits of coordinated language access services for patients and the organization's effectiveness. Further, FMC created a permanent interpreter/cultural care coordinator position.

Please contact Mailyn Salabarría for more information about the Family Medicine Center's language access policy and procedures: 970.495.8821 or mns1@pvhs.org.

» **APPENDIX B**

Methods and Modes for Providing Language Access

METHODS OF PROVIDING LANGUAGE ACCESS

Method	Description	Advantages	Considerations
Bilingual Providers/ Staff	<ul style="list-style-type: none"> Providers or staff proficient in common language(s) spoken by patient population 	<ul style="list-style-type: none"> Direct communication 	<ul style="list-style-type: none"> Serious errors if not fully fluent Pay incentives may help retain these high-in-demand individuals
Staff Interpreter	<ul style="list-style-type: none"> Employed part time or full time by health service organization Usually recruited in most common language(s) of patient population 	<ul style="list-style-type: none"> Interpreter is familiar with provider and patient population Interpreter should have formal training and incentives for continuing education On-site availability May also serve as language services and cultural care coordinator 	<ul style="list-style-type: none"> Need to create additional full-time position Need to train staff on how to incorporate new position into service delivery
Bilingual Dual-role Interpreter	<ul style="list-style-type: none"> Employed by health service organization for duties other than interpreting Provide interpreting on on-call basis and according to availability 	<ul style="list-style-type: none"> Interpreter is familiar with provider and patient population On-site availability 	<ul style="list-style-type: none"> Can pull staff away from other duties, causing frustration for both interpreter and staff required to fill in Resources needed to train staff as interpreters
Contract Interpreters	<ul style="list-style-type: none"> Not employed by health service organization, but available per diem or on call Can be scheduled in advance or contacted on short notice when needed 	<ul style="list-style-type: none"> Can be more cost-effective than staff model when demand is low 	<ul style="list-style-type: none"> Need to ensure interpreter has received formal training Staff time needed to coordinate contracting, dispatching and payment of interpreter

(Continued on next page)

Method	Description	Advantages	Considerations
Agency Interpreters	<ul style="list-style-type: none"> Provided to health service organization by language agency that recruits, contracts and dispatches interpreters on demand Agencies can be for-profit companies, community interpreter banks or community-based organizations 	<ul style="list-style-type: none"> Responsibility for recruiting, screening, training and paying interpreters lies elsewhere Access to wider variety of languages 	<ul style="list-style-type: none"> Health service organization has no direct oversight for quality or performance of interpreters
Volunteer Interpreters	<ul style="list-style-type: none"> Similar to contract interpreters but not compensated 	<ul style="list-style-type: none"> Cost-effective Promotes volunteerism 	<ul style="list-style-type: none"> Need to assess language abilities and ensure volunteers have formal training Staff time needed to coordinate use of volunteers
Telephone-based (telephonic) Interpretation ("language line")	<ul style="list-style-type: none"> Consecutive interpreting through phone line while interpreter is located in different place Coordinated through commercial service 	<ul style="list-style-type: none"> Responsibility for recruiting, screening, training and paying interpreters lies elsewhere Access to wide variety of languages 	<ul style="list-style-type: none"> Health service organization has no direct oversight for quality or performance of interpreters Cost can be prohibitive for limited use Requires phone lines at service location Potential for echoes, feedback, static, etc. Speakerphones can create hearing issues for the interpreter Patients may not be comfortable with someone they cannot see Staff usually require training and practice to use effectively
Audiovisual Interpretation	<ul style="list-style-type: none"> Similar to telephonic interpretation with addition of video screen that allows patient and interpreter to both hear and see each other 	<ul style="list-style-type: none"> Responsibility for recruiting, screening, training and paying interpreters lies elsewhere Patients may be more comfortable being able to see interpreter Can be used for sign language interpreting Communication in certain Asian languages may be improved because digital audio captures tonal qualities better than phone line 	<ul style="list-style-type: none"> Health service organization has no direct oversight for quality or performance of interpreters Requires audiovisual equipment, generally more costly than telephone equipment

Sources: Models for the Provision of Language Access in Health Care Settings, National Council on Interpreting in Health Care, 2002; Communicating More for Less: Using Translation and Interpretation Technology to Serve Limited English Proficient Individuals, National Center on Immigrant Integration Policy, 2011.

MODES OF INTERPRETING

Mode	Description	Effective Use	Considerations
Consecutive	<ul style="list-style-type: none"> ■ Interpreter renders message in target language after speaker has paused or finished ■ Interpreter may periodically interrupt speaker to interpret what has been said 	<ul style="list-style-type: none"> ■ During conversations where natural pauses occur, such as question-and-answer sessions 	<ul style="list-style-type: none"> ■ Effectiveness limited to interpreter’s ability to memorize information before interpreting it ■ Interpreter must manage flow of conversation, which can be difficult when working with individuals with distinct personalities and communication styles
Simultaneous	<ul style="list-style-type: none"> ■ Interpreter begins message conversion before speaker has finished and delivers interpretation at almost same time ■ Simultaneous interpretation can be delivered with specialized audio equipment or using whisper technique called “chuchotage” 	<ul style="list-style-type: none"> ■ During mental health encounters when provider does not want to interrupt patient’s message ■ During encounters such as group sessions in which not everyone requires interpreter 	<ul style="list-style-type: none"> ■ Requires intense concentration and can lead to interpreter fatigue ■ Can require use of specialized equipment ■ In small groups, interpreter may be distracting to speaker if speaker can hear interpreter
Sight Translation	<ul style="list-style-type: none"> ■ Interpreter reads document in one language and delivers oral rendition in another language 	<ul style="list-style-type: none"> ■ Short texts, such as forms or instructions; consent forms or educational materials should be translated ahead of time 	<ul style="list-style-type: none"> ■ Requires interpreter to read and speak in different languages, which may be difficult for less experienced interpreters

Sources: Models for the Provision of Language Access in Health Care Settings, National Council on Interpreting in Health Care, 2002; Communicating More for Less: Using Translation and Interpretation Technology to Serve Limited English Proficient Individuals, National Center on Immigrant Integration Policy, 2011.



1600 SHERMAN STREET
DENVER, COLORADO 80203

PHONE: 303-837-1200
TOLL FREE: 888-847-9140
FAX: 303-839-9034

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