

**A PATIENT-CENTERED GUIDE
TO IMPLEMENTING LANGUAGE ACCESS SERVICES
IN HEALTHCARE ORGANIZATIONS**

SUBMITTED TO:
OFFICE OF MINORITY HEALTH
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEVELOPMENT OF A DRAFT HEALTH CARE
LANGUAGE SERVICES IMPLEMENTATION GUIDE
National Standards for Health Care Language Services Contract

CONTRACT No. 282-98-0029, TASK ORDER No. 48
PROJECT OFFICER: GUADALUPE PACHECO

SUBMITTED BY:
AMERICAN INSTITUTES FOR RESEARCH

**FINAL DRAFT
SEPTEMBER 2005**

Acknowledgments

This guide was developed for the Office of Minority Health (OMH), U.S. Department of Health and Human Services (DHHS) by the American Institutes for Research (AIR) under Contract No. 282–98–0029, Task Order No. 48. The development of the guide was based on valuable input from field experts, administrators, providers, and other healthcare professionals, as well as limited English proficient patients. We would like to extend our sincere thanks and appreciation to:

- Guadalupe Pacheco, Project Officer, OMH, DHHS, for his vision, guidance, and critical input into the development of the guide and for his commitment to ensuring quality health care for limited English proficient individuals
- Dr. Garth Graham, Deputy Assistant Secretary for Minority Health, OMH, DHHS, for his ongoing support and commitment to the development of the guide
- Our Expert Panel Members (listed below), for their dedication and commitment to language access issues of language minority populations and for helping to ensure that the guide represents the current state of the field through their extensive advice, input, and careful review of the guide
- The administrators and field staff who provided ground-level insights into the process of implementing language access services during our site visits to their healthcare organizations
- The administrators, providers, and other healthcare professionals with experience implementing language access services who provided valuable feedback on an outline of the guide
- The limited English proficient patients who helped us better understand the barriers, enablers, and ways to improve the healthcare experience during focus group discussions
- The core project staff, for their outstanding efforts throughout the duration of this project and their dedication to producing a quality product:
 - Leilani Francisco, AIR, Project Director
 - Maureen Maurer, AIR, Task Leader
 - Ria Eapen, AIR, team member
 - Jennifer Stephens, AIR, Task Leader, Project Manager
 - Kathy Joyce, M. Kathleen Joyce and Associates, team member
 - Christine Whitmore, AIR, Task Leader
 - Michelle Jones, AIR, Task Leader
 - Catherine McIlwain, AIR, team member
 - Jenny Wong, AIR, team member
 - Rita Kirshstein, AIR, Senior Advisor

Expert Panel Members

Wilma Alvarado-Little, M.A.
Program Manager, Center for the Elimination of
Minority Health Disparities
University of Albany, SUNY
Albany, NY

Deeana Jang, J.D.
Senior Civil Rights Analyst, Office for Civil Rights
U.S. Department of Health and Human Services
Washington, DC

Glenn Flores, M.D., F.A.A.P.
Director, Center for the Advancement of
Underserved Children, Department of Pediatrics
Associate Professor, Medical College of Wisconsin
Milwaukee, WI

Yolanda Partida, D.P.A.
National Program Director, Hablamos Juntos
University of Southern California
School of Policy, Planning, and Development
Los Angeles, CA

Elizabeth Jacobs, M.D., M.P.P.
Assistant Professor of Medicine
Collaborative Research Unit
Cook County Hospital and Rush University
Medical Center
Chicago, IL

Amy Wilson, M.P.P., C.P.H.Q.
Associate Director, Division of Standards and
Survey Methods, Joint Commission on
Accreditation of Healthcare Organizations
Oakbrook Terrace, IL

Holly E. Jacobson, Ph.D., M.A.
Research Assistant Professor, University of North
Texas Health Science Center
Fort Worth, TX

Mara Youdelman, J.D., LL.M.
Staff Attorney, National Health Law Program
Washington, DC

Disclaimer

While this guide contains Web links to third-party sites, OMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

The content of this publication does not necessarily reflect the views or policies of the U.S. Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

Contents

Introduction	1
<i>Importance of Language Access Services</i>	1
Access to Care	2
Quality of Care	2
Patient Satisfaction	3
Resource Utilization	4
<i>Background for Language Access Services</i>	4
History of the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care	5
Laws, Regulations, Policies, and Other Standards for Language Access Services	7
<i>Overview of the Guide</i>	9
What Is the Purpose of the Guide?	9
For Whom Is the Guide Designed?	10
How Is the Guide Organized?	11
How Can I Implement Language Access Services Using This Guide?	14
Step 1: Assessing the Language Needs of Your Patients	16
<i>Planning</i>	19
Collecting Patient Data	20
Assessing Patient Needs	25
<i>Implementation</i>	28
<i>Evaluating Your Solutions</i>	29
Step 2: Assessing Your Organizational Capabilities	32
<i>Planning</i>	35
Promoting Language Access Services at the Organizational Level	36
Assessing Your Organization’s Capacity for Providing Language Access Services	42
<i>Implementation</i>	47
<i>Evaluating Your Solutions</i>	50
Step 3: Planning and Implementing Language Access Services	52
Step 3: Planning and Implementing Language Access Services	53
Resource Unit A: Interpretation Services	54
<i>Planning</i>	57
Overview of Interpretation Services	57
Considering Types of Interpretation Services	60
Developing a Process for Ensuring Competence of Interpretation Services	72
Determining Policies and Procedures for Working With Interpreters	82
<i>Implementation</i>	83
<i>Evaluating Your Solutions</i>	85
Resource Unit B: Written Materials	88
<i>Planning</i>	92
Overview of Written Materials	93
Determining a Process for Making Materials Available in Other Languages	94
Considering Types of Services for Written Materials	97
Determining What Materials To Make Available in Other Languages	100
Developing a Process for Ensuring the Quality of Written Materials	104
Making Written Materials Accessible for Providers and Patients	106
Determining Policies and Procedures for Developing Written Materials	107
<i>Implementation</i>	108
<i>Evaluating Your Solutions</i>	111

Resource Unit C: Signage and Wayfinding.....	114
<i>Planning</i>	117
Overview of Signage and Wayfinding	117
Deciding What Type of Signage To Post.....	119
Deciding Where To Display Signage.....	121
Determining the Quality of Signage.....	122
Training Staff on New Signage.....	124
<i>Implementation</i>	124
<i>Evaluating Your Solutions</i>	126
Resource Unit D: Notice of Language Access Services to LEP Patients	129
<i>Planning</i>	132
Importance of Providing Notification of LAS to LEP Patients	133
Determining the Content of Notices.....	133
Determining Languages in Which To Provide Notice.....	134
Deciding How and Where To Provide Notice to LEP Individuals.....	134
Training Staff on LAS Notification.....	139
<i>Implementation</i>	140
<i>Evaluating Your Solutions</i>	141
Resource Unit E: Community Involvement	145
<i>Planning</i>	148
The Importance of Reaching Out To the Community	149
Deciding How To Use Community Input at Your Organization	150
Building and Maintaining Trust in the Community	151
Deciding Whom To Involve in Community Outreach	152
Deciding on Methods for Effectively Reaching the Community	153
Deciding How To Collaborate With Community Organizations.....	157
<i>Implementation</i>	158
<i>Evaluating Your Solutions</i>	161
Resource Unit F: Written Language Assistance Plans	164
<i>Planning</i>	167
An Overview of the Language Assistance Plan	167
Benefits of a Written Plan	168
Drafting a Language Assistance Plan.....	169
Operationalizing a Language Assistance Plan.....	170
<i>Implementation</i>	170
<i>Evaluating Your Solutions</i>	171
Step 4: Evaluating the Quality of Your Language Access Services	174
<i>Planning</i>	177
An Overview of Evaluation.....	177
Determining Whom To Involve in Designing the Evaluation	178
Designing the Evaluation	179
Conducting the Evaluation.....	189
Sharing the Findings of Your Evaluation.....	190
<i>Implementation</i>	190
<i>Evaluating Your Solutions</i>	192
Conclusion.....	195
Appendix A: Glossary of Abbreviations	197
Appendix B: Example Job Description, From Children’s Hospitals and Clinics	200

Appendix C: Funding Sources.....	207
<i>Federal, State, Local, and Other Funding Sources</i>	207
<i>Medicaid and SCHIP Coverage</i>	210
Provision of Interpreters.....	212
Hospitals.....	213
<i>Medicare Coverage</i>	213
<i>Coverage for Federally Qualified Health Centers and Rural Health Clinics</i>	214
Federally Qualified Health Centers.....	214
Rural Health Clinics.....	214
<i>Sample Costs for Language Access Services</i>	215
Interpretation.....	215
Translation.....	215
Appendix D: Example Waiver When Patient Chooses Informal Interpreter Over Formal Interpreter, From the Asian Pacific Health Care Venture.....	217
Appendix E: Examples of Medical Interpreter Trainings.....	218
Appendix F: Example of an Organization’s Policies and Procedures for Working With Interpreters, From Children’s Hospitals and Clinics.....	220
Appendix G: Examples of Multicultural Patient Education Material Web Sites.....	226
Appendix H: List of Documents Translated at One Organization by Bilingual Staff Members.....	228
Appendix I: Other Resource Documents on Implementing Language Access Services.....	230
References.....	235

Introduction

With growing concerns about racial, ethnic, and language disparities in health and health care and the need for healthcare systems to accommodate increasingly diverse patient populations, language access services (LAS)* have become more and more a matter of national importance.² The Office of Minority Health (OMH), U.S. Department of Health and Human Services (DHHS), has sponsored the development of this guide to help healthcare organizations implement effective LAS to meet the needs of their limited English proficient (LEP) patients, thereby increasing their access to health care. This introduction will address the importance of language access services, followed by the background of LAS and an overview of the guide.

Importance of Language Access Services

The need for LAS has become increasingly pertinent given the continued growth in language diversity within the United States. The number of individuals who speak a language other than English at home rose from 31.8 million in 1990 to 47 million in 2000. In addition, the number of individuals who speak English less than “very well” increased from 14 million in 1990 to 21.4 million in 2000, reflecting a 53 percent rise in the number of LEP individuals in the United States over the 10-year period.⁹

Language access services are especially relevant to racial and ethnic disparities in health care. A report by the Institute of Medicine (IOM) on racial and ethnic disparities in health care documented through substantial research that minorities, as compared to their White American counterparts, receive lower quality of care across a wide range of medical conditions, resulting in poorer health outcomes and lower health statuses. The research conducted by the IOM showed that language barriers can cause poor, abbreviated, or erroneous communication, poor decision making on the part of both providers and

* For a glossary of abbreviations used through this guide, see appendix A.

What are healthcare disparities?¹

Healthcare disparities are the differences in the quality of health care received by racial and ethnic minorities, even after patient needs, patient preferences, and the availability of services are taken into account.

—Institute of Medicine 2004

What are language access services?³⁻⁸

Language access services are also commonly referred to as language assistance services and linguistically appropriate services. LAS are services that are designed to ensure effective communication between limited English proficient individuals and English speakers. Primary LAS include interpretation (oral) and translation (written) services. LAS can also involve provisions that enhance communication, such as signage and symbols for wayfinding.

patients, or ethical compromises.¹ The implementation of appropriate LAS in healthcare settings can serve to:¹⁰⁻¹⁸

- Increase access to care
- Improve quality of care, health outcomes, and health status
- Increase patient satisfaction
- Enhance or ensure appropriate resource utilization

Each of these concepts is discussed in the sections that follow.

Access to Care

The implementation of appropriate LAS can increase LEP patient access to health care. Conversely, when appropriate LAS are unavailable, there is a greater likelihood that an LEP patient will not see a healthcare provider for needed care.¹⁹ For example, language barriers have led to fewer physician visits and reduced receipt of preventive services among LEP patients, even after considering factors such as literacy, health status, health insurance, regular source of care, and economic indicators.²⁰⁻²¹ Conversely, the use of clinical and preventive services has increased when professional interpretation services were provided.²² In addition, increased racial and ethnic diversity among professionals has improved access to care for minority patients.²³

Quality of Care

The provision of appropriate LAS can improve quality of care. For example, Latino children have experienced adverse health consequences, such as poor medical diagnoses and inappropriate prescriptions, as a result of the failure of medical staff to speak Spanish.²⁴ Conversely, among diabetics, LEP patients who were provided with trained medical interpreters were more likely than limited English proficient patients to receive care meeting selected American Diabetes Association guidelines.²⁵

“Right, like I had said when I was visiting the eye doctor. If someone was with me to interpret at that time, then I would understand what was wrong with my eye. But even now I still don’t know what is wrong with my eye.”

—LEP patient



Link to Web Resource on Issues in Multicultural Health

Multicultural Health 2002: An Annotated Bibliography

Prepared by Jann L. Murray-García for The California Endowment

http://www.calendow.org/reference/publications/pdf/disparities/2_nd_Ann_Bibliography2002.pdf

Language barriers have negatively affected patient-provider communication. For example, in an urban emergency room, Spanish-speaking patients who needed an interpreter but did not get one were significantly more likely to report a poor or fair understanding of their discharge diagnoses and treatment plans than those who used an interpreter or were proficient in English.¹⁸ Likewise, providers have frequently identified language or cultural barriers as elements that hinder the quality of patient education for diabetes care.²⁶

Patient Satisfaction

Appropriate LAS implementation can improve patient satisfaction. For example, in terms of racial and ethnic disparities, minorities—particularly Asian/Pacific Islanders and those with multiracial backgrounds—have reported lower satisfaction with their medical care than Whites.²⁷ Lower rates of satisfaction have been documented among LEP patients who have untrained or no interpreters, even when compared with patients of the same ethnicity who have good English skills.^{20 28} Patients who have needed interpretation services but did not get them have the lowest levels of satisfaction as compared with those not needing an interpreter and those who received an interpreter.²⁹ LEP patients as well as providers have reported being the most satisfied during healthcare experiences when using professional medical interpreters as compared with using family members and friends, telephone interpreters, bilingual support staff, or bilingual physicians. Regardless of preference, LEP patients have reflected higher satisfaction with their healthcare experiences when quality language services were made available to them.³⁰

Patient-provider communication can also be improved when appropriate LAS are implemented. For example, in an urban emergency room, Spanish-speaking patients who needed an interpreter but did not get one were significantly more likely to report a poor or fair understanding of their discharge diagnoses and treatment plans than those who used an interpreter or were proficient in English.¹⁸ Likewise, providers have frequently identified language or cultural barriers as elements that hinder the quality of patient education for

“I feel uncomfortable and dissatisfied because I thought [the doctor who did not speak Spanish] did not have sufficient information in my case. Having a person [who could interpret] would make it much better.”

—LEP patient

diabetes care.²⁶ With regard to the patient-provider interaction in general, Hispanic patients have reported being significantly dissatisfied with the reassurance and support provided by doctors and staff and the quality of examinations received as compared to White non-Hispanic patients.³¹

Resource Utilization

The implementation of LAS can enhance or ensure appropriate resource utilization.^{21 18} For example, physicians have performed more frequent and more expensive testing and made more use of intravenous hydration when a bilingual physician or professional interpreter was not available. The lack of interpretation services has also resulted in more frequent hospital admissions.³³

In general, the duration of patient visits has increased when LAS were not in place.^{33 34} However, some studies have shown no increase, and a few studies have shown a decrease in the length of visit.¹⁸ Although the use of a professional medical interpreter may lengthen the time of a visit, use of bilingual physicians and professional medical interpreters may decrease costs because of more appropriate resource utilization. Similarly, although implementing LAS may add costs in the short term, it may lead to reduced costs over time because of increased use of primary care and preventive services.³²

Background for Language Access Services

Effective patient-provider encounters are based on mutual understanding between providers and patients. When a provider cannot communicate effectively about a disease and treatment, or when a patient cannot describe an experience of illness, it can be difficult to build the trust and rapport needed in the patient-provider relationship, but more importantly, the patient and provider lack the basic connection needed to result in appropriate care. Appropriate communication is necessary for ensuring quality and safety in health care.³⁵

This section summarizes some recommendations and some requirements for providing LAS. These are useful

background information as you develop LAS at your organization, but it is beneficial to remember that providing patients with language assistance is good medical practice, even when it is not required.

History of the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care

OMH issued the recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care in December 2000 as a means to address the existing inequities in health services. The standards were developed through a rigorous research and review process that drew upon the input of hundreds of national experts and stakeholders. The CLAS standards were developed to provide consistent and comprehensive guidance to healthcare organizations and providers to promote cultural and linguistic competence in health care. The 14 CLAS standards are organized into three themes:

- Culturally Competent Care (standards 1–3)
- Language Access Services (standards 4–7)
- Organizational Supports (standards 8–14)

Exhibit I–1 lays out the 14 CLAS standards under their associated themes. This guide focuses mainly on standards 4 through 7, highlighted in the exhibit.



Link to Web Resource

OMH Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care

<http://www.omhrc.gov/clas>

Exhibit I–1: Office of Minority Health’s Recommended† National Standards for Culturally and Linguistically Appropriate Services in Health Care³⁶

Culturally Competent Care
<ol style="list-style-type: none"> 1. Health care organizations should ensure that patients/consumers‡ receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery.
Language Access Services
<ol style="list-style-type: none"> 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 LEP at all points of contact and in a timely manner during all hours of operation. 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. 6. Health care organizations must ensure 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). 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.
Organizational Supports
<ol style="list-style-type: none"> 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide CLAS. 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. 10. Health care organizations should ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated. 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities. 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers. 14. Health care organizations are encouraged to make available regularly to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

† CLAS standards are nonregulatory and therefore do not have the force and effect of law. The standards are not mandatory but they greatly assist health care providers and organizations in responding effectively to their patients’ cultural and linguistic needs. Compliance with Title VI of the Civil Rights Act of 1964 is mandatory and requires health care providers and organizations that receive Federal financial assistance to take reasonable steps to ensure LEP persons have meaningful access to services.

‡CLAS standards use the term patients/consumers to refer to “individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services” (page 5 of the comprehensive final report; see <http://www.omhrc.gov/clas>).

Laws, Regulations, Policies, and Other Standards for Language Access Services

In addition to the nonregulatory CLAS standards, there are laws, regulations, and other standards that may apply to LAS. Discussed below are the law, regulations, and policy guidance pertaining to Title VI of the Civil Rights Act of 1964, State and local laws and regulations, and standards from accrediting organizations.

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 states, “No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”³⁷ To avoid discrimination based on national origin, Title VI and its implementing regulations require recipients of Federal financial assistance to take reasonable steps to provide meaningful access to LEP persons.

In 2003, DHHS revised its guidance on providing services for people with limited English proficiency.³⁸ The revised guidance document clarifies the expectations of how Title VI applies to recipients of Federal funds with regard to promoting meaningful access to services among LEP individuals. This guide takes into account recommendations in the guidance when providing suggestions for implementing LAS.

State and Local Regulations

A few States have passed comprehensive language access laws to ensure communication with LEP patients. Some of these laws, in California, Massachusetts, New York, and Washington, DC, for example, include specific requirements for what providers must do. Many more States have tied language access laws to specific categories of health services.

For example, in California, the State’s Medi-Cal Managed Care program has established a primary language threshold for LAS, which is set at 3,000 beneficiaries residing in a county, 1,000 beneficiaries in



Link to Web Resource

Civil Rights Act of 1964

<http://usinfo.state.gov/usa/infousa/laws/majorlaw/civilr19.htm>



Link to Web Resource

Office for Civil Rights Revised HHS LEP Policy Guidance

<http://www.hhs.gov/ocr/lep/revisedlep.html>



Link to Web Resource on State and Local Regulations

Ensuring Linguistic Access in Health Care Settings

Prepared by the National Health Law Program for the Kaiser Commission on Medicaid and the Uninsured

Executive summary (PDF):

<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22093>

Ordering information (full report):

<http://www.healthlaw.org/library.cfm?fa=download&resourceID=62580&appView=folder&print>

a ZIP code, or 1,500 beneficiaries in two contiguous ZIP codes.³⁹

State statutes and common law rules governing professional malpractice define liabilities of inadequate communication with patients. Examples of professional malpractice could include:⁴⁰

- Liability for damages resulting from treatment in the absence of informed consent
- Claims that the failure to bridge communication gaps breaches professional standards of care
- Negligence

At a local level, cities and counties may have requirements for offering LAS. For example, Washington, DC, enacted a law requiring two dozen city agencies to implement plans to hire bilingual employees and to translate their most important documents, such as applications and complaint forms.⁴¹ Initial languages for translation include Spanish, Mandarin, Korean, Vietnamese, and the Ethiopian language Amharic; more languages may be added as the need grows.

Accrediting Organizations

A variety of accrediting organizations have standards for LAS. For example, most hospitals, ambulatory, home healthcare, long-term care, and behavioral health programs must meet the standards set by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The JCAHO standards related to CLAS are focused on the importance of quality and safety in health care and individual-centered care. For example, Standard RI.2.100 requires that organizations ensure effective communication between the patient and the organization through the provision of interpreter and translation services. The standards also require the collection of race, ethnicity, and language data.³⁵ Likewise, the National Committee for Quality Assurance places standards for accreditation on managed care organizations. The standards require managed care organizations to provide materials and



Links to Web Resources

Joint Commission on Accreditation of Healthcare Organizations

<http://jcaho.org>

National Committee for Quality Assurance

<http://www.ncqa.org>

publications in non-English languages that are spoken by at least 10 percent of their membership.⁴²

Overview of the Guide

This section describes the purpose of the guide, for whom the guide is designed, how the guide is organized, and how to go about implementing LAS using this guide.

What Is the Purpose of the Guide?

As part of its mission, the Office of Minority Health, DHHS, seeks to:

Improve the health of racial and ethnic minority populations through the development of effective health policies and programs that help to eliminate disparities in health.

OMH supported the development of this guide to help healthcare organizations implement LAS for LEP individuals.

The overall purpose of the guide is to provide practical, ground-level suggestions for how healthcare organizations and providers can implement LAS. The guide is designed to serve as a resource for organizations such as hospitals and health maintenance organizations, but hopes to address the needs of smaller organizations, such as family practices, health clinics, and healthcare specialists with limited resources, that seek alternative means of implementing LAS. The guide is based on the OMH recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care.

The American Institutes for Research (AIR) provided assistance to OMH for the development of this guide. AIR and OMH established a panel of experts in the field of LAS to provide valuable input on the content and format of the guide. Field research included site visits to small healthcare organizations with experience implementing LAS, telephone interviews with healthcare professionals on the content of the guide, and focus groups with LEP individuals.

It is important to recognize that language and culture go hand in hand. Although cultural competence and sensitivity are related to implementing LAS, they are complex topics in themselves and are beyond the scope of the guide.

Likewise, the language access issues discussed in this guide may apply to deaf or hard of hearing populations who use American Sign Language. However, the guide does not cover all issues related to language access for deaf and hard of hearing populations.

For Whom Is the Guide Designed?

This guide is intended to meet the needs of healthcare organizations from a variety of clinical settings. These include community health centers, clinics, and hospitals, as well as physicians' practices, mental health institutions, dental offices, long-term care facilities, substance abuse treatment centers, and the like.

The guide is designed to meet the needs of healthcare organizations of all sizes. It may be especially helpful for smaller organizations with resource constraints, as it provides useful information solicited from healthcare professionals who work in small healthcare organizations. Because organizations differ in size, resources, and capabilities, the guide provides basic implementation recommendations as well as additional alternatives to take into consideration when deciding how to implement LAS specific to your organization.

The guide's suggestions assume that LAS currently do not exist at your organization. In this way, the guide provides a user-friendly step-by-step approach to implementing such services. If you have some service components in place, you are already ahead of the game and can consider ways to enhance and improve your services.

Finally, the guide is intended to be patient centered and family focused. It is important to note that the term "patient" refers to someone who receives services at a healthcare organization, regardless of clinical setting. For example, a person utilizing mental health services may sometimes be referred to as a "client" or "consumer"; however, for the purposes of this guide,

the term “patient” is used throughout for ease of reference. Examples and quotes from the patient’s perspective are presented throughout the guide. The points at which patients make contact with your organization (referred to as patient points of contact) are also emphasized throughout the guide to highlight the importance of LAS that are patient centered.

How Is the Guide Organized?

This guide contains four steps and six resource units (labeled A–F) that provide guidance on the process of implementing LAS at a healthcare organization. The first two steps involve assessment. The third step focuses on the planning, implementation, and evaluation of the various components of LAS. The fourth and final step provides a detailed discussion of specific methods for monitoring, evaluating, and improving your LAS.

Each step and resource unit describes two case studies that depict a situation and reactions to the situation from patient and provider perspectives. The placement of the cases is designed to help readers apply what they have learned through the guide content. Placed at the beginning of each step and resource unit, Case 1 illustrates what an organization and its patients might experience in a setting where LAS are not well established. Case 1 is followed by a brief synopsis of the patient’s perspective as well as the provider’s perspective. Placed at the end of each step and resource unit, Case 2 illustrates what an organization and its patients might experience in a setting where LAS are better established as compared with Case 1. Case 2 is also followed by a brief synopsis of both the patient’s and provider’s perspectives. Each step and resource unit concludes with a summary of insights from the cases that illustrate the benefits of LAS for healthcare organizations.

Throughout the guide, you will find Web links to tools, resources, and tips for ease of access to additional information. These can be found in sidebars in the page

Sidebars are marked by these symbols:



Links to Web Resources



Tips

Quotes

Text

margins. The following symbols are used to indicate the content of the sidebar:



- Indicates links to Web resources



- Indicates tips on implementation

Text

- Indicates quotes from interviews with healthcare professionals or focus groups with LEP patients

Focus on Patient Points of Contact

This guide provides emphasis on patient-centered care by highlighting the process a patient and his or her family members go through when seeking healthcare services, specifically at each point of contact throughout the delivery of a continuum of care. Exhibit I–2 summarizes the various points of contact and the steps and/or resource units in the guide that may be relevant to each point of contact.



Links to Web Resources

AIR report on site visits to small healthcare organizations

<http://www.cultureandhealth.org/lang/site.asp>

AIR report on telephone interviews with administrators, physicians, and other healthcare professionals

<http://www.cultureandhealth.org/lang/TelephoneInterviews.asp>

AIR report on focus groups with LEP patients

<http://www.cultureandhealth.org/lang/focus.asp>



Exhibit I–2: Traveling Through the Points of Contact

Initial contact and appointment scheduling

- Patient enters the healthcare system, whether during business hours, after hours, nights, or weekends, through the emergency room or through a telephone tree.
- For information on preparing your organization on this point of contact, refer to Step 2.

Entering the healthcare organization and navigation through the system

- Patient uses signage and wayfinding techniques adapted by the organization as navigation tools and for explanations and orientation to the organization.
- For information on preparing your organization on this point of contact, refer to Resource Units B, C, and D.

Registration

- Client data collection (patient completes forms with assistance of staff/interpreter).
- Determination of interpretation needs (from the information provided by the patient in the forms, the organization identifies the language needs of the patient).
- For information on preparing your organization on this point of contact, refer to Step 1; Resource Units A, B, and D.

Preparation for visit

- Depending on the language needs of the LEP patient, the organization makes resources available for the LEP patient's appointment (i.e., speaker phones in examination rooms, scheduling and confirming interpreters).
- For information on preparing your organization on this point of contact, refer to Step 2; Resource Unit A.

Waiting in the lobby

- Organization provides informational materials, such as signage and patient education materials, in the languages commonly encountered in the patient population.
- For information on preparing your organization on this point of contact, refer to Resource Units B, C, and D.

Billing

- Organization has a system for communication internally between departments, and billing department personnel are aware of LAS needs. Interpreter accompanies patient to the billing department. Organization provides the appropriate translated information on navigation through the health insurance system and how to seek assistance with the billing process.
- For information on preparing your organization on this point of contact, refer to Step 2; Resource Units A, B, and C.

Procedures, radiology, and lab work

- Organization has a system for communication internally between departments, and lab personnel are aware of LAS needs. Interpreter accompanies patient to the appropriate departments.
- For information on preparing your organization on this point of contact, refer to Step 2; Resource Unit A.

Diagnosis and explanation of treatment and discharge plan

- With interpreter present, provider verifies that the patient understands the diagnosis and provides to the patient translated informational materials and discharge instructions.
- For information on preparing your organization on this point of contact, refer to Resource Units A, B, and C.

Assessment and clinical encounter, including physical exam

- Organization provides an interpreter or some kind of interpretation service and allots enough time for the appointment, taking into consideration the extra time needed for interpretation services.
- For information on preparing your organization on this point of contact, refer to Step 2; Resource Unit A.

Discussion of referrals

- Interpreter accompanies patient to the clerk for scheduling and referral. Clerk and interpreter explain to patient the referral process. Clerk calls outside referral organization to inform it of the LAS needs of the patient, ensures that it can cater to the patient's LAS needs, and schedules an appointment for the patient with the referral organization. Organization provides the appropriate multilingual handouts on returning to the organization.
- For information on preparing your organization on this point of contact, refer to Steps 1 and 2; Resource Units A, B, and C.

Pharmacy

- Organization has a system for communication internally between departments, and pharmacy is aware of LAS needs. Interpreter accompanies patient to the pharmacy. Pharmacy provides translated forms, prescription labels, and instructional sheets regarding prescriptions, as well as information on receiving refills.
- For information on preparing your organization on this point of contact, refer to Step 2; Resource Units A, B, and C.

Reminders and followup communication

- Reminders and followup communication are sent to the patient (via mail and/or telephone) in the patient's language. Patient contact information is confirmed and patient need for LAS is periodically re-assessed.
- For information on preparing your organization on this point of contact, refer to Steps 1 and 2; Resource Units A and B.

Patient complaint and incident reporting

- Organization informs the patient of his or her right to file complaints and incident reports and explains the process for doing so.
- For information on preparing your organization on this point of contact, refer to Steps 1 and 2; Resource Units A and B.

How Can I Implement Language Access Services Using This Guide?

This guide will walk you through the process of planning, implementing, and evaluating LAS using a step-by-step approach. Exhibit I–3 summarizes each of the steps and resource units discussed in the guide and provides a summary of insights associated with each step or resource unit.

Exhibit I–3: The Four Steps and Six Resource Units—With Related Insights

	Step	Related Insights
Step 1	Assessing the Language Needs of Your Patients	Identifying LEP populations and their needs in an organization's service community can help to better provide patients with appropriate services and ensure the quality of their care. In addition, it can save resources for the organization in the longer term and can prevent misunderstanding and potential malpractice suits.
Step 2	Assessing Your Organizational Capabilities	Moving an organization toward cultural competence and effective language services requires dedicated leadership and involves engagement that encompasses the entire organization.
Step 3	Planning and Implementing Language Access Services	Step 3 comprises Resource Units A through F. See each resource unit for related insights.
Resource Unit A	Interpretation Services	Offering competent interpretation services assists LEP patients with understanding and making informed decisions about their medical care.
Resource Unit B	Written Materials	Developing materials in other languages and/or translating materials to meet patients' needs can help patients better understand and manage their health. Including the patient community in developing the materials can help ensure that the materials are accurate, understandable, and useful.
Resource Unit C	Signage and Wayfinding	Posting meaningful signage and helping patients find their way within a healthcare organization demonstrates consumer friendliness and helps LEP patients and their families feel more comfortable in a stressful situation. In addition, signage may help patients receive timely care in emergency situations.
Resource Unit D	Notice of Language Access Services to LEP Patients	Providing LAS can make a difference in the quality of care and health outcomes of patients, but patients need to be aware of the services, by providing appropriate, visible notices about the availability of the services, which should be available when patients need them.
Resource Unit E	Community Involvement	Involving the community in LAS is a necessary component of providing effective LAS and has advantages for providers, administrators, healthcare organizations, and patients.
Resource Unit F	Written Language Assistance Plans	Developing and operationalizing an integrated written plan for offering LAS can benefit both healthcare organizations and providers by ensuring strategic action, providing a shared framework for the provision of LAS, and serving as a tool for evaluating services.
Step 4	Evaluating the Quality of Your Language Access Services	Monitoring, evaluating, and updating LAS are part of an iterative process and can help to ensure the highest quality of care and patient satisfaction.

In Step 1, you will learn about how to assess the language needs of your patient population to determine what LAS are needed. In Step 2, you will learn about how to assess your organization's capacity for providing needed services. You will then be able to use what you learned in Steps 1 and 2 to tailor your implementation of the various components of LAS, discussed in Step 3. In Step 4, you will learn about methods for monitoring, evaluating, and updating your LAS.

Within each step and resource unit, you will be given issues for consideration as you plan, followed by a summary of implementation issues, including a checklist of activities to use as a guide as you implement. The final section in each step and resource unit provides you with evaluation questions that you can cross-reference against each item in the implementation checklist to help you monitor, evaluate, and update your LAS. You can then refer to Step 4 for more detailed information on designing and conducting evaluation activities.

Exhibit I-2 (Traveling Through the Points of Contact) provides a summary of patient points of contact and potentially relevant steps and/or resource units. You can refer to exhibit I-2 as you plan, implement, and evaluate your LAS to help ensure that LAS are appropriately provided across the continuum of care.

Step 1: Assessing the Language Needs of Your Patients

Discussion Topics

- Collecting Patient Data
 - Internal Organization-Specific Data
 - External Data Sources
- Assessing Patient Needs
 - Determining the Number of LEP Individuals Served and Frequency of Contact
 - Determining the Nature and Importance of Services

The first step in implementing language access services (LAS) involves identifying the language needs of your patients. This section describes issues for consideration as you plan to implement the step. The discussion on planning is followed by a section on implementation, which includes a checklist of items to review as you implement the activities described in the step. The step concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to implement this step.

The planning section in Step 1 walks you through collecting data on your patients, including both data specific to your organization that can be collected internally as well as population trend data that you can collect from sources outside of your organization. Next, the step describes ways to use these data to assess your patients' language needs. This includes determining how many of your patients are limited English proficient (LEP), the frequency with which these LEP patients have contact with your organization, and the nature and importance of the services that they utilize at your organization.

The step describes two cases, one that demonstrates an organization at an earlier stage of implementing LAS and one that demonstrates an organization further along in the process. Each case also includes patient and provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

Two 13-year-old girls, who both speak Spanish as their primary language, have very similar social histories. Both have medical complaints consistent with appendicitis or ectopic pregnancy. However, each girl has a very different healthcare encounter, because one is treated at a community hospital that has little experience with LEP patients and the other is treated at a community health center that is implementing LAS.

Step 1: Patients' Profiles

Paulina Quesada and Merce Moreno:

- 13-year-old girls whose primary language is Spanish
- Speak English moderately well
- Parents speak little English
- Families have few financial resources and no health insurance
- Arrived home from school complaining of a stomachache
- Pain worsened during the night, parents sought medical treatment

Case 1–1: Paulina Quesada's Upset Stomach (Community Hospital)

Patient's Story

When Paulina Quesada and her parents arrived at the community hospital walk-in clinic, the front-desk receptionist, a young woman who spoke only English, handed them a clipboard of forms to complete. Although Paulina's stomachache made her very uncomfortable, she completed the forms. Her parents did not read English well enough to understand the requirements or instructions. The forms had no questions about racial or ethnic background. Paulina could not understand some of the questions on the form, but completed them as best she could. For example, she did not understand the instruction, "Enter first day of last menstrual period," so she left it blank. A long paragraph about "treating minors" confused her, but she understood where to sign her name.

When Paulina returned the form, the receptionist noticed that Paulina, not her parents, had signed it. She spoke loudly into the waiting room, telling Paulina's parents, in English, that they needed to sign the permission statement if they wished for the doctor to see Paulina.

Paulina waited a long time, then entered the examining room with her mother. When the doctor arrived, he probed Paulina's abdomen and could tell that she felt tenderness and pain. When he asked Paulina diagnostic questions, Paulina repeated each question to her mother in Spanish. Paulina answered the doctor only after her mother responded. Finally, the doctor said to Paulina, "Please answer me directly in English, then explain it to your mother when you leave." Paulina was afraid that she had made the doctor angry, so she answered in as few words as possible, not really responding to everything he asked.

Frustrated at his inability to get information from Paulina, the doctor asked the receptionist to call for someone in the hospital who could interpret in Spanish. Paulina and her mother waited in the examining room until the doctor returned with a young, Latino orderly. The orderly, interpreting for the doctor, asked if Paulina might be pregnant. Paulina dropped her eyes and answered, "No," almost too embarrassed to speak. The doctor noticed her shame, and saw that she had not entered the date of her last menstrual period on the intake form. He suspected that she had an ectopic pregnancy, although he knew that appendicitis was a possibility as well.

After Paulina was dressed, the doctor saw her again in the examining room. The interpreter had returned to the hospital. The doctor explained that he suspected that Paulina might have an ectopic pregnancy or appendicitis, but that he needed to conduct additional tests to diagnose the problem. Paulina interpreted the doctor's mention of appendicitis, but did not mention ectopic pregnancy. The doctor's staff arranged for the hospital radiology department to see Paulina immediately and told her family to go to the main hospital information desk when they arrived.

Patient's Perspective

“There were so many forms to fill out, and I couldn’t concentrate because of the pain. The forms were long and confusing, and I made a mistake about signing one. The receptionist yelled at my parents because of the mistake. I was so embarrassed! Why couldn’t they have forms in Spanish? The doctor seemed angry, I guess because we couldn’t speak English very well. I wanted my mom to understand what I was telling the doctor, but he told me to stop talking to her in Spanish. She’s my mom! Then, the doctor left the room and came back with this young Latino guy who asked me about being pregnant. I was wearing a gown that hardly covered me. I was so embarrassed!

“Couldn’t the doctor at least have found a woman to talk to me if he wouldn’t let me talk to my mom? Now we have to go to the hospital for more tests. I hope someone there speaks Spanish.”

Provider's Perspective

“I try my best to provide good medical care to every patient, but how do I serve patients that I can’t even communicate with? The poor girl was so scared that she asked her mother to respond to every question I asked. With an English-speaking patient, I could have asked the parent to let the child speak for herself. Here I had to ask the daughter and it made her even more nervous. In the end, I spent far more time than I had available with one patient, and I had to make her sit there while an interpreter came over from the hospital. He had no training; how did I know that he was even correctly interpreting my questions or her responses? In the end, I couldn’t make a diagnosis and had to send the girl, who was clearly in pain, for more tests. I just hope they can help her at the hospital. I think she definitely needs surgery for something, but I can’t help figure out what it is. What a demoralizing way to practice medicine!”

This step will walk you through assessing the language needs of your patients. The step first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to assess the language needs of your patients.

Planning

In this section on planning, you will first read about collecting patient data, including internal organization-specific data and external data sources. You will then read about assessing your patients’ needs using the data you collected, including the number of LEP individuals you serve or could potentially serve, the frequency of contact they have with your organization, and how to determine the nature and importance of the services that they access at your organization.

Collecting Patient Data

To determine what types and levels of LAS are needed, it is important to first identify the characteristics of your LEP patients and their language needs. This involves collecting information about the LEP patients in your organization and community and assessing their needs based on this information. Helpful sources of information include both internal organization-specific data as well as data external to your organization.

Internal Organization-Specific Data

Your organization may already be collecting data at intake, admission, or registration that can be useful for assessing the language needs of your patients. If you are unable to collect information from all of your patients, you might consider collecting the information from a sample or subset of your patients. The following information can be helpful for better understanding your LEP population and their needs:

Race and Ethnicity

- It is important to collect these data in a consistent way. It may be useful to collect information on race and ethnicity in a manner similar to the U.S. Census Bureau. For example, the bureau first asks for ethnicity—distinguishing between Hispanics and non-Hispanics—then race, covered by 15 categories, including White, Black or African American, American Indian or Alaska native, among others.

Language Preferences

- English proficiency, language preferences of the patient, patient’s parents/guardians, and other family members. Questions may include:
 - How would you rate your ability to speak English? (very well, well, not well, not at all)
 - What is your preferred spoken language?
 - What is your preferred written language, or in what language would you prefer to receive written materials?



Links to Web Resources on the Collection of Race and Ethnicity Information

Health Research and Educational Trust (HRET) Toolkit

www.hretdisparities.org

Commonwealth Fund Report on Data Collection in Hospitals

http://www.cmwf.org/usr_doc/hasnain-wynia_whowhenhow_726.pdf



Identifying Patient Language Preferences

“I-Speak” cards and point-to posters can be useful tools in helping you to identify the language preferences of LEP individuals.

For more detailed information on “I-Speak” cards and other useful tools, see Resource Unit C (Signage and Wayfinding).

Need for an Interpreter

- To determine language preference and need for an interpreter, you can consider using “I-Speak” cards or point-to posters. For more information on these tools and other resources, see Resource Unit C (Signage and Wayfinding).

Other Potentially Relevant Data

- Such data might include:
 - Gender of the patient
 - Literacy level and health literacy level
 - Whether someone else usually schedules appointments for the patient due to language barriers

Issue to Consider

In collecting client data, it can be helpful to consider the following:

- Storing this information in a simple electronic database can serve as a means to:
 - Easily transfer information to all those involved in the healthcare encounter, for example, providers and pharmacy and billing personnel.
 - Have automatic access to information language needs during future appointment scheduling.
 - Facilitate the scheduling of interpreters during future visits.
- If you do not have an electronic database:
 - You can add the language data fields to patient forms or insert a simple data collection form into patient files
 - You can use colored tags on patient files that are easily visible from the outside of their folders



Collecting Sensitive Information and Respecting LEP Individuals

When gathering information from LEP patients, particularly sensitive information, staff can take steps to ensure that the interaction is positive and yields accurate data. For example, during this interaction staff can:²

- Explain why they are requesting the information so that the patient feels more comfortable disclosing the information.
- Calm fears of discrimination by assuring the patient that the information is being collected so your organization can better serve his or her language and cultural needs.
- Ask the patient directly about his or her needs to prevent profiling or stereotyping, such as making assumptions based on a patient’s appearance, name, or address.
- Emphasize your organization’s commitment to maintaining patient confidentiality.
- In respecting your patients, also be respectful of those who do not wish to disclose this information to you.

- Training staff on how to enter data on language needs will allow for accurate recording and reporting and can prevent staff frustration.
- It is important to be aware that language preferences and abilities may change. You may need to ask and update language-related questions regularly in your records.
- Routinely asking for updated contact information and alternate or family member contact information can prevent difficulties in locating patients.

After the visit, it may be helpful to collect additional information that can help you evaluate and improve your services. You might consider collecting the following types of information:

- Whether bilingual staff or clinicians, dedicated staff interpreters, contract interpreters, or other LAS were used
- How long the patient waited for an interpreter to arrive
- Whether patients declined or refused to use an interpreter that your organization offered to them and why
- Whether patients received language assistance from a friend or family member

Additional sources of internal data may include:

- Data from telephonic interpretation services, such as usage rates and language preferences.
- In-house patient satisfaction surveys. See Step 4 (Evaluating the Quality of Your Language Access Services) for detailed information on patient satisfaction surveys.



Ensuring the Accuracy of Your Data

If your staff enter patient information into a database electronically, consider the following ways to prevent errors in data entry:

- Consider incorporating required fields, i.e., fields that must have data in them before staff can go to the next question in the database.
- For the patient's language preference, avoid setting the default for this field to "English." Rather, you can make it a required field so that staff must enter the patient's language ability and preferences.
- Consider incorporating skip patterns. For example, the database may ask, "Is the patient's primary language English?" If the answer is "No," staff can enter in "No," then the database can skip automatically to questions about language ability and preferences.
- Consider including drop-down menus and "Other" fields that can be filled in.
- Consider developing the system in a way that allows information to be added from multiple points in the organization (e.g., member services, grievances and appeals, and case management).⁴³
- Train staff on data entry procedures.

- Information on the usage of your organization's phone tree.
- In-house discussions with providers and staff on, for example, culturally ingrained beliefs among patients.

Community outreach is another useful means of gathering information on LEP patient needs. This can be done through:

- Surveys with community members on the variables described above in addition to satisfaction with the healthcare experience, including language services
- Focus groups with community members on similar issues, including LEP patients and parents of LEP patients
- Informal needs assessments, including patient complaints and resolutions, at community workshops, fairs, places of worship, or community meetings
- Inviting community members to participate in your organization's advisory committees
- Combining assessments of language needs with existing studies. In conducting general health surveys or, for example, an assessment of unnecessary patient admissions and misdiagnosis, the data collection instruments can include questions about language needs.
- Additional ways to involve the community in the implementation of LAS are further discussed in Resource Unit E (Community Involvement).

Sample Patient Satisfaction Survey Questions⁴⁴

You might consider soliciting yes/no responses to the following questions, or have the patient answer according to a 1-to-5 scale of satisfaction:

- The doctors and nurses listen to me.
- I understand what the doctors and nurses tell me.
- I wait more than 30 minutes for my doctor to see me.
- When a family member or I am sick, and the clinic is not in the area, I still have access to health care.
- I am satisfied with the medical care I receive at the health center.
- When I call the health center phone line, I understand the information given on the voicemail.
- The front-office staff treat me with courtesy and respect.

See Step 4 (Evaluating the Quality of Your Language Access Services) for detailed information on patient satisfaction surveys.

External Data Sources

The following external sources of information may help you gain a broader understanding of the language needs of LEP individuals in your area:

National Data

- U.S. Census Bureau data, including American Community Survey data
 - Race and ethnicity
 - Language use, English ability, and linguistic isolation (households in which all adults have limitations communicating in English). These data were captured during the 2000 census with the following questions:
 - Does this person speak a language other than English at home? (yes/no, for those who speak another language)
 - What is the language? (open question)
 - How well does this person speak English? (four-point scale: very well, well, not well, not at all)
 - Immigration data
- U.S. Citizenship and Immigration Services
- National Health Service Corps Uniform Data System

State Data

- Data from Medicaid and the State Children's Health Insurance Program (SCHIP)
 - Race and ethnicity
 - Primary language
- State departments of finance or planning



Reminder About Census Data²

When using census data, it is important to remember that demographic information may have changed since the census data were collected and that some racial and ethnic groups may be underreported in the data.

For an explanation of the collection of population origin and language data, see:

http://www.census.gov/dmd/www/pdf/07f_or.pdf



Links to Web Resources on National Data

U.S. Census Bureau

<http://www.census.gov>

American Community Survey (ACS)

<http://www.census.gov/acs/www/>

U.S. Citizenship and Immigration Services

<http://uscis.gov/graphics/shared/statistics/index.htm>

National Health Service Corps Uniform Data System

<http://nhsc.bhpr.hrsa.gov/resources/uds/index.asp>

County and Local Data

- School data
- Insurance data
- Information collected by community-based organizations, such as immigrant or refugee advocate groups
- Community councils

Research Data

- Published literature such as peer-reviewed journal articles
- Unpublished literature such as reports from local foundations, community-based organizations, advocacy and public policy organizations, and conferences

Assessing Patient Needs

After collecting internal organization-specific data on the LEP patients you serve and external data on LEP population trends at local, regional, State, and/or Federal levels, you can compile and analyze these data to help you tailor your LAS.

There are a number of ways to look at the data you have collected to assess the needs of your LEP patients. Three key factors to examine include:³⁸

- The number of LEP individuals your organization serves or could potentially serve in the community
- The frequency of the contact LEP patients have with your organization
- The nature and importance of the services provided by your organization



Link to Web Resource

American FactFinder (AFF)⁴³

<http://factfinder.census.gov>

Visit American FactFinder to access census data through an interactive database engine. AFF allows you to view data in many helpful ways, including:

- Selecting data sets
- Viewing data tables
- Displaying charts, graphs, and maps
- Downloading files

Other factors for consideration include:

- Services to which patients feel they need better access
- Services to which providers feel LEP individuals need better access
- Services that your organization will likely need to implement in the future given Federal, State, local, and other-level data on your LEP population
- Complaint forms, adverse effect reporting (such as medication errors), and morbidity and mortality reports
- Linking these factors with language-related data such as language preference or race/ethnicity can help you to better identify the needs of your LEP populations according to variables of interest.

Determining the Number of LEP Individuals Served and Frequency of Contact

If your organization stores language data on patients electronically, assessing the number of LEP individuals served and frequency of contact can be done through a simple data download. If language data on patients are stored in written format only, you can go through patient charts and take an inventory of patient variables. You may decide to extract information from all patient charts or from a sample of charts. You can sample charts randomly, select a specific time period, or choose other relevant delimiters.

You can use the internal and external data you collected to get a sense of how many LEP individuals your organization serves as well as how many LEP individuals in the community are in need of your services. In addition, both data sources can be used to project future need.



Benefits of Assessment

Assessment can help you:

- Identify ways to tailor your organization's LAS
- Create a business case to gain leadership support (for more information on creating a business case, see Step 2, Assessing Your Organizational Capabilities)
- Predict future LAS needs by monitoring population trends and shift patterns and projecting population growth, particularly if your LEP populations are in constant flux

Determining the Nature and Importance of Services

It can be difficult to determine the nature and importance of the services a patient needs without being able to communicate with him or her. Thus, it would be ideal to have language services in place for LEP patients, regardless of the nature and importance of the services they need. However, if your organization has limited resources, you may need to consider what services are more critical as compared to others, such as those provided in an emergency room. In doing so, it may be useful to consider the nature and importance of services received by patients at various points of contact throughout the healthcare experience. Examples of points of contact are listed below. For a more detailed description of the services commonly provided at each point of contact, see the discussion on points of contact in the introduction to this guide.

- Initial contact and appointment scheduling
- Entering the healthcare organization and navigation through the system
- Registration
- Preparation for visit
- Waiting in the lobby
- Assessment and clinical encounter, including physical exam
- Diagnosis and explanation of treatment and discharge plan
- Procedures, radiology, and lab work
- Billing
- Discussion of referrals
- Pharmacy
- Reminders and followup communication
- Patient complaint and incident reporting

“Talking is fundamental in health care.”⁴⁵

—Roter and Hall 1992

Implementation

Now that you have reviewed planning issues related to this step, you can decide on a plan of action and implement it. You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. In Step 2, you will learn about ways to conduct a comprehensive assessment of your organizational capabilities. You will need to consider your organization's capabilities when deciding which activities to undertake in association with this step. You can also use the checklist to monitor, evaluate, and update the activities associated with this step.

Collecting Patient Data

- Did you collect internal organization-specific data?
 - Did you decide upon the variables that you will use to identify your patients' language needs?
 - Did you decide upon ways to collect the data in a simple electronic database or to effectively transfer the data when they are in hardcopy only?
 - Did you train staff on how to collect and enter the data?
 - Did you collect data on whether language services were used during patient visits?
 - Did you collect data on when patients declined or refused an interpreter?
 - Did you collect data on whether patients received language assistance from a friend or family member?
 - Did you collect data on the duration of the visit?
 - Did you seek data from other internal data sources, such as patient satisfaction surveys?
 - Did you conduct community outreach to collect patient data?
- Did you collect information from external data sources?
 - Did you collect national, State, county, and/or local data?
 - Did you collect research data from published and unpublished literature?

Assessing Patient Needs

- Using the data you collected, did you assess your patients' language needs?
 - Did you analyze the number of LEP individuals your organization serves?
 - Did you analyze the frequency of contact that LEP patients have with your organization?
 - Did you analyze the nature and importance of services provided to LEP patients by your organization at each point of patient contact?

Evaluating Your Solutions

To ensure that your means of assessing the language needs of your patients are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to assessing the language needs of LEP individuals? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to assessing the language needs of LEP individuals? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your means of assessing the language needs of LEP individuals? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you come up with specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

Case 1–2: Merce Moreno’s Upset Stomach (Community Health Center)

Patient’s Story

When Merce Moreno and her parents arrived at the community health center, the front-desk receptionist, a young Latino man, welcomed them in English and Spanish, then asked which language they preferred. Merce’s mother explained that her daughter had a severe stomachache, and the receptionist invited Merce to sit down. He gave Merce’s father a packet of forms in Spanish and briefly explained the information needed on each one. Merce’s father requested an interpreter. The receptionist arranged for a female interpreter who spoke English and Spanish. He then explained that the doctor would talk with them through a telephone interpreter.

Merce and her mother listened as the receptionist explained in Spanish that an interpreter would be on a speaker phone in the exam room. He said that the doctor would speak to Merce in English and the interpreter would repeat his words in Spanish. Merce should answer in Spanish, and then the interpreter would repeat her words to the doctor in English. Once Merce was ready for the exam and she and her mother had met the doctor and interpreter, it took them a few moments to get used to the dialog. They found it especially difficult to remember to look at the doctor, rather than the telephone, when speaking.

The interpreter repeated the doctor’s words: that he was going to probe Merce’s abdomen and that she should explain when and where it hurt. Merce expressed exactly how the pain started, where it was located, and how it felt. Finally, the doctor said, “I think this could be appendicitis, but we’ll have to do some tests and have a surgeon see her. If this is appendicitis, the surgeon will probably want to do surgery immediately. I’m going to send you over to the hospital emergency department. We’ll call ahead so that they know you’re coming.” The doctor explained, through the interpreter, that the health center would inform the hospital that the family needed an interpreter and request a surgeon who spoke Spanish. The telephone interpreter helped the doctor explain that the family should take Merce directly to the main information desk at the hospital emergency department.

Before leaving the community health center, the receptionist took more information from them, entered it into the computer, then called the hospital to confirm Merce’s arrival and LAS needs. The receptionist had forwarded the appropriate data to the hospital electronically, so the Morenos would have minimal forms to complete. Any additional forms they needed to complete would be in Spanish.

Patient’s Perspective

“I felt at home immediately when the receptionist asked if he should speak in English or Spanish. I was too sick to interpret for my parents, especially medical things, which scare me and make me confused. The interpreter made it easy to tell the doctor exactly what hurt, and I felt at home with the interpreter too. The only thing is, it would have been even better if she was there in person. When the doctor said I would have to go to the hospital, I was so scared! But he assured my mom and me that we could be together, and that he would make sure there was someone at the hospital who spoke Spanish. He arranged everything so that we could go straight to the hospital and not have to go through all the paperwork again.”

Provider’s Perspective

“This young woman was obviously in a great deal of pain and very frightened. I could see that she had her mother’s support, but her mother was frightened too. The interpreter made it much easier for everyone. Both the patient and her mother relaxed visibly when the interpreter started speaking in Spanish, and I got the information I needed to make a diagnosis fairly quickly. It’s true that it takes longer to work with a patient through an interpreter, but I’m not sure I could have made a good diagnosis without the interpreter present. Plus, Merce Moreno didn’t have time to wait for extensive tests. I’m sure she needs surgery as soon as possible.”

Step 1: Insights From the Cases for Healthcare Organizations

Identifying LEP populations and their needs in an organization's service community can help the organization better provide patients with appropriate services and ensure the quality of their care. In addition, it can save resources for the organization in the longer term and can prevent misunderstanding and potential malpractice suits.

In the case of Paulina Quesada (Case 1–1), the lack of language services cost the organization time and resources during the patient's visit. For example, a receptionist was taken away from other duties to explain the forms for the Quesada family, an examining room in a busy office was tied up while the physician waited for an interpreter, and the interpreter was taken away from his duties as an orderly to attend to the doctor's patient. Also, without an effective way to communicate with the patient, the doctor could only narrow the diagnostic options, then order tests to rule out various possibilities (i.e., ectopic pregnancy and appendicitis), rather than making a more accurate initial diagnosis. Additional testing could equate to additional expenses for the hospital. Lack of LAS also created an atmosphere in which the patient was uncomfortable and embarrassed.

In terms of misunderstanding and potential liability, the office risked the patient providing inaccurate information through forms she could not read and in communicating with the doctor in a language she did not speak well. Also, if the receptionist had not noticed that Paulina, rather than one of her parents, had signed the permission form, the clinic would have treated a minor patient without parental permission, a potential liability.

In contrast (in Case 1–2), although the community health center realized a direct cost in providing a telephone interpreter for Merce Moreno (as well as upfront costs in developing forms and other information in Spanish), it did not have to take staff from other duties to provide interpreter services, nor did it tie up the examining room waiting for an interpreter to be available. In addition, the doctor was able to make an accurate diagnosis, based on conversation with the patient, and did not require additional diagnostic procedures.

Step 2: Assessing Your Organizational Capabilities

Discussion Topics

- Promoting Language Access Services at the Organizational Level
 - Determining and Enlisting Leadership Support
 - Promoting a Diverse Work Environment
 - Conducting Training on Language Access Services Delivery
- Assessing Your Organization’s Capacity for Providing Language Access Services
 - Determining Whom To Involve in the Organizational Assessment
 - Identifying Barriers and Enablers to Meeting Needs

The second step in implementing language access services (LAS) involves assessing your organizational capabilities. This section describes issues for consideration as you plan to implement this step and provides a checklist of items to review as you implement the services and questions to consider as you monitor, evaluate, and update your solutions.

The planning section of Step 2 walks you through promoting LAS at an organizational level, including determining and enlisting leadership support, promoting a diverse work environment, and conducting training on service delivery. Next, the step describes ways to assess your organization’s capabilities for providing LAS, including determining whom to involve in organizational assessment and identifying barriers and enablers to meeting needs.

This step describes two cases, one that demonstrates an organization at an earlier stage of implementing LAS and one that demonstrates an organization further along in the process. Each case also includes patient and

provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

A 72-year-old Chinese breast cancer patient has to navigate the hospital for a biopsy when her trusted Chinese-speaking doctor is away. Her first encounter (Case 2–1) is distressing as she discovers that the hospital has few capabilities to serve limited English proficient (LEP) patients. The patient’s experience improves during followup care (Case 2–2), as the hospital begins to assess its capabilities and provide additional LAS for its Chinese population.

Step 2: Patient's Profile

Ya Lin:

- 72-year-old Chinese woman
- Living in the United States more than 30 years
- Speaks little English
- Private health insurance and Medicare
- Mammogram showed mass in right breast; breast cancer strongly suspected
- Scheduled for a breast biopsy at hospital outpatient clinic
- Chinese-speaking physician, Wen Cheng, out of the country at time of biopsy

Case 2–1: Ya Lin's First Hospital Experience

Patient's Story

As he drove to the airport, Dr. Wen Cheng thought about his patients, especially Ya Lin. He had explained the importance of regular mammograms, but she had not had one in years—until he felt the lump in her right breast. Today was her biopsy, and he and his family were leaving for China, their first trip home since they moved to the United States 22 years ago.

Dr. Cheng had hardly gone on vacation since the Chinese population in the community had grown so big. Besides seeing patients, the office staff did all the hospital scheduling for patients who did not speak English. They provided clinical instructions before lab tests and other procedures, and the hospital or pharmacy often called them to interpret for patients or when patients asked for someone to explain their prescriptions or discharge orders. When the workload became overwhelming, Dr. Cheng had invited Dr. Huang, a charismatic young Chinese American doctor, to join his practice. Dr. Cheng hoped that the hospital would treat Mrs. Lin well, and wondered if Dr. Huang could convince the new hospital administrator to be more open-minded about providing LAS for the growing Chinese population.

Mrs. Lin and her husband arrived at the hospital. The admissions process was confusing, and the clerk was kind enough to call Dr. Cheng's office staff twice to help explain the forms and procedures. Mrs. Lin finally settled into a small cubicle in the outpatient waiting room, but she could not understand the questions the nurse asked in English. Finally, Mr. Lin said quietly, "Dr. Huang is coming." The nurse looked at her watch, aware that the scheduled time for the biopsy was fast approaching.

A cheery young aide appeared at the Lins' cubicle with a portable television and VCR. "This will explain your procedure," she said as she put a videotape in the player. Once the tape started, she noticed the blank look on Mrs. Lin's face. "Do you speak English?" the aide asked. When the Lins told her they did not speak English, the aide apologized and removed the television.

On their way in, the Lins had stopped to buy the Chinese newspaper, but the hospital gift shop sold only English-language reading materials. The Lins could only sit quietly until Dr. Huang arrived.

When Dr. Huang finally arrived, he coached Mrs. Lin through the paperwork and instructions and briefly explained the biopsy procedure. He saw her again in post-op and conferred with her surgeon. Because the surgeon did not speak Chinese, he asked Dr. Huang to tell Mr. Lin that his wife was doing fine. Dr. Huang would wait for additional confirmation from the lab and a conference with the oncologist before telling the Lins that Ya had cancer.

Patient's Perspective

“My time at the hospital made me appreciate Dr. Cheng and his staff even more. It’s the little things he does to make us feel welcome in his office, like Chinese magazines and artwork on the walls. There are so many Chinese people in this town now, and not one single thing that would welcome us to the hospital. Couldn’t they at least sell the Chinese newspaper in the gift shop? Speaking of Dr. Cheng’s office, what if we came in at night, for an emergency, and couldn’t call Dr. Cheng’s office to help us with the forms? What if Dr. Huang wasn’t there to help me understand the procedure? As it was, once I got into the operating room, the nurses and doctors were talking to me, and I had no idea what they were explaining. It would have been nice to have an interpreter, or a nurse, or someone in the room with me who could explain things in Chinese. Even if they had that video in Chinese, at least I would have understood what they were doing. I know many other Chinese people who have had biopsies. Couldn’t the hospital have something that explains it for us?”

Providers' Perspectives

Dr. Cheng: “I wish I could feel more comfortable about how Ms. Lin will be treated at the hospital. I’m one of few internists for the Chinese population, and I have pleaded with the hospital for years to provide better services for my patients. I know that the hospital could do more, but the former administrator just didn’t seem interested. It makes me angry; I refer all my patients there. My patients add to the hospital’s revenue like everyone else, and they deserve at least the same treatment. Instead, my staff has to provide services, such as interpretation and explaining procedures that the hospital should be offering.”

Admissions clerk: “I’m so tired of feeling stressed because I can’t even communicate with the patients without calling Dr. Cheng’s office. Not only does it take up precious time, but it makes me feel like I’m incompetent.”

Dr. Huang: “I understand that Mrs. Lin and our other patients need someone to explain things to them, but it complicates my schedules and the hospital’s schedule too when they can’t begin a procedure until someone from our office can explain the paperwork and instructions to the patient. Couldn’t the hospital be providing these services? They provide services for English-speaking patients, and Chinese patients pay the same fees as everyone else.”

This step will walk you through assessing your organizational capabilities. The step first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you came up with related to your organizational assessment.

Planning

Before assessing your organization’s capacity for implementing LAS, it is important to first identify the ways in which your organization can meet the linguistic needs of your patients at an organizational level. After thinking about these organizational-level activities and gaining leadership support, you can assess your organization’s capacity for promoting LAS to

systemically meet the specific needs of your patients, as assessed in Step 1 (Assessing the Language Needs of Your Patients).

Promoting Language Access Services at the Organizational Level

There are a number of things that can be done at an organizational level to promote LAS delivery. These include:

- Determining and enlisting leadership support for providing LAS
- Promoting a diverse work environment
- Conducting training on LAS delivery

Each of these topics is discussed in the sections that follow.

Determining and Enlisting Leadership Support

Implementing language access services requires vision, support, and guidance from the executive leaders at your organization.

If you are an executive, you may need to designate a program champion who will be responsible for implementing LAS. If you are not an executive, you may need to enlist support from executives, such as administrators, CEOs, or your board of directors. A cultural change within the organization may be required. Leaders can look at LAS not as a “program,” but as a way to retool the organization to deal with changing demographics reflected in the market. The following list highlights some options for enlisting leadership support:²

- Illustrate how providing language services is in line with the mission of your organization.
- Create a business case to show the need for language services and potential ways to fund the services.

“I think top management in most clinics sees the utility of it, they have to. . . . In certain areas of the country, you have no choice. I mean, 'cause these patients show up at your doorstep. But, you know, if somebody at a front desk has a lousy attitude about dealing with non-English speaking patients, I can assure you that that attitude is probably shared by others in that organization.”

—Healthcare professional with experience implementing LAS

- Enlist provider and staff support for language services.
- Engage community leaders or public opinion leaders within your organization.
- Show community support for language services.

Creating a Business Case

Creating a business case can be effective in enlisting leadership support in your organization. You can use the information collected on patient needs in Step 1 (Assessing the Language Needs of Your Patients) to build the business case. Other ways to make the business case include:^{46 47}

- Demonstrating potential cost reduction because of:
 - Reduction in potential mismanagement of conditions or illness, such as unnecessary tests resulting from more accurate assessments
 - Reduction in medical errors and potential malpractice
 - Increased compliance with appointments, treatments, and medication regimes
 - Fewer followup and emergency room visits
 - Fewer hospital admissions
 - Increased use of preventive services, such as breast and cervical cancer screenings, rectal examinations, fecal occult blood testing, and influenza immunizations

- Highlighting Federal recommendations and accreditation standards for language services, such as:
 - Office of Minority Health (OMH) recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS)
 - Title VI of the 1964 Civil Rights Act
 - Office for Civil Rights (OCR) revised DHHS LEP policy guidance
 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards
 - National Committee for Quality Assurance (NCQA) standards for managed care organizations
- Demonstrating the impact of language services on patient safety and quality of care
- Demonstrating staff satisfaction with language services
- Demonstrating patient satisfaction, including potential increases in earnings (i.e., revenue) and increases in number of patients seen at the organization (i.e., increasing market share)
- Providing potential ideas or ways for how your organization can fund these services
- Demonstrating that language access services enable LEP patients to understand procedures and give informed consent in an ethical manner

In addition, your organization may consider how to redirect the benefits of LAS to sustain interpretation services. For example, the Neighborhood Health Plan of Rhode Island noticed that physicians were reluctant to discharge babies from the neonatal intensive care unit (NICU) without communicating effectively with LEP parents. Each extra day in the NICU cost the health plan about \$5,100. The health plan hypothesized



Links to Web Resources on Federal Recommendations and Accreditation Standards

OMH Recommended CLAS Standards

<http://www.omhrc.gov/clas/ds.htm>

Title VI of 1964 Civil Rights Act

<http://www.usdoj.gov/crt/cor/coord/titlevi.htm>

OCR Revised DHHS LEP Policy Guidance

<http://www.hhs.gov/ocr/lep/revisedlep.html>

JCAHO Standards and Elements of Performance

http://www.jcaho.org/about+us/hlc/hlc_ic_stds.pdf

NCQA

<http://www.ncqa.org>

“I would say we attract mainly though our mission. It’s not a financial incentive—it’s more mission driven. We attract the kind of people who see cultural competency as a necessary part of medical care.”

—Physician with experience implementing LAS

that language services would allow providers to feel that the parents understood how to care for their babies, and they would be more likely to discharge patients on time. The health plan could then redirect those cost savings to providing language services.⁴⁷

If your organization has already identified the need for LAS, your focus may shift from creating a business case to determining how to offer these services cost effectively. This guide will offer different approaches that may be cost effective for your organization.

Promoting a Diverse Work Environment

Organizations can benefit from hiring culturally and linguistically diverse staff, even though it may require more effort up front to recruit, assess, and train these employees. Potential benefits include:²

- Using diverse staff as a resource for addressing cultural or linguistic issues that arise and for providing culturally and linguistically appropriate care
- Making linguistically diverse patients feel more comfortable
- Realizing a long-term cost savings when hiring bilingual providers and staff as compared to hiring staff interpreters

Although hiring bilingual staff may provide long-term cost savings, you will need to consider what is viable for your organization. For example, your LEP population may have more remote language groups or multiple language groups for which it would make sense to use an interpreter rather than hiring a bilingual staff person.

Attracting, Hiring, and Retaining Diverse Staff

One way to promote a diverse work environment is to attract and hire culturally and linguistically diverse



Attracting and Retaining Bilingual Staff

Organizations may consider investing in a “bilingual premium” (for benefits for bilingual providers and staff). If salary rates are 90 percent comparable, providers may be willing to choose a job based on other benefits. Examples of other benefits include:²

- Offering a different compensation packet
- Offering continuing medical education credits
- Paying for license and board certification
- Offering increased vacation time
- Providing funds for loan repayment

employees. Potential ways to attract diverse staff include.^{10-13 48}

- Listing language skills or a bicultural background as a requirement for hiring in job descriptions and announcements (see appendix B for an example job description from a hospital)
- Placing job advertisements in non-English media, such as newspapers, television, radio, or church bulletins
- Sending job announcements to universities (such as departments of foreign languages, allied health, social work, and international studies)
- Disseminating job announcements through local community groups, such as businesses, ethnic grocery stores, churches, temples, schools, and so forth
- Highlighting your organization's mission in job announcements
- Hiring from within the community
- Offering higher salaries to bilingual employees or dual-role interpreters (i.e., staff who also function as interpreters)
- Offering incentives to bilingual employees, such as extended vacation time, interpreter training, or loan-repayment programs
- Hiring interpreters who have completed local training programs

Alternative ways to recruit diverse staff include.^{11 14 15 48}

- Working with the local chapters of professional organizations, such as the National Medical Association, the National Hispanic Medical Association and other minority medical societies, the American Nurses Association, the National Hispanic Nurses Association and other minority nursing associations, or the Association of Asian Pacific Community Health Organizations, to recruit diverse staff to your organization

- Participating in initiatives that target people in entry-level healthcare jobs and encourage them to become higher level providers such as physicians, nurses, or lab technicians
- Using volunteers with language experience who need to gain experience for medical school
- Participating in initiatives that encourage diverse students to pursue medical professions, such as nursing, medicine, and dentistry
- Participating in programs that recruit bilingual residents or interns
- Participating in programs that provide scholarships to bilingual high school students to encourage them to enter healthcare professions

Ultimately, long-term solutions are needed to increase the number of qualified, diverse healthcare personnel.

Conducting Training on Language Access Services Delivery

Training is critical to promoting culturally and linguistically appropriate service delivery. You may want to develop trainings specific to your organization's needs.

Once language services are in place, the organization will need to train all employees on the policies and procedures for accessing those services. As the time and cost required for training often may be underestimated, it is important to acknowledge these costs to implement an effective program.¹⁶ You can plan to conduct an initial training, but may also consider providing training again in 6 months to prevent lapsing into previous habits.¹⁷

The following topics may be useful to include in the training:^{12 13 49}

- Organizational policies and procedures for language services
- Benefits of language services to providers



Changing Staff Behavior and Attitudes

Changing staff knowledge, behavior, and attitudes toward using language services may require a change in the organizational culture.

Staff members need to understand the reasons why providing LAS is important and, more specifically, why qualified interpreters are preferred to family and friends as interpreters.

People may be resistant to changing their behaviors because to do so they have to step outside of their comfort zone.¹²

Leadership support may counteract this resistance. The CEO of one organization with experience implementing language services was not tolerant of impertinence regarding language or culture. If a staff person had a problem, the CEO would talk to that staff person directly to resolve any issues.¹³

- How to access language services at your organization
- How to work effectively with interpreters
- How to build trust with interpreters
 - Stress confidentiality with patients
 - Explain the process of interpretation for new patients
- How to use and access written materials for LEP populations
- Federal requirements for language services

Organizations can address training topics in different ways. For example, training can be provided:^{12 13 49}

- During regular staff meetings
- On the organization's intranet
- At special diversity lectures
- By pooling resources with other community organizations to conduct training for all providers in the area
- During the annual inservice process

However your organization decides to provide training on LAS policies and procedures, the important thing is to make sure that all employees understand how to access language services and the expectations involved with using these services.

Assessing Your Organization's Capacity for Providing Language Access Services

Now that you have determined the language needs of your LEP patients and identified ways to promote LAS at an organizational level, you can assess your



How To Work Effectively With Interpreters^{50 51}

- Face the *patient* and speak directly to the *patient*.
- Speak slowly and clearly. It is not necessary to raise your voice and shout.
- Avoid metaphors, slang, idioms, and jargon.
- Explain all medical terms in simple language.
- Watch the *patient* during the translation to allow observation of nonverbal cues.
- Try not to interrupt the interpreter, and allow the interpreter to ask questions to clarify what the patient says.
- Allow time for patients to ask questions and seek clarification.
- If the interpreter seems to answer for the patient, inquire about this.
- Use diagrams, pictures, and translated written materials to increase understanding.
- Always ask patients to repeat instructions back to you to be certain they were understood.
- Some patients who request an interpreter may understand English well. The patient may understand any comments made to other providers or to the interpreter.
- Document the name of the interpreter in the progress notes.

organization's ability to meet those needs. This assessment involves:

- Determining whom to involve in the organizational assessment
- Identifying barriers and enablers to meeting patients' needs

Determining Whom To Involve in the Organizational Assessment

The first step in the organizational assessment involves assigning responsibility for this assessment. Depending on the size of your organization, the assessment team may be made up of one or two people or multiple people from different departments. When assigning responsibility, your organization may choose people with knowledge, skills, and interest in the following:¹¹

- Organizational assessment and planning
- Organizational dynamics
- Collecting, analyzing, and interpreting data
- Language access services

Other issues to consider include the credibility of the team members and the diversity of the team.

Identifying Barriers and Enablers to Meeting Needs

Begin by compiling a list of ways to promote culturally and linguistically appropriate services (as identified previously) and to meet the specific needs of your patients as identified in Step 1 (Assessing the Language Needs of Your Patients). Next, identify resources that are available within your organization.

Identifying Organizational Resources

A systematic investigation of organizational resources will help you to compile an exhaustive list of supports available to you. There are a number of types of organizational resources. Three primary types include human, technical, and financial resources.

Human Resources

Some organizations may start identifying organizational resources by determining the language capabilities of their staff.

You can begin by compiling a list of bilingual employees and making sure the list is updated and used.¹²

- Include the employee's ability to speak other languages on the employment intake form and update the list on a monthly, quarterly, or annual basis. Ask employees whether they would like to be part of a language resource pool. If so, consider assessment and training for interested employees to become interpreters.
- Have the unit secretary or operator or a language access coordinator keep and update the list.

This list can be used to analyze the strengths and weaknesses of your human resources. For example, it may be important to consider the following:⁵²

- Are there staff members who identify themselves as bilingual but cannot interact effectively with LEP patients or who have not learned the skills to interpret or translate?
- What is the level of language proficiency among self-identified bilingual staff?
- Are there bilingual staff members who can be trained as interpreters?
- How will the use of dual-role interpreters affect the organization's workload? For example, who will cover the primary responsibilities of the medical records supervisor if he or she is pulled away from these duties to interpret?

Some organizations may rely on employees to self-identify as bilingual. It is important to assess the language proficiency of any staff person interacting with LEP patients—whether it is front office staff, a staff interpreter, or a physician. Once assessed, the staff



Identifying and Testing Bilingual Employees

It is important to assess the language proficiency of any staff person interacting with LEP patients—whether it is front office staff, a staff interpreter, or a physician.

For more information on assessing competency of bilingual employees, see Step 3, Resource Unit A (Interpretation Services).

person will need training to become an interpreter. Different levels of training may be appropriate depending on the type of services the staff person provides along the continuum of care, or at his or her respective points of contact with patients.

Additional information about interpretation training programs and competence assessment can be found in Resource Unit A (Interpretation Services).

Technical Resources

Language services may require specific technical resources. For example, some type of interpretation may require:^{12 13 29 40}

- Speaker phones in private exam rooms to allow the provider and patient to hear the interpreter at the same time, as opposed to having to hand a phone back and forth
- Computer systems, including hardware and software
- Databases and informational systems that can collect language data
- A video monitor for video medical interpretation
- Dual headsets

Financial Resources

Organizations with experience implementing LAS have cited financial issues as one of the largest barriers to providing language services. However, they also note that because of the critical need for LAS, they have found ways to fund these services.^{12 13} Each organization should assess what is reasonable within its financial resources.

A 2002 Office of Management and Budget (OMB) report estimated that interpretation costs an average of \$4.04 per visit by an LEP patient, or 0.5 percent of the total cost of the visit. OMB acknowledged that costs could vary widely.⁵⁴ Cost considerations for types of



Preventing Burnout Among Bilingual Employees⁵³

Bilingual employees who are used as dual-role interpreters may experience burnout because of an increased workload. Ways to prevent burnout could include:

- Having a system in place for situations when bilingual employees are pulled from their job to interpret
- Scheduling services ahead of time
- Using telephone interpretation instead of face-to-face interpretation
- Educating providers and staff on working with interpreters and why interpreters are an important resource
- Compensating dual-role interpreters financially or otherwise
- Hiring more interpreters
- Reevaluating LAS to come up with further solutions

interpretation services are shown in exhibit 3A–2 in Resource Unit A (Interpretation Services).

When considering financial resources, your organization may consider the potential costs of not implementing interpreter services, which is further described under the Creating a Business Case section (see page 37). Also, the organization should consider the following potential direct and indirect costs:¹⁶

- Direct costs
 - Salaries of professional medical interpreters or translators on staff
 - Increases in salaries for dual-role interpreters
 - Contracted interpreter service fees, including travel or waiting fee and minimum time requirement
 - Costs for written materials in languages other than English
 - Translation fees
 - Costs for signage
- Indirect costs
 - Overhead and fringe benefits for employees, such as office space, health insurance, and taxes
 - Interpreter training, testing, and monitoring
 - Throughput issues with moving patients quickly through the organization, as healthcare visits may move slower with interpreters at first
 - Low initial utilization inefficiency, as the organization will need to do inservice trainings to change staff behaviors with regard to using interpreters
 - Time investment of administrative staff to coordinate and implement services

How Much Do Interpretation Services Cost?^{54 55}

Cost is an important consideration as your organization starts to implement LAS.

In 2002, the Office of Management and Budget estimated that interpretation costs an average of \$4.04 per visit by an LEP patient, or 0.5 percent of the total cost of the visit. The OMB's estimate does not discount for the costs of language services already provided or for reductions in other healthcare costs if there is better communication.

In 1997, one study estimated that cost of providing interpretation services was \$279 per person per year for a large health maintenance organization employing five full-time trained interpreters for Spanish- and Portuguese-speaking patients.

For more information on cost of interpretation services, see Appendix C, Funding Sources.

An organization may reduce costs by:^{10 12 13 56}

- Hiring bilingual staff and providers
- Tapping into free or already paid services
 - Some State Medicaid agencies may reimburse providers for language services
 - Some State governments provide interpreters at no cost to the provider
 - Third-party payers, including managed care plans, in your area may have interpreters on staff who can be used for patients covered by their plan
- Sharing LAS with other organizations in your community
- Getting grants from the Federal Government, city or county resources, or private foundations to provide language services

Costs associated with specific types of interpretation services are discussed in Resource Unit A (Interpretation Services). Funding sources are discussed further in appendix C.

When developing proposals and budgets and conducting programs and activities, providers could consider the need for language services for LEP persons served or encountered. Many agencies, including some in the Federal Government, have determined that costs associated with providing meaningful access to LEP individuals are considered allowable program costs.

After identifying the resources available at your organization, look at your list of needs and think about potential barriers and enablers to meeting those needs.

Implementation

Now that you have summarized the activities involved in implementing culturally and linguistically appropriate services and meeting specific patient needs, as well as the potential barriers and enablers to each

State Mechanisms for Providing Interpretation Services^{56 57}

Some States have passed legislation to provide interpretation services to LEP patients under Medicaid and the State Children's Health Insurance Program (SCHIP).

The following States offer mechanism for paying for language services under Medicaid and SCHIP:

- Hawaii
- Idaho
- Kansas
- Maine
- Massachusetts
- Minnesota
- Montana
- New Hampshire
- Utah
- Washington
- Virginia (expected to start in July 2005)

For specific information about how these States pay for interpretation services, see Appendix C, Funding Sources.

(including resources), you can develop solutions for implementing each activity that are realistic for your organization. You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider the needs of you LEP population when deciding which activities to undertake. You can use the assessment to help you decide what activities to undertake throughout the rest of this guide. You can also use the checklist to monitor, evaluate, and update the activities associated with this step.

Promoting Language Access Services at the Organizational Level

- Do you have support from leadership at your organization? If not, did you enlist leadership from your organization?
 - Did you consider creating a business case to enlist leadership support?
 - Did you illustrate how providing LAS aligns with the mission of your organization?
 - Did you enlist provider and staff support for LAS?
 - Did you engage community leaders or public opinion leaders within your organization?

- Does your organization promote a diverse work environment by attracting and hiring culturally diverse staff?
 - Did you list language skills or a bicultural background as a requirement for hiring in job descriptions?
 - Did you place job announcements in non-English media?
 - Did you send job announcements to universities?
 - Did you disseminate job announcements through local community groups?
 - Did you highlight your organization's mission in job announcements?
 - Did you hire from within the community?
 - Did you offer incentives to bilingual employees?
 - Did you hire interpreters who have completed local training programs?
 - Did you work with local chapters of professional associations?

- Did your organization conduct training on LAS delivery?
 - Did training address the following topics?
 - Organizational policies and procedures
 - Benefits of LAS to providers
 - How to access LAS at your organization
 - How to effectively work with interpreters
 - Building trust with interpreters
 - How to use and access written materials for LEP populations
 - Federal requirements for LAS

- Did you implement training:
 - At staff meetings?
 - On the intranet?
 - During an inservice training?
 - At a special diversity lecture?
 - With other organizations in the community?

Assessing Your Organization's Capacity for Providing Language Access Services

- Did your organization decide whom to involve in the organizational assessment?
 - Did you assign a coordinator with knowledge, skills, interest, and credibility to develop a LAS program?
- Did your organization identify enablers and barriers to meeting the needs of the LEP population?
 - Did you identify human resources?
 - Did you identify bilingual staff members?
 - Did you assess the proficiency of these staff members?
 - Did you train these proficient staff members to serve as interpreters?
 - For those bilingual staff members who will serve dual roles (one being an interpreter), is interpreting part of their job description? Did you consider how role changing will affect staff?
 - Did you identify ways to prevent burnout among bilingual staff members?
 - Did you identify technical resources?
 - Does your organization have speaker phones for telephone interpretation?
 - Does your organization have headsets for simultaneous interpretation?
 - Does your organization have the needed hardware and software for your LAS program?
 - Do the management information systems allow for the collection and recording of patient data such as race, ethnicity, or preferred oral and written language?
 - Did you identify financial resources?
 - Did you look at direct and indirect costs of implementing LAS?
 - Did you look at potential cost savings of implementing LAS?
 - Did you consider tapping into free or already paid services in your community?
 - Did you consider sharing LAS with other organizations in your community?
 - Did you consider getting grants to develop LAS?

Evaluating Your Solutions

To ensure that your means of assessing the language needs of your patients are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to assessing your organizational capabilities? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to assessing your organizational capabilities? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your means of assessing your organizational capabilities? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you come up with specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

Case 2–2: Six Months Later—Ya Lin’s New Hospital Experience

Patient’s Story

Mrs. Lin had a lumpectomy and chemotherapy. Six months later, she was having monthly appointments with her oncologist at the hospital.

Dr. Huang had been asked to serve on the hospital’s LAS committee. This morning, he was telling Dr. Cheng about the committee’s progress. “The new hospital administrator is a whirlwind of energy,” Dr. Huang told Dr. Cheng, “and she’s *highly* devoted to LAS issues.” The new administrator, Dr. Beverly Johnson, was trained in medical anthropology and had a real interest in cultural diversity and eliminating health disparities. She had asked for research on population data for the community and an analysis of the racial/ethnic data of the hospital staff. She was amazed that the hospital had not already done more with the growing Chinese community. The data said that the Chinese community was now a substantial portion of the hospital’s patient population and was, by far, the largest minority group that the hospital served.

“There’s nothing here to welcome our Chinese patients to the hospital,” Dr. Johnson had said at the first committee meeting, “nothing to let them know that they could have an interpreter. Did you know that we don’t collect data on staff language abilities or ethnic or cultural groups, so we have no idea how many Chinese people or Chinese speakers we have on the staff? We have no patient educational materials in Chinese. We don’t even have a Chinese newspaper in the gift shop!”

Dr. Johnson had put the entire hospital on notice that implementing LAS was a top priority. The human resources office was scrambling to find data on the number of Chinese nurses and technicians in the hospital and where to recruit more. The patient education department was obtaining Chinese education materials. The admissions office and the information technology department had formed a team to determine how to collect and track patient data related to language and culture. New artwork, with Chinese themes, adorned the hospital walls, the gift shop carried Chinese reading materials and snacks, and every reception area had “I-speak cards” in Chinese languages. As its first task, the committee developed a mission statement about how the hospital would embrace a commitment to meeting cultural and linguistic needs. Dr. Johnson had the statement printed—in English and Chinese—and posted on every floor in the hospital, where both patients and staff could see it.

There was more to come. Staff had already started to talk excitedly about an upcoming training, which would include learning basic Mandarin and Cantonese phrases. A new policy and budget for using interpreter services was being prepared, and the facilities department was researching new bilingual signage. The research office was continuing to collect data on patients’ needs and the hospital’s capacity to meet the needs, and the committee had started to examine the data and incorporate means of addressing cultural and linguistic needs within the hospital’s strategic plan.

Ya Lin and her husband arrived at the hospital for her oncology appointment, and Mrs. Lin again noticed all the changes that the hospital had instituted. There was Chinese artwork in the hallways. The admissions clerk asked Mrs. Lin’s primary language, called an interpreter, and offered her a little paper card, written in Chinese, that said, “I speak Mandarin.” As they made their way to the exam room, the Lins were pleased to see the statement, posted in the hallway in Chinese and English, that said that the hospital would honor the Chinese culture and people while striving to provide the best medical care possible.

Patient's Perspective

“What a difference! Nobody enjoys being treated for health problems, but the hospital made me feel so much better. People seemed to care about me, and everyone seemed so much nicer and friendlier this time. Someone is finally recognizing that the Chinese people are a part of this community too. Imagine, they offered to call an interpreter rather than Dr. Cheng’s office, and they have signs and pamphlets that I can read and understand. The artwork is the most special to me, though; it relaxes me. All of Dr. Cheng’s talking to the hospital finally paid off!”

Provider's Perspective

Dr. Cheng: “The pressure on my office has been greatly relieved with the hospital’s attention to serving language needs of the Chinese population. Patients are receiving better care too; I see daily that the LAS committee and staff training have led to much more respectful treatment of the Chinese patients.”

Dr. Huang: “It’s very rewarding to be part of something so exciting as the cultural competency committee. This is clearly a valuable way for me to serve my patients, perhaps as valuable as the direct medical care that I provide.”

Dr. Johnson (hospital administrator): “It has been a lot of effort and it has taken all of my leadership capabilities, but we are beginning to see some positive results in patient satisfaction just from assessing our patient population and needs and making small changes. I’m convinced that our data will also demonstrate increased access to and quality of care over time.”

Step 2: Insights From the Cases for Healthcare Organizations

Moving an organization toward cultural competency and effective language services requires dedicated leadership and should encompass the entire organization. In Ya Lin’s case, the patient immediately noticed the differences between her hospital experiences in which cultural competency and language services were not a priority (the first experience) and when they were a priority (the second experience). In the first case, when the hospital was not concerned about language services for its Chinese patients, hospital practices bred frustration in both the patients and the physicians who treated them. For example, Mrs. Lin’s doctor’s office had to provide much of the patient support that would normally fall to the hospital when it treated patients. The hospital had to trust that the patients were receiving correct and accurate information about diagnostic and postdischarge instructions. Plus, the hospital had no control over the quality or content of the instructions that patients received. For example, the hospital could ensure that the videotape about breast biopsy accurately portrayed the patient’s potential risks and outcomes. The hospital had no such assurances if its patients received information about biopsy from outside sources. Any adverse effects of incorrect or inaccurate information could result in ineffective care that would be at least partly the hospital’s liability.

Step 3: Planning and Implementing Language Access Services

Step 3 walks you through the various components of language access services (LAS). The step is divided into six resource units. Each resource unit describes issues to consider for planning, includes an implementation checklist, and poses questions for evaluation.

Resource Units

- Resource Unit A: Interpretation Services
- Resource Unit B: Written Materials
- Resource Unit C: Signage and Wayfinding
- Resource Unit D: Notice of Language Access Services to LEP Patients
- Resource Unit E: Community Involvement
- Resource Unit F: Written Language Assistance Plans

“I wanted to tell him that I was sick. All the time I have gone to the different appointments, I wanted to tell him I was sick, and all the times I saw him, he said I was well. Because of the language, he wasn't interested in searching into what was wrong with me and finding a person who could explain. I don't think it's discrimination, but they just don't want to take the time. They just want to keep moving from one patient to the next.”

—LEP patient

Resource Unit A: Interpretation Services

Discussion Topics

- Overview of Interpretation Services
 - Benefits to Provider and Patient
 - Using Multiple Strategies
 - Points of Contact and Determining the Scope of Interpreting
- Considering Types of Interpretation Services
 - Bilingual Staff and Clinicians
 - Dedicated Staff Interpreters
 - Dual-Role Staff Interpreters
 - Contract Interpreters
 - Telephone Interpretation Lines
 - Community Volunteers
 - Language Agencies
 - Emerging Technology
 - Family and Friends as Interpreters
 - After-Hours Interpretation Assistance
- Developing a Process for Ensuring Competence of Interpretation Services
 - Developing an Initial Screening Process
 - Determining Means of Training Interpreters
 - Assessing Performance
- Determining Policies and Procedures for Working With Interpreters

Resource Unit A walks you through issues related to interpretation services. This unit describes issues for consideration as you plan to implement interpretation services, then provides a checklist of items to review as you implement the activities in this unit. It concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed related to interpretation services.

After an overview of interpretation services, the planning section of this unit describes types of interpretation services. Following these descriptions, the planning section walks you through developing a process for ensuring competence of interpretation services, including developing an initial screening process, determining means of training interpreters, and assessing performance. The planning section then addresses issues related to determining policies and procedures for working with interpreters.

This resource unit describes two cases, one that demonstrates an organization at an earlier stage of implementing language access services (LAS) and one that demonstrates an organization further along in the process. Each case also includes patient and provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

An 85-year-old Chinese male with prostate cancer has difficulty making his treatment preferences known to his healthcare team. His granddaughter, interpreting for her grandfather, tells the hospital staff what the family wants the patient to do, not what the patient has asked. After employing more appropriate interpretation options, the hospital staff learn that they have been preparing the patient for a surgical procedure that he does not want to have.

Resource Unit A: Patient's Profile

Hong Wu:

- 85-year-old Chinese male
- Living in United States 12 years, with family
- Speaks almost no English
- Medicare for health insurance; family pays privately for prescriptions and additional medical expenses
- Elevated PSA test, diagnosed with prostate cancer, scheduled for brachytherapy

Case A-1: Hong Wu's Prostate Surgery

Patient's Story

Hong Wu was a patient of Dr. Wen Cheng, the internist to much of the community's Chinese population. After Dr. Cheng found elevated prostate-specific antigen (PSA), Mr. Wu went to see an oncologist, Dr. Steve Parker. Dr. Parker's office did not provide interpretation services, and Mr. Wu's granddaughter Suzy interpreted for him. Suzy was training at the hospital to become an x-ray technician, but acted like she was a doctor. Mr. Wu was embarrassed at the way she argued with Dr. Parker.

Mr. Wu was surprised when Dr. Cheng had told him that Dr. Parker had suggested "watchful waiting" as a treatment option. Suzy had said that the doctor recommended implanting radioactive seeds and that the procedure was simple, painless, and without side effects. After speaking with Dr. Cheng, who told him that the procedure did have side effects, including the possibility of incontinence and proctitis, Mr. Wu had decided against it. He also decided that Suzy had not told him the truth about her conversation with Dr. Parker. But Suzy convinced her mother, Ming (Mr. Wu's daughter), that the doctor recommended brachytherapy. Ming scheduled the procedure for her father.

Now, Mr. Wu, Suzy, and Ming were in the admissions office at the hospital. "No surgery," said Mr. Wu firmly. The admissions clerk looked up in surprise, and Suzy and Ming started talking quickly to her in English. They explained that Mr. Wu did not really understand the issue and that he really did want the surgery. Ming suggested that she sign the papers for her father, but the admissions clerk explained that without legal standing, Ming was not eligible to do so. Mr. Wu continued to quietly say, "No surgery." The admissions clerk had no idea what to do in a situation like this, and decided to call a hospital staff member she knew who spoke Chinese. It took more than 10 minutes for her to find Johnny Lee, and more than 15 minutes for him to arrive in the admissions office. By then, the surgical staff had called to say that they were waiting for Mr. Wu.

Johnny Lee started to speak in Mandarin, but quickly realized that Mr. Wu spoke Cantonese. "He speaks Cantonese," Lee told the clerk, "I speak Mandarin." "I thought you spoke Chinese," said the admissions clerk, and Lee explained that there were several Chinese languages. Lee and Mr. Wu talked in their separate languages, and Johnny Lee was not sure how much Mr. Wu understood of the conversation. The surgery staff called again, saying that if Mr. Wu did not arrive shortly, they would have to reschedule his procedure. Johnny Lee tried again: "Mr. Wu, the hospital has people ready to do your procedure. It's too late to add someone else to the schedule, and all those people's time will just be wasted. Come on now, I just need you to sign the paper and we can get you upstairs." Mr. Wu said again, "No surgery," and his daughter and granddaughter had no choice but to take him home.

Patient's Perspective

“My granddaughter is disrespectful to me, and she did not tell me the truth about the surgery and my options for other ways to treat the prostate cancer. There was no interpreter for me, either at the doctor’s office or the hospital, and I came very close to having surgery I did not want. Even if they saw that my granddaughter spoke Chinese, the hospital still should have asked me if I wanted an interpreter and provided one for me. And they should know that Chinese people speak different languages! It was not the interpreter’s place to try to change my mind. All I wanted was someone who could listen to me and explain my wishes.”

Provider's Perspective

Admissions clerk: “I’ve never had to handle a situation like this, and I wish the hospital would give us some better guidelines. The patient and his family disagreed and I was caught in the middle. The surgery department was pressuring me to get the patient up there, and I couldn’t do anything until he signed the forms. The whole admissions process was backing up because it was taking me so long with this family. Then I had to find a staff member to interpret, and he wasn’t happy to be pulled away from his other duties. Surgery had to cancel the procedure, leaving an unused room and staff waiting. I’m sure they’ll complain that it was the admissions department’s fault. With the hospital wanting to serve more of the Chinese population, I’m sure situations like this will happen again. I think everyone needs to know how to handle them.”

This resource unit will walk you through interpretation services and related issues. The unit first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you came up with related to interpretation services.

Planning

After an overview of interpretation services, the planning section of this unit describes types of interpretation services. This is followed by a discussion on developing a process for ensuring competence of interpretation services, including developing an initial screening process, determining means of training interpreters, and assessing performance. This planning section then addresses determining policies and procedures for working with interpreters.

Overview of Interpretation Services

Interpreting is “the process of understanding a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another language.”⁵⁸ Interpretation can be offered in different ways and can be provided via bilingual staff and

“They asked me where I was not feeling well, asked me what my illness was, what my symptoms were. I had a hard time explaining to them what it was.”

—LEP patient

clinicians, dedicated staff interpreters, telephone interpretation, and community volunteers, among others. Any medical interpreter should be language proficient in two languages and able to interpret back and forth between both languages. This step not only will consider the different types of interpretation services available, but also will look at developing a process for ensuring the competence of interpreters, determining policies and procedures for working with interpreters, and evaluating your solutions.

Benefits to Provider and Patient

An interpreter facilitates communication between a provider and a patient who do not speak the same language. Without an interpreter, both parties can feel frustrated about not being able to communicate. Patients may feel a lack of confidence in the provider's diagnosis when providers are unable to understand patients explaining their symptoms. Patients may leave feeling unsatisfied about the visit.¹³ Providers may feel like they have not been able to provide the highest quality of care.¹² Both providers and patients may wonder whether the communication was accurate.

Using Multiple Strategies

Your organization can identify long-term and short-term interpretation solutions that are feasible within the needs and resources of your organization. One type of interpretation service may not be enough to provide language services to the different linguistic groups in your area. Often, multiple strategies are needed to accommodate different language groups.

For example, a clinic in the Northeast documented that approximately 40 percent of its daily visits were with limited English proficient (LEP) patients. Of these LEP patients, about 70 percent spoke Spanish and 20 percent spoke Bosnian. The remaining LEP populations at the clinic included speakers of Russian (2 percent), French (2 percent), Arabic (2 percent), Vietnamese (2 percent), and other language groups (2 percent). After looking at available resources, the clinic decided to hire a full-time dedicated Spanish staff interpreter and a part-time Bosnian interpreter. The organization also used contract interpreters for Russian, French, and Arabic and

“But how can a doctor cure you if [he] does not know what you have?”

—LEP patient

What do you do with a patient [when] they don't have someone to interpret? . . . As a provider, it makes you feel very limited, not able to accomplish what it is that you need to accomplish. Even with interpreters, you can see limitations, but it's leaps and bounds beyond what you can do when you cannot speak the language of the patient that's in your office.”

—Physician with experience implementing LAS

telephone interpretation for the other languages encountered at the clinic. To best meet the needs of the LEP population in the area, the clinic used multiple interpretation strategies.¹³

As you read this step, think about which strategies will work for your organization.

Points of Contact and Determining the Scope of Interpreting

Language services are needed not only during the medical encounter, but also throughout the healthcare experience. In determining the types of LAS to implement at your organization, it is important to consider the different points of contact for an LEP patient within your organization. More detailed information on the points of contact can be found in the Introduction (see exhibit I-2 on page 13).

Communication with LEP individuals occurs throughout the entire healthcare visit. As a patient navigates through your organization, providers and staff at every point of contact can be made aware of the patient's need for LAS by flagging his or her chart electronically or by affixing a sticker or brightly colored card to hard copies of the patient's chart.⁴⁴

Also, interpreting during the medical visit requires different skills than interpreting during front-office interactions. Some staff members who are bilingual and proficient in both languages may not have the skills to become a medical interpreter. However, these staff members may be qualified to interpret in nonmedical situations, such as completing office forms, scheduling appointments, or billing.⁵²

For example, the Asian Pacific Health Care Venture, Inc. (APHCV), categorizes language proficiency at two levels. Level 1 is conversational only and level 2 is medical interpreting. Only staff members with a level 2 proficiency level are allowed by APHCV to function as a medical interpreter or backup interpreter (with training) in a clinical setting.¹⁰

Your organization may consider the skills and abilities of bilingual employees when deciding who should

“Because of the language, [the doctor] wasn’t interested in searching into what was wrong with me and finding a person who could explain. I don’t think it’s discrimination, but they just don’t want to take the time. They just want to keep moving from one patient to the next.”

—LEP patient



Link to Web Resource

Asian Pacific Health Care Venture, Inc.

<http://www.aphcv.org>

interpret in which situation. Furthermore, any employee who functions as an interpreter will need training.

Considering Types of Interpretation Services

As stated earlier, there are multiple ways to communicate orally with LEP patients. The sections below discuss various types of interpretation services. Exhibit 3A–1 highlights overall issues to consider as an organization decides which type of interpreter to use. Exhibit 3A–2 presents a description, cost considerations, and scheduling issues for each interpreter type. Costs presented in the exhibit may vary depending on geographical location and are subject to change. Types of interpretation services include:

- Bilingual staff and clinicians
- Dedicated staff interpreters
- Dual-role staff interpreters (i.e., staff who also function as interpreters)
- Contract interpreters
- Telephone interpretation lines
- Community volunteers
- Language agencies
- Emerging technology, such as video interpretation or remote simultaneous medical interpretation (RSMI)
- Family and friends as interpreters
- After-hours interpretation services

General information about cost can be found in Step 2 (Assessing Your Organizational Capabilities). Cost considerations for each type of interpretation service are shown in exhibit 3A–2. More information about funding sources can be found in appendix C.

“[A trained medical interpreter] is trained in correct interpretation, so she knows to use the first person when we talk. She knows how to position herself so she’s unobtrusive, does not interfere with the doctor-patient relationship, and [is] useful at being able to clarify when there seem to be misunderstandings.”

***—Physician
with experience
implementing LAS***

Exhibit 3A–1: Issues to Consider as an Organization Decides Which Type of Interpreter To Use

12 13 44 46 54 59–62

Interpreter Characteristics

- Is the interpreter fluent in both languages? Has the interpreter been assessed for language proficiency and competence?
- Has the interpreter been trained as an interpreter? Does the interpreter have basic interpreting skills?
- Does the interpreter know medical terms?
- Does the interpreter understand the importance of confidentiality? Has the interpreter had HIPAA training?
- Can the interpreter assess tone, body language, and nonverbal communication?
- Does the interpreter understand how to manage triadic communication (in terms of place and positioning)?
- Is the interpreter able to understand cultural differences?
- Is the interpreter familiar with organizational policies and procedures?
- Will the patients come to know the interpreter as part of the healthcare team?
- Are there trust issues with patients (e.g., social class or cultural differences between patient and interpreter)?
- Does the interpreter speak for the patient instead of interpreting for the patient?
- Is the interpreter objective? Is the interpreter willing to deliver “bad news”? Will the interpreter edit statements to protect the family or cover up abuse?
- Will the type of interpreter put the patient or family in an awkward position?
- Will the patient withhold information in front of the interpreter?

Organizational Considerations

- Can the interpreter go through all the points of contact with the patient?
- Which type of interpreter can be used when demand for an interpreter is low?
- Which type of interpreter is easily accessible for acute needs?
- Which type of interpreter is beneficial for less frequent language groups?
- Which type of interpreter can be used if a staff interpreter is running late or if there are not enough staff interpreters?
- Is the interpreter pulled away from primary duties to interpret?
- Does the interpreter need to be onsite?
- Which type of interpreter provides the most comfort to the patient?
- What are the challenges in recruiting or hiring each type of interpreter?
- What are the personnel management issues from an organizational perspective for each type of interpreter? Will the organization need other staff to oversee the interpreter(s)?
- Will the organization still have to pay the interpreter if the patient is a “no-show”?
- Is special equipment required (e.g., speaker phones in exam rooms, video monitors, or dual headsets)?
- Does the organization have direct control over quality and performance of interpreter?
- For telephone interpretation, video interpretation, and RSMI, is the sound quality sufficient?

Bilingual Staff and Clinicians

Both providers and patients have reported that bilingual staff and clinicians are the optimal choice for communicating with LEP patients.^{12 13 59} Bilingual staff and clinicians eliminate the need for interpretation by communicating directly with the LEP patient. Issues related to bilingual staff and clinicians who also function as interpreters for other staff are discussed in the later section about dual-role interpreters.

Ideally, all employees in an organization would be fluent in the languages of the LEP populations served. In the real world, this situation may not be achievable for your organization, especially if there are multiple language groups in your patient population. Organizations in many communities can hire bilingual front-line administrative support workers. Although finding bilingual physicians, pharmacists, nurses, and other licensed healthcare professionals may be more challenging, there are a number of strategies for doing so.⁴³ For more information on hiring bilingual staff, see Step 2 (Assessing Your Organizational Capabilities).

If your organization is considering using bilingual staff or clinicians instead of a trained medical interpreter, you may consider the following issues to ensure quality:^{12 43}

- Is the bilingual staff person fluent in both languages?
- Does the bilingual staff person know medical terminology in both languages?
- Does the bilingual staff person understand the cultural issues and nuances associated with communication in both languages?

For more information on ensuring competence, see the section on ensuring competence for interpretation services in this step (page 72).

Dedicated Staff Interpreters

Dedicated staff interpreters are medical interpreters who are employed part time or full time by a healthcare



Considering Culture⁶¹

Improving language access is an important step toward communicating with LEP patients, but cultural variables also affect communication. These variables may include the patient's:

- Country and region of origin
- Educational background
- Previous healthcare experiences
- Number of years in the United States
- Social class

Cultural differences may lead to misunderstandings of the patient's explanation and treatment of illness.

Providers may need to get an understanding of common cultural issues that might arise with the LEP populations in their area. Providers may:

- Ask the patients directly about their health beliefs and understanding of the U.S. health system
- Ask bicultural staff members about their culture
- Collect information about common issues that might arise in the LEP populations served

organization, and their job description is defined as a staff interpreter. The staff interpreter's sole responsibility is to interpret for LEP patients. The dedicated staff interpreter is often formally trained in medical terminology and interpreting, including ethics, the role of the interpreter, discourse management, notetaking, memory skills, cross-language differences, and other interpreting skills.

Some benefits of hiring dedicated staff interpreters include:^{12 13 60}

- The interpreter is familiar with provider and patient populations.
- The interpreter is familiar with organizational policies and procedures.
- The interpreter contributes to organizational efficiency because staff and providers do not struggle to find an interpreter.

Dedicated staff interpreters are usually recruited in the most common language or languages of the patient population. It may not be cost effective to employ staff interpreters in all language combinations.⁶⁰

Dual-Role Staff Interpreters

Dual-role staff interpreters are individuals whose primary job function in the healthcare organization is something other than interpretation—they could be physicians, nurses, therapists, social workers, billing clerks, receptionists, or orderlies.

If your organization decides to use a bilingual staff person to serve a dual role, one being to interpret, it is important to consider the following in addition to proficiency and training:^{46 60}

- How will workflow be affected if this person is pulled away from his or her normal duties to interpret?
- Are financial or other types of incentives offered to bilingual staff employees who interpret?

- Is interpreting listed in the job description for the bilingual employee?

For organizations with minimal language needs, dual-role staff interpreters may be an effective solution when employees are adequately trained and given support.^{46 60}

Contract Interpreters

Contract interpreters are not employed by the organization, but are available per hour or on call. Like staff interpreters, these interpreters are present in the exam room with the patient. Contract interpreters usually need to be scheduled in advance, but can sometimes interpret on short notice.

Use of this type of interpreter requires someone at your organization to coordinate screening, contracting, dispatching, and paying contract interpreters. Often, organizations pay an hourly rate plus transportation. However, depending on the usage frequency, the organization may save costs on benefits.

Your organization may choose to use contract interpreters for those language populations that are in less demand at your organization or to avoid issues of confidentiality if the patient and staff interpreter know each other.^{46 60}

Telephone Interpretation Lines

In addition to face-to-face interpreting, organizations may use telephone interpretation lines as a type of interpretation service. Telephonic interpretation services access interpreters via a three-way call using telephone equipment. Telephone interpretation can be used in house or contracted with an outside organization.

Some organizations have implemented telephone interpretation programs within their own organizations. Staff interpreters can be accessed via telephone from any point within the organization or building complex, eliminating the need for interpreters to run from one place to another.



Links to Web Resources

Telephone Interpretation Companies

There are a variety of telephone interpretation companies. Your organization can investigate which company is the best fit for your needs:

Certified Languages International

<http://www.clilang.com>
800-237-8434

CyraCom

<http://www.cyracom.net>
520-745-9447

Language Learning Enterprises

<http://www.lle-inc.com>
888-464-8553

Language Line Services

<http://www.language.com>
800-752-0093, ext. 196

New World Language Services

<http://www.phonetranslators.com>
800-873-9865

Online Interpreters

<http://www.onlineinterpreters.com>
888-922-3582

Pacific Interpreters

<http://www.pacificinterpreters.com>
800-311-1232

SpectraCorp

[http://www.spectracorp.com/
emailers/languages.htm](http://www.spectracorp.com/emailers/languages.htm)
800-375-7945, ext. 320

TELELANGUAGE Telephonic Interpretation Services

[http://www.telelanguage.com/
interpretation.cfm](http://www.telelanguage.com/interpretation.cfm)
888-877-8353

Tele-Interpreters

<http://www.teleinterpreters.com>
800-811-7881

OMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

Telephone interpretation services ensure that LEP patients have access to an interpreter 24 hours per day, 7 days per week. Using telephone interpretation lines can also be beneficial because they can:^{13 43}

- Be helpful for rarely encountered languages
- Be helpful with small language communities where the interpreter and patient may know each other and want to avoid issues of confidentiality
- Provide anonymity that some patients prefer
- Be helpful when dedicated staff interpreters or dual-role bilingual staff interpreters are unavailable
- Result in reduced costs through contracting with a specific company based on utilization rates

When using telephone interpretation lines, it is important to consider the following factors, which may need your added attention.^{12 13 30 46 59}

- Visual cues from body language and gestures cannot be seen.
- A telephone interpreter may be unfamiliar with local services and practices.
- Speaker phones or dual handset phones may be necessary in each place where an interpreter is needed, such as the front desk, exam room, and check out. If speaker phones are unavailable in all rooms, the organization may need to find a private space for telephone interpretation.
- The quality of sound of the interpretation through phone lines may need to be assessed, and the organization may need to be careful of background noise.
- Patients may prefer an inperson interpreter to telephone interpretation.

Although rates vary depending on usage, telephone interpretation lines may require an ongoing contract with a monthly fee, as well as payment per minute of interpretation.^{12 13 46} As the number of interpretations needed for a language group increases, telephonic interpretation services may become less cost effective than other types of services.⁴³

Community Volunteers

Occasionally, organizations may recruit volunteers to interpret for LEP populations. Volunteers may be an inexpensive way to provide language services and promote volunteerism in the community. However, few volunteers are trained in medical interpretation. Also, it may be difficult to hold volunteers accountable to minimum interpretation standards.⁶⁰

An organization can decide when using volunteers is appropriate. For example, an organization may use volunteers to help LEP patients navigate through the organization or healthcare system, but not for medical interpreting.¹²

Also, some organizations may take the step to train volunteers as interpreters. For example, Brown Medical School implemented a service learning program for bilingual undergraduate and medical school students called the Interpreter's Aide Program (IAP). The IAP is a collaboration between Brown students, the Rhode Island Hospital Department of Social Work, and Brown Medical School. Bilingual undergraduate and medical students are trained as medical interpreters and provide community service while developing cross-cultural skills.⁶³ For more information on community partnerships, see Resource Unit E (Community Involvement).

Language Agencies

Language agencies, also known as interpreter banks or community language banks, are essentially databases of potential interpreters who have come together to pool their talent for use in the community. Agencies can be run by interpreters, a hospital or community clinic, or community-based organization. The interpreters may be trained professionals or community volunteers,



**Link to Web
Resource**

**Association of Language
Companies**

<http://www.alcus.org>

depending on the type of bank. Some community language banks charge for their services; others do not.^{17 46 64}

Emerging Technology

Organizations may consider using emerging technology to provide translation services. This section briefly discusses video interpretation and remote simultaneous medical interpretation.

Video Interpretation

Video medical interpreting is the use of video conferencing connections to provide interpretation services for an LEP patient. Usually, a camera is attached to a TV monitor or computer screen, allowing the interpreter to see the patient and provider and allowing the interpreter to be off site but see the nonverbal communication of the patient.⁶⁵

Remote Simultaneous Medical Interpretation

RSMI uses highly trained medical interpreters who interpret as a speaker is speaking through wireless headsets. Many people have seen remote simultaneous interpretation used at United Nations proceedings. Patients and providers wear headsets during the encounter. The conversation is transmitted to a nearby receiver in the remote interpreter room. The interpreter, also wearing a headset, listens to what is being said by one party and then transmits the interpretation to the other. The patient and provider hear only their language. With this technology, only the patient and provider are present in the room.^{60 62 66}

Family and Friends as Interpreters

Family members or friends often accompany the patient to the medical encounter and may be ready to interpret. Patients may request that the family member or friend be used as an interpreter for the following reasons.^{59 67}

- The patient trusts his or her friend or family member to interpret.
- The friend or family member knows the patient personally and can speak on his or her behalf.



Links to Web Resources

The Use of Technology in Interpretation

Interpretation services can be made more efficient through the use of technology such as dual handset phones, wireless remote headsets, video interpretation, and remote simultaneous medical interpretation.

For a study on four modes of medical interpreting conducted by the Cambridge Health Alliance, see:

http://www.challiance.org/media_center/publication/tnt_hndbk.pdf

For an evaluation of video interpretation services conducted by Health Access California, see:

<http://www.health-access.org/providing/vmi.htm>

- The friend or family member facilitates communication between staff and the patient.
- The LEP community is small and the patient is concerned that the interpreter may know the patient or may not keep the information confidential.

However, the quality of interpretation by family members or friends may lead to misunderstandings and misdiagnoses.^{46 68} LEP individuals and providers may also have the following concerns with using friends or family members as interpreters.^{59 67}

- The friend or family member may not be proficient in both languages.
- The friend or family member may not know medical terminology.
- The friend or family member may have difficulty encountering words with no direct translation.

Other concerns with using friends or family members as interpreters include:^{46 61}

- The situation makes maintaining confidentiality difficult.
- Patients may not be as forthcoming about problems or symptoms in the presence of friends or family.
- A family member or friend may withhold clinical information or edit a patient's or provider's statements to protect the family or patient. Such information could include a history of domestic violence, drug abuse, suicide, sexual problems, and mental illness.

If an LEP patient insists on using a family member or friend to interpret, some organizations ask that a waiver be signed. The waiver would be in the second language and would state the risks of not using a qualified interpreter.^{12 13} An example of a waiver can be found in appendix D. Another solution is to ask that an interpreter be present to ensure accurate interpretation.



Link to Web Resource

Use of Formal Interpreters Even When Family and Friends Are Present

It is important to note that providers may still need to have an interpreter present in place of or in addition to the informal interpreter the patient has provided if concerns are present regarding competency, appropriateness, or conflict of interest with the patient's interpreter, such as in cases of abuse.

This issue is discussed in the Office for Civil Rights' Revised HHS LEP Policy Guidance, at

<http://www.hhs.gov/ocr/lep/revisedlep.html>.

“Community volunteers, family, friends—all that depends entirely on training and whether staff can really understand when they can use a family or friend. Like [when] the patient needs something and there’s a family member there who’s bilingual and you find out that she’d like some ice chips—perfectly appropriate in comparison with consent forms for gynecological surgery—and the son is interpreting.”

—Administrator with experience implementing LAS

Negative Impact of Using Children as Interpreters

Some organizations may face having to use a child to interpret—a situation that is uncomfortable for both patient and child. Although LEP patients may prefer to use a friend or family member to interpret, they have also reported that it is inappropriate and unethical to use children as interpreters. In addition to the issues mentioned above that arise when using family and friends as interpreters (i.e., related to proficiency and knowledge of medical terminology), using children as interpreters is complicated because children are placed in awkward situations having to communicate private and personal information about their parents. LEP patients expressed that children should not have to:^{18 59}

- Communicate vital medical information between the provider and parent
- Deal with serious medical conditions of family members

Children, especially young children, do not have the knowledge or maturity to handle the potential stress of a medical interpretation encounter. An encounter could be psychologically harmful to the child.

After-Hours Interpretation Assistance

Your organization may also need to consider what types of interpretation services are available to assist LEP patients after hours. Some organizations have reported:¹³

- Arranging for using a bilingual or trilingual answering service
- Accommodating multiple languages on their phone system
- Coordinating three-way conference calls between an interpreter on call (either staff or telephone interpretation lines), the provider on call, and the patient

As your organization considers which types of language services to implement, it is important to include after-hours access for LEP patients.

“It’s hard for a child to act as an adult.”

—LEP patient

Exhibit 3A–2: Types of Interpretation—Descriptions, Cost Considerations, and Scheduling Issues^{12 13 44 46 54 59–62}

Type of Interpretation	Description	Cost Considerations	Scheduling Issues
Bilingual staff and clinicians	<ul style="list-style-type: none"> ■ Communicate directly with the LEP patient, without the need for interpreters 	<ul style="list-style-type: none"> ■ Efforts to recruit bilingual employees ■ Costs associated with hiring bilingual physicians can be offset by hiring bilingual mid-level staff ■ May not be able to work with all language groups present in the LEP population 	<ul style="list-style-type: none"> ■ Potential overload of patients for bilingual clinicians
Dedicated staff interpreters	<ul style="list-style-type: none"> ■ Are employed part time or full time by a healthcare organization ■ Are responsible only for interpreting 	<ul style="list-style-type: none"> ■ Wages may range from \$10 to \$32 per hour ■ Organization must pay benefits (e.g., Federal Insurance Contributions Act [FICA] and Social Security contributions) ■ Finding office space ■ May need to pay for training 	<ul style="list-style-type: none"> ■ Consider needs of interpreter, provider, and room ■ May only work during office hours
Dual-role staff interpreters	<ul style="list-style-type: none"> ■ Have a primary job function in the organization other than interpretation ■ Are pulled away from primary responsibility to interpret 	<ul style="list-style-type: none"> ■ Organization must pay benefits (e.g., FICA) ■ Finding office space ■ May need to pay for training ■ Increased compensation for interpreting such as per-hour pay differentials, bonuses, overtime, and so forth 	<ul style="list-style-type: none"> ■ Balancing primary duties with interpreting
Contract interpreters	<ul style="list-style-type: none"> ■ Are not employed by an organization ■ Are available per hour or on-call 	<ul style="list-style-type: none"> ■ Usually requires minimum payment plus transportation ■ Hourly costs may range from \$25 to \$150 	<ul style="list-style-type: none"> ■ Need to schedule in advance

Exhibit 3A–2: Types of Interpretation—Descriptions, Cost Considerations, and Scheduling Issues (Continued)

Type of Interpretation	Description	Cost Considerations	Scheduling Issues
Telephone interpretation lines	<ul style="list-style-type: none"> ■ Access interpreters via a three-way conference call using regular telephone equipment 	<ul style="list-style-type: none"> ■ Office of Management and Budget estimated average cost of telephone interpretation to be \$132 per hour or \$2.20 per minute; may be less expensive, however, depending on the organization’s contract and utilization rates ■ May need to purchase speaker phones for exam rooms 	<ul style="list-style-type: none"> ■ Can be difficult to schedule exact time for medical visit
Community volunteers	<ul style="list-style-type: none"> ■ Are volunteers recruited to act as interpreters 	<ul style="list-style-type: none"> ■ May need to pay for coordination of volunteers ■ May need to pay for training 	<ul style="list-style-type: none"> ■ May not be consistently available
Language agencies (interpreter banks or community language banks)	<ul style="list-style-type: none"> ■ Are for-profit or nonprofit organizations that recruit, contract, and dispatch interpreters on demand to healthcare organizations 	<ul style="list-style-type: none"> ■ Agencies are usually paid per hour of interpreter services ■ Some may be for-profit agencies 	<ul style="list-style-type: none"> ■ Need to schedule in advance
Video interpretation	<ul style="list-style-type: none"> ■ Use video conferencing connections to provide interpretation services 	<ul style="list-style-type: none"> ■ May be expensive 	<ul style="list-style-type: none"> ■ May need to schedule for specific rooms with equipment
Remote simultaneous medical interpretation (RSMI)	<ul style="list-style-type: none"> ■ Uses highly trained medical interpreters who interpret as a speaker is speaking through wireless headsets 	<ul style="list-style-type: none"> ■ Costs associated with needed equipment ■ Extensive training for simultaneous interpretation required 	<ul style="list-style-type: none"> ■ May need to schedule in advance
Family and friends as interpreters	<ul style="list-style-type: none"> ■ Accompany the patient and may express interest in interpreting 	<ul style="list-style-type: none"> ■ Costs of not providing trained interpreters include: ■ Liability for errors in communication ■ Potential mismanagement of illness 	<ul style="list-style-type: none"> ■ None

Developing a Process for Ensuring Competence of Interpretation Services

Whether your organization decides to hire bilingual clinicians or a dedicated staff interpreter or to use contract interpreters, it is important to ensure the competence of the language services available for your LEP patients, because both providers and patients may wonder whether the communication was accurate.

Interpretation requires more skills than proficiency in two languages. Untrained interpreters may make errors in interpretation that could result in misunderstanding and miscommunication. Types of interpreter errors may include, but are not limited to:⁶⁸

- Omission—interpreter does not interpret a word or phrase said by the clinician or patient
- False fluency—interpreter uses an incorrect word or phrase that does not exist in the targeted language
- Substitution—interpreter replaces a word or phrase for a different word or phrase said by the clinician or patient
- Editorialization—interpreter provides his or her personal views
- Addition—interpreter adds information not said by clinician or patient

Organizations may have formal or informal methods of assessing the competence of various language services offered. The following sections discuss initial screening or assessment of bilingual staff and interpreters, determining means of training interpreters, and assessing performance.

Developing an Initial Screening Process

It is important to assess the language proficiency of any staff person interacting with LEP patients—whether it is front office staff, a staff interpreter, dual-role interpreter, or a clinician. As in any screening or hiring process, your organization can start by interviewing candidates and reviewing their background materials,



Skills Needed to Interpret

A person who is fluent in two languages may not be able to serve as interpreter for those languages. Interpreting requires the following skills:

- Language proficiency in both languages
- Knowledge of medical terminology
- Appropriate tone of voice
- Articulation when speaking
- Ability to pronounce words clearly in both languages
- Ability to manage the flow of communication
- Ability to manage the triadic relationship
- Good memory
- Understanding of cultural nuances of language
- Ability to think quickly—to convert messages on the spot, accurately
- Understanding of ethical issues
- Knowledge of dialects or language varieties
- Discourse management
- Drive to consistently work on language skills and vocabulary
- Knowledge in cross-cultural and cross-linguistic variation

If your organization chooses to hire an interpreter, you may assess these skills by using the information presented in this step.

such as their resume, letter of recommendation, and evidence of prior training.⁶⁹ For current bilingual employees, your organization can start by asking them whether they have interest in serving as dual-role interpreters.

Organizations can consider using written and oral tests, oral interviews, or an outside organization—or a combination of these methods—to assess bilingual staff and interpreters. Organizations may choose to develop a test in house or use one from another organization in the community. Also, if internal staff members are not able to do an assessment, your organization may consider using an outside agency.¹² Note that most tests and assessments have not been scientifically constructed or validated.

The National Council on Interpreting in Health Care (NCIHC) identifies six components of the initial assessment of interpreter skills:⁶⁹

- Basic language skills
- Ethical case study
- Cultural issues
- Healthcare terminology
- Integrated interpreting skills
- Translation of simple instructions

For each component, it is important to consider how to administer the test (such as orally or written) and the minimum score required. Likewise, it is important to decide who will rate or score the test or interview. The rater should be familiar with medical terms in both working languages and should have experience interpreting in a healthcare setting.⁶⁹

Note that different levels of interpretation may be needed at the different points of contact at your organization. Below is a brief description of each interpreter skill component.



Link to Web Resource

*A National Code of Ethics for Interpreters in Health Care*⁶

Prepared by the National Council on Interpreting in Health Care

http://www.ncihc.org/NCIHC_PDF/NationalCodeofEthicsforInterpreterinHealthCare.pdf

Basic Language Skills

Speaking and understanding speech in both languages is necessary for anyone wishing to serve as an interpreter. Assessment of basic skills includes testing the following:

- How well does the candidate understand spoken English?
- How well does the candidate speak English?
- How well does the candidate understand the targeted language?
- How well does the candidate speak the targeted language?

Testing basic language skills can range from informal to formal. An informal approach could be an unstructured oral interview between the candidate and a rater who speaks both of the candidate's languages. A more formal approach might involve a semistructured interview between the candidate and the rater with clear criteria for scoring. An even more formal approach might involve an official American Council on the Teaching of Foreign Languages (ACTFL) oral proficiency interview. The ACTFL test is conducted as a live interview or in the form of taped responses and applies an internationally recognized scale of language proficiency. The scale has four main levels: novice, intermediate, advanced, and superior, with low, mid, and high subdivisions in each level except superior. A challenge for the organization will be to determine which level of language proficiency is acceptable.⁶⁹

Ethical Case Study

As with any healthcare professional, interpreters need to demonstrate an understanding of ethical principles and ethical decision making. Written or oral-based case studies may be a useful tool for evaluating an understanding of ethical principles. Examples of ethical case studies are shown in the sidebar.



Link to Web Resource

American Council on the Teaching of Foreign Languages

<http://www.actfl.org>

Ethical Case Study Examples⁶⁹

Example 1

You just finished interpreting for a young woman. The doctor told her she is pregnant. You walk out of the exam room with the young woman. Her husband is sitting in the waiting room. He approaches you and says, "What did the doctor tell my wife?" What would you do and why?

Example 2

While waiting for the doctor, the patient tells you that her husband is beating her and asks you for advice. What would you do and why?

Scoring

When scoring the section, consider whether the candidate was able to justify the answer and relate the answer to a code of ethics. Because ethical situations rarely have one right answer, a range of answers may be acceptable.

Cultural Issues

In addition to language barriers, cultural issues may affect the interaction between the provider and patient. The interpreter must pay attention to those occasions when cultural beliefs create a barrier to effective communication and assist the provider and patient in exploring what the barrier may be. One way to evaluate candidates is to present different scenarios and ask them to respond in a written or oral form. For example, one scenario could be:

Describe a cultural belief, value, or practice that is important in the culture of patients for whom you interpret that you think may cause misunderstandings with providers in the United States. What kinds of misunderstandings do you think this may cause? What would you do as the interpreter? What would you say to the doctor? What would you say to the patient?

When scoring the scenario, consider whether the candidate showed an understanding of the cultural issues and if he or she would have intervened appropriately.⁶⁹

Healthcare Terminology

In addition to basic language skills, knowledge of medical terminology in both languages is a critical skill of an interpreter. Assessments of medical terms could be conducted through:

- A face-to-face oral test of medical terms
- An audiotaped oral test of medical terms
- Role play with medical terms in the text of the script
- Written translation of medical terms

It is important to include terms from areas in the healthcare field in which the interpreter will be working. Sample areas include, but are not limited to:

- Symptoms, such as nausea or pain
- Anatomy, such as bladder or tongue
- Disease, such as high blood pressure or diabetes
- Procedures and tests, such as x ray
- Common medications, such as aspirin
- Organization's departments, such as radiology or case management

The Massachusetts Medical Interpreters Association has compiled glossaries of various medical terms in different languages on its Web site.⁶⁹

Integrated Interpreting Skills

This component refers to the complement of skills that an interpreter needs to ensure the accuracy and completeness of the interpreted message. A way to assess integrated interpreting skills is through a role-play that simulates an interpreter-assisted clinical encounter. A 20-minute role play could include the following elements:⁶⁹

- An opportunity for the candidate to introduce himself or herself and briefly explain the role of the interpreter
- Medical terminology as well as patient language
- Cultural references
- Varying lengths of messages, from simple and short to long and complex

Translation of Simple Instructions

Although an interpreter is not necessarily qualified to translate written documents, information is not always presented in spoken form. An interpreter may need to



Link to Web Resource

Massachusetts Medical Interpreters Association

For a list of glossaries of medical terms in different languages, see the reference tools at:

<http://www.mmia.org/resources/links.asp>

translate written messages into spoken messages from signage, notices, appointment cards, prescription labels, or patient education materials. One method to assess the ability to translate simple text on site is to use text encountered in medical settings. Examples could include.⁶⁹

- Signage, such as “Cafeteria hours of operation: 6 a.m. to 9 a.m., 11 a.m. to 2 p.m., 5 p.m. to 8 p.m.”
- Appointment cards, such as “Your next appointment with Dr. Smith is on Friday, July 1, at 2 p.m.”
- Medication usage instructions, such as “Medication name: Erythromycin. Take two tablets, twice a day for 10 days. Take all medicine as directed until it is gone.”

These six components of assessment—basic language skills, ethical case study, healthcare terminology, integrated interpreting skills, and translation of simple instructions—were identified by the National Council on Interpreting in Health Care. For more information, see the full report, *Guide to Initial Assessment of Interpreter Qualifications*.⁶⁹

Physicians and other providers who self-identify as bilingual may or may not have the language abilities to communicate with LEP patients without an interpreter. It is important for organizations to assess the proficiency of physicians, as well as anyone who interacts with patients, to ensure interpretation competence.

Determining Means of Training Interpreters

It is important that staff members who will potentially interpret for patients be trained in interpretation. The goal of healthcare interpreter training is to provide the student with the tools necessary to ensure full communication between patient and provider across language and cultural barriers.

Training can range from informal workshops to certificate programs to baccalaureate and masters



Link to Web Resource

**National Council on Interpreting in Health Care
Guide to Initial Assessment of Interpreter Qualifications**

http://www.ncihc.org/NCIHC_PDF/InitialAssessmentofInterpreterfinalversionMay2001.pdf



Link to Web Resource

Interpreter Training Programs

There are a variety of interpreter training programs. Your organization may investigate which program is the best fit for your needs.

See the Cross Cultural Health Care Program's *Directory of Health Care Interpreter Training Programs the United States and Canada*:

<http://www.xculture.org/training/overview/interpreter/downloads/directory.pdf>

OMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

programs. There are different types of training programs available:⁷⁰

- Programs of short duration—targeted toward bilingual individuals already employed at a healthcare organization
- Programs offered by community-based organizations—aimed at individuals in the community who want to become interpreters
- Programs offered at 1-, 2-, and 4-year institutions—aimed at individuals who want professional training
- State- and county-sponsored programs—directed at training State and county employees
- Programs run by private agencies—provided by organizations whose business is interpretation training

Organizations may choose to hold interpreter training sessions in house, send potential hires to interpreter training programs, or hire individuals who have completed the interpreter training program in their area.

The Asian Pacific Healthcare Venture, Inc. (APHCV) has developed an in-house training program and requires that all bilingual staff who will potentially interpret for patients go through the training, regardless of whether their main responsibility is interpretation. The program covers:

- Roles and responsibilities of a medical interpreter
- Legal and ethical issues of interpretation
- Skills of interpretation
- Medical terminology and concepts

After attending the training, the trainee will observe 20 hours of interpretation sessions between current interpreters and patients before interpreting on his or her own. Then, an experienced interpreter will observe the trainee and provide feedback to improve

communication.¹⁰ For examples of other in-house training programs, see appendix E.

Other organizations with experience providing LAS have paid for training for their interpreters through various courses:¹³

- California Standards for Healthcare Interpreters, under which interpreters are tested on written concepts and oral rewording of medical terminology and complete a simulated interpreter session
- Cross Cultural Health Care Program’s “Bridging the Gap” training, a 40-hour basic/intermediate medical interpretation course
- State Area Health Education Center (AHEC) interpreter training programs

Interpreters and bilingual providers will need continuing education to improve their vocabulary and communication and interpreting skills. Your organization may consider providing inservice trainings or brown bag lunches on specific health topics, such as diabetes, preventive care, reproductive health, end of life decisions, and so forth.

A Note on Certification

Certification is “a process by which a governmental organization attests to or certifies that an individual is qualified to perform a certain service.”⁵⁸ Currently, there is not a national certification process for medical interpreters. However, various professional agencies may certify interpreters. At the moment, only Washington State certifies interpreters in seven languages.³⁶

Assessing Performance

Once your organization has identified, assessed, and trained interpreters, it is important to conduct ongoing or periodic assessment of their performance. This type of assessment emphasizes not basic skills, but adherence to professional standards. Assessment could be done by observation and feedback by more experienced interpreters.

Although no standards of healthcare interpretation services have been nationally accepted, a few organizations have developed qualification standards for healthcare interpretation. For example, the California Healthcare Interpreting Association (CHIA)⁷¹ and the Massachusetts Medical Interpreters Association (MMIA)⁷² have developed healthcare interpretation standards of practice. Both documents were created through a process of input collaboration and feedback among experts and professionals in the field. The National Council on Interpreting in Health Care is in the process of developing standards of practice for interpreters. The standards should be available in September 2005.

California Healthcare Interpreting Association’s Standards of Practice. CHIA’s standards of practice determine appropriate standards of practice and ethical behavior.⁷¹

CHIA specifies three protocols related to the healthcare encounter: pre-encounter, during the encounter, and postencounter. Select guidelines for interpreters are shown below:

Pre-Encounter

- Provide their name, language of interpreting, and organizational affiliation.
- State that they will maintain confidentiality.

During the Encounter

- Position themselves to maximize direct communication between provider and patient.
- Use the first person (“I”).
- Indicate clearly when they are speaking on their own behalf.



Links to Web Resources

California Healthcare Interpreting Association

<http://www.chia.ws>

Massachusetts Medical Interpreters Association

<http://www.mmia.org>

National Council on Interpreting in Health Care

<http://www.ncihc.org>

What Is the Triadic Relationship?⁷²

A triadic relationship is the interaction of three people in the healthcare encounter: the provider, the patient, and the interpreter.

Having three people instead of two has the potential to change the dynamics of the encounter. For example, the provider or the patient may talk directly to the interpreter rather than to each other.

The interpreter’s role is to encourage the provider and the patient to communicate verbally and nonverbally directly with each other.

Postencounter

- Inquire about any questions or concerns the parties may have for each other.
- Document the provision of interpreting services, as required by organizational policies.

CHIA also identifies six ethical principles:

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

Massachusetts Medical Interpreters Association Standards. The MMIA standards are divided into three sections. The first section focuses on the five complimentary skills of the interpreter:

- Setting the stage
- Interpreting
- Managing the flow of communication
- Managing the triadic relationships
- Assisting in closure activities

The second section deals mainly with the importance of culture in the healthcare interaction. The third section identifies ethical issues, such as maintaining confidentiality and impartiality, respecting the patient's privacy, maintaining professional integrity, and knowing how to deal with discrimination.

The MMIA standards of practice are presented as a series of mastery charts. Each component displays indicators of mastery and indicators of lack of mastery.

The standards may be used to develop training programs based on basic skills and knowledge; develop formative and summative evaluation tools to assess the progress of skill acquisition; assess level of proficiency of practitioners; educate providers on how to work with interpreters; and form the foundation for developing certification.⁷²

Determining Policies and Procedures for Working With Interpreters

Once your organization decides which types of interpretation services to use, your organization may need to develop policies and procedures for working with interpreters. After developing these policies and procedures, it is important to educate or train staff. For more information on staff training, see Step 2 (Assessing Your Organizational Capabilities).

Your organization may consider answering the following questions regarding policies and procedures:

- How do staff members access interpretation services for LEP patients?
- How do staff members schedule LEP patients, interpreters, and providers?
- How do staff members respond to LEP patients
 - In writing?
 - By telephone?
 - In person?
- In what situations can staff members use bilingual staff to interpret?
- In what situations is it acceptable to use family members or friends to interpret?
- What procedures do staff members follow when an LEP patient refuses an interpreter?
- Is there a system in place to get patient feedback on interpretation services?

As each organization is different, your organization will need to develop policies and procedures that fit the needs of your organization and LEP population. An example of an organization's policies and procedures for working with interpreters can be found in appendix F.

Implementation

Now that you have reviewed planning issues related to this resource unit, you can decide on a plan of action and implement it. You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider the needs of your LEP population (Step 1) and your organization's capabilities (Step 2) when deciding which activities to undertake. You can also use the checklist to monitor, evaluate, and update the activities associated with this resource unit.

Types of Interpretation Services

- Has your organization used multiple strategies to address the oral communication needs of your LEP population? Have you considered and used an appropriate combination of the following strategies?
 - Bilingual staff and clinicians
 - Staff interpreters
 - Dual-role interpreters
 - Is interpreting part of their job description?
 - Did you consider how role changing will affect staff?
 - Did you compensate or provide incentives for interpreting?
 - Contract interpreters
 - Telephone interpretation lines
 - Community volunteers as interpreters
 - Interpreters through an interpreter bank, community language bank, or language agency
 - Emerging technology such as video interpretation or RSMI
 - Family and friends as interpreters
 - If so, did you offer an interpreter to sit in on the visit?
 - If so, did you ask the patient to sign a waiver?
 - After-hours interpretation assistance
- Did you address language barriers at all patient points of contact at your organization?
- For any of the types of interpretation services used above:
 - Did you assess language proficiency?
 - Did you train interpreters or use trained interpreters?

Developing a Process for Ensuring Competence

- Did you develop a process for ensuring competence of the interpretation services?
- Did you develop an initial screening or assessment of bilingual staff and interpreters?
 - Did you consider NCIHC's six components of interpreter skills:
 - Basic language skills
 - Ethical case study
 - Cultural issues
 - Healthcare terminology
 - Integrated interpreting skills
 - Translation of simple instructions
 - Did you assess the language proficiency of self-identified bilingual providers?
- Did you determine a means of training interpreters?
 - Did you consider various training programs for interpreters?
 - Did you train potential staff interpreters or dual-role interpreters?
 - Did you hire trained interpreters?
- Did you assess the performance of interpreters?
 - Did you consider standards of practice for interpreters?
 - Did you provide feedback to the interpreter?

Determining Policies and Procedures for Working With Interpreters

- Did you develop policies and procedures on the following topics?
 - How do staff members access interpretation services?
 - How do staff members schedule interpretation services?
 - How do staff members respond to LEP patients in writing, by telephone, and in person?
 - In what situations can staff members use bilingual staff to interpret?
 - In what situations is it acceptable to use family or friends to interpret?
 - What procedures do staff members follow when an LEP patient refuses an interpreter?
 - Is there a system in place to get feedback on interpretation services?
 - Did you educate or train staff on these policies and procedures?
-

Evaluating Your Solutions

To ensure that your means of providing interpretation services are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to providing interpretation services? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to providing interpretation services? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your means of providing interpretation services? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you come up with specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

Case A–2: Hong Wu, 1 Year Later

Patient's Story

Hong Wu needed a prostatectomy. Dr. Parker, the oncologist, was a little suspicious of Mr. Wu's granddaughter, Suzy, who had not appropriately interpreted for Mr. Wu when Dr. Parker first diagnosed the prostate cancer. This time, Dr. Parker had called Dr. Cheng, Mr. Wu's internist, and made sure that Dr. Cheng explained the options and the recommended procedure to Mr. Wu directly.

Mr. Wu, his daughter Ming, and his granddaughter Suzy arrived at the admissions office of the hospital. The patient database said that Mr. Wu spoke Cantonese, and the admissions clerk pulled out a page written in Cantonese. The first question on the page confirmed Mr. Wu's primary language, and the rest of the page informed him of his right to an interpreter. "He doesn't read," Suzy told the clerk, as she took the page. Suzy skimmed the document, and told the admissions clerk that an interpreter was not necessary, as she could interpret for her grandfather. "Ah," thought the clerk, "that's why no one flagged this chart. Whoever called to schedule the surgery must have said that an interpreter wasn't needed."

There had been confusion about these types of issues in the past, and the clerk was now well aware of the hospital policies on interpretation and interpreter resources. "To protect the patient and the hospital, our policy is to provide an interpreter for patients who do not speak English. Unless the patient refuses an interpreter, we provide one. You can certainly be here and interpret for your grandfather if you wish, but the interpreter will be here too, just to be sure that your grandfather understands everything. Since he can't read the form to refuse an interpreter, I'll call one."

The admissions clerk knew that she had several options for interpreter services and that she could call a telephone service or arrange for face-to-face interpretation. She remembered that Suzy had been difficult in the past and opted for an interpreter to be in the office. The hospital had several interpreters on staff and had also provided a list of trained staff members who could interpret when required. When the interpreter introduced himself, Mr. Wu said, "I'm glad you're here." Suzy was visibly angry when Mr. Wu continued to communicate through the interpreter, but he did not care. Mr. Wu asked if the interpreter could accompany him to the surgery floor while he prepared for the procedure. The admissions clerk assured him that the interpreter could go upstairs with him and even accompany him into the operating room.

Patient's Perspective

"This is my surgery and I want to understand it completely. What a difference this time that I had the opportunity to ask for an interpreter. The hospital even supported me when Suzy said that she could take care of things. I wanted an interpreter who could help me communicate what I wanted, not a family member who's worried about me and trying to do what they think is best, rather than what I wish. The hospital even had papers written in Cantonese to explain my rights to an interpreter, and the interpreter was in the operating room to explain things to me at the beginning and end. Next time, I'll know I can have an interpreter and Suzy can stay home."

Provider's Perspective

Admissions clerk: "Now that I know the procedures for using interpreters, I'm no longer stuck between patients and their families, or between different departments in the hospital. I can see that, with interpreters, patients can understand their options better and can make the most informed choices about their care."

Resource Unit A: Insights From the Cases for Healthcare Organizations

Offering competent interpreter services assists LEP patients with understanding and making informed decisions about their medical care. In the first case, if Hong Wu had relied only on his granddaughter's interpretation of the options for treating prostate cancer, he would have had surgery he did not want. In addition, the surgery may have caused side effects about which he had not been informed. Operating on a patient who did not want surgery or who was not aware of potential adverse effects could have serious liability implications for the hospital. In addition, when the admissions clerk employed a hospital staff member without training in interpretation, the hospital may have opened itself up to additional liability risks. For example, the staff member used his role as interpreter to try to convince the patient to have surgery against his will. Also, because the interpreter and patient spoke different languages, the patient may still have misunderstood the dialog. In the end, the hospital had a surgery team and room sitting idle because of the language differences that resulted in scheduling a patient for a procedure that he did not want. In this case, the cost of providing a trained interpreter would have been significantly less than the cost of hospital personnel involved, including the admissions clerk and interpreter who were taken away from other duties and the idle surgery team.

In the second case, the hospital provided a trained interpreter with language skills in the appropriate language. Neither the hospital nor the patient was at risk of misunderstanding the medical procedure or the patient's decision about having the procedure as a result of language differences. The hospital had also trained the admissions clerk about how to deal with language services needs. As a result, the patient received the interpreter services he needed, instead of the hospital staff assuming that the patient wanted his family to provide interpretation. The hospital could also trust that the patient was hearing what the healthcare staff members were saying, rather than what the patient's family wanted him to hear.

Resource Unit B: Written Materials

Discussion Topics

- Overview of Written Materials
- Determining a Process for Making Materials Available in Other Languages
 - Ideas To Consider
 - Processes To Consider
- Considering Types of Services for Written Materials
 - Bilingual Staff
 - Web-Based Resources
 - Clearinghouses
 - Community Collaborations
 - Translation Companies
 - Materials for Purchase
 - Other Resources
- Determining What Materials To Make Available in Other Languages
 - Prioritizing Written Materials To Make Available in Other Languages
 - Determining Languages for Written Materials
 - Considering Literacy Level
- Developing a Process for Ensuring the Quality of Written Materials
 - Field Testing
 - Special Concerns for Ensuring Quality
- Making Written Materials Accessible for Providers and Patients
- Determining Policies and Procedures for Developing Written Materials

This resource unit describes issues for consideration as you plan to develop or translate written materials to communicate with limited English proficient (LEP) patients, includes a checklist of implementation items to review, and poses questions for monitoring, evaluating, and updating your solutions.

The planning section of Resource Unit B provides an overview of written materials and then walks you through determining a process for making materials available in other languages. Next, the planning section describes different types of services for developing written materials, determining what materials to make available in other languages, processes for ensuring the quality of written materials, and ways to make written materials accessible for providers and patients. The section concludes with a discussion on determining policies and procedures for developing written materials.

This resource unit describes two cases, one that demonstrates an organization at an earlier stage of implementing language access services (LAS) and one that demonstrates an organization further along in the process. Each case also includes patient and provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

A 67-year-old Chaldean woman with gastrointestinal complaints has two very different experiences when she has diagnostic procedures performed in two different clinics. In one clinic, where staff know little about the Chaldean community, the patient is misunderstood, embarrassed, and receives incorrect instructions. In the clinic that serves the local Chaldean population, the patient has a much more satisfying healthcare encounter and receives useful, culturally based information materials to help alleviate her symptoms.

Resource Unit B: Patient's Profile

Mariam Arrat:

- 67-year-old Chaldean woman
- Immigrated to United States from Iraq at age 30
- Settled in Detroit area, in largest Chaldean community outside of the Middle East
- Speaks the Chaldean dialect of Aramaic and little English
- Experienced periodic chest pain, saw Chaldean doctor
- Electrocardiogram (EKG) and other cardiac tests negative; doctor diagnosed gastroesophageal reflux disease (GERD) and ordered an upper gastrointestinal (GI) series
- Health insurance provider authorized the procedure for an outpatient center that did not normally serve the Chaldean community

Case B-1: Mariam Arrat's Upper GI Series

Patient's Story

On the day of Mariam Arrat's upper GI series, David Arrat accompanied his mother to the outpatient center. A young receptionist greeted them as Mrs. Arrat wrote her name on the sign-in sheet. Mrs. Arrat spoke to David in Aramaic and the receptionist shuffled through her files to gather a packet of forms. When she handed the papers to David, he saw that they were written in Arabic script. "My mother doesn't speak Arabic; we're Chaldean," he told the receptionist. "Oh, I knew you were Muslim, I just figured you spoke Arabic. Sorry," was the reply. David was eternally frustrated with the people who assumed he was Muslim. "Chaldeans are Catholic, not Muslim," he explained. "What country are you from?" asked the receptionist. "Mesopotamia, originally," replied David, "Now it's parts of Iraq, Syria, and Turkey." The receptionist, now confused, asked, "Farsi?" "Aramaic," said David, "We speak Aramaic." "OK," said the receptionist, "I can get a translation right here from our database." The receptionist fussed with the computer for several minutes, complaining loudly that she could not find what she wanted. Everyone in the waiting room was now staring at David and his mother. "Never mind," said David to the receptionist, "I'll fill out the forms in English."

While Mrs. Arrat was having her procedure, the receptionist continued to fuss with the computer and finally walked over to David and handed him a sheaf of papers with a triumphant smile. "This is a description of the upper GI series for your mom, the discharge instructions, and some information about GERD," she said. "I used our computer package to translate these into Aramaic. It does translations in over a hundred languages." David read through the materials while he waited. The translation was terrible, and he knew Mariam would laugh at the instruction to "Change diet to eat more food and bread." "This place better get its act together," thought David, "More Chaldeans are moving out this way all the time."

Patient's Perspective

“It was rude of the receptionist to assume that we were Muslim, and ignorant of her to offer materials in Arabic and Farsi. Wouldn't it have been better if she had asked if we needed translated materials, then asked the language we spoke? There are lots of Chaldeans in this region. None of us are Muslim, and our language, for thousands of years, has been Aramaic. It would be good for this center, and the hospital it's associated with, to learn more about our community, not just the population data about how many 'middle Easterners' live here, but who we really are.

“It was embarrassing to stand there while the receptionist fumbled with the computer trying to find something in Aramaic. She should have the materials readily available or forget about it. And those translated papers she gave us, the translation wasn't good at all. It's a good thing that it didn't tell me to do something dangerous, although telling a person with GERD to 'eat more food and bread' is dangerous enough. If the translation program isn't reliable, they shouldn't use it. Why not work with the Chaldean community to help get the right materials translated in the right way, and especially in the right language?”

Provider's Perspective

Receptionist: “We've had a lot more people from the Middle East come here lately. I learned a lot today when Mrs. Arrat's son explained about the Chaldean population. I guess from now on I should ask what language someone speaks. And, now I know that all people from the Middle East aren't Muslims. But the rest of the staff doesn't know this. The hospital has some responsibility here too. It was embarrassing to be so ignorant about our patient population. With more and more Chaldeans coming here, we should be taught more about them, and at least get the paperwork and instructions translated into Aramaic.”

This resource unit will walk you through developing written materials to communicate with LEP patients. The resource unit first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you came up with related to the unit.

Planning

This section on planning provides an overview of written materials and then walks you through determining a process for making materials available in other languages. Next, it describes different types of services for developing written materials. The section then walks you through determining what materials to make available in other languages, including prioritizing written materials, determining languages for

written materials, and considering literacy level. This is followed by considerations for ensuring the quality of written materials, such as verifying literacy and health literacy levels, field testing, and special concerns for ensuring quality. After the discussion on quality, this section provides guidance on making written materials accessible for providers and patients. Finally, this section will help you determine policies and procedures for developing written materials.

Overview of Written Materials

Some oral languages do not have a written counterpart. However, when they do, your organization may consider using written materials to improve communication with LEP patients. The goal of any written materials is to improve communication. It is important to clearly identify the target audience for any written materials, including literacy level, cultural concepts, and regional language variations.

Your organization may decide to make written materials available in other languages through translation of existing English-language materials. Translation is “the conversion of a written text into a corresponding written text in a different language.” The term “translation” is used for written messages, whereas the term “interpretation” is used for oral (or manual) messages.⁵⁸ Interpretation and translation require different skills sets.⁷³

As an alternative to translation, your organization may decide to develop new materials in other languages. Field experts have reported that creating a document in the language of the intended audience is preferable to translating existing documents, as the document will more accurately reflect the values and beliefs of the audience. In addition, creating new materials can prevent misunderstandings of content when words in English do not exist in other languages. If it is not feasible for your organization to create new materials, you can look for materials that were created for the intended audience or develop a plan to translate documents.¹¹

“I went to a clinic, a private clinic, and they gave me documents only in English. Then, I had trouble understanding.”

—LEP patient

What Is the Difference Between Interpretation and Translation?¹¹

Interpretation is spoken.

Translation is written.

Regardless of what your organization decides to do, written materials should be used to enhance the communication process between provider and patient.⁷⁰

Determining a Process for Making Materials Available in Other Languages

Ideas To Consider

As your organization determines a process for developing materials in other languages, consider the benefits that written materials offer to your patient population, the cultural implications of the materials, and the need for uniformity.

Benefits to Patient Population

Your organization may need to decide whether written materials will benefit the LEP patient populations served at your organization. Some issues to consider are:

- Does your patient population have a written language?
- Do the literacy levels of the written materials match the literacy levels of your LEP populations?
- Would written materials help interpreters and staff members communicate better with LEP patients?

Cultural Implications

It is important to consider the cultural implications of language when determining a process for developing materials in other languages. For example, translated materials in Spanish may not be effective for all Latino populations, as there are differences in vocabulary and culture based on country of origin. Therefore, materials that are appropriate for populations from Mexico may not be appropriate for populations from Peru. Likewise, some words may not translate directly from one language into another.^{11 12} Although there is language variation by culture, it can be expensive to develop or translate materials for each subpopulation. To accommodate the variations in cultural and linguistic needs, your organization can consider:⁵³

“Not only the patient, but the interpreter as well, are supported by [translated] documents. So the interpreter is not struggling to sight translate those documents. . . . Even if the family is not literate, the interpreter can probably read [the document] rather than having to sight translate the document and struggle with any technical or legal terminology. . . . That is one of the best ways not to burn out interpreters and dual role employees, by giving them that kind of support.”

—Healthcare professional with experience implementing LAS

- Translating a document first and then adapting it to specific populations
- Using symbols and pictures whenever possible
- Having various stakeholders come to consensus on translations
- Using terms that are commonly accepted across dialects or language varieties

Need for Uniformity

It may be beneficial to designate a coordinator who would be responsible for uniformity of written materials and language throughout your organization. This coordinator could be responsible for posting the materials on your organization's intranet or organizing the materials in a central location. Also, uniformity between written materials and oral communication is important. Vocabulary in written materials should match vocabulary used by staff and interpreters whenever possible.

Processes To Consider

Your organization may choose to develop new materials in another language rather than translate existing documents into that language. If your organization decides to translate existing materials for your LEP populations, you may consider different processes for translation.

Developing New Materials Versus Translating Materials

After looking at your patient population and your existing resources for written materials, your organization may find it necessary to develop new materials in other languages rather than translating existing materials. Developing materials specifically for your patient populations ensures that literacy levels and cultural implications fit the needs of your LEP populations.¹¹⁻¹³ Some organizations may choose to apply for grants specifically to develop these materials. Others may use existing grants or existing funding to develop patient education materials. For example, an

organization may receive funding to provide hepatitis B education, with part of the funding dedicated to updating or developing materials.¹² An example of a process for creating new materials follows:¹³

- Identify target audience.
- Conduct focus groups to refine messages with LEP patients; offer incentives to enhance participation.
- Decide who will develop the materials.
- Develop written materials; hire a designer/consultant with expertise in usability and information design, to ensure materials are user friendly and readable, if possible.
- Obtain feedback on materials:
 - From an advisory board of LEP patients
 - By asking LEP patients whether the materials are readable, understandable, and useful
 - By field testing materials with focus groups of LEP patients

If your organization decides to translate existing materials, you may consider developing a process to do so. For example, your organization may:⁷⁰

- Identify the target audience, including literacy level, cultural concepts, and regional language variations.
- Review English-language text for use, purpose, complexity, clarity, readability, assumptions embedded in the text, and cultural preferences.
- Decide whether to translate the document.
- Consider how to translate and who will translate the document.

The next section discusses ways organizations might go about translating written materials.

Translating Materials

The goal of translation is to ensure that the meaning and context of the written message are conveyed as intended. To accomplish this goal, it is not necessary to translate sentence by sentence or word for word.

There are a variety of ways to translate materials. Team translation involves two or more bilingual staff members who translate existing written materials. For example, a community clinic implementing LAS reported having one bilingual staff person translate a document and having a second bilingual staff person review the document to assess the readability of the translation. The two staff members negotiated any inconsistencies.^{12 13} Another method of team translation involves having two people translate the document, then compare the translations and negotiate any differences.⁷³

If your organization chooses to use translated materials, the next section discusses types of translation services available.

Considering Types of Services for Written Materials

Depending on the size, needs, and resources of your organization, you may consider a variety of options for developing or translating written materials, including the utilization of bilingual staff, finding Web-based resources, use of outside companies, or purchase of materials. Regardless of which option your organization chooses, it is important to assess whether the translator has been adequately trained and to review the documents for quality.

Bilingual Staff

Some organizations may use bilingual staff members to develop or translate forms or patient education materials from English into another language.^{12 13}



Qualifications of Translators^{11 73}

Interpretation and translation require different skill sets. Qualifications of translators may include:

- Formal education in target language
- Demonstrated ability to read and write in targeted language
- Ability to read and write in English
- Knowledge and experience with culture of intended audience
- Knowledge of healthcare terms and the healthcare industry
- Participation in professional development activities
- Certification by the American Translators Association
- Formal study in translation

Issues to consider when using bilingual staff members to translate or develop materials include:

- The time required for development or translation of materials—consider that bilingual staff may be pulled away from primary responsibilities to translate forms
- The skills needed to develop or translate written materials—note that they are different from those needed for interpreting and that being bilingual is only one skill needed to be a translator

Web-Based Resources

Some organizations may look for written materials online. Providers mentioned finding materials in Spanish from the following sources:¹²

- American Academy of Family Physicians
- MD Consult

Additional sources of translated materials include:⁴⁴

- American Academy of Pediatrics
- American Diabetes Association
- American Heart Association
- American Lung Association
- March of Dimes
- Planned Parenthood Federation of America
- Susan G. Komen Breast Cancer Foundation

Organizations also reported contracting with online companies such as Micromedex to purchase written materials in languages other than English.

McCarty and colleagues analyzed more than 75 multicultural health Web sites available on the Internet to identify the most useful sites for healthcare providers.⁷⁴ Highlighted Web sites can be found in



Links to Web Resources for Translated Materials on the Internet

American Academy of Family Physicians

<http://www.aafp.org>

and

<http://familydoctor.org>

MD Consult

<http://www.mdconsult.com>

American Academy of Pediatrics

<http://www.aap.org>

American Diabetes Association

<http://www.diabetes.org>

American Heart Association

<http://www.americanheart.org>

American Lung Association

<http://www.lungusa.org>

March of Dimes

<http://www.marchofdimes.com>

Planned Parenthood Federation of America

<http://www.plannedparenthood.org>

Susan G. Komen Breast Cancer Foundation

<http://www.komen.org>

Micromedex

<http://www.micromedex.com>

OMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

appendix G. The authors also noted universal problems among health education Web sites, including difficulties in printing materials, lack of material evaluation, uncertain quality of translation, and the lack of stability in Web sites.

Some organizations may consider using a Web site or specific software that translates materials for you. However, experts in the field of LAS caution that these programs may not be accurate. It is important that any translated materials an organization uses be evaluated for quality.

Clearinghouses

Clearinghouses collect information in a specific field and make that information available to people working in that field. Examples of clearinghouses include:

- Healthfinder was developed by the U.S. Department of Health and Human Services together with other Federal agencies for consumers. The site has links to information and Web sites from more than 1,500 health-related organizations. The Web site and some materials are available in Spanish.
- The Massachusetts Health Promotion Clearinghouse is specifically for providers in Massachusetts and offers materials in Haitian, Creole, Spanish, and English.⁷⁵
- The Health Communication Partnership has a database of materials from various countries, including the United States, and includes information on how to order materials.⁷⁶
- The National Network of Libraries of Medicine provides resources for multilingual health information.⁷⁷

Community Collaborations

Organizations in your area may consider a community partnership to share costs of developing, translating, or purchasing materials in another language.¹² Likewise, you may be able to hire community organizations to develop or translate materials.



Links to Web Resources for Clearinghouses

Healthfinder

<http://www.healthfinder.gov>

Massachusetts Health Promotion Clearinghouse

<http://www.maclclearinghouse.com>

Health Communication Partnership

<http://www.hcpartnership.org>

National Network of Libraries of Medicine

<http://nnlm.gov/train/chi/multi.html#lang>

OMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

For more information about community collaborations, see Resource Unit E (Community Involvement).

Translation Companies

Some organizations may consider hiring an outside firm to translate written materials at their organization. If your organization chooses to use an outside agency, you may consider a company that is certified by the American Translators Association (ATA) or that has translators who are ATA certified or have formal training such as a baccalaureate, master's, or doctorate in translation.

Materials for Purchase

Some organizations and providers may choose to purchase materials in other languages.^{12 13} If you purchase materials, you may want to be sure that these materials were tested and evaluated for the LEP populations that your organization serves.

Other Resources

Your organization may choose to consider other resources available in your area. For example, some State Medicaid programs have developed materials in other languages that are available for free on the Internet. Likewise, some third-party payers, such as insurance companies, may have developed materials that are available for use at your organization. Pharmaceutical companies may have patient education materials. However, it is important to evaluate materials in terms of source and potential biases. For example, materials provided by pharmaceutical companies may be focused on promoting particular medications. It is important to consider all available resources when choosing written materials to communicate with LEP patients that meet your organization's needs.

Determining What Materials To Make Available in Other Languages

Most organizations utilize a wide variety of written materials, including administrative and legal documents, clinical information, and patient education and outreach materials.¹⁰ As your organization determines what materials to make available in other



Link to Web Resource for Translation Directories

ProZ: The Translation Workplace

<http://www.proz.com/directory>

OMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.



Links to Web Resources for Translation Companies

American Translators Association (ATA)

<http://www.atanet.org>
703-683-6100

American Language Services, Inc. (ALSI)

<http://www.americanlanguageservices.us>
617-876-0833

MedTranslator.com

<http://www.medtranslator.com>
512-707-8928

Language Line Services

<http://www.language-line.com>
800-752-0093

Wordzone, Inc.

<http://www.wordzone.com/index.shtml>
209-729-5151

Eurasia Translations, Inc.

<http://www.eurasia-usa.com>
888-887-1884

OMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

languages, it is important to prioritize written materials to make available and to determine the languages in which the written materials will be made available.

Prioritizing Written Materials To Make Available in Other Languages

Your organization may need to prioritize which written materials should be made available in other languages. Other organizations with experience implementing LAS have developed processes for prioritizing written materials. For example, one organization has a standing committee that meets once a month to review requests for translation and prioritize them based on the content of the materials and the frequency of use. Another organization reported sending all requests for translated documents to one administrator. The administrator develops a budget to determine how many documents can be translated per year and selects the most needed documents for translation, based on utilization frequency.¹²

Examples of Priority Materials

Your organization may want to consider which forms to make available in other languages. These decisions may be made based on importance or frequency of use.

As your organization decides which documents should be made available in languages other than English, it may be beneficial to ask LEP patients which materials they think would be most helpful.⁵² Also, your organization may talk with community-based organizations in the area that work with LEP populations when deciding what materials to make available. Regular assessment of the LEP populations' needs may be helpful in determining on a continual basis which documents should be made available.⁷⁸

Priority materials might include:

- Consent forms
- Complaint forms
- Intake forms



State Medicaid Materials in Other Languages

Many State Medicaid programs have materials in other languages. For example, in California the Medicaid Program has 164 publications available on its Web site in up to 14 different languages. Use the link below to find your State's Medicaid Program Web site and check for the availability of materials in other languages.

Centers for Medicare & Medicaid Services list of State Medicaid Web sites:

<http://www.cms.hhs.gov/medicaid/stwebsites.asp?>

“Because there was a time I had a cold . . . I went to an American help desk. I trusted [the person at the help desk] and know that the medication he showed me was right, but I myself couldn't understand what I was reading and what the side effects were and the length of time in between to take it. Now if there were Chinese documents, then I would be able to know what the effects of the medication are, what medications I shouldn't take together with it, but with English it is a bit more difficult.”

—LEP patient

- Contact information for the organization
- Eligibility criteria, including loss of benefits or services
- Notices advising LEP persons of free language assistance and how to access them (for more information on notices, see Resource Unit D, Notice of Language Access Services to LEP Patients)
- Patient bill of rights
- Pharmaceutical instructions and interactions
- Preparation instructions for procedures and diagnostic tests
- Discharge instructions
- Advance directives
- Hospital menus
- Institutional Review Board materials, such as clinical research trial consent forms

Appendix H shows a complete list of documents translated at one site by bilingual staff members.

Determining Languages for Written Materials

Written materials may need to be available in multiple languages. To determine the languages in which to make written materials available, your organization can use the information collected in Step 1 (Assessing the Language Needs of Your Patients) to determine which language groups are most frequently encountered.

Considering Literacy Level

As part of your organization's prioritization, you may consider the literacy level of written materials. If your organization determined during Step 1 (Assessing the Language Needs of Your Patients) that your LEP populations have limited literacy or limited functional health literacy, your organization can consider



Link to Web Resource on Writing Reader-Friendly Documents

Developed by a Federal interagency plain-language group, this is a basic manual for developing plain-language skills.

Writing Reader-Friendly Documents

<http://www.plainlanguage.gov/howto/guidelines/Reader-Friendly.doc>

developing new materials or translating materials at a lower literacy level.

It is important to assess literacy and health literacy levels of materials for all patients. In 1992, the National Adult Literacy Survey (NALS) identified more than 90 million adults with limited English-language literacy in the United States. Of these adults, 15 percent were born outside the United States.⁷⁹ An individual's functional health literacy may be worse than his or her general literacy. Functional health literacy includes the ability to read and comprehend health information, such as:⁷⁹

- Prescription bottles
- Appointment slips
- Consent forms
- Discharge forms

Your organization may address literacy and health literacy levels for your LEP populations by asking patients to repeat back instructions orally for medication or other procedures to be sure that they are understood.

For people with low literacy, alternative formats for language assistance may include the following:⁷⁰

- Telephone numbers with recordings that offer explanations of certain topics or issues, such as the importance of cancer screening
- Informational videotapes
- Audiotapes on frequently used topics or issues, such as discharge instructions, that can be used instead of paying someone to read them aloud or sight-translate from English
- Greater use of graphics, props, and symbols that represent particular actions or concepts (for more information on symbols, see Resource Unit C, Signage and Wayfinding)



Assessing Literacy Levels in Languages Other Than English

Because languages are complex, measuring the readability of written materials is not a simple task. Tools such as the Fry method or SMOG (Statistical Measure of Gobbledegook) method assess reading level by counting the number of syllables in a given passage. These techniques may not adequately measure comprehension for the following reasons:

- Shorter sentences and shorter words are not necessarily easier to read.
- Languages vary in structure. For example, sentences tend to be longer in Spanish than in English.
- Grade levels vary by country. For example, reading at a second grade level in Mali, West Africa, may not be equivalent to reading at a second grade level in the United States.
- Languages vary in the types of scripts or characters used. For example, assessing literacy level in Chinese is determined by how many characters the person knows rather than counting syllables per sentence.

Developing a Process for Ensuring the Quality of Written Materials

It is important to ensure the quality of all written materials made available to LEP patients, whether they are new or translated documents. Generally, quality written materials are:¹¹

- Readable, understandable, and useful
- Targeted to a specific audience
- At the appropriate literacy level
- Professional in tone
- Culturally appropriate

Quality written materials may help your organization communicate more effectively with LEP patients. Also, there may be liability issues if materials given to LEP patients are not accurate and up to date. For example, if an informed consent document does not adequately express the risks in the second language, the organization or provider may be held liable for not communicating those risks.

This section will discuss field testing materials and specific concerns for translated materials.

Field Testing

Field testing allows the organization to know whether the written materials convey the messages they are intended to convey. Field testing can be done with new materials or with translated materials and can be conducted in a variety of ways. Your organization may choose to use materials or field test materials by:¹²

- Conducting individual interviews with LEP patients
- Conducting focus groups with LEP patients
- Getting feedback on materials from community groups and community-based organizations in your area

- Getting feedback on materials from your patient advisory board
- Informally asking LEP patients during their healthcare visits whether the written materials meet their needs

If your organization decides to field test its written materials, you will need to develop a field test protocol. The protocol could include questions related to:⁸⁰

- General reactions to materials
- Content of material
- Organization of material
- Writing style
- Document design
- Cultural appropriateness

Your organization may also consider collaborating with other providers, health education experts, medical anthropologists, and linguists to field test materials.

Special Concerns for Ensuring Quality

Word-for-word translations of written materials may not be considered high quality translations, because each language has a unique structure.^{12 81} Some concepts that take one or two words to express in English may take several phrases in another language and vice versa. Also, some languages have many dialects or language varieties.¹¹⁻¹³ Kaiser Permanente has convened a National Coalition for Quality Translation as part of a larger research study funded by the California Endowment. The coalition's intention is to develop a standardized translation process for terms in Spanish that are challenging to translate or unique to the U.S. healthcare system.

If you decide to obtain translated materials from an external source, it is important to assess the adequacy of



Link to Web Resource on National Coalition for Quality Translation

“Quality Translation in Health Care” (Apuntes journal article)

<http://inrades.org/Translation/KP.pdf>

those materials. Some questions to consider in the assessment include:^{52 80}

- Who prepared the materials? What are their credentials?
- What process was used to create the materials?
- Were the materials field tested?
- What is the literacy level of the materials, and does it match the literacy level of your LEP populations?
- Is the information concrete and action oriented?
- Is the information accurate and up to date?
- Does the content show awareness of and respect for diversity and use culturally appropriate terms and examples?

Making Written Materials Accessible for Providers and Patients

Organizations with experience implementing LAS have described procedures for making written materials available for providers and staff, including:¹¹⁻¹³

- Designating a person to be in charge of organizing written materials internally for providers and filling in materials for patients
- Saving translated materials on the organization's intranet
- Keeping translated materials in an organizer in one location in the office

If materials are properly organized and labeled, it may be easier for providers to distribute them to LEP patients as needed. Also, your organization may choose to display written materials for patients in various

places throughout the organization. Examples of places to display written materials may be:

- Front desk
- Waiting area or lobby
- Exam rooms
- Billing station

For more information on posting signage, see Resource Unit C (Signage and Wayfinding).

Determining Policies and Procedures for Developing Written Materials

Once your organization decides which types of translation services to implement, you may create policies and procedures for developing new or translating existing materials. After developing these policies and procedures, it is important to educate or train staff. For more information on staff training, see Step 2 (Assessing Your Organizational Capabilities).

Your organization may consider answering the following questions regarding policies and procedures:^{12 13 52}

- Who identifies the communication needs of LEP patients?
- How does your organization determine languages in which materials will be made available?
- How does your organization decide which materials to translate?
- Who approves the content and expense of translation or developing new materials?
- How do staff members request that documents be translated or developed?
- How are written materials disseminated to staff?

- Where are written materials stored? How are they organized?
- Who is responsible for organizing these materials?
- How are LEP patients made aware of available written materials?
- How are written materials distributed to LEP patients?
- Is there a system in place to receive feedback from patients on written materials?

As each organization is different, your organization will need to develop policies and procedures that fit the needs of your organization and LEP population.

Implementation

Now that you have reviewed planning issues related to this resource unit, you can decide on a plan of action and implement it. You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider the needs of your LEP population (Step 1) and your organization's capabilities (Step 2) when deciding which activities to undertake. You can also use the checklist to monitor, evaluate, and update the activities associated with this unit.

Determining a Process for Making Materials Available in Other Languages

- Did you consider the following ideas?
 - Whether written materials will benefit your LEP patient population
 - Cultural implications of written materials
- Did you designate a coordinator to ensure uniformity of written materials?
- Did you consider the following processes?
 - Developing new materials for your LEP population
 - Translating existing materials for your LEP population
 - Steps for translating materials

Types of Services for Written Materials

- Has your organization used multiple strategies to address the written communication needs of your LEP population? Have you used the appropriate combination of the following strategies?
 - Bilingual staff to develop or translate materials
 - Is translating part of their job description?
 - Did you consider how role changing will affect staff?
 - Did you compensate or provide incentives for translating?
 - Web-based resources
 - Materials from clearinghouses
 - Community collaborations to access written materials
 - Translation companies to translate existing materials
 - Purchasing materials
 - Other resources available in your community

- For any of the sources listed above, did your organization assess the quality of materials?

Determining What Materials To Make Available in Other Languages

- Did you prioritize written materials to make available in other languages, such as:
 - Consent forms
 - Complaint forms
 - Intake forms
 - Contact information for the organization
 - Eligibility criteria, including loss of benefits or services
 - Notices advising LEP patients of free language assistance and how to access it
 - Patient bill of rights
 - Pharmaceutical instructions and interactions
 - Preparation instructions for procedures and diagnostic tests
 - Discharge instructions
 - Advance directives
 - Hospital menus
 - Institutional Review Board materials, such as consent forms for clinical research trials
 - Other relevant materials

- Did you consider literacy level?

- Did you determine languages for written materials based on the needs of your LEP population?

Developing a Process for Ensuring Quality of Written Materials

- Are written materials:
 - Readable?
 - Understandable?
 - Useful?
 - Targeted to a specific audience?
 - At the appropriate literacy level?
 - Professional in tone?
 - Culturally appropriate?
- Did you verify literacy and health literacy levels of written materials?
- Did you consider field testing materials with LEP patients?
- Did you consider the following concerns for ensuring quality?
 - Limitations of word-for-word translations given the unique structure of each language
 - Cultural considerations
- If using outside materials, did you consider the following questions?
 - Who prepared the materials? What are their credentials?
 - What process was used to create the materials?
 - Were the materials field tested?
 - Does the literacy level match the literacy level of your population?

Making Written Materials Accessible for Providers and Patients

- Did you designate a person to be in charge of organizing written materials internally?
- Do you save written materials on your organization's intranet?
- Do you display and keep written materials organized in one location in the office?

Determining Policies and Procedures for Developing Written Materials

- Did you develop policies and procedures on the following topics?
 - Who identifies the communication needs of LEP patients?
 - How does your organization determine languages in which materials should be made available?
 - How does your organization decide which materials to translate?
 - Who approves the content and expense of translation or developing new materials?
 - How do staff members request that documents be translated or developed?
 - How are written materials disseminated to staff?
 - Where are written materials stored? How are they organized?
 - Who is responsible for organizing these materials?
 - How are LEP patients made aware of available written materials?
 - How are written materials distributed to LEP patients?
 - Is there a system in place to receive patient feedback on written materials?
- Did you educate or train staff on these policies and procedures?

Evaluating Your Solutions

To ensure that your means of developing written materials to communicate with LEP patients are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to developing written materials to communicate with LEP patients? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to developing written materials to communicate with LEP patients? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your means of developing written materials to communicate with LEP patients? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you come up with specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

Case B–2: Mariam Arrat’s Endoscopy

Patient’s Story

When Mariam Arrat continued to experience pain, her doctor ordered an endoscopy. Mrs. Arrat decided not to return to the outpatient clinic she had been to before, and her son David drove her to the hospital nearer the center of the Chaldean community. When they arrived, the Chaldean receptionist greeted them in Aramaic. Signage was posted in Aramaic and English. The receptionist, fluent in Aramaic and English, asked Mrs. Arrat which language she would prefer for the paperwork. When Mrs. Arrat answered, “Aramaic,” the receptionist asked her to wait just a moment. Within a few minutes, the receptionist printed a series of admission forms, a description of the endoscopy procedure, and educational materials about GERD, all in Aramaic.

David was impressed. “How did you do that so quickly?” he asked. “We have all the forms, instructions, and educational materials, in English and Aramaic, in PDF files in the database, and everything is labeled,” said the receptionist. “I click on a language, then click on the forms packages I need, the diagnosis, and the procedure. That prints out everything in the language the patient requests.”

Mrs. Arrat was reading through the GERD instructions. “You even mention specific Chaldean foods and how they might affect someone. That’s nice.” The receptionist explained that the hospital had conducted focus groups with Chaldean patients to make sure that all of the materials would be culturally appropriate, then tested the materials in the Chaldean community to be sure they were accurate and useful. The medical forms were translated by two trained staff and reviewed for inconsistencies, then tested with various groups to be sure they were understandable and at the appropriate reading level. Where they could, the hospital staff wrote documents in Aramaic, rather than translating from English, so that there would be no concerns about words or topics that could not be translated.

David thought the receptionist was very engaged in the topic and said so. She said that she had been on the hospital committee that developed the plan for the translated materials. “Must have cost a fortune,” said David, and the receptionist told him that they received a grant for about half of the work. “We were willing to pay for the rest,” she said, “Our cost-benefit analysis showed that we have enough Chaldean patients to make this very worthwhile to the hospital.” Mrs. Arrat laughed, “That clinic I was at before should come and see how you operate; they sure could learn a few things.” “Where was it?” the receptionist asked, switching to Aramaic, “I’ll happily call and tell them about our LAS. We’re willing to share our documents too, if they meet other organizations’ needs.” David expressed surprise that the hospital would give away the materials after all their trouble and expense. The receptionist shrugged. “We’re all trying to serve the Chaldean population,” she said.

Patient's Perspective

“What a difference from the other clinic! This is why I like this hospital. It knows our community and has worked in partnership with us to provide health care and materials that are useful and culturally appropriate, and in Aramaic if we choose. They planned what they needed and worked with the community to do it right. Now, I have correct instructions, in my own language, that even speak to my specific culture, about how to manage my GERD. That will certainly help me to get my health back under control. And the hospital is even willing to share with others who serve the Chaldean population! We're pretty lucky here. It would be great if every hospital could do this for their minority populations.”

Provider's Perspective

Receptionist: “I feel proud that the hospital has done such a good job of working with the Chaldean community and that I was invited to help assess the needs and develop materials. I'm especially excited to get the information about another clinic that serves the Chaldean population. We're doing something very good for patients here and I'm happy to share it with everyone.”

Resource Unit B: Insights From the Cases for Healthcare Organizations

Developing new materials in other languages or translating materials that meet patients' needs can help patients to better understand and manage their health. Including the patient community in developing the materials can help ensure that the materials are accurate and useful. Although it may appear that technology makes translation services easy to provide, the case illustrates some of the concerns about translation that organizations must take into account. For example, computer-based translation may be inaccurate, and documents should also be translated by two competent individuals and then reviewed for inconsistencies to ensure their accuracy. Also, organizations must ensure that translated documents meet patients' specific language and cultural needs. In the Case B-1 example, it was not enough for the receptionist to know that a patient “looked middle Eastern,” or was “Iraqi.” Without more specific information, the receptionist made assumptions about religion and language that did not serve the patient.

Involving members of the patient community can help ensure that documents accurately reflect patients' cultures and lifestyles. In the second case example, instructions about foods that the patient should avoid included foods from the traditional Chaldean diet; such specificity could help the patient better manage her condition.

Implications for hospitals include concerns related to liability and quality of care that occur when patients do not receive the health-related information that they need or when they receive inaccurate information. In addition, as the case illustrates, healthcare organizations may lose patients to other organizations that better meet the patients' language needs.

Resource Unit C: Signage and Wayfinding

Discussion Topics

- Overview of Signage and Wayfinding
- Deciding What Type of Signage To Post
- Deciding Where To Display Signage
- Determining the Quality of Signage
- Training Staff on New Signage

Resource Unit C examines options for signage and wayfinding. This section describes issues for consideration as you plan to implement the recommendations in the resource unit. The planning section is followed by a section on implementation, which includes a checklist of items to review as you implement the activities described in the resource unit. The resource unit concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to address signage and wayfinding needs.

The planning section in Resource Unit C first provides you with an overview of signage and wayfinding. It then helps you decide what types of signage to post throughout your organization. Next, the planning section provides tips on determining the quality of signage, including the quality of translations and literacy level used, and helps you decide where to display signage. Lastly, the section provides information on training staff on signage issues.

This resource unit describes two cases, one that demonstrates an organization at an earlier stage of implementing language access services (LAS) and one that demonstrates an organization further along in the process. Each case also includes patient and provider

perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

The two cases in this resource unit continue with the stories of the two 13-year-old girls presented in Cases 1–1 and 1–2 of Step 1, Assessing the Language Needs of Your Patients. The girls and their families again have very different experiences when one enters a hospital that has little experience with limited English proficient (LEP) patients and the other enters a hospital that is competently implementing LAS.

Resource Unit C: Patient's Profile

(NOTE: This case continues from Case 1–1: Paulina Quesada's Upset Stomach)

Paulina Quesada:

- Doctor suspects appendicitis or ectopic pregnancy
- Patient sent to hospital radiology department to confirm diagnosis and prepare for possible surgery
- Patient, who interpreted doctor's diagnosis and instructions for parents, did not mention pregnancy as a possible diagnosis

Case C–1: Paulina Quesada Lost at the Hospital

Patient's Story

Paulina Quesada and her parents arrived at the hospital. They turned into one parking lot, but an attendant waved them away. "Doctors only," he said, "Visitor parking is the garage on the left." Paulina tried to explain that they were not visitors, that she might need surgery, but she could not answer the attendant's questions about whether they were looking for the emergency room or outpatient surgery. In the end, they parked in the visitor garage and walked into the hospital. Once inside, they took several wrong turns before Paulina asked someone how to get to the main information desk. Without help, she would not have known to follow the signs that said, "Lobby." Paulina twice doubled over in pain before they reached their destination.

Paulina explained that she was there for tests to see if she needed surgery. The older woman at the information desk was quite kind, but Paulina did not know how to answer her questions about whether the surgery was scheduled and whether it was outpatient. Paulina doubled over in pain again, as her father haltingly said, "Appendix," and gave the name of the doctor they visited that morning. The women told the Quesadas to walk around the corner to the admissions desk.

When they arrived at the admissions desk, Paulina and her mother sat down while her father waited in line. When he got to the desk, he tried to explain Paulina's condition, but eventually had to call Paulina over to speak with the clerk. The clerk provided Paulina with a few forms for her parents to sign, then directed them to an elevator down the hall that they could take to the radiology department on the third floor. The clerk gave further directions about finding the right reception area, but Paulina was so focused on her pain that she missed most of them. Paulina heard that they should go past the lab and something about nuclear medicine; the rest was a blur.

They walked down the hall, but got on the wrong elevator, got off on the wrong wing of the building, and wandered anxiously for more than 30 minutes. Every sign looked like a foreign language to Paulina, and literally was a foreign language to her parents. They had no idea how to navigate their way through the hospital. Finally, a technician noticed that they had passed the same reception area three times. She asked if they were lost, and Paulina burst into sobs. "My appendix," she said, "I can't walk any more because of the pain. The doctor says that I have to have tests for surgery but I can't find where to go." The technician sat Paulina in a chair, then picked up the telephone. In 5 minutes, an orderly eased Paulina into a wheelchair and wheeled her to the radiology reception area on the third floor.

Patient's Perspective

"I couldn't explain to the parking lot attendant what we needed, so we had to walk so far to get into the hospital. That was the worst, walking and walking while I thought my whole body would burst in pain. Couldn't the parking lot attendants know enough about what patients need to direct us to the right place? And how would I know to follow the signs that say "Lobby" to get to the main information desk? It would be better if the signs said, "Main Information Desk," or, even better, if the signs could use the Spanish phrase "Servicio de Información." It would have been so much less painful if an interpreter could have met us and led us to the right place. Or even if someone gave us the directions in Spanish, or gave us a map in Spanish, or if the hospital had signs on the walls in Spanish. If that person hadn't asked if we needed help and gotten me a wheelchair, I think I would have collapsed within a few more minutes."

Provider's Perspective

Technician: "That poor child was completely lost, and the hospital has nothing that she could understand to find her way. If she had collapsed in a hallway someplace and no one found her soon enough, she could have been gravely ill. The patient would have suffered even more, and we would have had some explaining to do about our quality of care. Even something as simple as a sign or a map can have such a big impact on our ability to provide accessible care for patients. I think it would benefit both the patient and the hospital for us to do a better job of helping our Spanish-speaking patients find their way."

This resource unit will walk you through deciding on options for signage and wayfinding. The resource unit first discusses planning issues, followed by implementation issues, and concludes with a discussion on evaluating the solutions you came up with related to options for signage and wayfinding.

Planning

In this section on planning, you will read an overview of signage and wayfinding. You will then read about how to decide on the types of signage to post throughout your organization. Next, you will receive tips on determining the quality of signage, including the quality of translations and literacy level used, as well as tips on how to decide where to display signage. Finally, you will be presented with information on training staff on signage issues.

Overview of Signage and Wayfinding

For LEP patients to take full advantage of your organization's resources and services, it is important to provide them with the tools and knowledge necessary to

navigate through your organization. Many healthcare organizations accomplish this through the use of signage, within the context of “wayfinding” techniques. Wayfinding is a system of visual, audible, and tactile elements strategically placed throughout an organization to facilitate navigation. Wayfinding is unique in its use of components other than signs to help LEP patients feel more comfortable and welcome in an unfamiliar environment; it also encompasses architecture, lighting, landscape, and landmarks.⁸²

Wayfinding systems not only increase access to healthcare services, but also decrease interpretation needs and the costs associated with those needs.⁸³ When wayfinding is successfully executed, LEP patients are empowered with the necessary resources to navigate through your organization with ease. Thus, LEP patients have fewer uncertainties and questions about what to do when they reach your organization as they become more self-sufficient and require less assistance through translation or interpretation services.⁷⁰

If your organization is experiencing construction of new facilities or expansion, it is important to get involved with designers early in the construction process to ensure that all new areas are created with wayfinding elements in mind, including signage.

In the healthcare context, signage that incorporates wayfinding techniques improves access for LEP persons, persons with cognitive disabilities, and persons with low literacy.⁷⁰ Such signage serves as an important tool in educating patients on the services and resources available to them, how to access those services and resources, and their rights as patients. Communicating with LEP individuals through signage can be accomplished by posting easily understood signage in the languages commonly encountered in your patient population.

Signage can include words, symbols, pictures, or combinations of all three elements to convey a message. Signs with words address the needs of most individuals; however, signs with symbols or pictures are ideal for communicating with individuals with low literacy or who have cognitive disabilities.



Incorporating Wayfinding Techniques⁵³

If your organization is interested in incorporating wayfinding techniques within your facilities, you may want to refer to the American Institute of Architects:

<http://www.aia.org/>

Currently, there are no standards for healthcare symbols. The lack of standards for healthcare symbols can be attributed to the cultural complexities of identifying symbols that are universally recognized as well as the complexities in conveying medical terminology through symbols. Although there are no standards for healthcare symbols and there is no healthcare signage that is universally understood, the use of symbols on signage is advantageous because symbols are easier to learn and can be more easily recognized by both literate and illiterate individuals.

In addition, efforts are currently under way to develop recommendations for standards in signage, incorporating the use of symbols and wayfinding concepts. The recommendations from these efforts will apply to a variety of healthcare settings and will be focused on the development and implementation of a cohesive, multilingual wayfinding system of standard terminology and symbols that are easily understood by people regardless of factors such as primary language, country of origin, education level, literacy level, or socioeconomic status.⁷⁰

Regardless of how many signs are posted, it is important to provide LEP individuals with oral assistance whenever possible.¹²

Deciding What Type of Signage To Post

Before deciding what type of signage to post in languages other than English, it is important to take an inventory of the signs already present at your organization. Taking this step can help you compile a list of signs to translate as well as help you determine which English signs need to be updated. Options for assessing existing signage include:¹²

- Making an inventory of posted signs by taking photographs
- Walking through your organization with a wayfinder expert



Link to Web Resource on a Signage Recommendation Study

Signage recommendations are being developed through a study conducted by Hablamos Juntos. The study will ultimately develop 28 symbols by October 2005, which will be placed on the Hablamos Juntos Web site.

Hablamos Juntos Project

<http://www.hablamosjuntos.org/signage/default.index.asp>



Developing Signage¹²

When developing signage for your organization, you may want to consider the following:

- Develop signs based on demand and provider requirements.
- Start with basic signs containing general information.
- Develop signs as needed for special programs or classes.

Next, think about what you are trying to achieve in posting translated signage. Most signs are posted in an effort to influence a person's behavior. Therefore, for example, if you are trying to use posted signage to guide LEP persons through an unfamiliar healthcare facility, the signage should be composed of text and symbols that are clear and universally understood.

In the case of signs whose messages may have the same meaning but are expressed throughout the organization in multiple ways (for example, "Staff only," "Hospital staff only," "No admittance," or "Authorized personnel only"), it may be helpful to use the same phrasing universally across all of the similar types of signs. This will help eliminate multiple versions of the same sign and allow LEP patients to more easily recognize signs throughout your organization. One way to do this is by grouping the similar signs by concepts, developing simple wording across signs that can be understood at a low literacy level (fourth to sixth grade), and translating the terms into the appropriate languages. Once the signs are developed, make enough duplicates to replace the previously displayed signs. Signage can be developed in house (at a departmental or organizational level) or by a professional printer and posted by each department. For more tips on translation, refer to Resource Unit B (Written Materials).

Signage should be translated into the most common languages encountered in your patient population. Ideas for signage include:

- Availability of LAS³⁸
 - What services are available
 - How to gain access to certain services
 - What steps should be taken to acquire the services
 - Where to go in the facility to receive the services and how to get there



Precautions When Producing Signs⁵³

When deciding who will produce your organization's signs, it may be helpful to be aware that some sign-making companies may have difficulty working with languages that use an alphabet unlike that of the English language. In addition, they may be unfamiliar with medical terminology. A lack of language ability and/or a lack of knowledge in medical terminology could result in poor quality control and evaluation. Therefore, it is important to be selective when choosing a company to produce your signs.

- Patients’ rights, specifically the right to language assistance
- Conflict and grievance resolution process
- Office hours
- Right to access LAS
- Language identification⁷⁰
 - Welcome cards or posters displaying language identification charts
 - “I-Speak” cards
- “Do not enter” and disease-related signage in exam rooms¹³

To make the best use of available resources, partner with other organizations, colleges, and universities to develop and share resources. Refer to Resource Unit E (Community Involvement) for more recommendations on utilizing resources that are available through the community.

Deciding Where To Display Signage

To best reach LEP patients, strategically post signage in those areas of your organization with high volumes of LEP individuals seeking access to services.³⁸

Places to consider posting signage include:¹²

- Initial points of contact
 - Hospital entrances
 - Intake areas
 - Registration desks
 - Front desks
 - Waiting rooms



Links to Web Resources on I-Speak Cards

A set of I-Speak cards in 38 languages, used by the U.S. Census Bureau for the 2000 Census, is available at:

<http://www.usdoj.gov/crt/cor/Pubs/ISpeakCards.pdf>

An I-Speak poster displaying 30 languages is available through the Commonwealth of Massachusetts Department of Public Health at the following URLs.

Horizontal poster:

<http://www.mass.gov/dph/omh/interp/translation-horiz.pdf>

Vertical poster:

<http://www.mass.gov/dph/omh/interp/translation-vert.pdf>

A set of I-Speak cards in 13 languages is available through PALS for Health at:

<http://palsforhealth.org>

A set of I-Speak cards in 10 languages is available through the California Civil Rights Bureau at:

http://www.dss.cahwnet.gov/civilrights/ISpeakCard_1304.htm

A set of I-Speak cards in 10 languages is available through the Minnesota Department of Human Services at:

<http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4374-ENG>

“Yes, but sometimes you’d have to check the dictionary. It’s a bit more difficult.”

—LEP patient, in response to whether he or she is able to read patient education materials presented in English

- Financial screening rooms, where LEP patients may need to discuss and resolve billing issues
- Pharmacy reception, where LEP patients may pick up prescriptions
- Parking structures and public transportation
- Specific departments
 - Emergency rooms
 - Labor and delivery
 - Urgent care
 - Nursing areas
- Other frequented areas
 - Cafeteria
 - Gift shops
- Emergency evacuation routes

Determining the Quality of Signage

For signage to be effective in communicating with LEP patients, the signage must be of the appropriate quality with regard to content and appearance. Conveying messages through as few words as possible will allow LEP persons to easily see and read the signs. LEP individuals should be able to easily comprehend the signs without referring to a dictionary to translate medical terminology. For example, LEP individuals have reported that the need to refer to a dictionary while reading materials hinders their ability to gain a full understanding of the materials.⁵⁹ Therefore, signage should be simple, accurate, culturally appropriate, and organizationally standardized to minimize patient confusion.

As discussed earlier in this step, the difficulties involved in developing universally understood symbols have delayed the establishment of standards for



Creative Solutions and Alternatives for Producing Signs⁵³

- Use electronic and/or magnetic signs that can be changed frequently to reduce the long-term costs associated with updating signs
- Provide maps in multiple languages so LEP patients are not dependent on multilingual signs to navigate throughout your facilities
- Set up electronic, interactive kiosks that can provide information to patients in multiple languages
- Develop a coding system for various areas within your facilities, such as distinguishing departments/floors by different colors, shapes, or animals



Being Selective of Signs to Post⁵³

When making bilingual signs, it may be helpful to concentrate on making only those that will be utilized by LEP patients. For example, you may not need bilingual signs for the cryogenic department where medical staff pick up lab samples.

symbols. Therefore, it is advantageous for your organization to conduct periodic and rigorous testing of the symbols used in your facility's signage.⁸⁴ Testing of symbols could include incorporating the input of patients, staff, providers, interpreters, and translators. Options for testing signage include:¹²

- Seeking out patient and staff input through surveys or focus groups
- Pilot testing signage with patients and staff (for example, ask individuals to find specific places in the facility guided only by signage; then follow and time the individuals to evaluate the effectiveness of available signage⁸⁴)
- Requesting the participation of LEP individuals and their families in facility walk-throughs with organizational staff to assess the usefulness of signage and to gain feedback on what additional signs are needed
- Walking through your organization with a wayfinding expert once a week for several months

It may also be helpful to seek the input of local and national stakeholders, such as leaders from local and national organizations, to ensure that the symbols are appropriate for your patient population.² For more information on involving the community, refer to Resource Unit E (Community Involvement).

In addition to seeking the input of stakeholders, it is important to refer to the needs of the community, as discussed in Step 1 (Assessing the Language Needs of Your Patients). This is helpful in determining the languages as well as the literacy level to be used in the signage. For more recommendations on assessing and evaluating the quality of translated materials, including information on determining the appropriate languages and literacy levels for your organization, refer to Resource Unit B (Written Materials).



Determining the Location of Signage¹²

When deciding where to display signage:

- Involve your internal human resources department
- Check with State guidelines on regulations regarding signage size and location
- Keep materials in the same locations as English materials

Training Staff on New Signage

Once your organization has established a procedure for developing and posting signage, conduct staff orientations to help staff become more familiar with the goals of signage and to teach them about the organizational policy on developing new or updated signage. The orientations can be held online or as a class, depending on the size, location, and preference of your staff.¹² For more information on training, see Step 2 (Assessing Your Organizational Capabilities).

Implementation

Now that you have reviewed planning issues related to this resource unit, you can decide on a plan of action and implement it. You can use the checklist below to keep track of signage and wayfinding activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider the needs of your LEP population (Step 1) and your organization's capabilities (Step 2) when deciding which activities to undertake. You can also use the checklist to monitor, evaluate, and update the activities associated with signage and wayfinding.

Overview of Signage and Wayfinding

- Did you incorporate signage and wayfinding techniques within your organization?
 - Did you incorporate signage and wayfinding within existing facilities?
 - Did you incorporate plans for signage and wayfinding within facilities under construction and/or future facilities?
 - Does your signage include words, symbols, pictures, or a combination of all three elements to convey their message?

Deciding What Type of Signage To Post

- Before deciding what type of signage to post in languages other than English, did you take an inventory of the signs already present at your organization?
- Is signage effective in increasing access to services for your LEP patients?
 - Did you eliminate multiple versions of signs conveying the same message to allow for more easily recognizable signs throughout your organization?
 - Did you make enough duplicates of new signs to replace previously displayed signs?
 - Did you use simple wording that can be understood by those with low literacy?

- Did you translate signage into the most common languages encountered in your patient population?
- Does signage answer the following questions for LEP patients?
 - What services are available?
 - How does one gain access to certain services?
 - Are patients' rights explained, specifically the right to language assistance?
 - Are conflict and grievance procedures explained?
 - What are the office hours?
- Did you partner with other organizations, colleges, and/or universities to develop and share resources?

Deciding Where To Display Signage

- Did you strategically post signage in the areas of your organization that LEP individuals most frequently access?

Determining the Quality of Signage

- Did you post signage that LEP individuals can easily read and comprehend without referring to a dictionary to translate?
- Did you use signage that is simple, accurate, culturally appropriate, and organizationally standardized to minimize patient confusion?
- Did you incorporate the input of the following groups to ensure that the words and symbols you use are appropriate for your patient population?
 - Patients
 - Staff and providers
 - Interpreters and translators
 - Local and national stakeholders, such as leaders from local and national organizations
 - The community

Training Staff on New Signage

- Did you conduct orientations and trainings to help staff become more familiar with the goals of signage and to teach them about the organizational policy on developing new or updated signage?

Evaluating Your Solutions

To ensure that your signage and wayfinding techniques are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to providing signage and wayfinding options? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to providing signage and wayfinding options? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your means of providing signage and wayfinding options? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you come up with specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

Case C–2: Merce Moreno Finds Her Way at the Hospital

(NOTE: This case continues from Case 1–2: Merce Moreno’s Upset Stomach)

Merce Moreno:

- Doctor strongly suspects appendicitis
- Patient sent to hospital emergency department to confirm diagnosis and prepare for possible appendectomy
- Through online registration system at community health center, patient was preregistered at hospital; hospital was aware that patient needed interpreter services

Patient’s Story

Merce slumped in the back seat of the car while her dad drove into the hospital parking lot. From a small kiosk, a parking attendant stopped the car and asked, in English, where they were headed. Merce raised her head and explained that she might need to have her appendix removed and that the doctor had sent her to the emergency room. The guard pointed, “Park over there so you don’t have to walk so far. Go in through the main door, and the information desk will be right in front of you, in the center of the lobby. Let them know if you need a wheelchair.”

At the information desk, the clerk pointed to a small book with tabs on each page. Each tab listed a language. Merce’s mother turned to the Spanish tab to show a card that said, in Spanish, “I speak Spanish.” The clerk asked, in passable Spanish, “What is the patient’s name?” She obtained the necessary papers, in Spanish, and Merce’s father signed them. The clerk gave them a small card to take with them, which also said, “I speak Spanish.” Then she showed them another card with a picture of someone sitting in a wheelchair. She gestured that they could help themselves to one of the wheelchairs at the back of the lobby if they needed one. Shortly, Merce was called. An interpreter worked with the medical team and stayed with Merce when the surgeon sent her upstairs for an appendectomy.

The clerk at the information desk gave Merce’s parents a hospital map written in Spanish, drew an “X” to represent where they were standing, then traced their path to get to the third floor surgery reception area. She smiled warmly at them, and promised in passable Spanish, “We’ll take good care of your daughter.” Merce’s father suspected that the clerk had learned a few phrases just to work with Spanish patients. The Morenos easily found their way to the surgery reception area with the map and the Spanish signs posted on the walls. At the reception area, a nurse told the Morenos, in Spanish, that the medical team was preparing Merce for surgery. She told Merce’s parents that there would be a wait and encouraged them to get something to eat. She took their map and traced a path to the cafeteria, explaining that the menu items were listed in English and Spanish. The Morenos felt that Merce was in good hands and went to find the cafeteria.

Patient's Perspective

“I felt safe for the first time in a few days. The hospital was so big and I worried whether we’d be able to find the right place to go. It was so nice that the parking lot attendant knew where to send us, and that he was considerate enough to think that it would be hard for me to walk a long way. My parents said that those cards that said, “I speak Spanish,” plus the hospital map and the Spanish signs, helped them to feel like they were helping me through this, rather than depending on me. Even though her accent was terrible, we all really appreciated that the admissions clerk spoke a few important phrases in Spanish. I felt like I wanted to run when the doctor said I had to go to the hospital, but I feel comfortable here. Having surgery still scares me, but this place isn’t as bad as I imagined it.”

Provider's Perspective

Hospital administrator: “Mercede Moreno’s case is a good example of how I want this hospital to run. She and her family had the support they needed at every stage of their healthcare experience, to ensure that they received effective, understandable, and respectful care. This kind of care occurred from the moment they entered the hospital campus to the time they left. Ensuring the kind of care we want isn’t just about interpreting or translating language, either. We want every staff member to treat patients with kindness, openness, and acceptance. In the Mercede Moreno case, I think we did a good job.”

Resource Unit C: Insights From the Cases for Healthcare Organizations

Posting meaningful signage and otherwise helping patients to find their way within a healthcare organization demonstrates consumer friendliness and helps LEP patients and their families feel more comfortable in a stressful situation. In addition, signage may help patients receive timely care in emergency situations. In the case of Paulina Quesada, the patient suffered pain and risked potentially dangerous complications to her emergency condition while she wandered the hospital looking for treatment. Not only was the situation difficult for the patient, it was also a risk to the hospital. The hospital had accepted the patient for treatment, but had not provided appropriate assistance to ensure that the patient could find her way to receive the treatment. In the end, busy staff from other departments had to tend to the patient, and she did not receive timely care for an emergency condition. Staff time was not used most effectively, and the hospital risked liability. In contrast, in the case of Mercede Moreno, the patient and her family had correct instructions for finding their way from the parking lot straight through to the surgery department. The patient was treated in a timely manner and did not risk the complications of having to wait unnecessarily for emergency medical attention.

Resource Unit D: Notice of Language Access Services to LEP Patients

Discussion Topics

- Importance of Providing Notification of LAS to LEP Patients
- Determining the Content of Notices
- Determining Languages in Which To Provide Notice
- Deciding How and Where To Provide Notice to LEP Individuals
 - Signage, Brochures, and Tools
 - Cultural Mediation
 - Community Outreach
 - Telephone Communication and Voicemail
 - Non-English Media
- Training Staff on LAS Notification

Resource Unit D describes issues for consideration as you plan to provide notice of language access services (LAS) to your limited English proficient (LEP) population. The discussion on planning is followed by a section on implementation, which includes a checklist of items to review as you implement the activities described in the resource unit. The unit concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to provide notice of LAS to your LEP population.

The planning section in Resource Unit D explains the importance of providing notification of LAS to LEP patients and provides guidance on determining the content for notice of LAS to LEP individuals, as well as the languages in which to provide the notice. Next, the resource unit walks you through deciding how and where to provide the notice to LEP patients. Lastly, the resource unit provides information on training staff on LAS notification.

This resource unit describes two cases, one that demonstrates an organization at an earlier stage of implementing LAS and one that demonstrates an organization further along in the process. Each case also includes patient and provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

A 34-year-old Ethiopian man receives medical attention twice for a sinus infection. In the first encounter (Case D–1), the patient sees the doctor without an interpreter because the patient is not aware that interpretation services are available to him. Because he cannot understand either the doctor’s or the pharmacist’s instructions, the patient takes his medication incorrectly and his infection does not heal. In his second encounter (Case D–2), the patient seeks treatment in a facility that provides interpretation services. He receives care and instructions that cure his infection.

Resource Unit D: Patient's Profile

Araya Kutre:

- 34-year-old Ethiopian man
- Living in United States for 4 years
- Speaks English poorly
- Works in small factory that provides minimal health insurance
- Normally quite healthy
- Has been home from work for 2 days with sinus pain and severe headache; sister has convinced him to go to the community clinic

Case D-1: Araya Kutre's Trip to the Doctor (Community Health Clinic)

Patient's Story

Several minority populations were growing rapidly in the small town where Araya Kutre lived, and the community health clinic had been struggling to keep up with the demand for services. Mr. Kutre called to see the doctor, and the receptionist worked him in for a late afternoon appointment the following day. Mr. Kutre had not been to the clinic before and was surprised to see a "Patient's Bill of Rights" posted in the waiting room, written in several languages, including Amharic (the Ethiopian language). The document stated that patients could have an interpreter. He asked the receptionist if his insurance covered interpretation services. She replied that it did not, and then said, "It doesn't really matter anyway. The volunteer interpreters aren't available this late in the day. And, besides, we only have one who speaks Ethiopian, and she's usually too busy." Mr. Kutre wondered why they announced the services if they were not really available.

Communicating as best they could, Mr. Kutre described his symptoms and the doctor diagnosed a sinus infection and provided a prescription for antibiotics. Mr. Kutre understood that he was to take medicine, but did not understand the doctor's instructions about how to take it. He tried to read the words on the prescription, but it looked like the doctor had written in a foreign language, with a few undecipherable words and symbols. When he checked out of the office, Mr. Kutre showed the prescription to the receptionist and asked, "How many do I take?" She told him that the pharmacist would explain everything to him. At the pharmacy, it took Mr. Kutre several attempts before he believed that he understood how to take the medication. The instructions were that Mr. Kutre should take two pills a day for 10 days. He understood that he should take one a day, and stopped taking them as soon as he started to feel better.

Patient's Perspective

“Why would they mention interpreter services, then not really have them available? I still am not sure that I understand how to take my medicine. It seems to me that insurance companies would want to pay for interpreter services so that patients would know what to do. It’s the immigrants who need interpreters, and most of us are too poor to pay for them. None of it makes sense to me. But I do know this: It’s not just the doctor’s office where we need interpretation. What about the pharmacy? Even if I understand what the doctor says is wrong with me, I still have no idea how to take the medicine.”

Provider's Perspective

Doctor: “I’m glad this wasn’t something serious. I’m not sure if he understood what I was telling him, but at least I’m pretty sure that his condition will improve with antibiotics. When we first started using interpreters, I thought it was time-consuming and too expensive. Even now, we avoid advertising that we offer free interpreter services. Now that I’m used to interpreters, though, I realize practicing medicine without them is much more difficult, and maybe even more costly, both for us and for the patients.”

Pharmacist: “I always worry about my patients who don’t speak English well. Did Mr. Kutre really understand me? If not, he’ll get worse, or at least not get better. And, what are the consequences for me if he doesn’t understand? Not only is there a professional liability, but it really disturbs my professional ethics to think that I may be treating a patient incorrectly because he doesn’t understand what I’m telling him.”

This resource unit will walk you through deciding on methods for providing notice of language access services to LEP patients. The resource unit first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to provide notice of LAS to LEP patients.

Planning

In this section on planning, you will read an overview on the importance of providing notification of language access services to LEP patients. Next, it provides guidance on determining the content for notice of LAS to LEP patients, as well as the languages in which to provide the notice. Then the resource unit walks you through deciding how and where to provide notice to LEP patients. This includes methods such as signage, brochures, and tools; cultural mediation; community outreach; telephone communication and voicemail; and

non-English media. Lastly, the resource unit provides information on training staff on LAS notification.

Importance of Providing Notification of LAS to LEP Patients

Notifying LEP patients about the provision of LAS is a very important process, as many LEP patients go through the healthcare experience without ever knowing that free language assistance is available to them.¹² Proactively notifying LEP patients of available LAS not only helps patients better utilize your organization's services, but also helps them learn to be more informed consumers of health care, as they are able to more efficiently move through your organization and the healthcare system in general.

In addition, when LEP patients are empowered with the tools necessary to take advantage of LAS, your organization has less to worry about in regard to legal ramifications from misinterpretation between provider and patient, which could potentially lead to malpractice. Without being aware of available LAS, such as interpretation, LEP patients are unable to truly provide an informed consent or play an active role in their own health decisions. However, when LEP patients take full advantage of LAS, they are able to more clearly communicate their health conditions, concerns, and preferences in treatment decisions. Therefore, clear communication means accurate diagnoses, proper treatment, and overall improved health.

Determining the Content of Notices

Notification should describe what LAS are available and to whom they are available. It should also clearly state that LAS are provided by the organization free of charge, when applicable, to LEP patients.

Organizations must provide meaningful access to services when receiving Federal funds, with the exception of certain cases in which providers receive only Medicare Part B payments.³⁸ Therefore, it is helpful to explain to an LEP patient the benefits of using LAS. If the patient refuses the services, you should ask him or her to sign a form that says he or she understands that language assistance is available, and

he or she chooses to decline these services. You should document that the patient has been notified about these rights, as well as the patient's preferences in utilizing LAS, as a precaution in case any issues arise regarding whether certain information was provided to and understood by the patient.¹²

Determining Languages in Which To Provide Notice

Notice of LAS may need to be available in multiple languages. To determine the languages in which to make notification available, your organization can use the information collected in Step 1 (Assessing the Language Needs of Your Patients). In addition, notice of LAS should be developed using simple wording that can be understood at a low literacy level (fourth to sixth grade). For more tips on communicating with LEP patients, refer to Resource Unit A (Interpretation Services) and Resource Unit B (Written Materials).

Deciding How and Where To Provide Notice to LEP Individuals

After implementing LAS at your organization, you can decide how to provide notice of your available services. It is important to provide notice within your organization. You can assess how well established your services are when deciding how to provide notice of available services in the community. For example, in planning efforts to inform the community of your available LAS, make sure that all LAS are firmly set and that staff are fully prepared. It is important to realize that as the awareness about your LAS grows within your community, your organization will need to be prepared for increasing numbers of patients entering the organization and requesting those services. It may be wise to gradually implement services and inform the community, little by little each year as services are fully developed.¹² No matter how you decide to spread the word, it is important to educate the community about what services you have to offer them. Without being notified of the availability of LAS, some patients will not request certain services, because they will be unaware that the services exist or that they have a right to those services. Other patients will continue to refrain from utilizing your organization altogether because they



Providing Meaningful Access to Services³⁸

Organizations receiving Federal funding from sources other than Medicare Part B must provide meaningful access to services. Below is one way of effectively providing notice of services:

- Post a "Patient's Bill of Rights" in the registration area for LEP patients that describes Title VI of the Civil Rights Act of 1964.¹² The sign can include a statement that clearly states, "You have the right to receive free interpretation service in your language. If you would like to receive such services, please inform the front desk."¹⁰
- Provide notice of the patient's right file a complaint with your organization and/or with the Office for Civil Rights (OCR) within the U.S. Department of Health and Human Services. You can provide information on whom to contact within your organization as well as the phone number for the OCR national complaint hotline (1-800-368-1019).

may be under the impression that you cannot meet their needs as LEP individuals.

Multiple strategies can be used to provide notice to LEP individuals. These may include:

- Signs and brochures
- Cultural mediation
- Community outreach
- Telephone communication and voicemail
- Non-English media

Each of these modes is described below.

Signage, Brochures, and Tools

Signage or other written materials can be used to successfully inform literate LEP patients about LAS and their rights to those services. Develop signs and materials in the languages regularly encountered in your patient population, and consider attaching an announcement of available LAS to the front of written materials handed to them.³⁸ For those who may not be literate, information can be conveyed orally or through signage using symbols or pictures.¹⁰ For more tips on signage, refer to Resource Unit C (Signage and Wayfinding).

It can be effective to place notice of LAS in areas of your organization that serve the highest volumes of LEP patients.³⁸ Displaying notice in central and clearly visible areas in your facility is helpful. Good places to display notice of available LAS include:¹⁰

- Points of entry/intake
 - Registration desks
 - Front desks
 - Waiting rooms



Using a Language Globe¹²

One organization developed a tool called the “Language Globe” that is displayed throughout the facility. The Language Globe is a multifaced, globe-shaped figure that says “I need an interpreter” in many languages (with a different language on each face). The tool allows the patient to point to his or her respective language and informs the patient that the organization offers LAS. This also helps staff assess the language needs of each patient.



Notification Through a Video¹²

You can create a video in the languages commonly encountered in your patient populations that helps LEP individuals better understand the healthcare system and how to navigate through it, particularly your organization. The video can be distributed among various mutual assistance programs for recent immigrant groups and to other community and social service agencies in the area.

- Financial screening rooms, where LEP patients may need to discuss and resolve billing issues
- Pharmacy reception, where LEP patients may pick up prescriptions
- Areas where clinical work is performed, such as triage and medical exam rooms

Cultural Mediation

It is important to maintain good communication with LEP patients to ensure that they are aware of available LAS and how to access them. A creative way of achieving this is by developing a cultural mediation program. A cultural mediator can act as a liaison between the culture of your health organization and the culture of the patient's family. Your organization can use programs such as these to educate LEP patients on how to enter and navigate through the organization and better utilize your organizational services. Options for the program include:

- Verbally informing patients of their right to request an interpreter and providing patients with flash cards in their primary language that say "I need an interpreter."¹³
- Explaining available services to LEP patients and providing them with written translated materials that they can take home and refer to when they have questions. It is important to do this, because general procedures for navigating the healthcare system may contradict cultural norms in health-seeking behavior (e.g., practices related to visiting the emergency room versus setting up appointments at the clinic).¹³
- Assigning representatives from your organization to accompany patients to membership services, help them with application forms, and teach them about the appointment system and how to make appointments.¹³



Sending a New Patient Postcard¹¹

When you send out informational packets to new patients, include a multilingual postcard that informs them about available language access services. New patients can then mail the postcard back to your office, requesting that materials be sent to them in their preferred language.



Helpful Reminder to Staff¹²

Include a check box on intake forms reminding staff to inform patients about LAS.

- Educating patients about your triage service and making patients aware that they do not necessarily need to visit the emergency room for all health issues. If your organization has not traditionally had many LEP patients utilize your triage service, you can focus on specifically educating those families that are already patients.¹²

An additional strategy for notifying LEP individuals through mediation is by developing a health promoters program whose staff train community members to share health and resource information with other community members.⁴⁴

For more information about the development of written materials, please refer to Resource Unit B (Written Materials). For more information on signage, please refer to Resource Unit C (Signage and Wayfinding).

Community Outreach

Providing notification throughout the community is also important for reaching those who may be unaware of your organization or what your organization can offer to them.

Consider sending notification through the following types of organizations:

- Local health departments¹²
- Community-based organizations
- Community churches and other religious organizations
- Schools
- Any other stakeholders who would benefit from having information on health services³⁸

If your organization does not have the resources to support campaigns dedicated to informing the community about your available LAS, concentrate on developing good relations with surrounding community-based organizations, healthcare organizations, and providers so they may refer LEP patients to your organization for LAS.¹²



Spotlight on Spreading the Word¹²

If your organization does not have the financial resources to sponsor efforts to inform the community about your available LAS (such as holding lunches and informational sessions throughout the community dedicated to LAS), take advantage of events held in the community that are sponsored by your organization or other community-based organizations (such as health/cultural fairs) as opportunities for your LAS department to spotlight your available services.

Listed below are a few creative methods for notifying your community about language access services:

- It is helpful to form good relationships with community-based organizations in your area. One way to achieve this is to create a task force coordinated by an external organization, such as a university medical school in a town that does not operate a competing hospital. The external organization can serve as a somewhat neutral center, as opposed to a hospital or other healthcare system. The task force can be a loosely held group with regular monthly meetings and can serve as a great way for various organizations to share information and resources. In turn, the organizations can share the information with their patients.¹²
- It is helpful to form good relationships with surrounding providers, so that they may inform their own patients about the services available at your organization. If your organization has a department dedicated to LAS, ask department staff to speak with providers to make them aware of the department's presence and the services it offers to LEP patients. As physicians need to refer LEP patients, the physicians will be able to tell the patients that language services are available at your organization as well as let your organization know that the patient will require LAS.¹²
- Your organization can also participate in community events, such as cultural, health, and employment fairs. This involvement not only notifies the community of available LAS, but also allows organizations to serve as mentors for others. Mentoring organizations can provide examples of how to use existing resources and guidance for other organizations to create materials tailored to their patient populations.¹²
- Distributing information about your organization's available LAS to local health departments and having materials on display at health departments can be beneficial in reaching much of the population in the community that may be uninsured and/or undocumented. This will not only help the

population learn about services available to them, but will also help your organization gain a better understanding of the LEP population in your service area that may not be documented through available data collection mechanisms, such as the U.S. Census.¹²

For more information on working with your community, refer to Resource Unit E (Community Involvement).

Telephone Communication and Voicemail

It is helpful for your organization to standardize procedures for staff members who serve as the initial point of contact for LEP patients who call your organization to set up an appointment. Staff members can be provided with a script to ensure that they inform LEP patients of their right to LAS and ask whether they will need an interpreter.³⁸

Multilingual phone trees and voicemail could also inform LEP patients of available LAS and how to access them.³⁸

Non-English Media

You can also notify patients of your language access services through non-English media, such as:¹²

- Television
- Newspapers and magazines
- Radio

Training Staff on LAS Notification

Provide training or orientation to staff and providers on available LAS so that they are able to properly inform patients of what your organization has to offer. It is important to encourage providers to educate LEP patients on how to better utilize the LAS available at the organization, because the providers will already have developed a relationship with the patients.¹³

Implementation

Now that you have reviewed planning issues related to this resource unit, you can decide on a plan of action and implement it. You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider the needs of your LEP population (Step 1) and your organization's capabilities (Step 2) when deciding which activities to undertake. You can also use the checklist to monitor, evaluate, and update the activities associated with providing notice of LAS to your LEP population.

Determining the Content of Notice

- Did you provide notice of LAS to your LEP patients?
 - Did you describe what LAS are available and to whom they are available?
 - If applicable, did you clearly state that LAS are provided free of charge to LEP patients?

Determining Languages in Which To Provide Notice

- Did you provide notice of LAS in the appropriate languages?
- Did you provide notice of LAS in simple wording that can be understood by those with low literacy?

Deciding How and Where To Provide Notice to LEP Individuals

- Did you ensure that all LAS are firmly set and that staff are fully prepared for increasing numbers of patients entering the organization and requesting those services?
- Are you utilizing any of the following strategies to provide notice to LEP individuals?
 - Signs and brochures—Did you post notice in any of the following locations?
 - Points of entry/intake
 - Registration desks
 - Front desks
 - Waiting rooms
 - Financial screening rooms
 - Pharmacy reception
 - Areas where clinical work is performed, such as medical exam rooms

- Cultural mediation
- Community outreach
 - Did you develop relationships with and send notice of your LAS to any of the following types of organizations?
 - Local health departments
 - Community-based organizations
 - Community churches and other religious organizations
 - Schools
 - Surrounding healthcare organizations and providers
 - Any other stakeholders who would benefit from having information on health services
 - Did you participate in community events, such as cultural, health, and employment fairs?
- Telephone communication and voicemail
- Non-English media
 - Television
 - Newspapers and magazines
 - Radio
 - Latino Web sites

Training Staff on LAS Notification

- Did you provide training or orientation to staff and providers on available LAS so that they are able to properly inform patients of what your organization has to offer?
- Did you encourage staff and providers to educate patients on how to better utilize the services available at your organization?

Evaluating Your Solutions

To ensure that your means of providing notice of LAS to your LEP population are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to providing notice of LAS to your LEP population? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to providing notice of LAS to your LEP population? What should be revised, improved, or eliminated?

- What recommendations have you come across for improving your means of providing notice of LAS to your LEP population? Which of these recommendations should be implemented?

- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you come up with specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

Case D-2: Araya Kutre's Trip to the Doctor (Community Hospital)

Patient's Story

Araya Kutre's sinus infection returned, worse than before, and Mr. Kutre realized that he needed to see the doctor again.

A friend told Mr. Kutre, "The hospital's walk-in clinic is where you want to go. They have better services for Ethiopians." The friend reminded Mr. Kutre about an advertisement for the clinic that appeared periodically in the Ethiopian newspaper. When Mr. Kutre went to the hospital clinic, he saw a "Patient's Bill of Rights" poster, similar to what he had seen in the community health center, but this poster said that the services were free. Mr. Kutre saw the doctor, with Rahel Juma present. Ms. Juma was an Amharic interpreter provided by the hospital free of charge. She helped Mr. Kutre understand that he had taken his medication incorrectly. This time, the doctor asked Mr. Kutre to repeat the dosing instructions so that both were sure that Mr. Kutre understood them.

As he was leaving, Mr. Kutre met up with Ms. Juma and remarked to her how different his experience was at this clinic, versus his encounter at the community health center. As they talked further, Mr. Kutre was surprised to learn that the community health center also provided interpreter services free of charge. But, Ms. Juma explained, "They don't want to pay for the services, so they don't tell anyone that they're free. They also only use one Ethiopian interpreter and don't make an effort to find others if the interpreter isn't available. Now the hospital is getting frustrated because all of the Ethiopian patients are coming here and interpreter services are costing them a fortune." Mr. Kutre asked, "Does the law say they have to provide the services for free?" The interpreter replied, "At most organizations that receive Federal funding, interpreter services are free, and the extent of services that an organization provides is based on an analysis that they have to do."

Mr. Kutre asked about other language services and was again surprised to learn that many clinics were providing patients with documents and educational materials in the patients' own languages and hiring staff that reflected the culture and languages in the patient community. "Think about it," said Ms. Juma, "Wouldn't your life have been a lot easier if the doctor or pharmacist had instructions written in Amharic that explained your problem and how to treat it?" Mr. Kutre thought about the interpreter's words as he went to fill his prescription, confident this time that he knew how to take the medication.

Patient's Perspective

“This experience at the doctor, with an interpreter, was so much better than my experience at the community health clinic. And now, maybe I’ll actually get better. It was great that the clinic provided the interpreter at no cost to me, and that the doctor was so careful that I understood the instructions for the medicine. But it bothers me that the community health center isn’t really publicizing the services it should be offering to the Ethiopian community. Even with the ads in the paper, I’m sure that many people don’t know that they can go to the hospital clinic. They suffer through illnesses without being able to communicate, when there are resources that should be available to provide more effective and understandable care.”

Provider's Perspective

Rahel Juma (interpreter): “As part of the healthcare team, I’m frustrated at stories like Mr. Kutre’s. Both the hospital and clinic could promote their language services more; we have community gatherings often and we could pass out brochures, or someone from the hospital could come and speak. If people just knew that services were available, that could make a big difference in the health and vitality of the Ethiopian community. If the cost is a problem, maybe people in the community could volunteer to interpret for others. All the hospital and clinic would have to do is train them.”

Resource Unit D: Insights From the Cases for Healthcare Organizations

Providing LAS can make a difference in the quality of care and health outcomes of patients, but patients need to be aware of the services, by providing appropriate, visible notices about the availability of the services, which should be available when patients need them. The cases of Araya Kutre demonstrate examples of patients not being notified of available language services and, as a result, assuming that such services are not available. Many patients do not know about language services unless healthcare organizations clearly state that they provide such services. In Mr. Kutre’s case, not knowing that language services were available led him to a medical encounter without an interpreter. He then misunderstood the instructions for taking antibiotics. Not only did the misunderstanding lead to a recurrence of Mr. Kutre’s condition, but it also may have contributed to the larger public health problem of antibiotics becoming less effective through continued improper use. In addition, the community health clinic could have been held liable for medical error.

Resource Unit E: Community Involvement

Discussion Topics

- The Importance of Reaching Out To the Community
- Deciding How To Use Community Input at Your Organization
- Building and Maintaining Trust in the Community
- Deciding Whom To Involve in Community Outreach
- Deciding On Methods for Effectively Reaching the Community
 - Notifying LEP Patients of Language Access Services
- Deciding How To Collaborate With Community Organizations

Resource Unit E discusses ways to involve the community in implementation of language access services (LAS). This resource unit describes issues for consideration as you plan to implement strategies for community involvement. The discussion on planning is followed by a section on implementation, which includes a checklist of items to review as you implement the activities described in the resource unit. The resource unit concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to involve the community.

The planning section in Resource Unit E first explains the importance of reaching the community. The resource unit then provides information on deciding how to use community input at your organization. After providing tips on building trust in the community, the resource unit helps you decide whom to involve in community outreach. Next, you are presented with methods for effectively reaching the community. Lastly, the resource unit walks you through deciding how to collaborate with community organizations.

This resource unit describes two cases, one that demonstrates an organization at an earlier stage of implementing LAS and one that demonstrates an organization further along in the process. Each case also includes patient and provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

The cases in this resource unit are a continuation of Cases D–1 and D–2 in Resource Unit D (Notice of Language Access Services to LEP Patients). Two leaders of the Ethiopian community offer to partner with local healthcare organizations to improve LAS. Directors of the healthcare organizations initially refuse the Ethiopians’ offer. Later, when a near-tragedy occurs because a child’s family was not offered appropriate LAS, the Ethiopian community and healthcare organizations decide to work together.

Resource Unit E: Community Members' Profiles

(NOTE: This case continues from Case D–2: Araya Kutre's Trip to the Doctor)

Araya Kutre:

- Recently learned the advantages of having an interpreter present at a doctor visit
- Wants to obtain language services for others in the Ethiopian population

Rahel Juma:

- 27-year-old woman, born in America to Ethiopian parents
- Speaks Amharic and English fluently
- Trained as medical interpreter with a master's degree in public health
- Helping Araya Kutre obtain language services for the Ethiopian community

Case E–1: Araya Kutre and Rahel Juma Offer the Community's Help

Community Members' Stories

Araya Kutre had been spreading the word about the availability of health-related language services to the Ethiopian community. He urged friends and neighbors to ask for services at the community health clinic, the hospital, the pharmacy, and their doctors' offices. Rahel Juma spoke at a community meeting. She asked those at the meeting to let her know their experiences when they asked for interpreter services, and she kept a log of those who did and did not receive the services they requested. So many called her to interpret for them that she could no longer manage the workload.

Ms. Juma and Mr. Kutre met with representatives from the hospital and the community health center to articulate the health and language services needs of the Ethiopian population. The needs were great, but, at the same time, as Mr. Kutre explained, the community offered resources that could help. "Now," he said, "physicians think we won't follow directions, when the problem is really that we don't understand them. Our better understanding and following instructions could make physician's practices easier."

Mr. Kutre and Ms. Juma had carefully prepared their presentation, and they discussed many options for ways that the Ethiopian community could work with the hospital and clinic, ranging from sponsoring health fairs to providing translation or interpreter services for others in the community. "We could even have volunteers at the hospital," said Ms. Juma, "to help people get registered and find their way around." Mr. Kutre and Ms. Juma concluded their presentation with an offer to provide the resources that they could, if the hospital and clinic would do the same. The hospital and clinic representatives at the meeting listened politely and said that they would consider the offer over the next several months. Ms. Juma and Mr. Kutre understood that their offer was being politely refused.

Community Members' Perspectives

Ayara Kutre: “How disappointed we are. The more we learn about our community’s needs and resources, the more we understand the advantages of building a partnership with the hospital and the community health center. I know they only listened to our presentation because Rahel is a health professional and knows many of the members of the medical community in town. They never really intended to work with us. It’s a shame, because Ethiopians are happy to share the burden of the sick in our community.”

Rahel Juma: “I’ve learned a great deal about how to create community partnerships and how well they can work to everyone’s advantage. We have so much useful information that we’ve obtained from the Ethiopian community about their experiences and insights into the health system. It’s not even like the hospital or clinic would have to invest a lot in patient data collection. And we’re offering to do more of the work. It seems like they just don’t want to work with the Ethiopian people.”

Provider’s Perspective

Hospital administrator: “The Ethiopians made a good presentation, but they just don’t understand what’s involved here. Who would coordinate all of the volunteers? How could we be sure that they’re trained? What would the training cost? Who would deliver it? Community partnerships may seem like a great idea, but to me it just looks like a lot of work for providers with very little gain. I’d have to understand more about what the partnership could offer, how we could manage it, and what the advantages and disadvantages for everyone would be. At the moment, there just doesn’t seem to be enough reason to take this on. We’re so busy already!”

This resource unit will walk you through ways to involve the community in language access services implementation. The resource unit first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to involve the community in LAS implementation.

Planning

In this section on planning, you will read an overview on the importance of reaching the community. The resource unit then provides information on deciding how to use community input at your organization. After providing tips on building trust in the community, the resource unit helps you decide whom to involve in community outreach. Next, you are presented with methods for effectively reaching the community, which includes notifying limited English proficient (LEP) patients of language access services. Lastly, the

resource unit walks you through deciding how to collaborate with community organizations.

The Importance of Reaching Out To the Community

Your organization can connect with its community by reaching out to individuals and by connecting with community organizations in your area.

There are a number of benefits to connecting with individuals in the community, which will help you better serve your LEP populations. These benefits include:

- Learning about what populations live in your service area
- Gaining a better understanding of community needs
- Learning what LAS are needed and how to improve existing services
- Discovering more effective methods for notifying LEP individuals of services
- Building a sense of trust between your organization and the local community

Community outreach can help your organization gain a greater understanding of your patient populations and how to better serve them. By developing your LAS around the needs of your patients, the patients will be able to move through your organization with greater ease, utilizing services and resources that they may not have been aware of or comfortable using otherwise. This not only makes the healthcare experience more pleasant for the patients, but also makes the experience more pleasant for your organization, as time, staff, and resources are more efficiently used.

Developing your services to meet the needs of the community you serve is critical to developing effective language access services. It is important to reach out into the LEP community and build a strong relationship with your patients. Rather than depending on LEP individuals to approach you with ideas for making LAS

“There is a difference between relaying a message and connecting with the community—they don’t want to be told about their problem, they need someone who understands and can help.”

—Community health specialist with experience implementing LAS

more patient centered, there are a number of ways in which you can reach out to the community and provide its members with opportunities to contribute their input and guidance.

Likewise, connecting and collaborating with community organizations, including other provider organizations, in your area offers advantages. For example, your organization can benefit from:

- Reciprocated alliances
- Coordination of language services
- Savings in cost-sharing of resources (such as sharing translated materials and interpretation services across organizations)

Reaching individuals in the community is discussed in this step, followed by a discussion of connecting with community organizations in your area.

Deciding How To Use Community Input at Your Organization

In creating a plan for community outreach, first determine how community input can benefit your organization. Think about the benefits described above as you consider which outreach activities might be feasible for your organization. Then, decide on the procedures to implement to effectively connect with your community. Steps to do so are described below, including:

- Building and maintaining trust in the community
- Deciding whom to involve in community outreach
- Deciding on methods for effectively reaching the community
- Deciding how to collaborate with community organizations

Building and Maintaining Trust in the Community

To recruit individuals from the community to participate in your organization's activities, it is important to develop positive rapport within the community. Forming community partnerships means building trusting and long-lasting relationships within the community. This is a delicate process that can provide you with a deeper understanding of the inner workings of your community.

If you are working on developing your first partnerships, start by engaging the organized ethnic communities, because they will be easier to access. You can develop relationships with less prominent communities after you have established relationships with the larger communities. When first introducing your organization to community groups, realize that it is not uncommon for them to initially receive you with some negativity as community members express frustrations with their experiences with health care. In cases such as these, it is advantageous to be as welcoming as possible, to listen in a nondefensive manner, to solicit suggestions for improvement, and to continue to meet with the groups and make contacts. As the group members see that you are there to learn from them, relationships will grow and trust will develop.⁸⁵

It is especially important to reach out to LEP patients who may face acculturation and immigration challenges that inhibit their ability to voice their concerns and opinions. Some of these challenges include:⁸⁶

- Undocumented immigration status
- Low-paying and unstable jobs
- Racism and prejudices
- Existing social and political divisions within the community

Understanding how these challenges affect an LEP individual's interaction with the healthcare system is critical in developing LAS that allow LEP individuals

“They’re helping us with cultural competency, and we’re helping them with services. The needs are mutual.”

—Physician commenting on working with a local Punjabi group

to feel comfortable and fully utilize what your organization has to offer.

It is also important to remember that those conducting community outreach represent your organization and are a reflection of the services that your organization provides.⁸⁶

Gaining trust in the community is just a stepping stone to community involvement. As you build trust within your community, it is advantageous to follow through with commitments and strengthen relationships to maintain trust. In addition to involving the community during the developmental stages of LAS, you can help maintain trust with community members by updating them on the progress of your LAS implementation. No matter what policies or procedures your organization decides upon regarding LAS, it is always important to interact with the community and incorporate its members' input whenever possible.¹² This will demonstrate to community members that your organization is sincerely interested in their ideas.

Deciding Whom To Involve in Community Outreach

The next step in creating a plan for community outreach involves determining who will be responsible for the coordination of outreach. Depending on the infrastructure of your organization, you may choose to designate certain staff members to be in charge of community outreach efforts, or you may choose to set up a committee or advisory board to manage the task.

It is helpful to enlist leadership support from management, providers, and staff within your organization who are members of the surrounding community, specifically those who are familiar and comfortable with your service area and patient population. This could include:¹³

- Interpreters and translators
- Case workers
- Social workers



Community Outreach as a Strategic Goal¹²

If your organization is just starting out or going through a strategic planning process, think about including community outreach in your goals and objectives so that your organization operates around the needs of your community. This will help your organization become more patient centered, as well as help ensure that your organization's strategic plan is supported by your LEP community.

- Office managers
- Health educators
- Patient advocates/navigators
- Providers

If you have limited resources, you may prefer working with your volunteer department to identify individuals already lending their time who might be interested in helping with community outreach. You could also develop methods for reaching out to former LEP patients, many of whom might be grateful for the services your organization provided to them and interested in giving back to the organization.⁴⁹

Deciding on Methods for Effectively Reaching the Community

You may consider conducting assessment surveys, interviews, focus groups, or some combination of the three with individuals from the community. In determining where to focus your efforts to build community relations and recruit individuals for surveys, interviews, and focus groups, think about the following key questions.⁸⁷

- How can you forge an alliance or partnership that is meaningful?
- Through what means can you best reach your community members?
- What is the history of population and migration patterns here in the United States and in your LEP population's country of origin?
- Who are the community's leaders? (Community leaders may not necessarily hold formal positions as leaders.) What is the structure of the community?



Ways To Enhance Community Outreach⁵³

Below are ways that your organization can enhance its community outreach efforts:

- Utilize diverse staff to conduct outreach.
- Utilize staff who are community leaders, community health workers, or already connected to the community in some way.
- Collaborate with community leaders and other community-based organizations that work with LEP populations in the area, such as schools, churches, community centers, and refugee organizations.
- Establish or serve on community advisory boards.



Incorporate LAS Within Existing Community Outreach

If your organization is already conducting outreach activities, consider incorporating a component on LAS.

- What grassroots community-based organizations and institutions exist in your community?
 - Who are the key contacts and leaders within each organization?
 - What is the mission of each of these community-based organizations?

Consider developing a community outreach strategy that is specific, culturally appropriate, and implemented throughout your organization to ensure that all departments are working in the same direction. Factors to think about include:

- Materials to be used
 - Presentations
 - Flyers
 - Brochures
- Content of the materials
 - Information about your organization
 - Available LAS
 - Health education topics
- Languages to be used
- Community events to target
 - Health fairs
 - Cultural fairs and festivals
- Media to be used
 - Ethnic radio and television programs

Five Principles of Cultural Competence in Community Partnerships⁸⁸

1. Listen for community concerns.
2. Understand community values.
3. Learn cultural perspectives (beliefs) on health problems.
4. Recognize institutional and geographic expressions of concerns, values, and beliefs.
5. Identify and partner with respected and neutral community leaders.



Get To Know Your Community¹²

Encourage your staff members to volunteer at community organizations to become more familiar with your patient population.

- Locations to target
 - Churches and other religious organizations
 - Grocery stores
 - Free food resources
 - Housing organizations
 - Immigrant and refugee community organizations
 - Adult education and English as a second language (ESL) classes
 - Social centers, such as family associations and social clubs
 - Senior centers
 - Hair salons
 - Laundromats
 - Bus stops
 - Locally owned stores that serve specific populations, such as grocery stores that sell products from specific countries

If you choose to create a committee or advisory board dedicated to the task of handling community outreach, you may want to consider including:⁸⁵

- Internal staff and providers
- Community leaders and advocates
- Representatives of community-based organizations
- LEP patients



Attracting Survey, Interview, or Focus Group Participants¹²

One way to attract participants is to schedule the interviews and focus groups at places and times that are convenient for them. For example, you can conduct interviews/groups after regularly scheduled religious services, such as church or temple.

If you wish to invite LEP patients to join the committee or advisory board but are not sure how to do so, you may consider the following options:

- Ask your providers to recommend LEP patients who may be interested and request permission from the providers to contact the individuals.
- Check with staff members who may live in the local community to see whether they have friends and neighbors who may be interested in joining the committee or advisory board.
- Ask community-based organizations to recommend members who may be interested in serving on the committee or advisory board.

After receiving these recommendations, you can send the LEP individuals a letter and contact them by phone to extend the invitation. If you have the resources, you may choose to offer the LEP individuals a stipend for their contributions as a committee or board member.⁸⁵

Another way to incorporate the input of your LEP patients is to invite them to general organizational meetings. You can invite patients and community members to attend these general meetings and offer them opportunities to discuss their concerns and recommendations during the meetings.⁴⁹ It would be advantageous to ensure the presence of interpreters at the meetings to help LEP patients actively participate. If you have the resources to do so, you can offer patients headsets for simultaneous interpretation—routing the discussion to interpreters who translate the meeting proceedings into the patients’ preferred languages. (Thus the patients hear the meeting proceedings in their language via the headsets.)

Notifying LEP Patients of Language Access Services

When sending representatives into the community to introduce your organization and build trust within the community, you can also use this opportunity to notify LEP individuals about the available LAS your organization has to offer them. For more information on



Extend an Invitation¹²

Host lunches periodically to invite community leaders and LEP individuals to voice their concerns and interests in your organization’s activities.

this topic, refer to Resource Unit D (Notice of Language Access Services to LEP Patients).

Deciding How To Collaborate With Community Organizations

An effective way of connecting with your community is through partnerships with community-based organizations.

Building relationships within your community does not necessarily mean starting new relationships. Think about the relationships your organization has already established and how those relationships can be expended to facilitate LAS.¹²

Partnerships not only help your organization build a stronger connection to your community, but also serve as a cost-effective means to running your business. Try to think of ways to combine and share resources with surrounding organizations. For example, you could partner with another community health organization to hire one or multiple full-time interpreters, which could be more cost effective than telephone interpretation.¹³

When partnering in the community, seek to build partnerships and strategic alliances that are mutually beneficial.⁸⁷ It is not necessary to build all partnerships simultaneously, as establishing multiple solid ties throughout the community is a long-term process.

Organizations to consider collaboration with include:

- Public health departments
- Refugee settlement agencies
- Local YMCAs
- Chambers of commerce
- Ethnic and minority associations and organizations
- Faith-based organizations

It is helpful to collaborate with organizations at various levels, including:

- Making presentations at general meetings held by community-based organizations
- Serving on boards of community-based organizations
- Contributing to community-based grant proposals, or submitting joint proposals with community-based organizations to foundations or Government agencies¹³
- Following up with other providers to see what LAS are provided to LEP community members at other healthcare organizations¹³

When collaborating with other organizations in your community, consider the following:

- Try to understand the priorities and motivations of community-based organizations.⁸⁷
- Be aware of the time and resource constraints faced by community-based organizations. Be conscious of the potential for overburdening.
- When partnering with an organization, develop a contract that reflects co-equity and clearly lays out each organization's role and responsibilities. This can ensure that both entities have a clear understanding of the intentions behind developing the partnership.

Implementation

Now that you have reviewed planning issues related to this resource unit, you can decide on a plan of action and implement it. You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider the needs of your LEP population (Step 1) and your organization's capabilities (Step 2) when deciding which activities to undertake. You can also use the checklist to monitor, evaluate, and update the activities you implement associated with involving the community in LAS.

Deciding How To Use Community Input at Your Organization

- Did you decide on a process for involving the community in LAS implementation?

Building and Maintaining Trust in the Community

- Did you develop positive rapport within in the community?
 - Did you develop partnerships within your community?
 - Did you reach out to LEP patients who may face acculturation and immigration challenges that inhibit their ability to voice their concerns and opinions?
 - Did you follow through with commitments you made to the community?

Deciding Whom To Involve in Community Outreach

- Did you designate an individual or group of individuals to be in charge of community outreach efforts?
 - Did you enlist leadership support from management, providers, and staff within your organization who are members of the surrounding community and are familiar and comfortable with your service area and patient population, such as:
 - Interpreters and translators
 - Case workers
 - Social workers
 - Office managers
 - Health educators
 - Patient advocates/navigators
 - Providers
 - Volunteers

Deciding on Methods for Effectively Reaching the Community

- Did you incorporate a component on LAS within your existing community outreach activities?
- Did you develop a community outreach strategy that is specific, culturally appropriate, and implemented throughout your organization to ensure that all departments are working in the same direction?
- Did you identify community-based organizations that exist in your community?
 - Did you choose to work with organizations that share similar or complimentary goals?
- Did you identify leaders in your community?
 - Did you choose to work with community leaders who share similar or complimentary goals?

- Did you conduct any of the following with individuals from the community?
 - Assessment surveys
 - Interviews
 - Focus groups

- When conducting community outreach, did you consider any of the following factors?
 - Materials to be used
 - Content of materials
 - Languages to be used
 - Community events to target
 - Media to be used
 - Locations to target

- Did you include the input on your community outreach efforts from any of the following members of the community?
 - Community leaders and advocates
 - Representatives of community-based organizations
 - LEP patients

Deciding How To Collaborate With Community Organizations

- Did you expand existing relationships with community-based organizations to facilitate LAS?

 - Did you develop new relationships with community-based organizations to facilitate LAS?

 - Did you implement ways to combine and share resources through partnerships?

 - Did you establish partnerships that are mutually beneficial for all parties involved?

 - Did you collaborate with any of the following organizations?
 - Public health departments
 - Refugee settlement agencies
 - Local YMCAs
 - Chambers of commerce
 - Ethnic and minority associations and organizations
 - Faith-based organizations

 - Did you collaborate with organizations at various levels?

 - When collaborating with other organizations in the community, did you consider any of the following?
 - Understanding the priorities and motivations of community-based organizations
 - Being aware of the time and resource constraints faced by community-based organizations
 - Developing a contract that reflects co-equity and clearly lays out each organization's role and responsibilities
-

Evaluating Your Solutions

To ensure that your means of involving the community in LAS implementation are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to involving the community in LAS implementation? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to involving the community in LAS implementation? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your means of involving the community in LAS implementation? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you come up with specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

Case E–2: Six Months Later, the Partnership Begins

Araya Kutre and Rahel Juma:

- Attempted to develop partnerships with local healthcare organizations to provide language services
- Local hospital and community health center rebuffed their efforts
- Six months later, the healthcare organizations want to develop a partnership

Community Members' Stories

Araya Kutre and Rahel Juma often commiserated that it would take a tragedy before the hospital and community health center would work in partnership with the Ethiopian community. They were right. A young Ethiopian boy almost died in the hospital emergency room after a health center physician and the boy's mother miscommunicated about his symptoms and treatment. The mother had not understood the physician's question about allergies to medications, and the physician ordered penicillin. The pharmacist filled the prescription and labeled it with English labels, which the boy's family could not read.

Tragically, the boy had barely survived the first dose. The Ethiopian community was enraged that the boy was treated in the physician's office and in the emergency room without an interpreter. The news had made the mainstream media, and the hospital, health center, and pharmacy were targets of scathing editorials.

It was not long before Mr. Kutre and Ms. Juma were invited to a meeting at the hospital. This time, representatives from the hospital, community health center, pharmacy, several physicians' offices, and other healthcare organizations were in attendance and listening closely. The hospital representative explained that this group was an established partnership between local healthcare providers, and that they had agreed to invite members of the Ethiopian community to join them.

Ms. Juma enumerated advantages to everyone of inviting the Ethiopians to the partnership and suggested that the group explore options for increasing community involvement. She gave such examples as establishing patient advisory committees and including members of the Ethiopian community (and other minority communities) on the organizations' boards. She suggested that both the organizations and the Ethiopian community could conduct research to determine community needs and identify resources for meeting the needs, adding that shared resources would also come from the community, not just from the healthcare organizations. She finished with a reminder that addressing immediate language services needs, such as interpretation and patient education materials, should be made a top priority. Mr. Kutre offered community help with testing documents and forms, and said that they had already begun assessing additional needs. The group officially invited Mr. Kutre and Ms. Juma into the partnership, and asked them to make a presentation about the healthcare needs of the Ethiopian population at the next meeting.

Community Members' Perspectives

Araya Kutre: “Finally, we have made some progress! It is sad that it took a near tragedy to form this partnership. We can provide a share of what is needed with the resources in the community so that the entire burden of the Ethiopian people’s health does not fall on the providers. They can give resources too, which seems fair, since we pay for services like everyone else. The key is that now we can work together to leverage all of the resources for everyone’s benefit.”

Rahel Juma: “Now the Ethiopian people will have the services they need, and I will not feel responsible for providing all of them. There is still a great deal of work to do, but the largest obstacle is overcome. We have agreed to work together, determine needs, establish priorities, and make the commitment to providing language services. I’m not naïve enough to think that it will be easy, but I do think that we can avoid another tragedy, and that will make every ounce of effort worthwhile.”

Provider's Perspective

Hospital administrator: “I think we learned that waiting for an event to force us into a community partnership is a bad idea. Although we considered the costs of working in partnership with the Ethiopians, we did not consider the benefits, either to the healthcare organizations or to the patients. Almost losing that little boy made it very clear that the partnership is important. All it really takes is a little willingness from everyone to work together and a commitment to the patient population that we’re trying to serve.”

Resource Unit E: Insights From the Cases for Healthcare Organizations

Involving the community in LAS is a necessary component of providing effective LAS and has advantages for providers, administrators, healthcare organizations, and patients. In the cases profiled in this resource unit, the hospital and other healthcare organizations realized the importance of involving the community in providing language services. Not only did the community have the power to affect the hospital’s reputation (when the hospital made a medical mistake based on miscommunication with an LEP patient), but the community also had the power to assist in restoring the hospital’s reputation. The community could also offer data, language assistance, or cultural insights that might otherwise cost the hospital significant resources to obtain. When the hospital needed, for the sake of its reputation and the safety of its patients, to offer language services, it realized that partnering with the community could provide benefits that the hospital could not accrue on its own. The partnership also accrued benefits to the community, by ensuring that its members received high-quality health care in an appropriate cultural context with effective language services.

Resource Unit F: Written Language Assistance Plans

Discussion Topics

- An Overview of the Language Assistance Plan
- Benefits of a Written Plan
- Drafting a Language Assistance Plan
- Operationalizing a Language Assistance Plan

Now that you have learned about assessing your patients' needs and your organizational capabilities, as well as the various components of language access services (LAS), you can develop a written language assistance plan (LAP). This resource unit describes issues for consideration as you plan to implement an LAP. The section on planning is followed by a discussion of implementation issues, including a checklist of items to review as you implement the activities described in the step. The resource unit concludes with questions to consider as you monitor, evaluate, and update the solutions you came up with to develop and operationalize a written LAP.

The planning section in Resource Unit F provides an overview of language assistance plans, followed by a discussion of the benefits of a written plan. It then provides a framework for drafting a plan. Next, it discusses tips for operationalizing the LAP. The discussion on planning concludes with questions to consider as you monitor, evaluate, and update your LAP over time.

This resource unit describes two cases, one that demonstrates an organization at an earlier stage of implementing LAS and one that demonstrates an organization further along in the process. Each case also includes patient and provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

As she progresses through her pregnancy, a 28-year-old Colombian woman receives health care in a community clinic that is implementing LAS. Initially the language assistance is ad hoc and incomplete, resulting in confusion for the patient (Case F-1). At her next visit, she learns that the clinic wants to develop a more comprehensive and integrated language assistance plan (Case F-2).

Resource Unit F: Patient's Profile

María Lopez:

- 28-year-old Colombian, entered the United States 3 years earlier on a legal visa
- When visa expired, did not return home
- No health insurance
- Studied English in Colombia; does not speak or understand English well
- 14 weeks pregnant

Case F-1: María Lopez's First Prenatal Visit

Patient's Story

A friend had told María Lopez about a local clinic that advertised health services for the Latino population. The clinic did not make appointments, and Mrs. Lopez wanted to arrive early, so that she could be seen and then go to work. However, signs posted in the clinic's office building were only in English, and Mrs. Lopez lost her way several times before finding the clinic's entrance.

When Mrs. Lopez finally arrived and signed in, there was a long line ahead of her. The receptionist, a young woman who spoke Spanish, gave her some forms to complete. Mrs. Lopez noted that most, but not all, of the forms were in Spanish. "We're still working on some of the translations," said the receptionist, "Let me know if you need help." Printed at the top of several forms was the clinic's mission: "We strive to provide quality health services for all underserved members of the Latino population."

Mrs. Lopez sat in the waiting room, which had a Spanish-language television station playing quietly. She looked for something to read, but the few Spanish-language magazines were already taken. After a very long wait, a nurse interviewed Mrs. Lopez about her visit and gave her reading materials about pregnancy and prenatal care. "I provide Spanish-language materials for all of my patients," the nurse said proudly. Mrs. Lopez found the materials somewhat difficult to follow, because they included phrases and concepts that she was not familiar with, including some Spanish expressions that Colombians did not use. Another problem was that the materials were written from a medical perspective and complicated to read. The materials had also been photocopied so many times that some parts were almost illegible.

The doctor, Heather Lonergan, was a resident, on a rotation at the clinic. Her Spanish was only passable, although she believed that her skills were fluent enough to conduct the medical interview. When the doctor struggled with the language, the nurse tried to help with interpreting. The doctor also gave Mrs. Lopez pamphlets, in Spanish, about pregnancy and childbirth. The materials were quite different from those the nurse had provided earlier, and Mrs. Lopez was confused about which pamphlets to use.

When Dr. Lonergan asked if she was a U.S. citizen, Mrs. Lopez looked up in fear. She had assumed that a clinic for the city's Latino population would not ask such a question. The nurse gave the doctor a glaring look and said firmly, "That's not information we collect here." The doctor asked Mrs. Lopez why she had not come sooner for prenatal care and insisted that she come back every 2 weeks until the doctor felt confident that Mrs. Lopez was in good health and appropriately preparing for the baby. "That means getting lots of exercise and good food," the doctor explained. "You should try to walk at least a half-hour a day and eat five servings of fresh fruits and vegetables." Finally, the doctor wrote a prescription for special prenatal vitamins that Mrs. Lopez knew she could never afford.

Patient's Perspective

“That was more difficult than I thought it would be for a clinic that serves Latinos. I can see that they’re trying, but everything seems so scattered, like there’s no real plan. There were no signs to direct me to the clinic once I got to the office building. I was late because I couldn’t find my way, then I had to wait forever to be seen. It was nice that the materials were in Spanish, but they were hard to read and understand, and the doctor and nurse gave me different things. And the doctor asked about my citizenship, even though the nurse made it clear that the clinic didn’t ask those questions! I’m very nervous about coming back here now.

“Then, the doctor talked about exercising and eating fresh fruits and vegetables, and she wants me to come every 2 weeks! That’s \$20 a month for the visits, plus I have to wait so long that it’s a whole day off from work with no pay. And, with a baby coming, I can’t afford luxuries like five servings of fresh fruits and vegetables every day. And, ‘Walk a half-hour a day.’ With no car and sometimes no money for the bus, I would be glad to walk only a half-hour a day! Why couldn’t they have doctors who understand some of our problems?”

Provider's Perspective

Clinic director: “We’ve made such an effort to serve the Latino population. We have regular staff meetings, and every time someone has a good idea, we implement it. We found translated forms that we use for some of our needs, and I’ve told the staff to find resource materials in Spanish, to photocopy and give to patients. We’ve also been getting medical residents on rotation who speak Spanish. That way, we can be sure that the patients are receiving care with appropriate language services. We’ve announced that we serve the Latino population, and the clinic is getting really busy. Some days, though, I wonder if all of our efforts are really improving services. It all seems so scattered. I thought we had a plan, but some days it seems like we’re just running in all directions at once.”

This resource unit will walk you through developing and operationalizing an LAP. The resource unit first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you came up with related to the LAP.

Planning

In this section on planning, you will read about an overview of LAPs, the benefits of a written plan, and ways to think about drafting and operationalizing an LAP.

An Overview of the Language Assistance Plan

To effectively implement LAS, it is important to formulate a course of action that will help your organization accomplish the task. It is also important to

put these guiding principles into a written plan that strategically outlines goals, objectives, means for achieving goals and objectives, and an accountability mechanism.⁸

Taking the time to develop a written LAP can provide numerous benefits to your organization. Developing a clear and comprehensive plan can be a fairly simple task. One easy way to do this is to address the strategies you came up with in association with each step and resource unit in this guide. Operationalizing the plan involves basic communication and training of providers and staff members. Finally, on an ongoing basis, you can monitor and update the language assistance plan to ensure that it is relevant and effective. Each of these concepts is discussed in the sections that follow.

Benefits of a Written Plan

Taking the time to go through each step and put your plan into a written format can offer numerous benefits to your organization. For example, an LAP can:

- Stress the importance of language services at your organization
- Serve as a starting point for providing LAS by clearly defining what needs to be done for limited English proficient (LEP) patients
- Provide guidance to staff members in providing LAS to LEP patients, including how to use services, whom to contact, and ways to handle challenges
- Ensure that new employees understand the organization's guidelines related to LAS¹³
- Facilitate training of managers, clinicians, and staff on the LAP
- Keep all employees “on the same page” in terms of LAS
- Ensure that all key players in the organization agree on the organization's guidelines to increase buy-in
- Ensure that LEP patients are receiving appropriate services by building in accountability

- Evaluate the quality of LAS at your organization
- Provide a framework for measuring LAS outcomes

Drafting a Language Assistance Plan

If you work through each step and resource unit in this guide, drafting a patient-centered and culturally sensitive LAP will be easier than starting from scratch. Your organization can pull out the strategies and guidelines you formulated for each step and resource unit and use them to write the plan.

- From Step 1, describe strategies and guidelines related to assessing LEP patient needs.
- From Step 2, describe strategies and guidelines related to assessing organizational capabilities.
- From Step 3, Resource Unit A, describe strategies and guidelines on interpretation services.
- From Step 3, Resource Unit B, describe strategies and guidelines on developing written materials to communicate with LEP patients.
- From Step 3, Resource Unit C, describe strategies and guidelines on signage and wayfinding.
- From Step 3, Resource Unit D, describe strategies and guidelines on notifying LEP individuals about LAS.
- From Step 3, Resource Unit E, describe strategies and guidelines related to community involvement.
- From the evaluation section within each step and resource unit, as well as from Step 4, describe strategies and guidelines on monitoring and evaluating the quality of LAS at your organization.

For an example of an organization's LAP with regard to interpretation, see appendix F. For a list of items to consider when developing your LAP, see the section in this resource unit on implementation (page 170).

Getting stakeholder input on a draft of the plan can ensure buy-in and relevancy. Consider soliciting feedback from administrators, providers, staff, advisory board members, and members of the community.¹¹

Operationalizing a Language Assistance Plan

Once the LAP has been developed and written, it is important to operationalize the plan to ensure that all employees understand the importance of LAS at your organization.

Your organization may benefit from clearly designating staff roles and responsibilities, as well as contact information, when it comes to operationalizing the plan. In conjunction with designating staff roles and responsibilities, it may also be helpful to develop a timeline for implementation and ensure that deadlines are met by those with designated responsibilities.

Also, it may be beneficial to educate and update staff on changes to the LAP to ensure compliance. For example, an organization can educate or update staff via:^{12,13}

- Orientation
- Formal trainings
- Staff meetings
- Memos

Implementation

Now that you have reviewed issues to consider when planning for the development and operationalization of your LAP, you can draft a plan and operationalize it.

You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider your organization's capabilities when deciding which activities to undertake. In Step 2, you learned about ways to conduct a comprehensive assessment of your organizational capabilities. You can use the assessment results to help you decide what activities to undertake in association with this resource unit. You can also use the checklist to monitor, evaluate, and update the activities associated with this resource unit.

“You know, where can you get help? What if something happens and you need to contact someone? Like if you have a child translate some information that’s very private and the parent is upset or something. . . . Who would be the person in the organization that you would call first? How would you begin to address this?”

—Healthcare administrator with experience implementing LAS

Drafting a Language Assistance Plan

- Did you use the strategies and guidelines that you developed in association with each step and resource unit in the guide to write your LAP?
- Did you solicit stakeholder input on a draft of the LAP?
- Did you use stakeholder input to revise the draft of the LAP?

Operationalizing a Language Assistance Plan

- Did you designate roles and responsibilities for those involved in operationalizing the LAP?
 - Did you develop a timeline for operationalizing the LAP?
 - Did you educate your managers, clinicians, and staff on the contents of the LAP?
-

Evaluating Your Solutions

To ensure that your LAP and its operationalization are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to an effective LAP and its operationalization? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to an effective LAP and its operationalization? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your LAP and its operationalization? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

You can apply these four questions to each of the items in the implementation checklist in the previous section to help you formulate specific questions for your evaluation activities. For more detail on designing and conducting evaluation activities, see Step 4 (Evaluating the Quality of Your Language Access Services).

“Where you talk about developing the language assistance plan, I read that as sort of a manual on how to do this. A manual that could include the policies that your organization has developed and as long as [it’s with] all of those, . . . I think that’s the only real way it gets addressed. Because then it’s reviewed and revised and updated along with all of the other policies of the organization. If it’s an organization [within which] that’s going to be viable, they’re going to have to do that at some point anyway. But if it’s this a separate thing that’s sort of set aside, then it gets overlooked.”

—Healthcare professional with experience implementing LAS

Case F–2: María Lopez’s Next Prenatal Visit (Eight Weeks Later)

After talking with friends, María Lopez felt confident that she did not need to be concerned about her immigration status at the clinic. She returned 8 weeks later.

Mrs. Lopez was surprised when the receptionist handed her a survey, written in Spanish, asking her opinion of services in several areas: communication and interpretation, written materials, signage, notice about language services, and community involvement. The receptionist explained that the clinic director thought that the clinic needed a written plan to truly determine the language services that patients needed and the best way to provide them. “We’ve all been doing a lot,” said the receptionist, “but we need to step back, decide priorities, and figure out who is going to do what and how we’re going to pay for it. We’ve made a good start and have a lot of ideas, but now we need to collect some data, get organized, and figure out a step-by-step approach to doing what we want to do.”

The receptionist explained further that one way for the clinic to develop the plan was to ask patients’ opinions about what the clinic should be doing. Mrs. Lopez laughed, “You could start with taking appointments so that I don’t have to take a whole day off of work every time I come here.” “Write it down,” the receptionist said, “and put your survey in the red box on the table.”

Mrs. Lopez was nervous about writing on the survey until she saw that she did not have to use her name. She wrote about her frustration with not being able to make an appointment, her confusion over the documents that she had been given on her previous visit, and her problems finding the office the first time she came. Because the survey did not directly ask, Mrs. Lopez did not provide any comments about her doctor or any other staff whom she had encountered on her visit.

Patient’s Perspective

“Because I’m so concerned that I have health care for my baby, I would never have complained or offered suggestions about how to change the clinic services. But I do have a lot of good ideas, and I’m glad that they asked me to share them. I wish I could have told them about how my actual visit with the doctor went, but they did not ask. I hope that they’ll ask in the future, but I would only respond if no one knew who made the comments.”

Provider’s Perspective

Clinic director: “I realized that we needed to make a more comprehensive and integrated plan for LAS. Then I realized that we didn’t really know what to put in the plan. We know the pieces of LAS, but not the patient’s needs. Our team decided that the place to start was to ask patients both about needs and about experiences in the clinic. One of the first survey responses was a huge eye-opener for me. I was so proud of all of our signage in the clinic, but it never occurred to me that our patients were getting lost in the building trying to find the clinic. I’m meeting with the building owner today to arrange for Spanish signs to direct people to the office. We’ll have to do more thinking to plan some of the other issues we want to address, but it seems obvious that we need to organize our thoughts and lessons learned into a written plan.”

Resource Unit F: Insights From the Cases for Healthcare Organizations

Developing and operationalizing an integrated written plan for offering LAS can benefit both healthcare organizations and providers by ensuring strategic action, providing a shared framework for the provision of LAS, and serving as a tool for evaluating services. Providing LAS in a piecemeal fashion may not be as effective as when the services are offered as part of a more strategic approach. For example, in Case F-1, the organization provided translated written materials. However, because the materials were obtained and provided to patients in an ad hoc manner, they did not serve the patient's needs. The written materials were difficult to understand, unclear, and not well presented, and the patient was confused to receive different materials on the same topic from different healthcare personnel. The clinic was "providing translated materials," but not really addressing the larger question of how to provide access to understandable health information for its patient community.

As another example, the clinic made an effort to provide signage in Spanish inside the clinic itself, but patients could not find their way through the office building to reach the clinic. In this case, the clinic appeared to respond to a question—"How can we provide Spanish signs?"—but not the more strategic, and important, question—"How can we ensure that patients have access to the clinic, by being able to reach the services?" A comprehensive answer to the second question would address not only signage in the clinic, but also wayfinding to the clinic and even external communication with the clinic, such as access to bilingual phone trees to obtain directions or ask questions.

In another example, the clinic made an effort to hire staff who could communicate in Spanish, but ignored the larger questions of whether the staff could also understand the patients' life context and culture. For example, the doctor spoke Spanish, but did not understand the circumstances of her patient's life.

As illustrated in Case F-2, one important way for organizations to understand their larger planning questions is to ask for information from patients about their needs and experiences. Patient input can be used to better understand what should be in the LAP, as well to monitor and evaluate the effectiveness of the LAP.

Step 4: Evaluating the Quality of Your Language Access Services

Discussion Topics

- An Overview of Evaluation
- Determining Whom To Involve in Designing the Evaluation
- Designing the Evaluation
 - Determining What You Want To Evaluate and Why
 - Deciding From Whom To Collect Data
 - Deciding How To Collect the Data
 - Collecting Data From Your LEP Populations
 - Collecting Data From Managers, Providers, and Staff
 - Collecting Data From Patient Grievances and Incident Reports
 - Developing Instruments To Collect Your Data
- Conducting the Evaluation
- Sharing the Findings of Your Evaluation

The fourth step in implementing language access services (LAS) involves evaluating the quality of the services that you are providing. This step describes issues for consideration as you plan to implement your evaluation. The discussion on planning is followed by a section on implementation, which includes a checklist of items to review as you implement the activities described in the step. The step concludes with questions to consider as you monitor, evaluate, and update the solutions you have developed to implement this step.

The planning section in Step 4 begins with an overview of evaluation. It then provides tips on determining whom to involve in designing an evaluation. Next, it discusses how to design the evaluation, including determining what you want to evaluate and why, from whom to collect data, and how to collect the data. The section on how to collect data includes a discussion on collecting data from your limited English proficient (LEP) populations, managers, providers, and staff; collecting data from incident reports and patient grievances; and developing instruments to collect your data. The planning section concludes with a discussion on conducting the evaluation and sharing the findings of your evaluation.

This step describes two cases, one that demonstrates an organization at an earlier stage of implementing LAS and one that demonstrates an organization further along in the process. Each case also includes patient and provider perspectives. Insights for organizations, based on the cases, conclude each section of the guide.

The cases in this resource unit are a continuation of Cases F–1 and F–2 in Resource Unit F (Written Language Assistance Plans). Over time, the patient provides feedback to the clinic and observes changes in the clinic’s services. As the patient progresses through her prenatal visits, she continues to evaluate services, both old and new, provided by the clinic.

Step 4: Patient's Profile

This case continues from case F-2: María Lopez's Next Prenatal Visit (Eight Weeks Later)

María Lopez:

- Now 28 weeks pregnant, María Lopez continues regular prenatal appointments at the local Latino clinic

Case 4-1: María Lopez Provides More Information

Patient's Story

The clinic was taking appointments now, and María Lopez would likely be able to get back to work for half a day. When she arrived, Mrs. Lopez was surprised to see Spanish signs directing patients to the clinic in the building's lobby and hallways. Once inside, she had another surprise: a rack of new, easy-to-read patient educational materials.

A young woman approached her and asked, in Spanish, if she could ask Mrs. Lopez a few questions. Mrs. Lopez still remembered the doctor asking about her citizenship, and she drew back fearfully. The woman reassured Mrs. Lopez and explained that she was a student in public health working on a project at the clinic. She was learning about patients' experiences so that the clinic could improve its services. Mrs. Lopez's responses would be confidential and no one would know what she said. The student also said that she and her colleagues were preparing reports that summarized everyone's comments, so that no patients would be identified individually.

The student asked about all the topics on which Mrs. Lopez had opinions, plus more: written health education materials, the reception process, the interpreter, the waiting area, communicating with the doctors and nurses, the cost, the convenience, and other topics. Mrs. Lopez commented on the new materials and signs and expressed her appreciation that the clinic was now taking appointments. The student told Mrs. Lopez that the survey and interview data revealed the problems, and the clinic administrator made the changes quickly to better serve the community.

Mrs. Lopez thought of one other item to tell the student—"Even though the Americans seem to think that Latinos are one big group, we're really a lot of smaller communities with different types of communication and different beliefs and customs. The clinic should take that into account."

"To start the planning process, we did some population research," said the student, "This area used to be almost all Cuban and Puerto Rican families, but now there are many other Latino cultures here as well. The biggest one is Colombian. We want to make a special effort to learn more from our Colombian patients." "I'm Colombian," said Mrs. Lopez, "and I will be happy to help."

Patient's Perspective

"I'm so glad that the clinic is asking patients about their services, especially the services related to communicating with the doctors and nurses. More importantly, I'm happy that they're doing it in a way that I feel comfortable talking about it. And, they're actually making changes based on what patients tell them! I'm pleased that they're recognizing the growing Colombina population, and I'll do my best to help provide the information they need."

Provider's Perspective

Clinic director: "The planning process continues to be quite interesting. I've always thought of this as a clinic largely for Cubans and Puerto Ricans, but now I'm learning about the other Latino cultures that we support as well. We clearly need to learn more about all of our patient populations. That's why I contacted the local university about having some graduate students help us with patient interviews and data analysis."

This step will walk you through evaluating the quality of LAS. The step first discusses planning issues, followed by implementation issues, and concludes with questions to consider as you monitor, evaluate, and update the solutions you came up with related to evaluating the quality of LAS. This step covers only the basics of evaluation to help you conduct some simple evaluation activities. You can consult other, more comprehensive resources (such as the *W. K. Kellogg Foundation Evaluation Handbook*) to gain a deeper understanding of the full range of evaluation options.

Planning

In this section on planning, you will read an overview of evaluation. After providing tips on determining whom to involve in the quality assurance process, the step walks you through the development and implementation of quality assurance monitoring procedures. This includes incorporating input from patients, providers, and staff members on language access services as well as reporting on the results of your evaluation.

An Overview of Evaluation

In addition to developing LAS, it is important to consider developing a process for evaluating and updating those language access services. Developing this process will help provide your organization with a mechanism for measuring the effectiveness of services and thus improving them as needed over time. It is



Link to Web Resource on Conducting Evaluation

W.K. Kellogg Foundation Evaluation Handbook

<http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf>

important to note that there is a difference between evaluating the quality of LAS and evaluating the competence of the individuals in your organization who provide the services, as described in Step 3. According to the American Evaluation Association, “Evaluation involves assessing the strengths and weaknesses of programs, policies, personnel, products, and organizations to improve their effectiveness.”⁸⁹

Evaluation, as it relates more specifically to LAS and this guide, includes determining the effectiveness of your organization’s LAS for your LEP populations.³⁸ Taking the appropriate measures to evaluate and update LAS is critical, as they help ensure access to services and thus safeguard patient satisfaction and patient-centered care.² Evaluation of services is likely a part of the normal operation of your organization. You can consider adding an evaluation of LAS to your current evaluation procedures.

Determining Whom To Involve in Designing the Evaluation

When determining whom to involve in the design of the evaluation, it is important to designate:

- Who will be responsible for conducting the evaluation
- Who will be involved with designing the evaluation

In terms of designing the evaluation, you can solicit input from stakeholders informally or, depending on the size of your organization and LEP population, you can consider developing an advisory committee dedicated to LAS evaluation.¹² You can solicit input on the evaluation design from stakeholders within your organization, such as:¹⁰

- Executive director
- Medical director
- Fiscal manager
- Nursing manager
- Health education manager

- Clinic coordinator
- Associate managers
- Other organizational decision makers
- Staff representatives, especially those who have direct contact with LEP patients
- Risk management staff
- Patient relations staff

You can solicit input on the evaluation design from stakeholders in the community, such as:¹⁰

- LEP patients
- Local health departments
- Community-based organizations
- Community churches and other religious organizations
- Schools

Designing the Evaluation

It can be helpful to conceptualize your LAS as a whole, then decide on the specific elements that you would like to evaluate. To conceptualize your LAS as a whole, you can consider and solicit input on the following questions:⁹⁰

- What do you want to accomplish through the implementation of LAS?
- How will you know whether you have accomplished your goals?
- What activities will you undertake to accomplish your goals?

- What factors might help or hinder your ability to accomplish your goals?
- What will you want to tell others who are interested in your LAS?

You can also use the implementation checklists and the questions for consideration provided in the Evaluating Your Solutions section at the end of each step and resource unit to help you answer these questions.

In answering these questions, you can determine the problem areas that your LAS are trying to address, the goals and objectives of your LAS, the target audience for your LAS, the activities that you will need to conduct to accomplish your goals and objectives, and the outcomes that you would like to achieve with your LAS.

After conceptualizing these issues, you can lay out a model of your LAS as a whole, then decide which elements of your LAS you would like to evaluate. Once you decide which elements it makes sense to evaluate, you can design your evaluation.

In designing your evaluation, you will need to consider:

- What you want to evaluate and why
- From whom to collect data
- How to collect the data
- When you will collect and analyze the data
- Availability of resources to conduct the evaluation

Determining What You Want To Evaluate and Why

It is important to first decide what you want to evaluate and why you want to evaluate it, including what you want to get out of the evaluation and how you will use the results. You might consider evaluating:

- Your assessment procedures (Steps 1 and 2)
- Components of your LAS (Resource Units A–F)

- Your evaluation procedures (Step 4)
- Promising practices among organizations that have experience implementing LAS¹³

Again, you can take a look at the model that describes your LAS as a whole and then decide on what elements of your LAS you would like to evaluate. If, for example, the model includes interpretation services, translation services, use of signage and wayfinding techniques, and other LAS components, you might decide to first evaluate patient satisfaction with interpretation services. This case example will be used in the sections that follow to illustrate each of the components of evaluation design.

Deciding From Whom To Collect Data

Now that you know what you want to evaluate and why, you can determine from whom to collect data. You can consider who can best give you input that will serve the goals of your evaluation.

Patients are an important source of data regarding satisfaction with any services provided by your organization, including LAS. Patients provide firsthand knowledge of their access to services and their experience with care, including interpretation, translation, signage, and patient education materials.² Incorporating patient input within your LAS evaluation can help ensure that your services are responsive and patient centered. Because patients provide such valuable feedback, it is advantageous for your organization to collect information from LEP patients and their families on LAS.

It can also be helpful to collect information from managers, providers, and staff, including interpreters, because they are the ones providing the healthcare services and using the LAS as they communicate with their patients.²

Soliciting feedback from community-based organizations and advocates can be an effective way to gather information on patient experiences, especially given the reluctance of some patients to report problems and concerns.⁵³ For more information about



Helpful Percentages To Consider When Developing Quality Assurance Procedures

Evaluation of process and outcome factors through changes in the following percentages can assist your organization in determining how to update LAS.⁵¹

- Percentage of LEP patient-provider contacts using a trained interpreter
- Percentage of LEP patients satisfied with care received
- Percentage of providers comfortable with using interpreters
- Percentage of providers satisfied with their communications with LEP patients
- Percentage of LEP patients with “acceptable” levels of knowledge following health education instruction

Other percentages to consider:⁵³

- Percentage of patients assessed for English proficiency, of those who said they speak a primary language other than English and/or speak a language other than English at home
- Percentage of people receiving training to be interpreters or to work with interpreters
- Percentage of complaints received among the number of office visits

community, refer to Resource Unit E (Community Involvement).

Given the case example described above, to better understand patient satisfaction with interpretation services, you could collect data from LEP individuals, including your patients and their families, and from LEP individuals in your community.

Deciding How To Collect the Data

You can now decide how best to collect the data given what you want to evaluate, why, and from whom you will collect the data. Methods for collecting data might include:

- Collecting archival data (such as patient data described in Step 1)
- Conducting written and/or oral surveys
- Collecting data from patient grievances and incident reports
- Conducting focus groups

With regard to the case example, you might want to conduct surveys with patients and collect data from incident reports and patient grievances.

The sections that follow first will detail specific methods for collecting your data, then will detail ways to develop instruments for collecting your data.

Collecting Data From Your LEP Populations

If you decide to conduct surveys with patients, you may consider the following:

- Written surveys¹⁰
 - Attach the survey to the patient’s medical chart in his or her preferred language before appointment dates.
 - Attach a copy of the survey for every patient appointment, even if a patient makes multiple



Creating Patient Satisfaction Surveys¹²

Patient satisfaction surveys can be created internally or externally. You may consider involving the following:

- The department within your organization responsible for interpretation and translation services
- Interpretation and translation experts
- Applied linguists
- External evaluation agencies

- visits in the same month, to ensure that the survey is completed at least once. If you know that a patient has made multiple visits over the past month, ask him or her whether a survey has been completed. If the patient says he or she has not yet completed one, administer the survey.
- Attach an English version of the survey to the medical chart if the patient’s preferred language is one for which your office does not offer translation, and have a trained interpreter orally administer the survey to the patient.
 - Ask interpreters and staff members working with providers to remind a patient to complete the survey if it looks like he or she might have forgotten. But also explain to the patient that completion of the survey is voluntary and will not affect the care he or she receives in any way.
 - Ask interpreters to be available to help patients complete the survey.
 - Encourage the patient to complete the survey in person before he or she leaves your office (each survey can be sealed in an envelope and placed in a box by the patient to ensure confidentiality).¹²
 - Try to keep spare copies of the survey at the front desk in case nurses or providers need extra copies or if patients request a new copy.
 - If patients have access to the Internet, provide them with an address for your organization’s Web site, which will allow them to access online surveys at their convenience.¹²
- Oral surveys¹²
 - Consider conducting one-on-one 5-minute interviews immediately following the patient’s appointment.
 - Consider phone surveys with patients who have visited the emergency room.



Reach for a Goal¹⁰

Set a goal for how many patients you will survey. For example, “During the next assessment period, we will distribute patient satisfaction surveys to a minimum of 25 percent of the patients seen.”



Link to Web Resource on a National Patient Satisfaction Survey

Bureau of Primary Health Care

Patient Satisfaction Survey

<http://bphc.hrsa.gov/quality/patienttool.htm>

If you cannot administer a survey to all LEP patients, you may consider developing a procedure for selecting which LEP patients you will survey. This could mean administering patient satisfaction surveys to all LEP patients seen in the ambulatory setting or just randomly selected patients in the inpatient setting.¹²

If you choose not to dedicate an entire survey to LAS, you can include an LAS evaluation section in a general patient satisfaction survey.

You can also collaborate with community-based organizations to conduct surveys of LEP patients throughout the community. By collaborating with community-based organizations, LEP patients may feel more comfortable responding honestly and openly about the services they receive at your organization. In addition to helping you learn more about the satisfaction of LEP patients with LAS at your organization, you may also learn more about the services that LEP patients receive from other healthcare organizations in the area.

Regardless of how patient feedback is gathered, it is advantageous for your method of gaining feedback to be available in the main languages encountered in your LEP population and to be tested on several characteristics, including:²

- Cultural appropriateness
- Literacy levels
- Validity to your LEP population

Refer to Resource Unit B (Written Materials) for more information on developing or translating materials.

Collecting Data From Managers, Providers, and Staff

One way to gather manager, provider, and staff feedback is through your organization's employee evaluation process. Including LAS as a component of evaluation reinforces to staff members that these services weigh into their performance as employees and make up an important part of organizational policy.¹⁰

The evaluation can be conducted at the end of a 3-month probationary period for new employees, as well as at the annual evaluation for all employees. Self-evaluation can be a good method, because it allows the staff member to evaluate his or her own performance and compare it to standards set by your organization. After the staff member has completed his or her self-evaluation, the evaluation can be assessed by a supervisor. The staff member and supervisor can then discuss the evaluation together.¹⁰

At this time, both parties can discuss what LAS policies and procedures work effectively/ineffectively, which are easy/difficult to implement, and what can be improved. Providers, staff members, and interpreters can also provide feedback related to their experiences working with one another on LAS. In addition, or in place of collecting managers, provider, staff, and interpreter feedback on LAS policies and procedures during the employee evaluation process, your organization may choose to gather this information via confidential surveys. Confidential surveys may allow providers, staff, and interpreters to respond more honestly and openly. Regardless, the information you gather can provide valuable input on what can be done to facilitate their working relationships.¹⁰

Collecting Data From Patient Grievances and Incident Reports

As it is important to provide all patients with an outlet for voicing their concerns about services received at your organization, it may be helpful to incorporate questions about meeting the needs of your LEP patients within existing grievance and incident procedures.

If you choose to incorporate LAS-related questions within your organization's general grievance procedure, you may want to make a special effort to ensure that LAS grievances are tracked as LAS issues rather than as general organizational issues. This will help your organization handle LAS issues effectively and appropriately. You can also appoint a staff person to serve as a liaison between the department responsible for LAS and the department responsible for grievance and resolution procedures.² This individual can review all comment cards, forward grievances to the



Ways To Inform LEP Patients About Grievance Procedures⁸⁵

- Through oral communication
 - One-on-one communication between staff and patient
 - Focus groups conducted to gain LEP patient input
 - Refer to Resource Unit A (Interpretation Services) for more information
- Through patient education materials
 - Fliers, brochures, and informational packets available to LEP patients on language access services
 - Referenced to or included as a section on patient satisfaction surveys
 - Refer to Resource Unit B (Written Materials) for more information
- Via signage
 - Signs strategically posted throughout the organization describing grievance procedures and how to file grievances
 - Refer to Resource Unit C (Signage and Wayfinding) for more information

appropriate supervisors or managers, and generate a report for the individuals or team responsible for the evaluation of LAS.¹⁰

As you are developing your grievance procedures, it is important to be aware of fears or cultural beliefs of some individuals that may prevent them from openly expressing discontent with your organization or the services they have received.² In addition, dealing with grievance procedures and voicing complaints to those who may resemble authority figures (i.e., providers, managers, and supervisors) can be intimidating for LEP patients who may be unfamiliar with the U.S. healthcare system. When a patient is unable to communicate his or her discontent or lack of knowledge about LAS and your organization is unaware of the patient's dilemma, the result may be that the patient receives substandard care.⁸⁵

Therefore, establishing procedures for filing of grievances and making all patients, including LEP patients, fully aware of grievance procedures can be crucial to improving all organizational services, including LAS, on an ongoing basis. To ensure that there is a clear understanding between your organization and patients regarding grievance procedures, it may be helpful for you to clarify for your patients what they can expect when they file a grievance. Some procedures to clarify for your patients include:²

- How grievances of varying levels of severity are handled
- Who in the organization will be responsible for grievances
- How long it will take to review and resolve grievances
- What kind of response to expect, such as an acknowledgment of receipt of grievance and a written resolution of grievance

Your organization may want to consider reviewing incident reports related to language barriers and

miscommunication. Keeping track of these incident reports may highlight further ways to improve LAS.

As with other data collection methods, it is important to translate incident report and grievance comment cards into the major languages encountered at your organization.⁸⁵

Developing Instruments To Collect Your Data

After you decide on appropriate methods for collecting your data, you can design your instruments for collecting that data. At the end of each step and resource unit you applied the four general evaluation questions to each of the items in the implementation checklist to help you come up with specific questions for your evaluation activities. You can use these questions to develop your instruments.

In connection with the case example described previously, this section provides examples of questions that you can use to develop instruments for conducting patient satisfaction surveys and for collecting data from patient grievances and incident reports.

Patient satisfaction surveys on LAS can inquire about any language-related issues that LEP patients may have experienced at your organization.¹⁰ The questions below are specific to collecting patient data on satisfaction with interpretation services.^{12 53}

- Were you told about interpretation services?
- Were you asked whether you needed an interpreter?
- Did you ask for an interpreter?
- Did you receive an interpreter?
- If you did receive an interpreter:
 - How long did you have to wait for the interpreter to arrive?
 - Was communication better because of the interpreter?

“We find that the more we do not follow those standards and ethics, the more errors are made and the more problems arise.”

—Administrator with experience implementing LAS, regarding a code of ethics for interpreters

- How do you feel about the services you received?
 - Were you satisfied with the services?
 - Did you feel respected?
 - Do you feel that your cultural needs were met?
- How could the services be improved?
- Would you like to have an interpreter at your next visit?
- How do you feel your quality of care was?
- If you did not receive an interpreter:
 - What did you do?
 - What was the quality of communication between you and the staff and providers?
 - How do you feel your quality of care was?
 - Do you feel that your cultural needs were met?

With regard to collecting incident report and patient grievance data, you may decide to incorporate questions about LAS into already existing procedures. Topics for inclusion in a general instrument might cover:²

- Quality of services
- Accessibility of services
- Timeliness of service provision
- Staff attitudes and behaviors

When inserting questions specific to interpretation services (per our case example), you can consider the following topics for inclusion:²

- Quality of communication between the patient, interpreter, and provider
- Accessibility to an interpreter
- Timeliness of interpreter arrival
- Provider attitudes and behaviors as they relate to the use of an interpreter

Regardless of the type of instrument that you develop, it is important to ensure that the instrument addresses issues of confidentiality to assure respondents that their identities will not be revealed to anyone. This can help ensure that they respond to your questions accurately and can relieve fears about retribution. Similar to other procedures associated with communicating with LEP patients, it is helpful for your organization to translate instruments into the major languages encountered in your patient population and test them for cultural appropriateness and literacy level.²

As you design the evaluation, you will also need to consider resources available to help you conduct the evaluation and a timeline for conducting the activities. The timeline should incorporate time for evaluation design, data collection and analysis, writing up your results, and sharing your findings with stakeholders.

Conducting the Evaluation

Now that you have determined what resources are available to you, what timeline you will follow, what to evaluate and why, from whom to collect the data, and how to collect the data (including developing your instruments), you can conduct your evaluation activities. If you have the resources, you can first pilot test your instruments. Next, you can conduct your formal data collection activities. After collecting your data, you can analyze them and put your findings into a simple report.

Sharing the Findings of Your Evaluation

It is critical that the results be shared with decision makers in your organization to ensure that needed changes to your services are implemented. Decision makers can use your findings to update and reconfigure your LAS solutions, strategies, and guidelines.¹⁰

It is also important to share evaluation results with those from whom you solicited input. It is helpful to build relationships with those who help you improve your services, so that they may be inclined to provide further assistance in the future. You can achieve this by summarizing the results of your evaluation efforts and illustrating to survey participants how you used their feedback in a meaningful way.²

Your evaluation findings can be discussed during advisory committee meetings or along with other quality assurance issues during organizational meetings. For example, you may consider discussing these issues among clinic staff, by department, and organizationwide. If possible, your organization can hold more than one meeting per month at each level and dedicate meetings to particular quality assurance topics.¹⁰

Publicly reporting information not only serves as an important quality-improvement incentive for healthcare organizations, it also provides patients with valuable information they need to make more informed healthcare choices. Again, it can be helpful to translate the report into the languages encountered in your patient population.

Implementation

Now that you have reviewed planning issues related to evaluation, you can decide on a plan of action and implement it. You can use the checklist below to keep track of activities as you implement them. The checklist outlines activities that vary in scope. You will need to consider the needs of your LEP population (Step 1) and your organization's capabilities (Step 2) when deciding which activities to undertake. You can also use the checklist to monitor, evaluate, and update your evaluation activities.

Determining Whom To Involve in Designing the Evaluation

- Did you designate someone to be responsible for conducting the evaluation?
- Did you designate whom to involve in the design of the evaluation?

Designing the Evaluation

- Did you develop a model of your LAS as whole by answering the following questions?
 - What do you want to accomplish through the implementation of LAS?
 - How will you know whether you have accomplished your goals?
 - What activities will you undertake to accomplish your goals?
 - What factors might help or hinder your ability to accomplish your goals?
 - What will you want to tell others who are interested in your LAS?
- Did you use the implementation checklists and questions for consideration at the end of each step and resource unit to help you answer the questions above?
- Did you determine what within your LAS model you want to evaluate and why?
- Did you decide from whom you will collect data?
- Did you determine how to collect the data by considering the following?
 - Collecting data from your LEP populations
 - Collecting data from managers, providers, and staff
 - Collecting data from patient grievances and incident reports
 - Ways to develop instruments to collect your data
- Did you determine what resources are available to you to help you conduct the evaluation?
- Did you determine a timeline for implementing the evaluation activities?

Conducting the Evaluation

- If possible, did you pilot test your instruments?
- Did you collect your formal evaluation data?
- Did you analyze your data?
- Did you write a report of your findings?

Sharing the Findings of Your Evaluation

- Did you share the results with the following stakeholders?
 - Decision makers
 - Advisory committee members
 - Those who helped design the evaluation and other stakeholders
 - Organizational department heads, managers, providers, and staff
 - Other healthcare organizations and community members
-

Evaluating Your Solutions

To ensure that your means of evaluation are continually effective, it is important to monitor, evaluate, and update the solutions you have put in place on an ongoing basis. It may be important to consider the following overall questions as part of your analysis:

- What are the enablers to evaluating LAS? What should be supported, encouraged, and replicated?
- What are the challenges or barriers to evaluating LAS? What should be revised, improved, or eliminated?
- What recommendations have you come across for improving your means of evaluating LAS? Which of these recommendations should be implemented?
- Given your current situation and potential changes in LEP population demographics, where does it make sense to use your human, technical, financial, and other resources?

Case 4–2: María Lopez Evaluates the Clinic’s Progress

Patient’s Story

María Lopez tried to provide more feedback to the clinic each time she went. If there was no student interviewing patients, there was a box in which patients could submit their ideas in writing. Mrs. Lopez had also been invited to participate in a meeting about the clinic’s services. After the meeting, the clinic hosted a dinner for the participants and their families. It was nothing fancy, but Mrs. Lopez and her husband appreciated a free night out. The meeting was interesting because the participants evaluated the new changes to the clinic. For example, someone suggested that it was sometimes difficult for pregnant women to bend low and asked that the patient education brochures about parenting and breastfeeding be moved higher up on the new materials rack.

When Mrs. Lopez checked in for her next appointment, the receptionist, noting that she was close to her delivery date, asked if she would like an interpreter at the hospital if one of her providers did not speak Spanish. The receptionist explained that, as a part of the hospital’s new language assistance plan, the clinic could preregister whether patients needed an interpreter. “It’s nice to know that I won’t have to worry about that when we get to the hospital,” said Mrs. Lopez. She was pleased that the clinic was working with the hospital on language services needs, and looked forward to assessing the services when she used them.

The doctor examined Mrs. Lopez, said that she might go into labor “any day now,” and assured her that both she and the baby were doing fine. As Mrs. Lopez prepared to leave the clinic, the receptionist called her aside and said, “Mrs. Lopez, I know you’ll be busy with the baby, but you’ve been so helpful with providing ideas in the past, I want to ask for your help again. We want to evaluate our services to make sure that they serve all of our patient groups. Do you think you might be able to answer a few more questions about the Colombian community, maybe come to another meeting, once you get settled in with the baby?” Mrs. Lopez was honored to be asked and agreed to help. She was encouraged that the clinic was implementing what it learned from its evaluations, and pleased that she could make a difference for other Colombian families.

Patient’s Perspective

“I’m learning that improvement is always possible, and I notice my awareness changing. Now, I watch for ways to improve the clinic, and make it a point to provide my feedback. They must think it’s useful, because they’ve asked me to contribute more. I don’t think that they could have made so much progress without input from the patients as well as the staff. And, it looks like they’re also reaching out to the hospital by partnering to provide language services for patients there too.”

Provider’s Perspective

Clinic director: “The evaluations are teaching us a great deal about how to improve our programs for patients. For me, the best part is that the evaluation process isn’t very expensive. We’re asking patients for feedback and getting assistance from the university to collect other data and do some research for us. We’ve even started to work with the hospital, to address concerns such as providing interpreter services for our patients. Once you get into the habit, evaluation can be second nature and just part of normal operating procedures.”

Step 4: Insights From the Cases for Healthcare Organizations

Monitoring, evaluating, and updating LAS are part of an iterative process that can help ensure the highest quality of care and patient satisfaction. Evaluation results should feed into revised plans and new implementation, and the new or improved services should be evaluated again. In the simple example in Cases 4–1 and 4–2, a major change involved providing improved patient educational materials, but that change was evaluated and improved incrementally through evaluation (e.g., moving certain materials to a more accessible place for pregnant patients). As the cases in this section also demonstrate, it is especially important that evaluation be based on data, preferably including patients’ opinions. Evaluation does not need to be expensive, but it should be thorough and ongoing as part of the normal business process.

Conclusion

Implementing language access services (LAS) provides benefits not only to limited English proficient (LEP) individuals and their families, but also to healthcare administrators, providers, staff, and the community within which the healthcare organization is situated. This is documented in the research literature. This guide also illustrates such benefits through the use of vignettes in each step and the direct quotes provided by LEP patients, administrators, providers, and other healthcare professionals.

The primary goal of this guide is to walk you and your organization through the process of implementing LAS, so that everyone involved in the system of care can benefit from the advantages offered by having such services in place. The basic steps for implementing LAS are laid out in this guide, so that the process for carrying out each step is explained in detail and supplemented with links to resources and tips on alternative ways to complete the step. Exhibit C–1 summarizes each of the steps discussed in the guide and provides a summary of insights associated with each step.

Exhibit C–1: The Four Steps and Six Resource Units—With Related Insights

	Step	Related Insights
Step 1	Assessing the Language Needs of Your Patients	Identifying LEP populations and their needs in an organization's service community can help to better provide patients with appropriate services and ensure the quality of their care. In addition, it can save resources for the organization in the longer term and can prevent misunderstanding and potential malpractice suits.
Step 2	Assessing Your Organizational Capabilities	Moving an organization toward cultural competence and effective language services requires dedicated leadership and involves engagement that encompasses the entire organization.
Step 3	Planning and Implementing Language Access Services	Step 3 comprises Resource Units A through F. See each resource unit for related insights.
Resource Unit A	Interpretation Services	Offering competent interpretation services assists LEP patients with understanding and making informed decisions about their medical care.

Exhibit C–1: The Four Steps and Six Resource Units—With Related Insights (Continued)

Step		Related Insights
Resource Unit B	Written Materials	Developing materials in other languages and/or translating materials to meet patients' needs can help patients better understand and manage their health. Including the patient community in developing the materials can help ensure that the materials are accurate, understandable, and useful.
Resource Unit C	Signage and Wayfinding	Posting meaningful signage and helping patients find their way within a healthcare organization demonstrates consumer friendliness and helps LEP patients and their families feel more comfortable in a stressful situation. In addition, signage may help patients receive timely care in emergency situations.
Resource Unit D	Notice of Language Access Services to LEP Patients	Providing LAS can make a difference in the quality of care and health outcomes of patients, but patients need to be aware of the services, by providing appropriate, visible notices about the availability of the services, which should be available when patients need them.
Resource Unit E	Community Involvement	Involving the community in LAS is a necessary component of providing effective LAS and has advantages for providers, administrators, healthcare organizations, and patients.
Resource Unit F	Written Language Assistance Plans	Developing and operationalizing an integrated written plan for offering LAS can benefit both healthcare organizations and providers by ensuring strategic action, providing a shared framework for the provision of LAS, and serving as a tool for evaluating services.
Step 4	Evaluating the Quality of Your Language Access Services	Monitoring, evaluating, and updating LAS are part of an iterative process and can help ensure the highest quality of care and patient satisfaction.

Every organization differs in size, available resources, and capabilities. This guide recognizes this variability, by providing both basic solutions and additional alternatives that organizations can consider when deciding how to develop LAS that best suit their needs. Implementation is an evolutionary process. This guide can help you get started. As your community and your organization evolve over time, you can use this guide to assist you with the evolution of your LAS. As such, as a healthcare organization, you can continue on your mission to provide quality health care to all of the patients who seek your assistance, regardless of their language ability.

Appendix A: Glossary of Abbreviations

ACS	American Community Survey
ACTFL	American Council on the Teaching of Foreign Languages
AFF	American FactFinder
AHEC	Area Health Education Center
AIR	American Institutes for Research
ALSI	American Language Services, Inc.
ANHC	Anchorage Neighborhood Health Center
APHCV	Asian Pacific Health Care Venture, Inc.
ATA	American Translators Association
CEO	Chief Executive Officer
CHC	Community Health Center
CHIA	California Healthcare Interpreting Association
CLAS	OMH Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care
CNM	Certified Nurse Midwife
DHHS	U.S. Department of Health and Human Services
DSH	Disproportionate Share Hospital
EKG	Electrocardiogram
ESL	English as a Second Language
FICA	Federal Insurance Contributions Act
FQHC	Federally Qualified Health Center
GERD	Gastroesophageal Reflux Disease



Links to Web Resources

Glossaries of Terms in Healthcare Interpreting

Developed by the NCIHC

http://www.ncihc.org/NCIHC_PDF/TheTerminologyofHealthCareInterpreting.pdf

Developed by NHeLP

www.healthlaw.org/library.cfm?fa=download&resourceID=63130&appView=folder&print

GI	Gastrointestinal
HABLA	Healthcare Access by Language Advocacy (referral network and clinic)
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HRET	Health Research and Educational Trust
IAP	Interpreter's Aide Program (Brown Medical School)
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LAP	Language Assistance Plan
LAS	Language Access Services
LEP	Limited English Proficient
LIST	Language Interpreter Services and Translation program (Washington State)
MMIA	Massachusetts Medical Interpreters Association
NALS	National Adult Literacy Survey
NCIHC	National Council on Interpreting in Health Care
NCQA	National Committee for Quality Assurance
NHeLP	National Health Law Program
NICU	Neonatal Intensive Care Unit
NOAH	New York Online Access to Health
NP	Nurse Practitioner
OCR	Office for Civil Rights, U.S. Department of Health and Human Services
OMB	Office of Management and Budget
OMH	Office of Minority Health, U.S. Department of Health and Human Services
PA	Physician Assistant
PPS	Prospective Payment System

PSA	Prostate-Specific Antigen
RHC	Rural Health Clinic
RSMI	Remote Simultaneous Medical Interpretation
SCHIP	State Children's Health Insurance Program
SMOG	Statistical Measure of Gobbledygook
TDD	Telecommunications Device for the Deaf
TTY	Teletype or Teletypewriter

Appendix B: Example Job Description, From Children’s Hospitals and Clinics

	<h3>Criteria-Based Job Description</h3>
---	---

Job Title:	Medical Interpreter and Cultural Resource
Job Code:	217
Department:	Interpreter Services
Date Last Reviewed/Revised:	9/21/03

JOB SUMMARY

Provides systemwide foreign language interpreting (verbal) and translation (written) to enable understanding and successful communication between the Children’s patients/families with limited English proficiency (LEP) and Children’s providers and staff. Adheres to medical interpreter standards of practice and code of ethics. Provides education and consultation to both providers and patient families on culturally specific values, beliefs, and practices that are relevant to the health care encounter. Supports the Interpreter Services program at the Children’s through working constructively in a team, participating in program functions, and performing other programmatic tasks as requested by the program supervisor or director. Documents required information and data accurately and in a timely manner.

QUALIFICATIONS

Please specify the knowledge, skills, abilities, and experience necessary to qualify for the job. These specifications should be stated as the **minimums** that must be present to perform the job successfully. **Do not** indicate desired qualifications that exceed minimum requirements.

Minimum Qualifications:

- Demonstrated interpreting and translating experience in health-related contexts
- Two-year college degree or equivalent; 4-year degree preferred
- Effective personal communication skills
- Ability to facilitate understanding in communication between others who speak different languages
- Demonstrated verbal proficiency in both English and a target language; ability to grasp readily and completely what others say in either language; ability to speak and be readily understood in either language
- Demonstrated written competence in both English and the target language

(Criteria-Based Job Description Continued)

- Ability to find means of expression that will enable understanding when there are no equivalent words or phrases between the two languages
- Ability to connect divergent culturally conditioned explanatory models held by individuals
- Operational knowledge of multiple cultures involved in the patients' care and ability to function with competence and sensitivity in cross-cultural situations
- Knowledge of basic anatomy and physiology, as well as medical diagnostic procedures and treatments
- Operational knowledge of and adherence to the medical interpreter standards of practice and code of ethics
- Problemsolving skills
- Positive attitude and ability to work well in a team
- Prior experience in and/or demonstrated affinity to working with children and families

Desired Qualifications:

- Bachelor's degree or equivalent
- Academic preparation or interpreter training and/or certification
- Knowledge of specialized vocabulary and concepts in the area of pediatrics
- Public speaking skills
- Cultural mediation skills
- Advocacy skills

CAREER PATHING

Normally promoted from:

May be promoted to:

In the spaces provided, list:

- | | |
|----------------------------------|---|
| ■ Major responsibilities: | General statements of major accountabilities |
| ■ Percentage of time: | How much time this responsibility takes |
| ■ Percentage of weight: | Based on overall importance of the job responsibility |
| ■ Performance criteria: | Specific statements that include what will be done, how it will be measured, and when it will be accomplished |

(Criteria-Based Job Description Continued)

Responsibility 1: Standards of Behavior	
CRITERIA	
Excellence—We will continuously strive for excellence in everything we do.	
■ I will act in the best interest of the child and family.	
■ I will work with families and the community on behalf of children.	
■ I will share my knowledge and expertise with coworkers.	
■ I will continually evaluate myself in order to improve.	
■ I will focus on what I am doing at the moment, doing my best to do it well.	
■ When I need help, I will ask for it.	
■ I will strive to learn new skills and improve my current skills.	
Respect—We will treat each other and everyone we serve with respect.	
■ I will respect the diversity in all of us.	
■ I will make the effort to understand how others want to be treated.	
■ I do not have to like someone to treat them respectfully. Everyone deserves to be treated with courtesy and dignity.	
■ I will handle anger and conflict in such a way that I will not harm, disrupt, or intimidate others.	
■ If I see disruptive behavior in others, I will not just ignore it or accept it. I will take appropriate action.	
■ I will not tolerate any form of discrimination, abuse, or harassment against myself or others.	
Cooperation—We will demonstrate full cooperation and teamwork across Children’s.	
■ I will do my part within the team.	
■ We will work together as an organization, not only as individuals or departments.	
■ I will acknowledge past problems in a working relationship and commit to moving forward to improve the relationship.	
■ I will use a multidisciplinary approach, working across shifts, departments, and campuses.	
■ I will work as part of the team, not always needing to be right or in the lead.	
■ I will take advantage of opportunities to learn what is going on in other work areas.	
■ I will work to bring out the best in each individual and group, acknowledging others’ moments of excellence.	

(Criteria-Based Job Description Continued)

Communication—We will communicate with one another directly, honestly, and constructively.	
■ I will speak up with new ideas, questions, or concerns. I also will be open to new ideas, questions, or concerns.	
■ I will share information that others need.	
■ If I am having a problem with someone, I will talk directly with that person about it. If I can't resolve it on my own, I will get help from an appropriate source. If I choose not to deal with it, I will let it go and not discuss it with others.	
■ My communication will be direct, honest, and constructive.	
■ I will listen; if I don't understand, I will ask.	
■ When I see someone doing good work, I will tell them so.	
Fairness—Common rules and standards of behavior will be applied equally to all.	
■ I will treat each person as an individual, not as part of a category or group.	
■ I will treat no one as a second-class citizen at Children's.	
■ I will treat each person's time as important. As a team, we will remain flexible to serve the best interests of the child and family.	
Self-care—We will take care of ourselves so we can better care for children and families.	
■ I will identify ways to deal with stress and take care of myself, and encourage others to do the same.	
■ I will take steps to deal with personal stress if it is affecting my work, or work-related stress if it is affecting my personal life.	
■ I will give over and above at times, and at other times I can say "no."	
■ I will improve with experience, continuing to learn and mature.	
Personal Accountability—We will be personally accountable for our actions and performance.	
■ I will conduct myself in a professional manner at all times.	
■ I accept responsibility for establishing and maintaining healthy working relationships.	
■ I will be accountable for my own expressed thoughts and opinions.	
■ I will own my mistakes and shortcomings, rather than blaming someone else or something else for them.	
■ I am committed to finding solutions to problems, rather than simply complaining or blaming.	
■ I will take responsibility to get the information I need.	

(Criteria-Based Job Description Continued)

Responsibility 2: Optimal Use of Resources	
CRITERIA	
<ol style="list-style-type: none"> 1. Manages time effectively by: <ul style="list-style-type: none"> ■ Completing work within schedule time ■ Adhering to break times ■ Arriving for work on time ■ Assisting others when time is available 2. Manages resources effectively, including supplies, equipment, and personnel 3. Takes responsibility to maintain and enhance job-related competence 	

Responsibility 3: Interpretation Between LEP Patient Families and Children’s Providers/Staff	% of Time
CRITERIA	
<ol style="list-style-type: none"> 1. Introduces self and explains role in a way that is responsive to the demands of the situation 2. Addresses the “comfort needs” of the patient in relation to the interpreter with regard to factors such as age, gender, and other potential areas of discomfort 3. Manages the spatial configuration of patient–provider–interpreter to maximize ease and directness of communication 4. Selects mode of interpretation (simultaneous, consecutive, summary; first or third person) that is appropriate to the situation at hand and interpreter’s competence 5. Accurately and completely transmits information between patient and provider 6. Maintains the style of the speaker on the continuum between formal and informal. 7. Encourages direct communication between patient and provider 8. Guides the flow of communication to preserve accuracy and completeness, as well as enhance the patient-provider relationship 9. Takes responsibility for (1) interpreter’s understanding of the message from the speaker and (2) listener’s understanding of the message as conveyed by the interpreter 10. Manages conflict when necessary 11. Provides sight translation as needed and requested 12. Provides followup outside of the interpreted encounter as necessary 	

(Criteria-Based Job Description Continued)

Responsibility 4: Translation of Written Materials	% of Time
CRITERIA	
<ol style="list-style-type: none"> 1. Translates written materials when not doing interpretation or as requested by the program supervisor 2. Utilizes the departmental editorial process to ensure high-quality translation 3. Accomplishes translations within the timeframe established 	

Responsibility 5: Cultural Mediation	% of Time
CRITERIA	
<ol style="list-style-type: none"> 1. Uses behavior that is culturally appropriate to both patient and provider 2. Pays attention to verbal and nonverbal cues that may indicate implicit cultural content or culturally based miscommunication (e.g., responses that do not fit the transmitted message; display of discomfort when certain topics are brought up) 3. Assesses the urgency/centrality of the issue in the particular situation at hand and modifies intervention based on that assessment 4. Shares cultural information that may be relevant and may help clarify the problem 	

Responsibility 6: Ethical Behavior	% of Time
CRITERIA	
<ol style="list-style-type: none"> 1. Maintains confidentiality 2. If privy to information regarding suicidal/homicidal intent, child abuse, or domestic violence, acts on the obligation to transmit such information in keeping with institutional policies, interpreting standards of practice and code of ethics, and the law 3. Maintains impartiality 4. Maintains professional integrity 5. Does not cross limits of personal competence or ability 6. Deals with discrimination 7. Adheres to all other stipulations of the professional code of ethics 	

(Criteria-Based Job Description Continued)

Responsibility 7: Program Support	% of Time
CRITERIA	
<ol style="list-style-type: none"> 1. Works in a team with other staff interpreters, participating in program and department tasks/functions as requested by the program supervisor or director 2. Accepts work assignments only from and in coordination with the interpreter services scheduler 3. Assists with communication about the interpreter services program and works to improve delivery of services to staff and families 4. Understands and follows the interpreter services policies and procedures 5. Attempts to constructively solve any problems with immediate persons involved. Informs the program supervisor as needed and in a timely manner 6. Successfully prioritizes and manages multiple tasks 7. Completes recording of appropriate documentation in an accurate and timely manner 8. Participates in education and training of providers and staff, as arranged with the program supervisor or director. (Possible topics may include: working effectively with an interpreter; cultural determinants of health care behavior in a specific population of interpreter's expertise; or developing culturally competent health care approaches with a population of interpreter's expertise) 	

Responsibility 8:	% of Time
CRITERIA	
1.	

Responsibility 9:	% of Time
CRITERIA	
1.	

Appendix C: Funding Sources

This appendix presents the following information and resources on funding for language access services:

- Federal, State, local, and other funding sources
- Medicaid and State Children’s Health Insurance Program (SCHIP) coverage
- Medicare coverage
- Coverage for federally qualified health centers and rural health clinics
- Sample costs for language access services (LAS)

Federal, State, Local, and Other Funding Sources

A variety of potential funding sources exist for implementing LAS. Exhibit AC–1 lists possible funding sources for organizations and provides a brief description of each funding source and places to go for additional information.

Exhibit AC–1: Funding Sources^{a 53 91}

Resource	Source Type	Description	For More Information
Medicaid	Federal funding; State reimbursement	Federal matching funds are available for State expenditures on language services for recipients of Medicaid. Eleven States offer direct reimbursement for these services (Hawaii, Idaho, Kansas, Massachusetts, Maine, Minnesota, Montana, New Hampshire, Utah, Virginia, and Washington).	See the information in the Medicaid and SCHIP section (page 210). Contact your State Medicaid program. http://www.cms.hhs.gov/medicaid/stateplans
State Children’s Health Insurance Program (SCHIP)	Federal funding; State reimbursement	Federal matching funds are available for State expenditures on language services for recipients of SCHIP. Eleven States offer direct reimbursement for these services.	See the information in the Medicaid and SCHIP section (page 210). Contact your State Medicaid program. http://www.cms.hhs.gov/schip

^aAll of the information on funding sources is subject to change without notice. Please check with the listed agencies to verify funding information.

Exhibit AC–1: Funding Sources (Continued)

Resource	Source Type	Description	For More Information
Medicare Part B	Payment for services	Payments for interpretation services provided as part of psychotherapy are permissible.	Contact the patient's Medicare Part B contractor/insurer.
Office of Minority Health (OMH), U.S. Department of Health and Human Services	Federal funding	Funding is provided for language services through the Bilingual/Bicultural Service Demonstration Grant Program. It awards funds to community-based organizations to provide language assistance to limited English proficient individuals seeking health care.	For a complete list of funding opportunities available from OMH, please see the OMH Web site: http://www.omhrc.gov/omh/whatsnew/2pgwhatsnew/funding.htm
State and county departments of health and departments of social services	State and local funding	States may offer additional funding of language services through: <ul style="list-style-type: none"> ■ Offices of minority health ■ Departments of health ■ Departments of social services 	Contact your local and State offices and departments.
Refugee offices	Local funding	State and local refugee offices may provide funds for language assistance to refugees.	Contact your State or local refugee office.
Federal 330 Community Health Centers (CHC) grants	Grant	Provided by the Division of Community and Migrant Health, Bureau of Primary Health Care, the CHC Federal grant program is authorized under Section 330 of the Public Health Service Act. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population. CHCs tailor services to the needs of the community.	Division of Community and Migrant Health Bureau of Primary Health Care Parklawn Building, Mail Stop 17–61 5600 Fishers Lane Rockville, MD 20857 301–594–4300 301–594–4497 (fax) http://bphc.hrsa.gov/programs/CHCPrograminfo.asp
California Endowment	Charitable foundation	The California Endowment has made cultural competence and linguistic access a major funding initiative by funding research, education, organizational development, and standards of interpretation services, language access policy and advocacy, and interpreter training and consumer education.	http://www.calendow.org

Exhibit AC–1: Funding Sources (Continued)

Resource	Source Type	Description	For More Information
The Commonwealth Fund	Charitable foundation	The Commonwealth Fund provides support of independent research, healthcare practice, and healthcare policy through grants in three program areas: Improving Insurance Coverage and Access to Care, Improving the Quality of Healthcare Services, and International Health Policy and Practice.	http://www.cmwf.org
Robert Wood Johnson Foundation	Charitable foundation	The Robert Wood Johnson Foundation funded the Hablamos Juntos project, which provided grants to organizations to test systems of language services.	http://www.rwjf.org http://www.hablamosjuntos.org
Foundation Center	Internet search resource	The Foundation Center provides searchable databases (for a fee) on philanthropy and is dedicated to serving grantseekers, grantmakers, researchers, policymakers, the media, and the general public.	http://www.fdncenter.org
Grantmakers in Health	Internet search resource	Grantmakers in Health provides a resource center on health philanthropy (for a fee), collects basic information on foundations and corporate giving programs funding in health, and looks across the field to identify trends and emerging issues.	http://www.gih.org
Managed care organizations (MCOs) and health maintenance organizations (HMOs) and private insurance companies	Varies	MCOs and HMOs may provide reimbursement for interpreters or supply LAS, such as interpreters, telephone interpretation, or translated materials.	Contact the patient's insurance company for available services and coverages.

Exhibit AC–1: Funding Sources (Continued)

Resource	Source Type	Description	For More Information
Administrative revenue or overhead	Internal funding	Include language access services as part of the organizational budget. When developing proposals and budgets and conducting programs and activities, providers could consider the need for language services for limited English proficient (LEP) persons served or encountered. Many agencies, including some in the Federal Government, have determined that costs associated with providing meaningful access to LEP individuals are considered allowable program costs.	Contact your organizational administrators. See Step 2 (Assessing Your Organizational Capabilities), specifically the Creating a Business Case section (page 37). See also the Introduction section titled Importance of Language Access Services (page 1) for material on rationale.

Medicaid and SCHIP Coverage

Each State currently has the option to receive matching funds from the Federal Government for services provided to recipients of Medicaid and SCHIP. Matching funds can be obtained as an administrative expense (equal to 50 percent of the cost) or as a covered service in a State.⁹¹ States that adopt language assistance as a covered service are eligible to receive a higher percentage of the total costs based on the State’s Federal Medical Assistance Percentage (which is the Federal Government’s share of a State’s expenditures for Medicaid, determined annually by a statutory formula).^{91 107}

The decision is made on a State-by-State basis whether to receive Federal matching funds for State expenditures on language services at all, and then, if the State chooses to, as an administrative cost or as a covered medical service.

States can choose to reimburse for language services directly, no matter how they choose to receive Federal matching funds. According to the National Health Law Program, only 11 States provide a mechanism for providing language services directly. Please see exhibit AC–2 for detailed information on States that provide mechanisms for reimbursing for language services.^{53 56 60}

Exhibit AC–2: Medicaid and SCHIP Reimbursement Models for Language Services From the NHeLP Language Services Action Kit^{a 56 60}

State	Whom Does the State Reimburse?	For Which Enrollees Does the State Pay for Language Services?	Which Providers Can Submit for Reimbursement?	How Much Does the State Pay for Language Services Provided to Medicaid/SCHIP Enrollees?
Hawaii	Language agencies	Fee-for-service	Fee-for-service	\$36/hour (in 15-minute increments)
Idaho	Providers	Fee-for-service	Fee-for-service	\$12/hour ⁵³
Kansas	EDS (the State Medicaid fiscal agent)	Fee-for-service	Fee-for-service	Spanish—\$1.10/minute Other languages— \$2.04/minute
Massachusetts	Hospitals and psychiatric facilities	Fee-for-service	Hospitals and psychiatric facilities	Determined by Medicaid agency
Maine	Providers	Fee-for-service	Fee-for-service	\$30/hour (business hours) \$40/hour (nonbusiness hours) \$7.50/15 minutes after first hour
Minnesota	Providers	Fee-for-service	Fee-for-service	\$12.50/15 minutes Lesser of \$50/hour or usual and customary fee
Montana	Interpreters	All Medicaid	All	Lesser of \$6.25/15 minutes or usual and customary fee
New Hampshire	Interpreters (who are Medicaid providers)	Fee-for-service	Fee-for-service	\$15/hour \$2.25/15 minutes after first hour
Utah	Language agencies	Fee-for-service	Fee-for-service	\$22/hour (phone) \$39/hour (in person)
Virginia ⁹²	Health departments	Fee-for-service	Health departments	Unknown
Washington	Public entities	All	Public entities	50 percent of allowable expenses
	Brokers; interpreters and language agencies	All	Nonpublic entities	Brokers receive an administrative fee Interpreters/language agencies receive up to \$28/hour

^aAs of 2002.

A review of the 11 States that directly reimburse for language assistance shows that States that claim the Federal share of matching funds as a covered service receive a higher percentage of their State’s costs than States that claim their share as an administrative expense. Exhibit AC–3 details the percentage of States’ costs paid by the Government by claim type. However, this rate is based on each State’s Federal Medical Assistance Percentage.⁹¹

Exhibit AC–3: Medicaid and SCHIP Reimbursement Claims by Type and Percentage of Federal Payments of States’ Costs From the NHeLP Language Services Action Kit^{56 60}

State	How Does the State Claim its Federal Share—As a Covered Service or Administrative Expense?	What Percentage of the State’s Costs Does the Federal Government Pay (FY 2002)?
Hawaii	Covered service	Medicaid—58.77% SCHIP—71.14%
Idaho	Covered service	Medicaid—70.96% SCHIP—79.67%
Kansas	Administrative expense	Medicaid and SCHIP—50%
Maine	Covered service	Medicaid—66.22% SCHIP—76.35%
Massachusetts	Unknown	Medicaid and SCHIP—50%
Minnesota	Administrative expense	Medicaid and SCHIP—50%
Montana	Administrative expense	Medicaid and SCHIP—50%
New Hampshire	Administrative expense	Medicaid and SCHIP—50%
Utah	Covered service	Medicaid—71.24% SCHIP—79.87%
Virginia ⁹²	Administrative expense	Medicaid and SCHIP—50%
Washington	Administrative expense	Medicaid and SCHIP—50%

Methods for securing language services and eligible entities for receiving reimbursement for language services vary by State.

Provision of Interpreters

All 11 States cover some form of an interpreter. How providers engage an interpreter differs from State to State.^{53 56}

- Hawaii contracts with two language service organizations, and Utah contracts with five organizations to provide interpreters. Virginia contracts with an area health education center and other subcontractors.
- In Idaho, Maine, Minnesota, and Montana, providers are responsible for arranging interpreters.

- Kansas provides access to a telephone interpreter line for all providers serving Medicaid fee-for-service enrollees.
- In Montana, the interpretation must be face-to-face to be considered reimbursable.
- In New Hampshire, interpreters must enroll as Medicaid providers and can bill Medicaid directly or work for an organization that coordinates interpretation services.
- In Washington, nonpublic entities must call a regional broker to arrange for an interpreter. Public entities must arrange for interpreters.
- No State reimburses bilingual staff and providers who offer services directly in a non-English language. If a bilingual staff person or provider is acting in an interpreter capacity for another provider, he or she may be eligible for reimbursement for that service.

Hospitals

Although the costs of interpreters and language services are directly reimbursable to providers or other entities in these 11 States, the cost of language services for hospitals is not directly reimbursable for inpatient services. For hospitals, the cost of language services is considered an administrative cost and included in their payment rates. Hospitals that provide outpatient fee-for-service clinics can get reimbursed just like other Medicaid providers in States that provide reimbursement.⁵⁶

Massachusetts and Washington, however, provide some form of reimbursement to hospitals. In Massachusetts, hospitals receive supplemental payments for interpretation services provided.⁵⁶ In addition, State law requires that reimbursement be provided to hospitals for the Medicaid managed care patients served by the hospital.⁴⁰ In Washington, public entities can only use certified interpreters and are reimbursed for 50 percent of their costs.⁵⁶

Federal funding is also provided to States for disproportionate share hospitals (DSHs). This funding can be used by States to support State-designated hospitals that serve a disproportionate share of Medicaid and uninsured patients. States distribute this funding to DSHs as they see fit and can consider language services expenses when allocating funding.

Medicare Coverage

Medicare does not provide or reimburse for LAS. However, under Medicare Part B, language interpreters are covered for psychotherapy services delivered by a doctorate- or masters-level psychologist, clinical social worker, and, in some States, a nurse practitioner or a clinical nurse specialist.^{93–98}

The Federal Government contracts directly with health plans and healthcare providers under Medicare. Some of the contracted agencies, including managed care organizations, health maintenance organizations, and providers, may provide interpretation and language services to patients using their own funding structure.⁹⁹

Coverage for Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) can be private, nonprofit, or public organizations that are eligible to receive funding through Section 330 of the Public Health Service Act.

FQHCs provide preventive primary health services to people who face barriers in accessing health services because they have difficulty paying for services, because they have language or cultural differences, or because there is an insufficient number of health professionals/resources available in their community.¹⁰⁰ FQHCs must provide basic health services and services that help ensure access to basic health and social services, including interpretive services.

Some of the benefits of being designated a FQHC include:¹⁰¹

- Enhanced Medicare and Medicaid reimbursement
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and nonprescription medications for outpatients at reduced cost through the 340B Drug Pricing Program
- Access to National Health Service Corps
- Access to the Vaccine for Children program
- Eligibility for various other Federal grants and programs

Rural Health Clinics

Rural health clinics (RHCs) can be for-profit or not-for-profit clinics located in areas that are designated as medically underserved.¹⁰²

RHCs are required to use a team approach of physicians and mid-level practitioners (nurse practitioners [NPs], physician assistants [PAs], and certified nurse midwives [CNMs]) to provide primary care services. RHCs may also provide other healthcare services, but they may not be reimbursed for those services based on their allowable costs.¹⁰²

Some of the benefits of being designated a RHC include:¹⁰¹

- RHCs receive special Medicare and Medicaid reimbursement.
- Medicare visits are reimbursed based on allowable costs, and Medicaid visits are reimbursed under the cost-based Prospective Payment System (PPS).
- RHCs may see improved patient flow through the utilization of NPs, PAs, and CNMs.

An RHC cannot be approved for Medicare as both an FQHC and an RHC.

Sample Costs for Language Access Services

Interpretation

Interpretation rates range in price. Inperson interpretation rates are generally charged on an hourly basis or another interval of time (e.g., 15-minute intervals). Telephone and video interpreting services tend to charge by the minute. Exhibit AC-4 gives some examples of the range of rates for interpretation services.

Exhibit AC-4: Sample Rates for Interpretation Services^{a 60 91}

Program	Rate ^b
Face-to-Face Interpretation	
Alameda Alliance for Health (Oakland, CA)	\$90–\$100/hour, 2 hour minimum
Idaho Medicaid Fee-for-Service	\$12/hour ⁵³
Maine Medicaid Fee-for-Service	Reasonable costs ⁵³
Montana Medicaid	Lesser of \$6.25/15 minutes or usual and customary fee
Multicultural Association of Medical Interpreters (Oneida, NY)	\$45–\$60/hour (with discounted contract rates)
Utah Medicaid Fee-for-Service	\$39/hour (in person)
Washington nonpublic entities	Up to \$28/hour
Telephonic Interpretation	
Kansas Medicaid Fee-for-Service	Spanish—\$1.10/minute Other languages—\$2.04/minute
Utah Medicaid Fee-for-Service	\$22/hour
Language Line Services (Monterey, CA)	Prices range from \$2.20 to \$4.50 per minute ^c
Pacific Interpreters (Portland, OR)	Pricing depends on size of facility and the volume of non-English patients that the organization serves

^aAll of these costs are estimates and are subject to change without notice. Costs may vary according to regional location. Please check with your local companies to confirm cost of services.

^bAs of 2002.

^cAs of 2004.

Translation

Rates for translation of documents also range in price. Rates are by word, by word block, and by page. These rates can further vary by language, subject matter, timeline for completion, and minimum rates. Exhibit AC-5 gives some examples of the range of rates for translation services.

Exhibit AC–5: Sample Rates for Translation Services^{a b}

Company/Organization	Rate ^c
Language Line Services ¹⁰³ (Monterey, CA)	Spanish, Chinese (Mandarin and Cantonese), French, Japanese, Korean, Russian, Vietnamese: \$9.50 per 25-word block \$40 minimum Armenian, Cambodian, German, Haitian Creole, Italian, Polish, Portuguese, Farsi, Tagalog, Thai, Urdu and all other languages: \$13.00 per 25-word block \$60 minimum
Eurasia Translations, Inc. ¹⁰⁴ (Encino, CA)	Minimum rate is \$100 European language translations: \$0.26 per word Scandinavian language translations: \$0.30 per word Asian language translations: \$0.30 per word
Essence Translation Services ¹⁰⁵	Less than 10 words: Flat rate \$10 11–100 words: Flat rate \$15 101–2,000 words: \$0.20 per word 2,001–10,000 words: \$0.18 per word More than 10,000 words: \$0.16 per word
Polyglot Translation and Academic Services ¹⁰⁶	English to Chinese: \$0.12 per source word Chinese to English: \$0.08 per source word
Washington State Language Interpreter Services and Translation (LIST) program ⁹⁹	Language assistance organizations contracted by the LIST program bill the State, and the State pays a \$35–\$45 flat rate.
Utah’s fee-for-service Medicaid, State Children’s Health Insurance Program, and medically indigent programs ⁹⁹	Language assistance service organizations contracted by the State of Utah bill the State, and the State pays \$35 per page for written translation services.
Minnesota’s fee-for-service and managed care Medicaid program and State Children’s Health Insurance Program ⁹⁹	The State reimburses \$25–100 per page for written translations, depending on the language and complexity of the document.

^aOMH provides these estimates of cost as a convenience. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

^bAll of these cost estimates are subject to change without notice. Costs may vary according to regional location. Please check with your local companies to confirm cost of services.

^cAs of 2005.

Appendix D: Example Waiver When Patient Chooses Informal Interpreter Over Formal Interpreter, From the Asian Pacific Health Care Venture

Request/Refusal Form for Interpretive Services¹⁰

Patient name: _____

Patient/Parent's language: _____

I understand my rights to receive interpretation services free of charge, and was offered access to such services. Staff also explained the issues surrounding my use of family members, friends and/or untrained individual as an interpreter.

Yes, I am requesting interpretive services.

Language (s): _____

I prefer to use my family or friend as an interpreter.

No, I do not require interpretive services. I am able to communicate with providers in English.

N/A

Please explain: _____

Patient Signature

Date

Parent's or Guardian's signature

Date

MR #: _____

Staff Name & Title: _____

Appendix E: Examples of Medical Interpreter Trainings^a

The following are examples of training programs created by volunteer-based programs in the United States.⁴⁸

Name/ Contact Info	Type of Organization	Overview	Details of Training	Logistics	Costs/Needs	Lessons Learned
Anchorage Neighborhood Health Center (ANHC) (Alaska) Joan Fisher Executive Director 907-792-6528	Federally Qualified Community Health Center. Over 50% LEP patients speaking many languages.	ANHC created a community language bank for many community agencies. They trained bilingual staff and volunteer interpreters to serve internally and in the community.	One-hr oral pre- test and written exam, then 48 hrs of intensive training. Spanish and several Asian languages. Interpreters found the schedule difficult but rewarding. Training was held once only (to date).	Charged trainees \$35 for pre-test, \$480 for training. Held off site, Tues through Friday evenings (4 hrs) and all day Saturday for 3 weeks. Trainer provided all materials.	Cost about \$15,000 per training. Partially grant supported. Director/assista nt time: 20 hrs/wk for 8 wks. University & nonprofit provided test & training sites.	Train a trainer. (Trainer was expensive.) Fewer than half the candidates passed the pre- test. Many interpreters cannot perform well in both languages.
Arlington Free Clinic (Virginia) Lee Miller Volunteer Director 703-979-1425 Ext. 12	Free clinic. Over 50% Latino patients.	Uses paid, professional interpreters for mental health and other complex/ specialty appointments. Uses volunteer interpreters (with 5-hour training) for general appointments.	A brief orientation, then a one-day 5-hr workshop for volunteers. (Paid interpreters trained in Bridging the Gap.) Staff were trained by the initial trainer to continue offering in- house workshops after startup. Ongoing.	On-site. Trainees are screened and informally pre- tested. A training packet, resources, and vocabulary list were developed.	Startup costs of \$2,000 and 60 hrs of Volunteer Director's time to administer and to recruit trainees.	Startup costs of \$2,000 and c. 60 hrs of Volunteer Director's time to administer and to recruit trainees.
La Clínica del Pueblo (Washington, DC) Isabel Van Isschot Interpreter Services 202-462-4788	Bilingual/ bicultural free clinic, primarily for uninsured Latinos.	Clínica trains bilingual staff and volunteer interpreters. Also operates interpreter referral system for other clinics.	A 40-hr Bridging the Gap training with trainee screening, proficiency testing, and post-tests (oral and written). Spanish only, in-depth exercises and role plays; interactive and dynamic. Not ongoing.	Off site. Held on five Saturdays for bilingual staff from several clinics. Held in Spanish. Trainees were not charged. Not an ongoing program due to expense.	Startup costs included having a trainer on staff. With one staff trainer and one outside trainer, site costs, etc., training can run from \$4,000 to \$5,000. Requires significant staff time.	It is often hard to find a comfortable location. Holding it in Spanish worked well for this group of native Spanish speakers.

^aOMH provides these training examples as a convenience and does not endorse the trainings. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

Name/ Contact Info	Type of Organization	Overview	Details of Training	Logistics	Costs/Needs	Lessons Learned
HealthReach HABLA (Healthcare Access By Language Advocacy) (Illinois) Mayra Rubalcava Program Manager 847-263-5486	Referral network with free clinic. About 75% Hispanic patients.	Full-time program manager coordinates volunteer interpreters and training. Interpreters are used in clinic and the community at large.	Home study program of 10 lessons w/live sessions once a month, tests and supervised clinical encounters. Materials include take- home manual, CD w/slides and audio for computer use. Ongoing.	Agency charges \$5 per lesson for cost of materials. Live sessions held on site. Program Manager supervises trainees.	Program requires an on- going full-time manager. Space needed on site for manager, live sessions, tests. Program required about 1 year to set up.	It is important to post-test all interpreters to ensure skill level. Certify them.
Primary Care and Hope Clinic (Tennessee) Lisa Pewitt Clinical Director 615-893-9390 Ext. 229	Nonprofit community health center (sliding scale).	After the interpreters were trained, two were hired part time; others are used as volunteers. Several are also used by the community at large.	Two hours of class per week by staff trainers off site for 8 wks (16 hrs), then 6 hrs on- site observation, 3 weeks interpretation with a preceptor and a comprehensive written exam. Spanish only. Held twice: may repeat in future.	Each session is presented in a PowerPoint format with accompanying notebook. Guest speakers. Each interpreter receives pocket guide and other resources. Tailored to organization.	\$10,000 to \$12,000 for total 33 trainees, including 170 hrs staff time. It required curriculum dev't, manual, materials. University donated training site. Interpreters later became widely used by the community.	It's good to post-test and certify the trainees: it gives them credibility. This is a big endeavor. Costly but worthwhile: it solved the problem, and the clinic later hired two trainees.

Additional examples of interpreter training programs and resources can be found on the National Council on Interpreting in Health Care Web site at: <http://www.ncihc.org/hot.htm>.

Appendix F: Example of an Organization's Policies and Procedures for Working With Interpreters, From Children's Hospitals and Clinics



Policy Number:	111.00	Review/Revision #	2
Category:	RI		
Site:	System		
Responsible for Review:	Interpreter Services		
Original Effective Date:	2/1/99		
Review/Revision Date:	5/17/05		
Next Review Date:	5/17/07		

Policy: Children's will provide appropriate and necessary interpreters, as well as auxiliary aids and services, to patients and their parents or other responsible parties ("responsible parties" in further text) who have limited proficiency in English and/or have hearing and visual impairments. The purpose of the policy is to ensure that optimal communication occurs between staff and patients/responsible parties to facilitate care at Children's Hospitals and Clinics. These services will be provided at no cost to the patient/responsible party.

1. Situations in which appropriate interpreters and/or auxiliary aids and services must be utilized to assure accurate and thorough communication include, but are not limited to, the following:
 - Explanation of the admission procedure
 - Determination of patient's medical, psychiatric, psychosocial, nutritional, and functional history or description of condition
 - Discussion of patient's rights, informed consent, or permission for treatment
 - Determination and explanation of patient's diagnosis or prognosis, and current condition
 - Explanation of procedures, tests, treatment, treatment options, or surgery

**Policy
(Continued):**

- Explanation of medications prescribed (such as dosage, instructions for how and when the medication is to be taken and side effects or food or drug interactions)
- Explanation of follow-up treatments, therapies, test results, or recovery expectations
- Explanation of changes in the treatment program and need for ongoing/continued care
- Explanation of the rationale for the patient to follow the prescribed treatment regimen
- Blood donations or aphaeresis (removal of blood components)
- Discharge planning and discharge instructions
- Provision of mental health evaluations, group and individual therapy, counseling, and other therapeutic activities, including but not limited to grief counseling and crisis intervention
- Explanation of billing or insurance issues that may arise
- Educational presentations, such as classes concerning nutrition, CPR, and care at home
- Social work, chaplaincy, and child life interventions
- Explanation of health care directives or powers of attorney (or their availability)
- Any time upon family's and/or staff's request
- Any other circumstance in which a qualified interpreter is necessary to ensure a patient's rights provided by law.

Definitions:

Limited English Proficient (LEP):

Any person who is not able to interact effectively in a health care context due to limited abilities in speaking, reading, writing or understanding the English language.

Interpretation:

Enabling oral communication between two or more individuals who do not speak a common language through an additional individual (interpreter) who is highly proficient in both languages. Skills in interpretation include understanding what was said, extracting the underlying meaning and intent, and expressing the message in another language in a way that carries the same meaning.

Translation:

Providing an accurate written version of a text, in a language different from the original, or source, language.

Professional medical interpreter:

Individual with appropriate training and experience who is able to interpret consistently and accurately in a health-care context. This professional functions in accordance with medical interpreting standards of practice and adheres to a code of professional ethics.

Responsible Party:

Responsible Party means:

- a. a person legally authorized to make health care decisions on behalf of the patient
- b. a person whom the patient indicates should communicate with hospital personnel about the patient; participate in any treatment decision; play a role in communicating the patient's needs, condition, history, or symptoms to hospital personnel; or help the patient act on the information, advice, or instructions provided by hospital personnel
- c. such other person with whom the hospital personnel would ordinarily and regularly communicate concerning the patient's condition and care.

Procedure:

Identifying need	For all patients, staff will perform a communication assessment and document the findings in the patient’s record. This will include information on the primary language spoken in the patient’s home, as well as whether an interpreter is needed for each of the key family members/responsible parties involved in the child’s care.
Informing patients of their rights	Staff will inform the patient/responsible party of the interpreters and auxiliary aids available to them, and explain that there is no charge for their use. This information will also be made widely available through the use of Children’s <i>language globes</i> , which are placed in waiting rooms, at welcome and registration desks, and at other significant points of contact between patients/responsible parties and Children’s staff. Staff will honor the patient’s choice of interpreter if possible.
Obtaining an interpreter	<p>All interpreting at Children’s is coordinated by calling (xxx) xxx-xxxx at all times. Calls may be answered by one of the following:</p> <ol style="list-style-type: none">1. By an interpreter services scheduler. Mon-Fri 7am-4:30pm.2. By an on-call staff interpreter for Hmong, Somali and Spanish languages. Mon-Fri 4:30-10pm; Sat/Sun 10am-10pm.3. By a contracted outside agency. Mon-Fri 4:30pm-7am; Sat/Sun 24hrs/day4. By Language Line. 24/7 (this option can be selected from the phone menu at any time). See additional information below under “Language Line.” <p>Some units also have an automated computerized process for requesting interpreters.</p>
Using children as interpreters	Children under 18 should not be used to interpret.
Using family or friends as interpreters	Children’s interpreters—either staff members or outside contractors—are trained, experienced, and screened professionals. Using family or friends as a substitute for trained interpreters is strongly discouraged. This may be justified only when all other options have been exhausted and/or at the direct request of the family, and only after it was clearly explained to the family that a professional interpreter is readily available at no cost to them. Children’s interpreter services reserves the right to examine the interpreting competence of any outside person and when such competence is in doubt, Children’s interpreter may be deployed to the appointment in a “shadow” capacity in order to assure accuracy in communication. When a Children’s interpreter is deployed, Children’s will not cover the costs of any additional interpreting services at that appointment for the same language. Staff is to inform the family that any request to use, or actual use of, family or friends to provide interpreter services will be documented in the patient’s chart, and that the hospital will not compensate such friends or family for services rendered voluntarily.

Using other personnel as interpreters	Children’s discourages the use of other employees, who do not have training as interpreters, to engage in interpreting.
Bilingual providers and staff	<p>Knowledge of a second language is a valuable asset for building rapport and trust with limited-English proficient patients. However, unless this knowledge is at the level of native-like fluency, it is best not to depend on it for any clinically significant interactions.</p> <p>Bilingual providers and staff who feel competent to engage with patients in a language other than English should first contact interpreter services for an assessment of their language skills.</p>
In-person vs. telephonic interpreting	<ol style="list-style-type: none">1. In-person interpreting. This mode is provided most frequently for actual visits to the hospitals and clinics. The interpreter can be either a staff member or an outside contractor.2. Telephonic interpreting. Staff will use telephonic interpreting as an interim measure while waiting for an in-person interpreter to arrive. They will also rely on this mode for brief, unanticipated and/or emergent needs. Whenever feasible, staff will check that all parties are in agreement that sufficient accuracy in communication is achievable over the phone.
Language Line	Language Line is a telephonic back-up system for obtaining an interpreter in any spoken language. It is accessible at all times through the phone menu of Children’s interpreter scheduling line (xxx-xxx-xxxx), or directly by calling (xxx) xxx-xxxx. Children’s client number is XXXXXX. Personal code is the name of the department/unit and the full name of the person making the call. Each department/unit should have a readily accessible “Using an Interpreter Over the Phone” reference card, offering step-by-step instructions. All providers and staff should be proficient in using this service. Training is available from Children’s Interpreter Services upon request.
Deaf and hard-of-hearing interpreting	<p>Requests for American Sign Language interpreters are made at all times by calling Children’s interpreter scheduling line, (xxx) xxx-xxxx.</p> <p>Communication attempts should not stop while waiting for an interpreter to arrive. Between the time an interpreter is requested and the time an interpreter arrives at the hospital to interpret, staff will continue to try to communicate with the patient/responsible party for such purposes and to the same extent as they would have communicated with the person but for the disability, using all available methods of communication.</p> <p>TDD/TTY phones (text telephones used by individuals who are hearing impaired) are available from the Welcome Centers on each campus. These devices may be used by hearing impaired individuals who, while staying at Children’s Hospitals and Clinics, wish to make contact via phone with someone on the outside.</p> <p>Incoming and outgoing calls between staff and deaf and hard-of-hearing families will be handled through the Minnesota Relay Services, a 24/7 service for telephone-based communication between deaf and hearing individuals in the community.</p>

The use of auxiliary aids

Beyond TDD/TTY devices, other auxiliary communication aids include phone handset amplifiers, telephone ring signalers (light flashes when phone rings), communication boards, pen/pencil and paper, various visual aids, TV closed captioning, etc.

Should an auxiliary communication aid be needed and/or requested by the family, staff will coordinate arrangements and enlist assistance from various internal resources such as the ITS, family services, and facilities.

Documentation

For all patients, staff will perform a communication assessment and document the findings in the patient's record, as per "Identifying Need" above. Beyond this initial assessment, staff should record in the patient's chart any ongoing provision of interpreter services and/or auxiliary aids. This includes: (a) time of interpreter requests, arrivals, and departures; (b) full name of the interpreter used; (c) whether interpreting was done via phone or in person; (d) any auxiliary aids provided for family's use.

Cultural mediation

In order to facilitate the best possible communication between health care providers/staff and patient families, Children's staff interpreters function as cultural mediators. In that role, they maintain awareness of verbal and nonverbal cues indicating implicit cultural content and potential for culturally based miscommunication that may affect care (e.g., display of discomfort when faced with a certain behavior or when certain topics are brought up; responses that do not fit the transmitted message, etc.) Staff interpreters assess the urgency/centrality of the issue in the particular situation at hand, and intervene by sharing the cultural information deemed relevant and likely to help improve patient care.

In cultural mediation activities, staff interpreters work closely with other members of the immediate health care team. Other internal (the office of ethics, chaplaincy, social work...) and external resources (extended family, family/community leaders, home clergy or spiritual advisors...) may be included in collaboration, as needed and appropriate.

Provider/staff training

The cross-cultural communication skills of providers and staff, and their proficiency in working through an interpreter, are crucial factors for successful health care of Children's LEP patients. Children's interpreter services staff members facilitate various individual and group educational opportunities throughout the organization aimed at building competence in cross-cultural and/or cross-linguistic clinical situations. This includes a regular training session at each new employee orientation.

Written translation

All requests for translation of written materials should be submitted to the interpreter/translation services supervisor at (xxx) xxx-xxxx.

Providers who would like to hand out any type of translated material should always inquire, through an interpreter, about the parents' level of written literacy in their native language. Some people who do not speak/read/write in English may not have these abilities in their native languages, either. Thus, utility of Children's translated material, although undeniable in building relationships and trust with families, needs to be checked with each individual family before relying on it for conveying critical information.

References:

Policy Guidance on Title VI A guide clarifying the responsibilities of health and social services providers under Title VI of the Civil Rights Act’s prohibition against discrimination on the basis of national origin as it affects persons with limited English proficiency.

Minnesota Bilingual Services Act Minnesota Statutes 15.441, Subdivision 1, states that “Every state agency that is directly involved in furnishing information or rendering services to the public and that serves a substantial number of non-English-speaking people shall employ enough qualified bilingual persons in public contact positions, or enough interpreters to assist those in these positions, to ensure provision of information and service in the language spoken by a substantial number of non-English-speaking people”

The Americans with Disabilities Act (ADA) The ADA mandates equal access to health care for the disabled, and requires that hospitals provide effective means of communication for patients, family members, and hospital visitors who are deaf or hard of hearing.

Key Words: translation; interpretation; interpreter

Review/Revision Dates: Original policy: Language Interpreters, Minneapolis #184.00 8/25/93
Original policy: Interpreter Services, St. Paul #Adm-20 8/96
Original policy: Language Interpreters, West #121.00 8/15/94
Revised system policy: 2/1/99, 6/8/99
Revised: 7/25/02

Appendix G: Examples of Multicultural Patient Education Material Web Sites^{a b}

Source	Description
American Academy of Child and Adolescent Psychiatry	
http://www.aacap.org/publications/factsfam/index.htm	<p>Educates parents about psychiatric disorders affecting children.</p> <p>More than 80 topics available in English, Spanish, German, French, Polish, and Icelandic.</p> <p>Copies may be duplicated and distributed for free.</p>
Association of Asian Pacific Community Health Organizations	
http://www.aapcho.org	<p>Seeks to “promote advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the United States, its territories and freely associated States, primarily through our member community health clinics.”</p> <p>Patient education materials are available on a variety of topics, such as cancer, diabetes, thalassemia, and tuberculosis, and are available in Chinese, English, Hmong, Korean, Lao, Tagalog, Samoan, Vietnamese, and Ilocano.</p> <p>Most materials are available for a fee.</p>
National Center for Cultural Competence, Georgetown University Center for Child and Human Development <i>A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials</i>	
http://gucchd.georgetown.edu/nccc/documents/Materials_Guide.pdf	<p>The purpose of this document is to provide guidance on how to assure that health promotion materials reflect the principles and practices of cultural and linguistic competence.</p> <p>The guide aims to assist these groups in making appropriate choices among existing materials, as well as to provide recommendations to adapt such materials for use in health promotion efforts. The guide is designed to be used by a variety of audiences, including those who implement health promotion activities and want to ensure cultural and linguistic competence; community organizations, including faith-based organizations, that want to address health issues; and public health officials and funders who want to assure that health promotion activities they support are culturally and linguistically competent.</p>

^aAll Web sites were last accessed on 6/29/05.

^bOMH is not responsible for the content of any linked sites. OMH provides these links as a convenience and does not endorse the companies or contents of any linked sites. Names, descriptions, and information do not constitute endorsement of a product, service, or site.

Multicultural Health Communication Service, NSW Department of Health, Australia	
http://www.mhcs.health.nsw.gov.au	<p>Provides information and services to help health professionals communicate with non-English speaking communities.</p> <p>Patient education materials are available in more than 40 languages on more than 240 topics (not all topics available in all languages).</p> <p>Brochures can be downloaded for free.</p>
MultiLingual-Health-Education.net	
http://www.multilingual-health-education.net/faq.asp	<p>A nonprofit alliance of Canadian health agencies that provides translated materials for public use.</p> <p>More than 40 topics covered in English, French, Farsi, Hindi, Punjabi, Korean, Spanish, Chinese, Japanese, Vietnamese, Darshan, Italian, and Tagalog.</p>
New York Online Access to Health (NOAH)	
http://www.noah-health.org/index.html	<p>Seeks to provide "access to high quality full-text consumer health information in English and Spanish that is accurate, timely, relevant and unbiased."</p> <p>The site contains more than 50 topics, with multiple subtopics in English and Spanish.</p> <p>Links and brochures can be accessed for free.</p>

Appendix H: List of Documents Translated at One Organization by Bilingual Staff Members

Note: This organization was one of the sites visited as part of this project.¹³

- After-hours instruction sheet
- Authorization for disclosure of health information (release of medical records from previous provider)
- Authorized representative form
- Cholesterol test results form
- Client behavior contract (written notice of violation of policy)
- Congratulations on birth of baby/instructions to apply for Medicaid
- Consent to sterilization
- Cover letter
- Dental checkup reminder
- Depo Provera factsheet
- Health history
- Health screen
- Healthy Kids application instructions
- HIPAA notice of privacy practices
- Immunization reminder
- Information and resource card
- Information sheet on transportation resources
- Informed consent for counseling
- Instructions to prepare for a flexible sigmoidoscopy

- Lab/diagnostic test results form
- Medical instruction sheet (in 10 languages; all other forms in two primary limited English proficient languages)
- Missed appointment/moving letter
- Missed appointment/no-show letter
- New patient registration packet
- Ninth month of pregnancy information sheet
- Notice of appointment change
- Parental consent form to provide care to a minor
- Patient bill of rights
- Patient contract for care
- Patient information sheet (about clinic services and hours)
- Patient intake form
- Prenatal database questionnaire
- Prenatal patient intake form
- Prescription pickup permission form
- Procedure consent form
- Referral confirmation
- Refusal for procedure form
- Transfer of care questionnaire
- Violation of policies letter

Appendix I: Other Resource Documents on Implementing Language Access Services

This annotated bibliography was created using documents that were uncovered through a comprehensive search for resources on language services.

1. J. R. Betancourt, A. R. Green, and J. E. Carillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (Washington, DC: The Commonwealth Fund, 2002).
 - Target Audience: Organizations in the healthcare system
 - Type of Document: Promising and practical practices
 - Focus of Content: Culturally competent care; recommendations on improving cultural competence
 - Information based on: Literature review, 37 interviews with field experts, and four site visits to models of culturally competent care at an academic, Government, managed care, and community healthcare programs

2. B. Downing and C. Roat, *Models for the Provision of Language Access in Health Care Settings* (Santa Rosa, CA: National Council on Interpreting in Health Care and Hablamos Juntos, 2002), http://www.ncihc.org/NCIHC_PDF/ModelsfortheProvisionofLanguageAccessinHealthCareSettings.pdf.
 - Target Audience: Healthcare providers
 - Type of Document: Resource toolkit
 - Focus of Content: The need for a mix of interpretation models to provide services to multiple groups of limited English proficient (LEP) patients given organizational needs and resources
 - Information based on: Review of literature and existing models in the United States

3. E. V. Gallardo, V. Y. Huang, and C. Niski, *Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices* (Sacramento, CA: California Primary Care Association, 2004), <http://www.cPCA.org/resources/research/pdf/PPGuide.pdf>.
 - Target Audience: Community clinics and health centers
 - Type of Document: Promising practices
 - Focus of Content: What has been done at clinic sites, advocacy agencies, and at the State level to better provide service to LEP persons. A history of the organization and their activities revolves around four keys to compliance: (1) assessment, (2) written LEP policy, (3) training staff, and (4) monitoring compliance.
 - Information based on: California-based community health clinics and centers

4. Grantmakers in Health, "In the Right Words: Addressing Language and Culture in Providing Health Care," *Issue Brief (Grantmakers in Health)*, no. 18 (2003): 1–44.
 - Target Audience: Foundations (or organizations that offer grants)
 - Type of Document: Issue brief
 - Focus of Content: Interpretation and translation services; topics covered include recent immigration trends and demographic changes, the effect of language barriers on health outcomes and healthcare processes, laws and policies regarding the provision of language services, strategies for improving language access, and roles for foundations in supporting improved language access
 - Information based on: Discussions with health grant makers and health policy and practice experts

5. S. Kashiwagi, *A Functional Manual For Providing Linguistically Competent Health Care Services As Developed by a Community Health Center* (Los Angeles, CA: Asian Pacific Health Care Venture, Inc., 2004).
 - Target Audience: Community health centers and other healthcare providers
 - Type of Document: Resource manual
 - Focus of Content: A framework to comply cost-effectively with Title VI and the 2002 DOJ LEP Policy Guidance. Focuses on (1) assessment (client and organizations); (2) development of comprehensive written policy and procedures (interpreters, translation, hiring diverse staff, notifying LEP patients); (3) training of staff (cultural sensitivity, staff, interpreter); and (4) vigilant monitoring (updating and evaluating)
 - Information based on: Practices of Asian Pacific Health Care Venture

6. National Council on Interpreting in Health Care, *Guide to the Initial Assessment of Interpreter Qualifications* (Santa Rosa, CA: The National Council on Interpreting in Healthcare Working Paper Series, 2001), <http://www.ncihc.org/NCIHCDocRep/DocumentViewer.html>.
 - Target Audience: Agencies that employ interpreters and agencies that refer interpreters for assignments in healthcare settings
 - Type of Document: Guide on assessing interpreter qualifications
 - Focus of Content: Initial assessment of interpreters in the absence of certification through screening and interviewing. Details processes for assessment of interpreter basic language skills, ethical standards, cultural issues, healthcare terminology, and integrated interpreting skills, and translation of simple instructions. Includes resources on where to find testing materials and other resources to conduct assessment.
 - Information based on: The Massachusetts Medical Interpreters Association's Medical Interpreting Standards of Practice, the Standard Guide for Language Interpretation Services developed by the American Society for Testing and Materials, and the Bridging the Language Gap report written by Minnesota's Interpreter Standards Advisory Committee; a screening process used successfully over the past few years by a consortium of healthcare agencies that employ interpreters in Madison, Wisconsin; the formal certification process being developed by the Massachusetts Medical Interpreters Association

7. National Health Law Program, *Language Services Action Kit* (Washington, DC: National Health Law Program and The Access Project, 2004), <http://www.accessproject.org/downloads/LEPreprint04.pdf>.
 - Target Audience: Advocates and others working to ensure that LEP individuals receive appropriate language assistance in services in healthcare settings
 - Type of Document: Resource toolkit
 - Focus of Content: Federal laws and policies; Federal funding; making the case for language services; advocacy; resources
 - Information based on: Research in Iowa and New Hampshire; input from field experts

8. K. Paez and others, *Providing Oral Linguistic Services: A Guide for Managed Care Plans* (Baltimore, MD: Centers for Medicaid and Medicare Services and Agency for Healthcare Research and Quality, 2003), <http://www.cms.gov/healthplans/quality/project03.asp>.
 - Target Audience: Managed care organizations, specifically Medicare+Choice organizations
 - Type of Document: Guide for managed care plans
 - Focus of Content: Definition of the linguistics needs of LEP members and development of strategies to meet those needs. The guide presents six steps toward linguistic competence: (1) identify oral linguistic needs of membership; (2) assess the capabilities of managed care plan; (3) identify points of contact for members of managed care plans; (4) consider different oral linguistics strategies; (5) assemble an oral linguistic services plan; and (6) monitor oral linguistic services strategies.
 - Information based on: Input from advisory board, research with health plans and content experts

9. K. Paez, M. Gunter, and C. Brach, *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans* (Baltimore, MD: Centers for Medicare & Medicaid Services, 2004), <http://www.cms.gov/healthplans/quality/project03.asp>.
 - Target Audience: Managed care organizations, specifically Medicare+Choice organizations
 - Type of Document: Guide for managed care plans
 - Focus of Content: Steps toward fostering a culturally diverse workforce, providing linguistic services (primarily translation), and improving cultural competence. Topics include policy/procedure, client assessment, organization assessment, translation, cultural competence, and diverse workforce
 - Information based on: Input from advisory board, research with health plans and content experts

10. J. Perkins, M. Youdelman, and D. Wong, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, Second Edition* (Los Angeles, CA: National Health Law Program, 2003)
 - Target Audience: Recipients of Federal funds (including hospitals, nursing homes, managed care organizations, State Medicaid agencies, home health agencies, health service providers, and social service organizations)
 - Type of Document: Issue brief

- Focus of Content: Responsibilities under current federal civil rights laws, U.S. Department of Justice guidance, U.S. Department of Health and Human Services guidance, and Office of Minority Health CLAS standards. In addition, the brief provides examples of State policy and program developments.
 - Information based on: Federal laws, State law requirements, and accreditation standards; examples from the field (nine State Medicaid programs; one local government initiative; four hospital-based initiatives; two health maintenance organizations; two community-based organizations; three educational models)
11. C. Roat, *Addressing Language Access Issues in Your Practice—A Toolkit for Physicians and Their Staff Members* (San Francisco, CA: California Academy of Family Physicians and CAFP Foundation and The California Endowment, 2005).
- Target Audience: Physicians and staff members
 - Type of Document: Resource toolkit
 - Focus of Content: (1) Difference between communicating directly with a patient versus using an interpreter with a patient, (2) difference between a trained and an untrained interpreter, and (3) use of friends and family as interpreters; three steps to communicating effectively with patients; some content specific to California
 - Information based on: input from physicians, interpreters, healthcare professionals, and administrators
12. Wendy Siegel, *Building Linguistic and Cultural Competency: A Toolkit for Managed Care Organizations and Provider Networks That Serve the Foreign-Born* (Chicago, IL: Mid-America Institute on Poverty: Heartland Alliance for Human Needs and Human Rights, 1998), <http://www.consultmillennia.com/documents/Building%20Linguistic%20&%20Cultural%20Competency.pdf>.
- Target Audience: Managed Care industry, administrators, and practitioners
 - Type of Document: Resource toolkit
 - Focus of Content: Rationale and steps for managed care organizations to implement cultural competence practices, including bilingual hiring practices, interpretation, translation, and staff training; also includes making the business case/convincing administrators that targeting the LEP population pays
 - Information based on: Input from members of the Immigrant and Refugee Health Task Force; other
13. M. Youdelman and J. Perkins, *Providing Language Interpretation Services in Health Care Settings: Examples From the Field* (New York: The Commonwealth Fund, 2002), http://www.cmwf.org/usr_doc/youdelman_languageinterp_541.pdf.
- Target Audience: Healthcare organizations
 - Type of Document: Field report
 - Focus of Content: Field examples of interpretation services provision
 - Information based on: Assessment of 14 programs designed to improve access to interpretation services in healthcare settings. Sponsors of the programs included State and local governments, managed care organizations, hospitals, community-based organizations, and educators.

14. M. Youdelman and J. Perkins, *Providing Language Services in Small Health Care Provider Settings: Examples From the Field* (New York: The Commonwealth Fund, 2005), http://www.cmwf.org/usr_doc/810_Youdelman_providing_language_services.pdf.
- Target Audience: Small healthcare provider settings
 - Type of Document: Field report; promising practices
 - Focus of Content: Promising practices, creative methods that are effective and replicable; practices include: recruiting bilingual staff for dual roles; ongoing cultural and language competence training for interpreter staff; using community resources like hospitals, managed care organizations, students, and volunteers; and capitalizing on underutilized funding sources; an eight-step plan to help providers develop a strategy to meet the needs of their LEP patients and the community
 - Information based on: 11 site visits and 7 phone interviews at small healthcare provider settings (those with 10 or fewer clinicians)

References

1. B. D. Smedley, A. Y. Stith, and A. R. Nelson, *Unequal Treatment: Confronting Racial and Ethnic Health Disparities in Health Care. Institute of Medicine Report* (Washington, DC: National Academy Press, 2004).
2. Office of Minority Health, DHHS, *Improving Access to Health Care: Draft Recommendations for National Standards for Health Care Language Services. Developed by the American Institutes for Research (AIR)*. (Rockville, MD: Office of Minority Health, Department of Health and Human Services, 2003).
3. R. F. Boyd, “A Message to Recipients from Ralph F. Boyd, Jr., Assistant Attorney For Civil Rights, United States Department of Justice” (memorandum). (Washington, DC: U.S. Department of Justice, 2005), <http://www.usdoj.gov/crt/cor/Pubs/BoydLEPArt.htm>.
4. SC Department of Mental Health, “SC Department of Mental Health Medical Records and Utilization Review Tool.” (2005), http://www.state.sc.us/dmh/dmhforms/outcome_measures/ps303.pdf.
5. U.S. Department of Justice, “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” *Federal Register* 67, no. 13 (2002): 2671–2685.
6. L. M. Anderson and others, “Culturally Competent Healthcare Systems: A Systematic Review,” *American Journal of Preventive Medicine* 24, no. 3 Suppl. (2003): 68–79.
7. D. Andrulis, N. Goodman, and C. Pryor, *What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured With Limited English Proficiency* (Boston, MA: The Access Project, 2002).
8. Office of Minority Health, *Recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care* (Washington, DC: U.S. Department of Health and Human Services, 2000), <http://www.omhrc.gov/clas>.
9. U.S. Census Bureau, “Language Use.” (2005), http://www.census.gov/population/www/socdemo/lang_use.html.
10. S. Kashiwagi, *A Functional Manual For Providing Linguistically Competent Health Care Services as Developed by a Community Health Center* (Los Angeles, CA: Asian Pacific Health Care Venture, Inc., 2004).
11. K. Paez, M. Gunter, and C. Brach, *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans* (Baltimore, MD: Centers for Medicare & Medicaid Services, 2004), <http://www.cms.gov/healthplans/quality/project03.asp>.

12. Office of Minority Health, DHHS, *Health Care Professionals' Perspectives on the Content and Structure of the Draft Health Care Language Services Implementation Guide (HC-LSIG)*. Developed by the American Institutes for Research (AIR). (Rockville, MD: Office of Minority Health, Department of Health and Human Services, 2005), http://www.cultureandhealth.org/lang/documents/NSHCLSFinalINTreport_v14_05-11-05.pdf.
13. Office of Minority Health, DHHS, *Small Health Care Organizations That Provide Language Access Services: A Site Visit Report*. Developed by the American Institutes for Research (AIR). (Rockville, MD: Office of Minority Health, Department of Health and Human Services, 2005), <http://www.cultureandhealth.org/lang/documents/HCLSIGSiteVisitReport.pdf>.
14. B. Downing and C. Roat, *Models for the Provision of Language Access in Health Care Settings* (Santa Rosa, CA: National Council on Interpreting in Health Care and Hablamos Juntos, 2002), http://www.ncihc.org/NCIHC_PDF/ModelsfortheProvisionofLanguageAccessinHealthCareSettings.pdf.
15. Maricopa County Medical Interpreter Project, *Medical Interpreting in Arizona* (Phoenix, AZ: Maricopa County Medical Interpreter Project, 2003).
16. J. J. Orellana, C. Soltoff, and B. Seagrave-Whittle, *Measuring the Costs and Benefits of Language Services* (paper presented at Fourth National Conference on Quality Health Care for Culturally Diverse Populations: Integrating Community Needs into the National Health Agenda, 2004, Washington, DC).
17. W. Alvarado-Little (personal communication), Guide Vignettes—Brainstorming Conference Call, January 31, 2005.
18. G. Flores, “The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review,” *Medical Care Research and Review* 62, no. 3 (2005): 255–299.
19. G. Flores, M. Abreu, and S. C. Tomany-Korman, “Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers Are Measured Matters,” *Public Health Reports* 120, no. 4 (2005): 418–430.
20. C. Brach and I. Fraser, “Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model,” *Medical Care Research and Review* 57 Suppl. 1 (2000): 181–217.
21. S. Yeo, “Language Barriers and Access to Care,” *Annual Review of Nursing Research* 22 (2004): 59–73.
22. E. A. Jacobs and others, “Impact of Interpreter Services on Delivery of Health Care to Limited-English-Proficient Patients,” *Journal of General Internal Medicine* 16, no. 7 (2001): 468–474.

23. The Sullivan Commission on Diversity in the Healthcare Workforce, *Missing Persons: Minorities in the Health Professions*. (Washington, DC: The Sullivan Commission, 2004), <http://www.cumc.columbia.edu/dept/chum/data/SullivanFinalReport000.pdf>.
24. G. Flores and others, "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics and Adolescent Medicine* 152, no. 11 (1998): 1119–1125.
25. T. M. Tocher and E. Larson, "Quality of Diabetes Care for Non-English-Speaking Patients. A Comparative Study," *Western Journal of Medicine* 168, no. 6 (1998): 504–511.
26. E. B. Vandervort and G. D. Melkus, "Linguistic Services in Ambulatory Clinics," *Journal of Transcultural Nursing* 14, no. 4 (2003): 358–366.
27. M. G. Haviland and others, "Do Health Care Ratings Differ by Race or Ethnicity?," *Joint Commission Journal on Quality and Safety* 29, no. 3 (2003): 134–145.
28. O. Carrasquillo and others, "Impact of Language Barriers on Patient Satisfaction in an Emergency Department," *Journal of General Internal Medicine* 14, no. 2 (1999): 82–87.
29. D. W. Baker, R. Hayes, and J. P. Fortier, "Interpreter Use and Satisfaction With Interpersonal Aspects of Care for Spanish-Speaking Patients," *Medical Care* 36, no. 10 (1998): 1461–1470.
30. D. Kuo and M. J. Fagan, "Satisfaction With Methods of Spanish Interpretation in an Ambulatory Care Clinic," *Journal of General Internal Medicine* 14, no. 9 (1999): 547–550.
31. L. S. Morales, S. P. Reise, and R. D. Hays, "Evaluating the Equivalence of Health Care Ratings by Whites and Hispanics," *Medical Care* 38, no. 5 (2000): 517–527.
32. C. Brach, I. Fraser, and K. Paez, "Crossing the Language Chasm," *Health Affairs (Project Hope)* 24, no. 2 (2005): 424–434.
33. L. C. Hampers and J. E. McNulty, "Professional Interpreters and Bilingual Physicians in a Pediatric Emergency Department: Effect on Resource Utilization," *Archives of Pediatrics and Adolescent Medicine* 156 (2002): 1108–1113.
34. R. L. Kravitz and others, "Comparing the Use of Physician Time and Health Care Resources Among Patients Speaking English, Spanish, and Russian," *Medical Care* 38, no. 7 (2000): 728–738.
35. Joint Commission on Accreditation of Healthcare Organizations, *Joint Commission 2005 Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care*. (Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2005), http://www.jcaho.org/about+us/hlc/hlc_jc_stds.pdf.

36. Office of Minority Health, *Recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care: Executive Summary* (Washington, DC: U.S. Department of Health and Human Services, 2001), <http://www.omhrc.gov/clas>.
37. Civil Rights Act of 1964, Public Law 88-352, §601, 78 Stat 252 (42 USC 2000d).
38. U.S. Department of Health and Human Services, “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” 68 *Federal Register*, 47311 (August 8, 2003).
39. State of California, “Medi-Cal Threshold Languages,” (n.d.), http://www.medi-cal.ca.gov/MDLoan_Language.htm.
40. J. Perkins, M. Youdelman, and D. Wong, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, Second Edition* (Los Angeles, CA: National Health Law Program, 2003).
41. D. Cohn, “More Residents Lack English Fluency: DC Law Aims to Make Agencies Accessible to Immigrants,” *Washington Post*, June 22, 2004.
42. Office of Minority Health, DHHS, *Cultural Competency and Nursing: A Review of Current Concepts, Policies, and Practices. Developed by the American Institutes for Research (AIR)*. (Rockville, MD: Office of Minority Health, Department of Health and Human Services, 2004), <http://www.cultureandhealth.org/rn/documents/CCNMEnvironmentalScanFINAL2004.pdf>.
43. K. Paez and others, *Providing Oral Linguistic Services: A Guide for Managed Care Plans* (Baltimore, MD: Centers for Medicaid and Medicare Services and Agency for Healthcare Research and Quality, 2003), <http://www.cms.gov/healthplans/quality/project03.asp>.
44. M. Youdelman and J. Perkins, *Providing Language Services in Small Health Care Provider Settings: Examples From the Field* (New York: The Commonwealth Fund, 2005), http://www.cmwf.org/usr_doc/810_Youdelman_providing_language_services.pdf.
45. D. L. Roter and J. A. Hall, *Doctors Talking With Patients/Patients Talking With Doctors: Improving Communication in Medical Visits* (Portsmouth: Greenwood, 1992).
46. O. Carter-Pokras, M. J. O'Neill, V. Cheanvechai, M. Menis, T. Fan, and A. Solera, “Providing Linguistically Appropriate Services to Persons With Limited English Proficiency: A Needs and Resources Investigation,” special issue, *American Journal of Managed Care* 10 (2004): SP29–SP36.

47. M-P. Avery, C. Roat, and W. Alvarado-Little, *Building the Business Case for Culturally and Linguistically Competent Care and Reducing Health Disparities: A Roundtable Discussion* (paper presented at Fourth National Conference on Quality Health Care for Culturally Diverse Populations: Integrating Community Needs into the National Health Agenda, 2004, Washington, DC).
48. M. Bancroft and G. L. Goldin, *Overcoming Language Barriers Part II: For Administrators: A Volunteers in Health Care Guide* (Pawtucket, RI: Volunteers in Health Care, 2003), <http://www.volunteersinhealthcare.org/Manuals/VIH.Lang.Barr2.manual.pdf>.
49. G. Rollins, "Limited Budget, Unlimited Support," *The Safety Net* 16, no. 1 (2002): 22–25.
50. J. E. Poss and T. Beeman, "Effective Use of Interpreters in Health Care: Guidelines for Nurse Managers and Clinicians," *Seminars for Nurse Managers* 7, no. 4 (1999): 166–171.
51. J. Enslein and others, "Evidence-Based Protocol: Interpreter Facilitation for Individuals With Limited English Proficiency," *Journal of Gerontological Nursing* 28, no. 7 (2002): 5–13.
52. Expert Panel (Office of Minority Health Project to Develop a Draft Health Care Language Services Implementation Guide) (personal communication), First Expert Panel Meeting, August 27, 2004.
53. Expert Panel (Office of Minority Health Project to Develop a Draft Health Care Language Services Implementation Guide) (personal communication), Second Expert Panel Meeting, June 3, 2005.
54. Office of Management and Budget, *Report to Congress: Assessment of the Total Benefits and Costs Implementing Executive Order No. 13166: Improving Access to Services for Persons With Limited English Proficiency* (Washington, DC: Office of Management and Budget, 2002), <http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf>.
55. E. A. Jacobs and others, "Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services," *American Journal of Public Health* 94, no. 5 (2004): 866–869.
56. National Health Law Program, *Language Services Action Kit* (Washington, DC: National Health Law Program and The Access Project, 2004), <http://www.accessproject.org/downloads/LEPreprint04.pdf>.
57. M. Youdelman, *Testimony of Mara Youdelman* (New York: National Health Law Program, 2003), <http://www.healthlaw.org/pubs/200308.testimony.html>.

58. National Council on Interpreting in Health Care, *The Terminology of Health Care Interpreting: A Glossary of Terms* (Santa Rosa, CA: The National Council on Interpreting in Healthcare Working Papers Series, 2001), <http://www.ncihc.org/NCIHCDocRep/DocumentViewer.html>.
59. Office of Minority Health, DHHS, *Health Care Experiences of Limited English Proficient Individuals. Developed by the American Institutes for Research (AIR)*. (Rockville, MD: Office of Minority Health, Department of Health and Human Services, 2005), http://www.cultureandhealth.org/lang/documents/NSHCLSFinalFGReportv14_05-09-05.pdf.
60. Grantmakers in Health, “In the Right Words: Addressing Language and Culture in Providing Health Care,” *Issue Brief (Grantmakers in Health)*, no. 18 (2003): 1–44.
61. E. Jacobs and G. L. Goldin, *Overcoming Language Barriers Part I: For Clinicians, A Volunteers in Health Care Guide* (Pawtucket, RI: Volunteers in Health Care, 2002), <http://www.volunteersinhealthcare.org/Manuals/VIH.Lang.Barriers.Manual.pdf>.
62. L. Saint-Louis and others, *Testing New Technologies In Medical Interpreting* (Cambridge, MA: Cambridge Health Alliance, 2003), http://www.challiance.org/media_center/publication/tnt_hndbk.pdf.
63. A. D. Monroe and T. Shirazian, “Challenging Linguistic Barriers to Health Care: Students as Medical Interpreters,” *Academic Medicine* 79, no. 2 (2004): 118–122.
64. H. Suárez, A Outzen, and P Yacovone (personal communication), Definitions of Interpreter Bank, Community Language Bank, Language Agency, and Community Service Agency, April, 2005.
65. Central Nebraska Area Health Education Center, *Video Medical Interpreting* (Grand Island, NE: Hablamos Juntos, 2005).
66. J. Gonzalez and others, *Using Technology to Reduce Language Barriers* (presented at Diversity Rx Third National Conference on Quality Health Care for Culturally Diverse Populations, 2002, Chicago, IL).
67. G. Flores, “Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Health Care,” *Journal of Pediatrics* 136, no. 1 (2000): 14–23.
68. G. Flores and others, “Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters,” *Pediatrics* 111, no. 1 (2003): 6–14.
69. National Council on Interpreting in Health Care, *Guide to the Initial Assessment of Interpreter Qualifications* (Santa Rosa, CA: The National Council on Interpreting in Healthcare Working Paper Series, 2001), <http://www.ncihc.org/NCIHCDocRep/DocumentViewer.html>.

70. Office of Minority Health, DHHS, *Health Care Language Services: An Environmental Scan. Developed by the American Institutes for Research (AIR)*. (Rockville, MD: Office of Minority Health, Department of Health and Human Services, 2003).
71. California Healthcare Interpreters Association Standards & Certification Committee, *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention* (Woodland Hills, CA: The California Endowment, 2002).
72. Massachusetts Medical Interpreters Association and Education Development Center, *Medical Interpreting Standards of Practice* (Boston, MA: Massachusetts Medical Interpreters Association, 1998).
73. B. Torres, *Best Practice Recommendations for Hospital-Based Interpreter Services* (Boston, MA: Massachusetts Department of Public Health, Office of Minority Health, 2001), <http://www.mass.gov/dph/bhqm/2bestpra.pdf>.
74. L. J. McCarty and others, "Cross-Cultural Health Education: Materials on the World Wide Web," *Journal of Transcultural Nursing* 13, no. 1 (2002): 54–60.
75. Massachusetts Health Promotion Clearinghouse, <http://www.mclearinghouse.com>.
76. The Health Communication Partnership, <http://www.hcpartnership.org>.
77. The National Network of Libraries of Medicine, <http://nnlm.gov/train/chi/lang>.
78. M. Youdelman, *Side-By-Side: Comparison of HHS Aug 2000/Feb 2002 LEP Guidance to DOJ June 2002 and HHS Aug 2003 Guidance* (Washington, DC: National Health Law Program, 2003).
79. Ad Hoc Committee for the AMA Council on Health Literacy for the Council on Scientific Affairs, "Health Literacy: Report of the Council on Scientific Affairs," *Journal of the American Medical Association* 281, no. 6 (1999): 552–557.
80. J. McGee, *Writing and Designing Print Materials for Beneficiaries: A Guide for State Medicaid Agencies* (Baltimore, MD: Health Care Financing Administration, 1999).
81. Expert Panel (Office of Minority Health Project to Develop a Draft Health Care Language Services Implementation Guide) (personal communication), Expert Panel Conference Call, March 14, 2005.
82. S. Aust, "In Search of...Wayfinding," SignWeb. (n.d.), <http://www.signweb.com/ada/cont/wayfinding.html>.
83. J. Bolek, *Symbol Usage in Health Care Settings for People With Limited English Proficiency, Part Two: Implementation Recommendations* (Claremont, CA: Hablamos Juntos, 2003).

84. P. Guthrie, "Grady Hospital Tests Universal Symbols," *The Atlanta Journal-Constitution*, May 5, 2005, <http://www.ajc.com/hp/content/metro/atlanta/0505/05gradysigns.html>.
85. U.S. Department of Justice, *ADA Business Brief: Communicating With People Who Are Deaf or Hard of Hearing in Hospital Settings* (Washington, DC: Civil Rights Division, U.S. Department of Justice, 2003), <http://www.usdoj.gov/crt/ada/hospcombrprt.pdf>.
86. E. Haworth, *A Case Study of Cultural Competent Health Promoter Outreach Steps Valuable in Addressing Latino Health Disparities* (paper presented at The Society for Applied Anthropology 65th Annual Meeting, 2005, Santa Fe, NM).
87. W. Siegel, *Building Linguistic and Cultural Competency: A Toolkit for Managed Care Organizations and Provider Networks That Serve the Foreign-Born* (Chicago, IL: Mid-America Institute on Poverty: Heartland Alliance for Human Needs and Human Rights, 1998), <http://www.consultmillennia.com/documents/Building%20Linguistic%20&%20Cultural%20Competency.pdf>.
88. N. J. Chrisman, *Cultural Competence in Health Care—Clinic and Community Presentation* (presented at the School of Nursing, University of Washington, 2002).
89. American Evaluation Association, <http://www.eval.org/>.
90. W. K. Kellogg Foundation, *W. K. Kellogg Foundation Evaluation Handbook*. (Battle Creek, MI: W. K. Kellogg Foundation, 2005), <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf>.
91. M. Youdelman and J. Perkins, *Providing Language Interpretation Services in Health Care Settings: Examples From the Field* (Washington, DC: The Commonwealth Fund, 2002), <http://www.cmwf.org>.
92. Virginia Department of Medical Assistance Services, *Coverage of Interpreter and Translation Services for Fee-For-Service Medicaid Recipients Progress Report* (Richmond, VA: Commonwealth of Virginia, 2004), http://www.dmas.virginia.gov/downloads/studies_reports/2004-SD22.pdf.
93. CIGNA Corporation, *March 2004 Medicare Bulletin—Tennessee General Release*. (Nashville, TN: CIGNA Medicare, 2004), http://www.cignamedicare.com/partb/bltin/all/04bltin/04_03/tn/tn_march04.html.
94. CIGNA Corporation, *Medicare Part B Carrier—Idaho Local Coverage Determination*. (2003), http://www.cignamedicare.com/partb/lmrp_lcd/id/cms_fu/98-003.html.
95. T. J. Triana, "Empire Medicare Services Local Coverage Determination." (2005), http://www.empiremedicare.com/Nyorkpolicya/policy/A06-0001-R_FINAL_GUIDELINE.htm.

96. Noridian Medicare Services, “Noridian Administrative Services LLC Government Services Medicare Part B Policies, Psychiatry Medicare Policy for Coverage.” (2005), http://www.noridianmedicare.com/provider/pubs/med_b/policy/final/6state/B1995_psych_w6.html.
97. Wisconsin Physicians Service Insurance Corporation, “Wisconsin Physicians Service Insurance Corporation.” (2005), <http://www.wpsic.com/medicare/policies/wisconsin/psych13.shtml>.
98. Cahaba Government Benefit Administrators, “LCD for Clinical Social Workers (L6710).” (2005), <http://www.gamedicare.com/policies/L6710.htm>.
99. Asian and Pacific Islander American Health Forum, *Federal Funding for Language Assistance Services for Limited English Proficient Health Care Consumers* (Policy Brief). (San Francisco, CA: Asian and Pacific Islander American Health Forum, 2002), http://www.apiahf.org/policy/culturalcompetence/2002brief_fundingLanguageAssistance.htm#wa.
100. C. Schlosberg, *Immigrant Access to Health Benefits: A Resource Manual* (Washington, DC: The Access Project and National Health Law Program, 2005), http://www.accessproject.org/downloads/Immigrant_Access.pdf.
101. M. Niemeier, *FQHC Frequently Asked Questions* (Grand Forks, ND: Rural Assistance Center, 2005), http://www.raconline.org/info_guides/clinics/fqhcfqa.php.
102. M. Niemeier, *Rural Health Clinics Frequently Asked Questions* (Grand Forks, ND: Rural Assistance Center, 2005), http://www.raconline.org/info_guides/clinics/rhcfqa.php.
103. Language Line Services, *Language Line Document Translation Service Customer Charges*. (Monterey, CA: Language Line Services, 2005), http://www.languageline.com/pdf/DocTrans_Customer_Charges_042005.pdf.
104. Eurasia Translations Inc., <http://www.eurasia-usa.com>.
105. Essence Translation Services, “Attractive Rates.” (2005), <http://www.top-translation.biz/attractive-rates.html>.
106. Polyglot Translation/Academic Services, <http://www.polyglot-translation.com>.
107. Centers for Medicare & Medicaid Services, “Increased Federal Medical Assistance Percentage Legislation: Questions and Answers.” (2003), <http://www.cms.hhs.gov/medicaid/mbes/fy03fmapleg.pdf> (accessed September 7, 2005).