

Universal Access to Language Services in Health Care: *Making DC a Model of Excellence*



A REPORT BY:
The Language Access for
All Project Advisory
Committee

CONVENED BY:

**LA CLÍNICA
DEL PUEBLO**
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This report is dedicated to Iris Zúñiga and other patients who left us this year after silently battling chronic illnesses while navigating an unwelcoming health care system.

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EXECUTIVE SUMMARY

Effective communication between a patient and medical personnel is essential to ensuring appropriate and high quality care for the patient. For health care providers, taking steps to ensure universal access to languages services for limited English proficient (LEP) patients yields many important benefits, including the following:

- Increased quality of care and enhanced patient safety;
- Increased patient compliance, satisfaction, and loyalty;
- Reduced exposure to risk and liability for health care providers, including hospitals and physicians; and
- Reduced disparities in health care and health outcomes for limited English proficient patients.

With support from the DC Department of Health's Chronic Care Initiative, La Clínica del Pueblo established the *Language Access for All Project* to assess the state of access to language services in health care in the District and to develop recommendations for enhancing the District's existing language access infrastructure. To this end, La Clínica convened an advisory committee of experts on language access in health care – including government officials, researchers, advocates, and practitioners – to guide the project and develop the recommendations. This report is a product of their work and represents a consensus document of their recommendations for achieving universal access to language services in health care in the District.

The Findings

The Language Access for All Project conducted a survey of local hospitals and gathered patient stories to understand the current state of language access in health care in the District. The survey results showed that while local hospitals collectively use many promising practices, there is great variance in practices across hospitals, and many gaps in and barriers to full access to language services remain. The Project Advisory Committee concluded that the most significant gaps and barriers to full access to language services in District hospitals are:

1. Inconsistencies in type and quality of language services offered;
2. Insufficient staff capacity – including both dedicated staff to coordinate language services and inadequate training for all staff – to ensure full access to language services;
3. Inadequate systems to collect data on language service needs and services provided, as well as to monitor and enhance service quality; and
4. Unequal investment in language services.

Envisioning Universal Language Access

The Language Access for All Advisory Committee envisions a health care system in the District of Columbia in which *all patients* receive the highest quality of care, regardless of their native language or ability to speak English. In the system envisioned, all providers view the provision of language services as integral to quality medical care and make the necessary investment in policies, practices, and systems to ensure the availability of high quality language services. Above all, this report finds that achieving universal language access is a *shared responsibility*.

Recommendations

Achieving universal access to language services will require both the commitment of hospitals and the support of other stakeholders. The major stakeholders identified in these recommendations are hospitals themselves, the DC government, community-based organizations, and patients. While different stakeholder groups have put promising practices in place, the following recommendations lay out a series of benchmarks that all stakeholder groups should aim to reach to ensure that they are fulfilling their role in providing full access to language services.

Recommendations for Hospitals:

1. Develop a coordinated language access plan within their institution to make high quality language services available 24 hours a day, 7 days per week through multiple modes of service provision.
2. Make an investment in building infrastructure for language services.
3. Support the development of a forum for Language Access Improvement where various hospitals collaborate to share best practices to improve quality and resources in order to maximize funds and language service availability.

Recommendations for DC Government:

1. Provide funding and strengthen political support for language service infrastructure improvement at hospitals.
2. Enact a Medicaid State Plan Amendment to include language services as a Medicaid covered service.
3. Ensure that the preferred language of all patients enrolled in public health care programs is consistently recorded, tracked, and utilized across providers.
4. Monitor the quality of language services.

Recommendations for Community Health Centers:

1. Nonprofit health centers and clinics should ensure that their own institutions have comprehensive language access plans.
2. Nonprofit health centers and clinics should educate patients.
3. Nonprofit health centers and clinics should help patients request an interpreter.
4. Community organizations can partner with hospitals to build their capacity.

Recommendations for Patients:

1. Learn about their language access rights in hospital settings.
2. Provide feedback to health care providers and the Patient Ombudsman's office on service quality and accessibility.
3. Engage with DC government through hearings, meetings, forums, and other mechanisms of accountability

Conclusion

Ensuring equal access to health care is mandated by law and is a civil right for LEP patients. Ensuring that LEP patients have universal access to language services is a shared responsibility. While health care providers must deliver competent language services for LEP patients, they should have support from a range of stakeholders – including funders, government, community

groups, and patients themselves. As the nation’s capital, Washington, DC can and should be a model of excellence in the provision of language access in health care for LEP individuals.

INTRODUCTION

Effective communication between a patient and medical personnel is essential to ensuring appropriate and high quality care for the patient. When language barriers prevent the patient from fully understanding their health condition and prescribed treatment, or from asking clarifying questions of their provider, medical staff and patients are not communicating effectively. In a medical setting, language services – including access to interpreters, translated documents, and/or bilingual providers – are an integral component of quality patient care, not an optional service that providers can choose to offer or not. The consequences of not having an interpreter can be not only costly, but potentially deadly.

“In our hospital, we train our medical staff to understand that having an interpreter by their side – either in person or on the phone – is as vital to an interaction with an LEP patient as having their stethoscope around their neck in their interactions with all patients.”

– Advisory Committee Member

As the nation’s capital, Washington, DC can and should be a model of excellence in the provision of language access in health care for limited English proficient (LEP) individuals. The District’s position as a relatively small city with a historic commitment to promoting access to health care for underserved populations provides it with a distinct advantage for developing and implementing systems that would create universal language access in health care. The District of Columbia has a golden opportunity to become a *city of excellence* in language service provision.

Who Are LEP Individuals?

Limited English Proficient persons are defined by the Department of Health and Human Services Office of Civil Rights as individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

With support from the DC Department of Health’s Chronic Care Initiative, La Clínica del Pueblo established the *Language Access for All Project* to assess the state of access to language services in health care in the District and to develop recommendations for enhancing the District’s existing language access infrastructure. To this end, La Clínica convened an advisory committee of experts on language access in health care – including government officials, researchers, advocates, and practitioners – to guide the project and develop the recommendations. This report presents the findings from the project’s assessment, a vision for universal access to language services in health care in the District, and recommendations for achieving universal access. [See *Appendix A: About the Language Access for All Project* for more information about the project, a list of Advisory Committee members, and a list of other project partners and stakeholders consulted.]

Above all, this report finds that achieving universal language access is a shared responsibility. It is the health care providers who must deliver competent language services for LEP patients, but

they should have the support from a range of stakeholders and funders, including government, community groups, and patients themselves.

The Need in the District

Provision of language services is particularly relevant in DC because of the large and diverse LEP population that resides here. In the District of Columbia in 2007:

- ✓ The total population of LEP individuals was estimated at 25,000
- ✓ 15% of all households – or, about 35,000 – spoke a language other than English at home
- ✓ 3% – or 7,000 households – were linguistically isolated

In the Washington Metropolitan Area as a whole in 2007, about 25% of households spoke a language other than English at home, with the total number of LEP individuals estimated at 500,000. The total number of LEP individuals who seek health care in the District includes people from this broad and growing group. Service providers in DC are quick to point out that many LEP community members who have moved to Maryland and Virginia continue to seek and receive health care in the District. In addition, LEP community members of the District are more likely to be low income, and are therefore more likely to be eligible for federal and local health insurance programs (Medicaid or the DC Healthcare Alliance).

The Benefits to Patients and Providers

For health care providers, taking steps to ensure universal access to languages services yields many important benefits – including increased quality of care, enhanced patient safety and satisfaction, cost-savings in the long run, and reduced disparities in access to quality care and positive health outcomes for LEP individuals. Each of these benefits is discussed below:

1. ***Increased quality care and enhanced patient safety.*** Patients with limited English proficiency risk misdiagnosis, medical errors, and poor quality care. When the patient and the clinician cannot clearly communicate, care is less efficient and more costly, as clinicians use more diagnostic resources or invasive procedures when they cannot elicit or understand patients' symptoms. According to several studies, LEP patients are more likely to leave the hospital against medical advice, miss follow-up appointments, and experience drug complications.¹ [See *Appendix B: List of Studies Reviewed* for a full list of studies reviewed.]
2. ***Increased patient compliance, satisfaction, and loyalty.*** LEP patients who need but do not receive an interpreter have the lowest satisfaction with interpersonal aspects of care of any group of patients. Patients who use ad hoc interpreters (i.e., friends or family with some English) are also less likely to be satisfied with their medical visit than LEP patients who receive language services.² Additionally, when patients have access to an interpreter, they are more likely to be compliant with treatment plans. In one DC hospital, the improvement in its language services led to a 30-45% increase in patient encounters per year, and has built up its reputation as a LEP- and deaf-friendly hospital.

¹ *Pay Now or Pay Later: Providing Interpreter Services in Health Care*, Leighton Ku and Glenn Flores, in *Health Affairs*, 24, no.2, 2005.

² Ku and Flores

3. *Reduced exposure to risk and liability for health care providers, including hospitals and physicians.* The universal provision of competent, quality language services:

- Protects patient safety by reducing medical errors that can arise through mis-interpretation, thus helping providers avoid costly lawsuits.
- Ensures compliance with laws and regulations, including Title VI of the 1964 Civil Rights Act, Office of Minority Health Culturally and Linguistically Appropriate Standards (CLAS), and Joint Commission Standards. [See *Appendix C: Summary of Relevant Laws and Regulations* for more information.]
- Facilitates more accurate diagnoses, helping providers to avoid unnecessary and potentially risky procedures.
- Reduces the likelihood that patients will delay care because of perceived language barriers, thus ensuring that health issues can be detected earlier. When problems are detected early, providers can use less costly treatment and patients have better health outcomes.

The law requires providers to make language services available to ensure access to their services. While providing universal access to language services requires a financial investment in systems, staffing, contracts, and training, these investments will reduce exposure to risk and liability, thus avoiding other costly interventions.

4. *Reduced disparities in health care and health outcomes for limited English proficient patients.*

Studies have found that LEP patients are less likely to have a regular health care provider and more likely to delay getting needed medical care. In a survey of Spanish-speaking parents, 25% identified language as a barrier to care, and 6% reported not bringing their children in for needed medical care because of language barriers. LEP individuals

use less care than those who speak English. As a result, LEP individuals are more likely than others to report fair or poor health. On the other hand, LEP patients who are provided with trained interpreters make more outpatient visits, receive and fill more prescriptions, and have the same outcomes for diabetes and hypertension as those with English proficiency.³

Achieving universal access means that LEP patients can receive the same level of health care access as their English-speaking counterparts.

New Joint Commission Standards

JCAHO announced new and revised standards for improving patient-provider communication in December 2009. Joint Commission surveyors will evaluate compliance with the Patient-Centered Communication standards beginning January 1, 2011 as a part of the hospital accreditation program.

The new and revised elements of performance (EPs) include the following issues.

- Addressing qualifications for language interpreters and translators
- Identifying patient communication needs
- Addressing patient communication needs
- Collecting race and ethnicity data
- Collecting language data
- Patient access to chosen support individual
- Non-discrimination in patient care
- Providing language services

³ Ku and Flores

LANGUAGE ACCESS FOR ALL PROJECT: KEY FINDINGS

Recognizing that baseline information was needed to properly evaluate current hospital language services, La Clínica del Pueblo developed and administered a needs assessment survey to 6 of the 12 major hospitals in the District of Columbia and administered it in partnership with the ISCOPE program at George Washington University. [See *Appendix D: La Clínica Language Access Needs Assessment Survey for Hospitals* to see the full survey.] La Clínica also partnered with the DC Language Access Coalition to provide an assembled Language Access Advisory Committee with stories gathered from patients about their personal experiences with language barriers in DC health care.

Many hospitals in DC have taken major steps toward addressing the language needs of the diverse populations they serve. Providence Hospital, for example, has instituted comprehensive training for their staff on how to work with interpreters. Howard University Hospital has hired staff interpreters in multiple languages to address the high demand for language services at their site. Washington Hospital Center employs at least 12 staff interpreters, which are shared between its inpatient and outpatient facilities. George Washington University Hospital has invested resources in a phone system for medical interpretation that can be accessed throughout the hospital, and Georgetown University Hospital and Children’s National Medical Center have invested in video interpretation equipment for their facility. HSC Pediatric Center records primary language in the patient record and tracks this information over time, while the National Rehabilitation Hospital makes “Interpreter Need” a required field on nurses’ assessments for patients. In addition to these types of efforts, a number of DC hospitals have invested resources in hiring a dedicated language services coordinator – someone who both understands federal requirements and has a passion for promoting access.

Despite these investments in promoting access, language services are not yet fully and consistently available across the DC hospital system. While many limited English proficient patients report positive experiences communicating with their provider during hospital visits, others report experiences that left them frustrated, confused, and discouraged from seeking further care. The story below presents one LEP patient’s journey.

A Patient’s Journey

Like many limited English proficient, publicly-insured residents of the District, Rosa⁴ entered the health care system through primary care services at a community health center, where bilingual staff provides direct services in her preferred language. Complications arose when Rosa required specialty care outside of her primary clinic. Rosa received a referral to a specialist, but Rosa’s community health center did not have a robust capacity to make appointments for its patients. When asked to make her own appointment, Rosa was unable to navigate the hospital voicemail system, even though it had bilingual features. Rosa had to return to her community clinic for help making that call, since the option for Spanish did not come up until late in the voicemail; she was unable to read her English-only referral, and she is not used to leaving telephone messages.

⁴ Rosa’s journey, although fictional, is a composite of stories collected by DC Language Access Coalition and La Clínica del Pueblo.

Once Rosa made it through this first hurdle and scheduled her specialty appointment, the next uncertainty she faced was whether or not an interpreter would be present during the visit. The scheduler at the hospital's outpatient services did not mention anything about interpreter services being available. Fortunately, Rosa had public insurance through an MCO and had been informed about her eligibility for language services. She was able to request a live interpreter who would meet her at the appointment location. These services were provided, based on the MCO contracts, by the Interpreter Services program at La Clínica del Pueblo. If Rosa had been told she couldn't have an interpreter through La Clínica, either because the request was made at the last minute or because there were too many requests and not enough interpreters available, she could have gotten discouraged from going to her appointment.

In order to get ready for her appointment, Rosa made an extra trip to the medical facility the day before to be sure she wouldn't get lost and miss her appointment, since she was unable to find directions in Spanish. Once she arrived, she faced her first language hurdle of the day in finding the doctor's office given that the signage in the hallways was not translated. Since Rosa did not speak enough English to "get by," she was unable to sign in, and she sat in the waiting room, waiting for someone to notice her arrival. Once she was finally noticed by the clinic's receptionist, Rosa was given paperwork to complete, but was not able to fill out paperwork without an interpreter. As the intake paperwork was not translated into her primary language, she became very anxious. A partially-bilingual staff person attempted to help, but there were many errors in completing the paperwork. Once Rosa's interpreter arrived, they were able to complete it correctly, but this took extra time, delaying the start of her appointment. Because of this delay, the provider was very rushed and hurried during the appointment. The provider, while using the interpreter, did not take the time to really listen to Rosa because he was trying to get back on schedule.

While Rosa's story showed a number of barriers to successfully completing her appointment, many things did work in her favor. In Rosa's worst case scenario: The hospital has taken no steps to determine her language preference, and has not assigned an interpreter or arranged telephonic interpretation. Rosa has no interpreter from La Clínica; she and her provider may rely on their limited language capabilities in one or the other's language, as well as gestures and diagrams, to communicate. Both situations greatly increase the chance that a medical error will occur and that Rosa will leave her appointment feeling disempowered, humiliated, and at risk.

While there have been many advancements and promising practices instituted in every single D.C. hospital, as we follow our fictional, though typical, patient through the health care system, we realize that there are a multitude of challenges and barriers that must be faced and overcome by both the provider and the LEP patient in order to ensure adequate access is provided in hospitals. For LEP patients with a chronic illness or a complex condition such as cancer, these barriers are multiplied by the greater number of visits they attend, the stress of each encounter, and the discouragement they feel in each step toward taking care of their health.

Hospitals Survey Results

The results of the Language Access for All needs assessment survey of six DC hospitals found significant variances in four key areas: Language services offered, human resources, data

systems, and funding. Each is discussed in depth below. [See *Appendix D: La Clínica Language Access Needs Assessment Survey for Hospitals* for the survey questions.]

1. *Inconsistencies in Language Services Offered*

- Four hospitals reported having bilingual clinicians and five have bilingual, non-clinical staff. However, only two hospitals reported using bilingual clinicians to provide services to LEP patients. Four reported using bilingual non-clinical staff as interpreters. However, none of the hospitals surveyed assess the ability of bilingual staff to provide language services.
- Five of six hospitals reported having interpreters on staff that they use often to very often to provide language services. These hospitals use a variety of ways to assess the skills of interpreters, including using a test and requiring a certain number of hours in medical interpretation training.
- All hospitals surveyed have telephonic interpretation available. Five of six hospitals surveyed use telephonic interpretation often or very often.

2. *Insufficient staff and training for Language Access*

- Four of six hospitals surveyed reported that there is a specific person or office devoted to language services.
- Four of the six hospitals reported providing training to new employees on how to provide adequate language services.
- Training on language services was found to be limited and typically includes only a brief overview of when and how to request an interpreter and access a language line.
- No hospital provides continuous and comprehensive employee training in how to identify primary language spoken, how to assess the need for an interpreter, how to work with an interpreter, or other best practices to make language service provision seamless.

Likewise, the DC Language Access Coalition found, in conversations with LEP individuals, that LEP patients have experienced the following: lack of awareness of service availability among staff, poor use of interpreters by providers, failure to consult patient records regarding language preference, and limited interpreter availability. These situations occur in hospitals and other health care facilities where language access is often successfully provided, suggesting that practices are not institutionalized or provided consistently to all LEP individuals who may need the services.⁵

3. *Inadequate Data Systems*

- Hospitals each had a unique way to collect data on preferred language, but they were not used consistently.
- Five of six hospitals record language data within the patient's record; however some record primary language, some preferred language, and some whether or not an interpreter is needed.
- Preferred language data are not transferred between providers within the same hospital.

⁵ Primary Health Care and Language Access in the District of Columbia, DC Language Access Coalition, September 30, 2009.

- Systems and practices for regular monitoring or accountability vary: several track usage of language services and several implement some quality improvement (e.g., through patient surveys).

4. *Unequal investment in language services*

- No hospital surveyed reported receiving any other outside funds to provide or supplement their language services.
- Two of six hospitals reported using the contract interpreters provided by the managed care organizations at no cost to the hospital for patients with managed care public insurance.

Together, La Clínica's survey, patient stories gathered by the DC Language Access Coalition, and the experiences and observations of the Advisory Committee members highlight areas for improvement as well as existing capacity upon which stakeholders can build.

The findings also point to a need for additional research. For example, while the survey provided information about reported practices, it did not evaluate whether these practices are carried out consistently. In addition, the survey did not distinguish between various language groups. Additional research is needed to better understand the experience of Spanish-speaking versus non-Spanish-speaking populations in the District. Since only 6 of 12 hospitals responded to the survey, and there is much yet to learn about gaps in language access throughout the city. Lastly, the survey provides little insight into the experiences of and barriers faced by those LEP individuals who never obtain care.

A VISION FOR UNIVERSAL ACCESS TO LANGUAGE SERVICES

The Language Access for All Advisory Committee envisions a health care system in the District of Columbia in which *all patients* receive the highest quality of care, regardless of their native language or ability to speak English.

In the system we envision and believe we can build, all providers view the provision of language services as integral to quality medical care and make the necessary investment in policies, practices, and systems to ensure the availability of high quality language services. All policies and practices related to the provision of care in DC hospitals will reflect the following principles:

What is Universal Language Access?

Universal language access exists when language services are an *integral* part of care and are available 24 hours a day, 7 days per week to all LEP patients.

Effective Communication

- The health care system is able to communicate in a way that patients can understand. Everyone who engages with the health care system is able to communicate with the system in a way that is understandable to them.
- Effective communication is no less and no more important for LEP patients than for anyone else.

Quality and Availability of Language Services

- High quality language services that address the patient's needs are readily available when needed (i.e., available 24 hours a day, 7 days per week).
- The provision of language services is seamless, with no disruptions in service or inconvenience to the patient or the provider.
- Providers have access to and use different modalities – i.e., in-person, video, and telephonic interpretation – to provide language services, based on the frequency of encounters with the language as well as the nature of the situation.
- Interpreters should be competent, i.e., trained in medical interpreting, familiar with the health care system, medical terminology in English and the non-English language, ethics, confidentiality and the appropriate role for an interpreter.

What is the Best Way to Provide Language Services?

In determining how to provide language services in any given situation, the key question should always be: *What modality – i.e., in-person, video, or telephonic interpretation – is most effective for the patient in the particular situation?* For example, in some situations, telephonic interpretation may be adequate, while in others the LEP patient and interpreter must be able to see each other.

Patient Empowerment

- Patients have a right to participate in shaping the course of their care. By understanding their situation and choosing the course of action, they have control over their health.

- Patients must know their rights to language services, as defined by provider policies and in keeping with the notion that *an informed patient is an empowered patient*.
- Providers should not only inform patients of their rights to language services but should actively promote the use of those services. Community based organizations can also play a role in educating patients about how they can access language services. The burden of demanding language access should not lie solely with the patient.

Funding of Language Services

- The responsibility to fund language services and infrastructure in hospitals is understood to be a shared responsibility, so that no one component of the health care system bears the full cost of funding language services.
- Payment systems should provide fair compensation for interpreters and translators, thus ensuring that language services are widely available and of high quality.

Accountability

- Language services in health care settings must be available as a matter of course, and all stakeholders – including government agencies that fund, administer or oversee health care programs – must be accountable for providing or facilitating the provision of those services.

RECOMMENDATIONS FOR ACHIEVING UNIVERSAL ACCESS

Achieving universal access to language services will require the commitment of hospitals and the support of various stakeholders. The major stakeholders identified in these recommendations are hospitals themselves, DC government, community-based organizations, and patients. The following recommendations lay out a series of benchmarks these stakeholder groups should aim to reach to ensure that they are fulfilling their role in providing language access. While most individual organizations and institutions within these stakeholder groups have already been working on at least some of these benchmarks, they all still play an important part in contributing to improvements in the system and share the responsibility of ensuring that language access is of high quality and consistently available for LEP individuals receiving care in DC hospitals.

Recommendations for Hospitals

To provide high quality care, ensure patient safety, meet legal requirements, effectively serve the diverse communities of the District, and avoid the costs of inefficient care, each hospital in the District of Columbia should:

1. ***Develop a coordinated language access plan within their institution to make high quality language services available 24 hours a day, 7 days per week through multiple modes of service provision.*** Hospitals should develop language access plans not only to meet the Joint Commission’s requirements, but also to ensure they have addressed the changes needed at various levels to effectively provide universal access to language services. In developing

language access plans, hospitals must consider policies and practices at various levels, components, and points of entry to the institution.⁶ The plan should involve:

- Creation of staff positions and infrastructure dedicated to language services provision.
- Inclusion of primary/preferred language and interpreter need in data collection, patient records, and databases.
- Training for staff on how to access language services and work with interpreters.
- A description of the financial investment of the hospital in language services and plans to leverage additional funds for language services through creative budget allocation and/or by seeking ways to supplement internal budgets for language services with outside grants and government support.

[See *Appendix E: Recommended Best Practices for Hospitals* for a more complete description of best practices for planning, delivering, and managing language services.]

2. ***Make an investment in building infrastructure for language services.*** Around the country, hospitals with high-quality, widely accessible language services all made initial, upfront investments to develop the necessary infrastructure – including staff with the authority to implement the plan, a place in the organizational structure, training, and new health information technologies (e.g., video interpreting equipment). The dollar amount of the investment needed will depend on each hospital’s size and can include both new funds as well as reallocating portions of existing budget items – such as professional development funds – towards developing language access infrastructure.

For example, one District hospital made an initial investment of \$200,000 to purchase new video/phone technology to provide quality on-demand interpreter services. This technology is expected to produce greater efficiencies – lower costs per encounter – and cost savings for language access delivery. For instance, of this initial \$200,000 investment, \$75,000 was a reallocation of budgeted interpreter services expenses, while the remaining \$125,000 were capital funds, which the Language Services Coordinator successfully argued would be offset in the savings from interpreter services operating expenses. Another hospital in the region received a grant from a private foundation through a national demonstration project. This gave them the capacity to develop infrastructure that remained even after the demonstration project ended.

In the District, there is already a significant amount of capital invested in the system in disparate locations:

- According to estimates provided by the six hospitals participating in La Clínica’s survey, these hospitals collectively invest about \$1 million per year in providing language services.
- MCOs contracted by the District to manage the care of DC HealthCare Alliance and Medicaid patients spend an estimated \$400,000 per year in directly providing language services to their beneficiaries.

⁶ A model Language Access Plan can be found in Chapter 2 of the National Health Law Program’s Pharmacy Resource Guide, <www.healthlaw.org/images/stories/Language_Services_Pharmacy_Resource_Guide_2010.pdf>

- La Clínica del Pueblo receives an estimated \$97,284 in federal grants to provide interpretation for LEP uninsured and Medicaid/Medicare covered persons living with HIV/AIDS.
- La Clínica del Pueblo has raised hundred of thousands of dollars in private funding to cover the interpreter needs of uninsured and Medicaid/Medicare patients over the past 14 years. In 2009 alone, La Clínica raised a total of \$85,000 to provide language access.

Taken together, these investments total close to \$2 million. However, to ensure even and consistent language access occurs throughout all DC hospitals, more funds will need to be leveraged by stakeholders to contribute to language services provision and infrastructure development.

- 3. *Support the development of a forum for Language Access Improvement where various hospitals collaborate to share best practices to improve quality and resources in order to maximize funds and language service availability.*** Hospital administrators can support participation of language access coordinators in such collaborative efforts by allocating staff time for it and by responding to requests from the group. This collaborative can be further strengthened through the intentional incorporation of patients’ suggestions and feedback when designing group priorities.

Through greater collaboration, hospitals can also leverage their individual investments. For example, Georgetown Hospital, through resource sharing within the system, has been able to reduce costs by an average of \$140 per LEP patient encounter and \$265 per deaf patient encounter. MedStar hospitals, including Georgetown Hospital, have been able to negotiate a lower rate with Language Line, a telephonic interpretation service. Improved coordination and sharing mechanisms across systems in DC could result in further efficiencies of scale. Other ways hospitals could collaborate include:

- Working together to develop and/or share policies, protocols, procedures and tools for implementing universal language access.
- Investing in a central interpreter bank and a central translation center that could, if costs are shared, decrease overall costs.
- Investing in shared video interpretation service and/or other technology solutions to improving access.
- Conducting joint staff training on how to work with interpreters and joint training of interpreters. In addition, when a national medical interpreter certification program becomes available in the future, hospitals could pool their resources and offer joint certification training.⁷
- Coordinating broader cultural competency training for staff.

Recommendations for Other Stakeholders

As noted earlier in this report, we believe that ensuring universal access to language services must be a shared responsibility among many stakeholders. Below, the report identifies ways in which other stakeholder groups can contribute to the achievement of hospital initiatives.

⁷ Certification training will become particularly relevant as national certification standards begin to take effect in the coming years. See <http://www.healthcareinterpretercertification.org/> for more information.

Role of DC Government:

- 1. *Provide funding to support language service infrastructure improvement at hospitals.*** For example, the Community Health Administration at the DC Department of Health provided funding to La Clínica, through the Chronic Care Initiative, to provide medical interpreter training to bilingual staff of health care providers, including hospitals. Building staff interpretation capacity expands the availability of language services. Additional funding could support collaborative efforts among hospitals, such as those described above, as well as the direct provision of language services to uninsured and fee-for-services Medicaid/Medicare recipients.
- 2. *Enact a Medicaid State Plan Amendment to include language services as a Medicaid-covered service.*** The DC Department of Health Care Finance, by adding language access services as a covered service under the Medicaid State Plan, can increase the available federal dollars for language services for fee-for-service Medicaid and SCHIP beneficiaries and ensure more of these beneficiaries are covered.⁸ States can recover at least 70% of language service costs for these beneficiaries.
- 3. *Ensure that the preferred language of all patients enrolled in public health care programs is consistently recorded, tracked, and utilized across providers.*** Asking for and recording preferred language is already mandatory and must be collected by hospital intake staff. The Income Maintenance Administration (IMA) within the DC Department of Human Services administers the application process for health care benefits and has a critical role to play in ensuring early identification of language service needs.
- 4. *Monitor the quality of language services and allow for community input in the monitoring process through the DC City Council Committee on Health and the Patient Ombudsman's office.*** The Committee on Health is responsible for budgetary and legislative oversight of the Department of Health, Department of Health Care Finance, and Department of Mental Health. Through site visits and public hearings with officials in these departments, it can ensure that language service regulations are being enacted.
- 5. *All health insurance companies doing business in DC should have adequate language access plans.*** The Commissioner of the DC Department of Insurance, Securities and Banking (DISB) should require it and consider that providing treatment outside of immediate emergency care without communication capability in the patient's language should be a reportable error alongside wrong-site surgery and hospital-acquired infections.
- 6. *Identify ways to support funding for language services by prioritizing language barriers in health care when putting together budgets.*** This might include setting up

⁸ For fee-for-service Medicaid patients, the District is currently only able to recover costs paid to one provider, The Language Doctors. However, this provider is not widely used. It is not known to most providers and only facilities with less than 15 staff can access this provider. In addition, with the current service provision structure, the District is only able to recover costs from the federal government at the lower administrative matching rate.

other initiatives such as the Chronic Care Initiative, etc. to provide funds to hospitals and community groups to pay for language services & trainings on working with interpreters, etc., and/or to integrate language services more into existing funded programs (i.e. programs they have already allocated funds to, seeing how language services fit in).

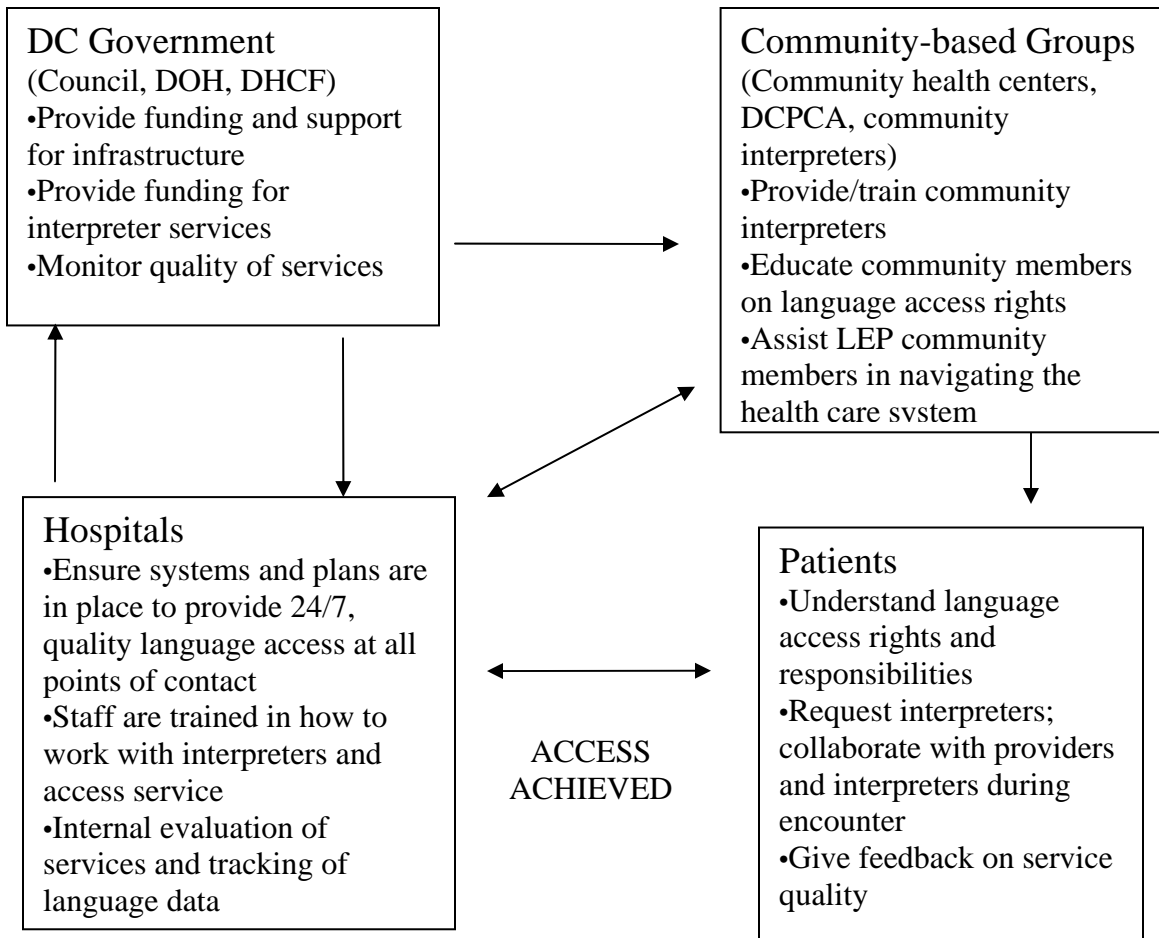
Role of Community Groups:

1. **Nonprofit health centers and clinics should ensure that their own institutions have comprehensive language access plans.** The DC Primary Care Association (DCPCA) can create a Language Access affinity group within DCPCA, and support DCPCA member health centers in developing their own language access plans.
2. **Nonprofit health centers and clinics should educate patients.** Health Center staff should educate LEP patients on their right to Language Access services. For example, they can inform LEP patients with DC Alliance or Medicaid managed care that they are eligible to receive free interpretation services through their MCOs and that they can schedule a live interpreter in advance of their appointment. They can inform Medicaid fee-for-service patients that they are eligible for free interpretation services through the DC Department of Health Care Finance for appointments at certain types of provider offices.
3. **Nonprofit health centers and clinics should help patients request an interpreter.** When making referrals for patients to receive specialty care in outpatient clinics, the referring provider should also notify the specialist that the patient needs an interpreter and/or request an interpreter to accompany the LEP patient. Although patients should be aware of their right to an interpreter and the process for requesting one, the burden should fall on the provider, not the patient.
4. **Community organizations can partner with hospitals to build their capacity.** Community organizations that serve and represent LEP communities – including health centers, clinics, and other kinds of providers – can partner with hospitals to help provide community input in developing trainings on language access regulations and cultural competency.

Role of LEP Patients:

4. **Learn about their language access rights** in hospital settings.
5. **Provide feedback to health care providers and the Patient Ombudsman's office** on service quality and accessibility.
6. **Engage with DC government** through hearings, meetings, forums, and other mechanisms of accountability.

Through a shared responsibility for language access among all stakeholders, these recommendations can be easily implemented. The connections and responsibilities of each partner are diagrammed below:



Currently, all of these stakeholder groups have taken some steps toward ensuring provision of language services for LEP patients. For example, DHCF, through MCOs, is already investing in covering their beneficiaries’ interpretation services in outpatient hospital care settings and clinics. All hospitals surveyed have some best practices in place, and many have designated language programs and designated language services coordinators. Two hospitals now offer video interpreting and most have a contract with a telephonic interpretation company. Lastly, most community health centers have bilingual staff, and La Clínica del Pueblo’s interpreter service helps fill in gaps in outpatient care.

Whether or not an LEP person is well-served in a hospital setting too often depends on the knowledge, skills, and commitment of the individual staff member with whom the LEP person comes into contact. It also depends on the right pieces – the people, the infrastructure, the communication, and technology – coming together to make the system work.

CONCLUSION

Ensuring equal access to health care is mandated by law and is a civil right for LEP patients. As the nation's capital, Washington, DC can and should be a model of excellence in the provision of language services in health care for LEP patients. For health care providers, taking steps to ensure universal access to languages services yields many important benefits – including increased quality of care, enhanced patient safety and satisfaction, cost-savings, and reduced disparities for LEP individuals. Methods that are affordable and effective are available and many are already in use by DC hospitals. However, language services are not yet an integral part of care, available 24 hours a day/7 days per week, to all LEP patients across all hospitals. Language services must be considered *an intrinsic* part of health care provision, part of all policies and procedures implemented in every health care setting, as well as enforced through District government regulatory mechanisms.

Achieving universal access to language services is a *shared responsibility*. Health care providers must deliver competent language services for LEP patients, but to do this they need the support of a range of stakeholders – including government, community groups, funders, insurers, and patients themselves. All of these stakeholders have a role to play, beginning with educating their own staff about the importance of universal access to language services in health care and then in implementing the recommendations discussed above. Ensuring that all health care providers in the District have written language access plans, *and that these plans are being implemented*, is an important next step around which stakeholders – especially health care providers, community groups, and DC government – can work together.

There is much to be done. We all have a responsibility for ensuring equal access to health services for all residents of Washington, DC.

APPENDIX A

About the Language Access for All Project

The Language Access For All project is a collaborative effort initiated by La Clínica del Pueblo to examine, define, and develop strategies for closing up the gaps in the District's existing language access infrastructure. Since 1996, La Clínica has been providing interpreter services to the patients of community health centers throughout the District and is thus uniquely positioned to hear about LEP patients' experiences with the broader health care system. La Clínica's interpreters accompany patients to outpatient appointments throughout the city and witness the impact of these gaps on LEP patients on a daily basis. La Clínica established the Language Access for All project to leverage the experience it has gained through direct service and work toward broader, systemic solutions.

To this end, La Clínica convened a group of experts in the field of language access and community stakeholders in health care to serve as an Advisory Committee to develop recommendations for changes to policy, practice, and funding needed to achieve universal language access in health care in the District. An explicit effort was made to convene Advisory Committee members who range from policy experts, academics, and community representatives, to representatives of stakeholder groups – including government, hospitals, and clinics – in order to bring in a variety of perspectives and expertise. La Clínica hired Mosaica: The Center for Nonprofit Development and Pluralism to guide the Advisory Committee process and assist with background research.

To develop the recommendations, the Committee:

- Mapped the current state of access to language services across the health care system, drawing upon the knowledge and experiences of Committee members, to identify priority areas for focus. Based on this mapping, the Committee decided to focus its additional research and recommendations on DC Hospitals, and particularly outpatient care.
- Created a shared vision for universal access to language access services in DC Hospitals, drawing on their own knowledge, stakeholder consultations conducted by the project team, and an extensive literature review of best practices around the country.
- Provided guidance to La Clínica in conducting a survey of hospitals. Recognizing that more baseline information was needed to properly evaluate current hospital language services, La Clínica del Pueblo developed and administered a needs assessment survey to major hospitals in the District in partnership with the ISCOPE program at George Washington University. La Clínica also partnered with the DC Language Access Coalition to provide the Advisory Committee with stories gathered from patients about their personal stories with language barriers in DC health care.

Language Access for All Advisory Committee Members

Sharon Baskerville <i>CEO</i>	District of Columbia Primary Care Association (DCPCA)
Victor Bonnet <i>Committee Clerk</i>	Office of DC Councilmember Yvette Alexander
Valentine Breitbarth <i>Management Analyst</i>	Office of Preventative and Acute Care, DC Department of Health Care Finance
Amber Carran-Fletcher <i>Graduate Intern</i>	DC Language Access Coalition
Miniabiyi Ford	Office of African Affairs
Laura Jacobus-Kantor <i>Assistant Research Professor</i>	Center for Integrated Behavioral Health Policy, George Washington University
Jessica Jones <i>Interpreter Services Coordinator</i>	Georgetown University Hospital
Sarah Lichtman Spector <i>Staff Attorney</i>	National Health Law Program
Joanne Lynn	Formerly of the DC Department of Health
Sapna Pandya <i>Co-Director</i>	DC Language Access Coalition
Marsha Regenstein <i>Research Professor</i>	Department of Health Policy, George Washington University
Aryan Rodriguez	Formerly of the DC Office of Human Rights
José Rosado-Santiago <i>Interpreter</i>	La Clínica del Pueblo
Catalina Sol <i>Chief Program Officer</i>	La Clínica del Pueblo
Tanchica Terry <i>Senior Policy Advisor</i>	Councilmember David Catania, DC Council Committee on Health
Isabel van Isschot <i>Interpreter Services Department Director</i>	La Clínica del Pueblo
Eric Vicks <i>Senior Community Relations Manager</i>	DC Primary Care Association

Stakeholders Consulted

La Clínica and Advisory Committee members made presentations to the following stakeholder groups:

- Chronic Care Initiative Coalition
- Chronic Care Initiative Intervention Teams
- Community Health Center staff (for four DC centres)
- DC Primary Care Coalition Medical Directors group
- DC Language Access Coalition member organizations
- La Clínica del Pueblo Interpreters
- La Clínica del Pueblo Patient Advisory Comité
- Trainees in Medical Interpretation from 12 health care facilities

La Clínica and Advisory Committee members also held informational meetings with over 40 stakeholders, including:

- Community Health Centers (7 centers)
- DC Hospital Association
- DC Council Committee on Health
- DC Department of Health Care Finance
- DC Health Care Ombudsman
- DC Hospitals (11 hospitals)
- Office of Latino Affairs
- Office of African Affairs
- Unison Health Plan

APPENDIX B

List of Studies Reviewed

Language Access: Understanding the Barriers and Challenges in Primary Care Settings
Association of Clinicians for the Underserved, 2008

Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey
National Association of Community Health Centers (NACHC), June 2008

Providing Language Services in State and Local Health-Related Benefits Offices: Examples from the Field
National Health Law Program (Mara Youdelman, Jane Perkinns, Jamie D. Brooks, and Deborah Reid), January 2007

Language Services for Patients with Limited English Proficiency: Results of a National Survey of Internal Medicine Physicians
American College of Physicians, 2007

Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey
The Health Research and Educational Trusts/AHA and National Health Law Program (Romana Hasnain-Wynia, Julie Yonek, Debra Pierce, Ray Kang, and Cynthia Hedges Greising), October 2006

Race, Ethnicity and Language of Patients Hospital Practices Regarding Collection of Information to Address Disparities in Health Care
National Public Health and Hospital Institute (NPHHI) with support from The Robert Wood Johnson Foundation (Marsha Regenstein, PhD and Donna Sickler, MPH), January 2006

Providing Language Services in Small Health Care Provider Settings: Examples from the Field
NHLP (Mara Youdelman and Jane Perkins), 2005

Language Access Solutions for OB/GYN Medical Practices
The American College of Obstetricians and Gynecologists, District IX California, 2004

Providing Health Care to Limited English Proficient Patients: A Manual of Promising Practices
California Primary Care Association, 2001-2002

Hablamos Juntos, Speaking Together Learning Collaborative Resources

APPENDIX C

Summary of Relevant Laws and Regulations

Title VI of the Civil Rights Act of 1964

States that “no person in the United States shall, on the 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.” 42 U.S.C. § 2000d
“National origin” includes individuals with limited English proficiency (LEP). There has been a longstanding expectation that LEP individuals must have meaningful access to federally funded programs and activities. In 2003, HHS Office for Civil Rights issued final guidance explaining expectations for federal fund recipients.

DC Language Access Act

The DC Language Access Act requires DC agencies to provide equal access and participation of all services, programs, and activities to all LEP DC residents. It requires data collection of primary language, provision of oral interpreters, and written translations. Regulations require that contractors or grantees hired to carry out services or programs comply with the Act.

The Joint Commission

The Joint Commission requires providers to:

- Collect preferred language for discussing health care, race, and ethnicity and recording of these in medical record
- Communicate with patient during the provision of care, treatment and/or services in manner that “meets the patient’s oral and written communication needs”
- Provide oral interpretation and written translation services

Other Quality and Accrediting Organizations

National Quality Forum – National Voluntary Consensus Standards for a Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency, www.qualityforum.org (Endorsed HRET The Health Research and Educational Trust Disparities Toolkit for collecting race, ethnicity & language data)

Institute of Medicine – Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (2009) (Offers standardization to allow apples-to-apples comparisons across health programs/plans/surveys)

National Committee for Quality Assurance – Voluntary, Multicultural Health Care Distinction (Offers recognition for documentation of race, ethnicity, and language and provision of language services including interpreting and translation)

APPENDIX D

La Clínica Language Access Needs Assessment Survey for Hospitals

Part I – Language Needs of Populations Served

1. How often does your hospital encounter patients who are Limited and/or Non English Proficient (LEP/NEP)?

- Daily Do not know
 Weekly
 Monthly
 Annually

2. Which of the following languages do you encounter?

	Never	Sometimes	Often	Do not know
Amharic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arabic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
French	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haitian Creole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Korean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Portuguese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tigrinya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vietnamese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous languages of Latin America	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____				
Do not know _____				

3. a) What percentage of your facility's **inpatient** population are limited or non-English proficient (LEP/NEP) patients? 0-2%

- 3-5%
 5-10 %
 10-20 %
 20-30 %
 30-40 %
 40-50 %
 over 50%
 Unsure (*skip to question 4*)

b) Can you estimate the number of inpatient patients this percentage indicates? _____

c) What percentage of your facility's **outpatient** population are limited or non-English proficient (LEP/NEP) patients? 0-2%

- 3-5%
 5-10 %
 10-20 %
 20-30 %
 30-40 %
 40-50 %
 over 50%
 Unsure (*skip to question 4*)

d) Can you estimate the number of outpatient patients this percentage indicates? _____

4. Which of the following sources of information does your hospital use to assess the language needs of the communities you serve? **Select all that apply.**
- Census data
 - Data from local community organizations
 - Hospital conducts community needs assessment
 - Hospital collects language data from patients
 - Other _____
 - Not applicable (have not assessed language needs of community)
 - Do not know

Part II – Resources Used to Provide Language Services

5. Our experience tells us that LEP/NEP patients have a variety of experiences when they access health care. We want to understand the extent to which each of these strategies is being used at your site. Could you please report which of these strategies you utilize? How is each coordinated? How often is each of the services being used?

Service	Available to patients		If available, how often do you use?				
	Yes	No	Never	Rarely	Some times	Often	Very often
Direct services in patient’s language							
<i>Bilingual health care provider:</i> A provider who is proficient in more than one language and can provide clinical services in the LEP/NEP patient's own non-English language.							
<i>Bilingual staff:</i> Non-clinical staff who is proficient in more than one language and can provide non-clinical services in the LEP/NEP patient’s own non-English language.							
<i>Proficient clinicians or staff:</i> Individuals who are not fully bilingual, but able to communicate effectively in the patient’s target language.							
Interpretation services							
<i>Staff interpreter:</i> Employees of the practice who are hired primarily to provide interpretation services. How many? _____ Which languages? _____							
<i>Bilingual staff interpreters with other official roles:</i> Employees of the practice who are hired to serve a different role but may provide interpretation part-time.							
<i>Telephonic interpretation:</i> Off site third party service that is often contracted Company name _____							
<i>Video interpretation:</i> Off site third party service that is often contracted Company name _____							

<i>Community interpreters.</i> From La Clinica del Pueblo or another non-profit. Which? _____							
<i>Volunteer interpreter.</i> Bilingual individual providing interpretation services at the hospital. How many? _____ Which languages? _____							
<i>Ad hoc interpreter.</i> Untrained, volunteer interpreter, such as a family member or a self-declared bilingual individual not employed through the hospital.							

Other techniques being used? _____

6. What, if any, activities do you undertake to assess the skills/competency of your interpreters and/or translators?
Please explain.

7. a) Do you assess the ability of bilingual employees (clinical and/or non-clinical) that provide services **directly** in non-English languages?

- Yes
- No (*skip to question 8*)

b) If you answered yes to question 6a, who are these bilingual employees assessed by?

- Hospital
- External agency (non-accrediting)
- External agency (accrediting)
- Take a competency test
- Other bilingual staff at agency
- Other _____

8. a) Does your hospital maintain a database or record on the languages spoken by bilingual employees (clinical and non-clinical)?

- Yes
- No (*skip to question 9*)

b) If you answered yes to question 8a, please describe how this information is recorded and how it can be accessed. What mechanisms are in place to record language skills of new hires?

9. Which languages do any of your bilingual employees (clinicians, staff, etc.) speak other than English? *Check all that apply*

- | | |
|---|--|
| <input type="checkbox"/> Spanish (Number ____) | <input type="checkbox"/> Chinese (Number ____) |
| <input type="checkbox"/> Amharic (Number ____) | <input type="checkbox"/> French (Number ____) |
| <input type="checkbox"/> Vietnamese (Number ____) | <input type="checkbox"/> Tigrinya (Number ____) |
| <input type="checkbox"/> Korean (Number ____) | <input type="checkbox"/> Arabic (Number ____) |
| <input type="checkbox"/> Hatian Creole (Number ____) | <input type="checkbox"/> Portuguese (Number ____) |
| <input type="checkbox"/> Other _____ (Number ____) | |
| <input type="checkbox"/> Other _____ (Number ____) | |

10. Are these bilingual employees working in any of the following areas? If so, please approximate what percentage of the employees working in that particular area are bilingual.

	Area includes bilingual employees		Percentage of employees in area who are bilingual
	Yes	No	
Reception/appointment desk and/or phone line (initial contact with public)			
Medical area (medical assistants, technicians, phlebotomist)			
Medical area (nurses, physicians, therapists, other clinicians)			
Administrative positions with public contact (financial, social services, etc)			
High-level administrators			
Facilities management staff			
Other (specify)			
Other (specify)			

11. a) When new employees (clinicians, staff, etc.) are hired, do they receive training as to how to provide adequate language services to patients?

Yes

No (*skip to question 12*)

b) If yes, could you please provide details on the training (i.e. content, amount of time, etc.)? _____

12. What mechanisms do you have in place to determine whether or not patients are LEP/NEP and if they will need an interpreter? **Check all that apply and indicate frequency of utilization.**

Service	Strategy employed		If yes, how often is it utilized?				
	Yes	No	Never	Rarely	Some times	Often	Very often
Staff/clinicians indicate and look for patient's interpretation needs in a "primary language field" or alert in the medical record							
Staff conducting intake or making the appointment assesses and determines interpretation need							
Patient is directly asked and determines their own need							
"I Speak" cards and/or posters help patients communicate their preferred language to employees							
Patients take responsibility to request interpretation services if they feel they will need them							
Other (indicate) _____							

13. a) Does your hospital record language data within the patient's record (electronic or hard copy?)

Yes

No (*skip to question 14*)

b) If yes, how exactly is the field labeled (i.e. primary language, preferred language, interpreter needed, etc.)?

c) Is this a required data field?

Yes

No (*skip to question 14*)

d) If yes, please describe the mechanism by which data entry into the field is required.

e) Can this language data be tracked over time?

14. a) How does your facility evaluate your language services? Is this evaluation part of any Quality Improvement (QI) evaluation?

b) Is there room for patient input in the evaluation process? If so, how specifically does this occur?

15. I'm going to ask you about various ways a LEP/NEP patient may find out about language services at your facility. Could you share with me which of these methods are being employed at your facility?

Methods	Method employed		If yes, how often?				
	Yes	No	Never	Rarely	Some times	Often	Very often
Clinicians and staff members educate patients about the available services							
Signs at registration inform patients about the interpretation/translation services available							
Signs throughout the facility inform patients about the interpretation/translation services available							
Fliers are provided to patients to inform them about the available services							
Patients are informed by friends and family members							
The facility does outreach into the community to inform about the services							
Other (specify) _____							

16. a) Is there a specific position or office devoted to language services at your facility?

Yes

No (*skip to question 17*)

b) What is the name of office and the name and title of the main contact person there?

f) In which department is this office located?

- g) Number of employees?
- h) When was it created?

17. a) If a LEP/NEP person walks up to the front desk at your facility speaking a language other than English and an interpreter is needed, how would the initial contact person go about getting language services for them (e.g., use of a telephonic interpretation service, use of staff interpreter, use of bilingual staff, etc.)? **Please describe the process in detail.**

- b) Specifically, if there is telephonic interpretation available at your facility (*see question 5*), what process would an employee at your facility follow to access the phone interpretation service?
- c) How long do you anticipate it taking for someone to receive service in his/her language?

For a Spanish speaker? _____
 For an Amharic speaker? _____
 For a Chinese speaker? _____

18. Does your hospital make available to patients translated documents and/or forms in their primary or preferred language?
 Yes
 No (*skip to question 25*)
 Unsure (*skip to question 25*)

19. How does your hospital obtain these materials? Select all that apply
 Translated internally by bilingual staff
 Obtained from a commercial source (specify) _____
 Obtained from a community/government source (specify) _____
 Other source (specify) _____
 Other (specify) _____

20. a) Given the routine written material given to English speaking patients, about what percent of them are in the following target languages? Please make your best estimate.

	Amharic	Chinese	French	Korean	Spanish	Vietnamese	<i>Other</i> _____
Applications, consent forms, patient rights policies, patient grievance policies, medical history forms, procedure instructions.							
Outreach and recruitment materials, other documents.							

b) Would you be willing to provide us with examples of these documents?
 Yes (*These can be picked up at the follow-up visit to the facility*)
 No

21. How would you rate the ease or difficulty of getting documents translated? **Please select only one.**
 Very difficult. Why? _____
 Somewhat difficult. Why? _____

- Neither difficult nor easy
- Somewhat easy
- Very easy
- Unsure

22. Which clinicians or staff members can request that a document get translated? How does the process work?

23. a) To the best of your knowledge, what is the total aggregate annual cost (gross, not net) to your hospital for providing language services? (Please include any amounts from reimbursements, philanthropy, etc.)

\$ _____

- Do not know

b) To the best of your knowledge, how much does your hospital pay **external sources** for overall language services (written translations and oral interpretations) per year?

\$ _____ Per year

- Do not know

c) To the best of your knowledge, how much does your hospital pay **external sources** for just oral language services (interpreters, telephonic interpretation, etc) per year?

\$ _____ Per hour (what is your most common per hour rate for oral interpreters?)

- Do not know

24. a) Does your hospital receive any direct reimbursement for language services (e.g. Medicaid and other state/local government programs, private payers, or others)?

- Yes
- No (*skip to question 25*)
- Do not know (*skip to question 25*)

b) Please indicate by which payers your hospital gets reimbursed for language services. **Select all that apply.**

- Medicaid and other state/local government programs
- Private payers
- Other _____
- Do not know

Part IV – Needs for Tools, Resources, and Support

25. We would like to learn about the types of **barriers** your hospital faces in providing language services.

	Is this item a barrier?			If yes, how important is this barrier?		
	Yes	No	Do not know	Very important	Somewhat important	Not too important
	Lack of community level data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of tools and training resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Staff/clinicians feel uncomfortable asking questions about primary language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff/clinicians have no means of identifying patients who need language services before they arrive at the hospital (e.g., data base)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Costs/reimbursement concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long wait times for interpreters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (<i>specify</i>)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do not face barriers

26. We would like to learn about the **tools** your hospital employees (clinicians, staff, etc.) would find useful in providing language services. Please note that we may not be able to provide all these tools directly as a part of our follow-up, but we will make our best effort to connect you to resources through which you may access these types of tools.

	Would this tool be useful?			If yes, how important is this tool?		
	Yes	No	Do not know	Very important	Somewhat important	Not too important
Self-assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Packaged in-service training programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Model approaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posters and Know Your Rights Cards/Brochures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. We would like to learn about the types of **training** your hospital employees would find useful in providing language services.

	Would this training be useful?			If yes, how important is this training?		
	Yes	No	Don't know	Very important	Somewhat important	Not too important
How to collect data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

on primary language
from patients

How to use data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to respond to people who do not speak English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural competency training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to work with an interpreter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical interpreter training for bilingual employees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training on language access laws and regulations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX E

Language Access: Recommended Best Practices for Hospitals

Provision of Language Services

Informing Patients About Their Rights:

- Inform patients about their rights through Patient Rights & Responsibilities brochures, I Speak cards, language posters, and patient advocates.
- Notify LEP patients of the available language services through their primary care provider, managed care organization outreach activities, including public ads, Patient Rights & Responsibilities brochures, and I Speak cards.

Identifying Language Services Needs:

- Inquire about patient's needs for language access during intake/registration and record in paper and electronic forms.
- Use combination of patient self-assessment (i.e., ask "In what language would you prefer to receive your health care?" Or "Would you be more comfortable with an interpreter?") and staff assessment of needs for language services
- Have a way to identify patients who need language services before they arrive at the hospital. Schedule an interpreter as soon as the appointment is made or set up an "alert" in the patient's electronic medical record that reminds the provider to arrange for an interpreter in advance.
- When scheduling appointments for LEP patients, take into account the availability of language services; use software to manage interpreter requests.

Providing Interpretation and Translation:

- Provide language services 24 hours a day, 7 days a week, through a combination of services including staff interpreters, contracted interpreters, video remote and phone interpretation.
- Provide language services during off-hours, off-site and at emergency departments
- Eliminate the use of friends, family members, especially children, as interpreters
- Refrain from using unscreened and untrained bilingual staff as interpreters.
- Have and use multiple "lines of defense" to provide language access, including following in order of preference:
 - Trained bilingual staff (clinical and non-clinical)
 - Onsite and offsite contract interpreters
 - Video interpretation
 - Telephone interpreter services
- Install telephone language service lines in exam rooms (as last resort for infrequently encountered languages)
- Hospital language programs provide interpretation to the outpatient providers located at their site (e.g., Georgetown does this and cover the costs of these interpretations).
- Develop patient education materials and clinical forms in languages other than English and at low literacy levels

Hospital Policies and Procedures

Preparing to Strengthen Language Access:

- Look at language access as a quality of care, disparity reduction and patient satisfaction issue, rather than just a legal issue.
- Take a proactive approach to learning more about the many ways that high-quality language services can be provided to their patients.
- Take inventory of current capacity, and create a plan to use resources effectively and efficiently to deliver language services.
- Conduct a needs assessment of language needs of service population.

Structure of Language Service Program:

- Designate a staff member who has the responsibility for coordinating language services.
- Identify a “home” for language services within the structure of the hospital.
- Regularly assess and seek to improve the language services program.

Staffing of Language Services:

- Identify plan for “lines of defense” – bilingual staff, onsite interpreters, contract interpreters, phone lines – so patients are seen in a timely matter.
- Invest in hiring bilingual staff to serve LEP patients.
- Pay bilingual staff additional compensation for interpretation services in addition to other job duties.
- Offer incentives for bilingual ability, such as an add-on to base pay, recognition (certificate, award, special event), rewards (meal tickets, paid language classes), or additional leave or comp time.
- Carry out research on the type and amount of incentive that is most effective in encouraging bilingual clinicians and staff to participate in language skills assessments, interpreter training, and dual-role interpreter capacity.

Data Collection:

- Have a formal mechanism for consistently obtaining patient primary language data. For example, data collection forms need to have a field for preferred language and hospitals need to ensure that personnel consistently fill these fields in. [Note: The Joint Commission has instituted a standard requiring hospitals to collect and document language information as part of the accreditation process.]
- Document language needs in patient records, appointment schedules, and MIS systems.
- Train appropriate staff to consistently collect this data.
- Have protocols for transferring data between providers. [Note: The CCI has funded the DC RHIO Project to develop new technology to allow providers to share their medical records.]
- Collect data on interpretation services (e.g., time provider spends with the patient, the time the provider waits for an interpreter, patient wait time).
- Use data to better understand LEP communities, make improvements, and provide more culturally-competent care.

- Conduct a periodic analysis of language needs, including both existing patient base and those eligible to be served; include questions about language services in patient satisfaction surveys.

Policies:

- Develop and adopt written policies and procedures for the following:
 - Language access services that will be provided
 - Human resource policies to support language access, e.g., policies for hiring interpreters or bilingual staff
 - The use of bilingual staff, clinicians and non-clinicians, serving as interpreters
 - A complaint process for LEP patients who experienced language barriers
 - Board development policies to support and reflect the patient population
- Formalize community involvement through an Advisory Board.
- Include language services as part of quality improvement evaluations. Test accessibility and quality of language access and update policies and procedures if necessary.

Ensuring Quality of Language Services:

- Contract with a qualified company or organization to assess the language skills of all bilingual staff – including bilingual physicians – who provide direct services or care to patients.
- Contract with a qualified company or organization to provide medical interpreter training for bilingual staff used as interpreters, individuals hired as interpreters, or volunteer interpreters.
- Require interpreters and bilingual staff providing services in languages other than English to adhere to the National Council on Interpreting in Health Care (NCIHC) Code of Ethics and Standards of Practice. When national medical interpreter certification becomes available, require all interpreters to meet this certification.
- Provide training to physicians and staff about how to communicate effectively through a trained interpreter.

Training for All Staff:

- Require that all staff – including clinicians – receive education on the critical importance of language services to patient care and training on how to access language services.
- Provide all employees periodic mandatory training – e.g., at new employee orientation, staff meetings, in-service training – on relevant laws and regulations, the organization’s language service policies, how to identify language service needs, language data collection methods, how to work with an interpreter, and issues related to cultural sensitivity.
- Ensure that staff at points of contact e.g., answering phone, registration, admissions, and billing have knowledge of LA services so they can inform patients about what services are available and how to access them.

Collaboration:

- Create a forum for sharing of ideas regarding language access among facilities (i.e. language access coordinators meet periodically to discuss issues they are facing).
- Collaborate to share resources and reduce costs. For example, the MedStar network negotiates a lower price for LanguageLine because they represent a number of hospitals

together. They now share that resource and each individual hospital pays less for telephonic interpretation.

Funding/Investment of Resources:

- Bill language services as a hospital expense and not as a departmental expense, so that there is no disincentive for individual departments to provide these services.
- Implement new technologies to increase the efficiency of interpretation encounters (e.g., remote video interpretation to eliminate travel time between encounters).

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