GRANTMAKERS IN HEALTH

IN THE RIGHT WORDS:

Addressing Language and Culture in Providing Health Care

ISSUE BRIEF NO. 18

AUGUST 2003

BASED ON A
GRANTMAKERS
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ISSUE DIALOGUE

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Foreword

As part of its continuing mission to serve trustees, executives, and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of experts from philanthropy, research, health care practice, and policy on April 4, 2003, to discuss the roles of language and culture in providing effective health care. During this Issue Dialogue, *In the Right Words: Addressing Language and Culture in Providing Health Care*, health grantmakers and experts from policy and practice participated in an open exchange of ideas and perspectives on language access and heard from fellow grantmakers who are funding innovative programs in this area. Together they explored ways to effectively support comprehensive language services, including the use of interpreters and translation of written materials.

This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants. It focuses on the challenges and opportunities involved with ensuring language access for the growing number of people who require it. Sections include: recent immigration trends and demographic changes; the effect of language barriers on health outcomes and health care processes; laws and policies regarding the provision of language services to patients, including an overview of public financing mechanisms; strategies for improving language access, including enhancing access in delivery settings, promoting advocacy and policy change, improving interpreter training, and advancing research; and roles for foundations in supporting improved language access, including examples of current activities.

The Issue Dialogue focused mainly on activities and programs that ensure linguistic access to health care for all patients. Although language and culture are clearly inseparable, a full exploration of the field of cultural competence and initiatives that promote its application to the health care setting are beyond the scope of this Issue Brief. The day's discussion did, however, raise provocative issues of culture that are reflected throughout this report.

Special thanks are due to those who participated in the Issue Dialogue, but especially to presenters and discussants: Ignatius Bau, J.D., program officer at The California Endowment; Maria-Paz Beltran Avery, Ph.D., senior project director at the Education Development Center; Alice Chen, M.D., M.P.H., Soros Physician Advocacy Fellow at the Asian and Pacific Islander American Health Forum; Pamela Dickson, M.B.A., senior program officer at The Robert Wood Johnson Foundation; Maren Grainger-Monsen, M.D., director of the bioethics in film program at Stanford University's Center for Biomedical Ethics; Carola Green, program coordinator at Vista Community Clinic; Timothy Henderson, M.A., vice president for programs at Quantum Foundation, Inc.; Terry Hernandez, program officer at Mid-Iowa Health Foundation; Vivian Huang, M.H.S., senior policy analyst at the California Primary Care Association;

Lindsay Josephs, program specialist at Endowment for Health; Kelvin Quan, J.D., M.P.H., chief financial officer and general counsel at the Alameda Alliance for Health; and Mara Youdelman, J.D., LL.M., staff attorney at the National Health Law Program.

Rea Pañares, M.H.S., program associate at GIH, planned the program and wrote this report with editorial assistance from Anne Schwartz, Ph.D., vice president of GIH, and Angela Saunders, communications manager at GIH. Judy Frabrotta of Frabotta Company also contributed to this report. Lauren LeRoy, Ph.D., president and CEO of GIH, moderated the Issue Dialogue and provided editorial assistance.

This program was made possible by grants from The California Endowment and The Robert Wood Johnson Foundation.

About GIH

Grantmakers In Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the nation's health. Its mission is to foster communication and collaboration among grantmakers and others and to help strengthen the grantmaking community's knowledge, skills, and effectiveness. GIH is known today as the professional home for health grantmakers and a resource for grantmakers and others seeking expertise and information on the field of health philanthropy.

GIH generates and disseminates information about health issues and grantmaking strategies that work in health by offering issue-focused forums, workshops, and large annual meetings; publications; continuing education and training; technical assistance; consultation on programmatic and operational issues; and by conducting studies of health philanthropy. Additionally, the organization brokers professional relationships and connects health grantmakers with each other, as well as with others whose work has important implications for health. It also develops targeted programs and activities and provides customized services on request to individual funders. Core programs include:

- **Resource Center on Health Philanthropy.** The Resource Center monitors the activities of health grantmakers and synthesizes lessons learned from their work. At its heart are staff with backgrounds in philanthropy and health whose expertise can help grantmakers get the information they need and an electronic database that assists them in this effort.

- **The Support Center for Health Foundations.** Established in 1997 to respond to the needs of the growing number of foundations formed from conversions of nonprofit hospitals and health plans, the Support Center now provides hands-on training, strategic guidance, and customized programs on foundation operations to organizations at any stage of development.

- **Building Bridges with Policymakers.** GIH helps grantmakers understand the importance of policy to their work and the roles they can play in informing and shaping public policy. It also works to enhance policymakers' understanding of health philanthropy and identifies opportunities for collaboration between philanthropy and government.

GIH is a 501(c)(3) organization, receiving core and program support from more than 200 foundations and corporate giving programs each year.

Diversity Statement

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions.

GIH uses the term, diversity, broadly to encompass both differences in the attributes of individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and of organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

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Introduction

Mutual understanding between providers and patients is essential for achieving satisfactory health care outcomes. Physicians must be able to obtain an accurate reading of the patient's symptoms and medical history, and patients must be able to grasp the nature of their condition and the recommended course of treatment. Often, life-altering decisions regarding treatment alternatives must be based solely on information about risks and benefits communicated in the span of a brief office visit. Even for those who are fluent in English and acculturated to the American medical system, the complexity of information coupled with the emotion and anxiety of illness creates substantial opportunities for miscommunication. Under even the best of conditions, patients may have questions and concerns they find difficult to put into words, or misconceptions that lead to tragic consequences. For the growing millions of people living in this country with limited English proficiency, and for the providers who care for them, linguistic and cultural barriers can represent additional and enormous obstacles to good medical care.

The growth in immigrant populations and the corresponding rise in language diversity in the U.S. have raised concerns about the ability of the nation's health care system to care for all patients appropriately. While the use of professional interpreters in other settings such as international diplomacy and law is standard, professional medical interpreters are still a luxury in most health care settings (Chen 2003). Providers and communities are struggling with how to address the needs of populations with diverse languages and distinct cultural perceptions of health. Public policy and private efforts from nonprofit organizations, health care systems, and foundations have made some progress in confronting these problems and providing resources for action, but more remains to be done. Foundations can play an important role in helping ensure that all patients have access to linguistically and culturally appropriate health care services.

Changing Demographics, Changing Needs

The U.S. experienced 13 percent population growth between 1990 and 2000. During this period, the nation became more racially and ethnically diverse, with declines in the non-Hispanic white population and increases in the Hispanic, non-Hispanic black, and Asian and Pacific Islander populations (Andrulis et al. 2003). In large part, growing diversity was fueled by the rise in the nation's foreign-born population, which increased 44 percent during this time period to 28.4 million people. In 2000, the foreign-born population comprised 10 percent of the total population, its highest proportion since 1930 (U.S. Census Bureau 2002c).

Growth in the foreign-born population has led to the increase in the nation's language diversity. Over 300 different languages are spoken in the U.S., and nearly 47 million people (almost 18 percent of the nation's population) speak a language other than English at home (Figure 1). Spanish is, by far, the most common foreign language spoken in the U.S. Spanish-speakers alone

> *"Imagine pulling in a member of the custodial staff to help you deal with the nuances of an international business deal. You can't."*
>
> ALICE CHEN,
> ASIAN AND PACIFIC
> ISLANDER AMERICAN
> HEALTH FORUM

Figure 1. *Languages Spoken at Home in the United States*

Language	Number	Percentage*
Language other than English	46,951,595	17.9
Spanish or Spanish Creole	28,101,052	10.7
Chinese	2,022,143	0.8
French (including Patois and Cajun)	1,643,838	0.6
German	1,383,442	0.5
Tagalog	1,224,241	0.5
Vietnamese	1,009,627	0.4
Italian	1,008,370	0.4
Korean	894,063	0.3
Russian	706,242	0.3
Polish	667,414	0.3
Arabic	614,582	0.2
Portuguese or Portuguese Creole	564,630	0.2
Japanese	477,997	0.2
French Creole	453,368	0.2
Other Indic languages	439,289	0.2
African languages	418,505	0.2
Other Asian languages	398,434	0.2
Greek	365,436	0.1
Other Indo-European languages	327,946	0.1
Hindi	317,057	0.1
Other Pacific Island languages	313,841	0.1
Persian	312,085	0.1
Other Slavic languages	301,079	0.1
Urdu	262,900	0.1
Other West Germanic languages	251,135	0.1
Gujarathi	235,988	0.1
Serbo-Croatian	233,865	0.1
Other Native North American languages	203,466	0.1
Armenian	202,708	0.1
Hebrew	195,374	0.1
Mon-Khmer, Cambodian	181,889	0.1
Yiddish	178,945	0.1
Navajo	178,014	0.1
Miao, Hmong	168,063	0.1
Scandinavian languages	162,252	0.1
Laotian	149,303	0.1
Other and unspecified languages	144,575	0.1
Thai	120,464	0.0
Hungarian	117,973	0.0

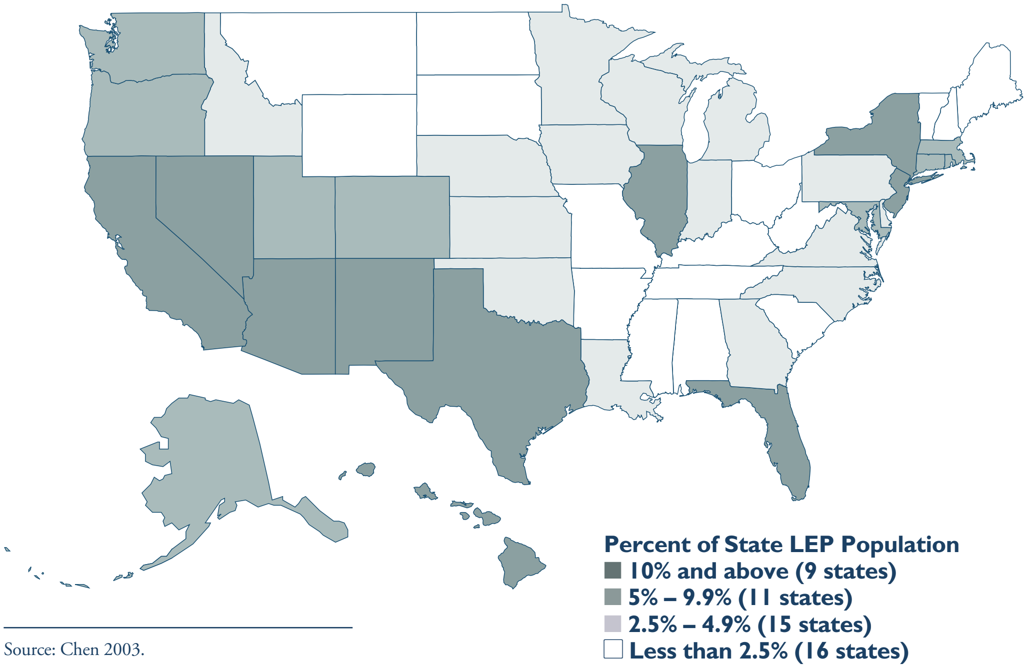
* All percentages are approximate.

Source: U.S. Census Bureau 2003b.

increased by 43 percent between 1990 and 2000, now comprising almost 11 percent of the total population. Over 21 million individuals self-report their ability to speak English as less than "very well" (U.S. Census Bureau 2003a). These individuals are often referred to as limited English proficient (LEP), defined in the context of the health care setting as "a person who is unable to speak, read, write, or understand the English language at a level that permits him/her to interact effectively with health and social service agencies and providers" (Office of Civil Rights 2002).

Foreign-born residents and associated LEP populations are concentrated in certain parts of the country (Figure 2). In five states, the foreign-born population rate exceeds the national average of 10 percent: California (26 percent), New York (20 percent), Florida (18 percent), New Jersey (15 percent), and Texas (12 percent). Moreover, half of the foreign-born population is concentrated in five metropolitan areas: Los Angeles, New York, San Francisco, Miami, and Chicago (U.S. Census Bureau 2002c). In California, 40 percent of its population speaks a language other than English at home, and in some areas the percentage is even greater; for example, in the Santa Ana/Anaheim area, 67 percent speak a language other than English at home. Miami/Hialeah leads the nation's largest cities with the highest percentage of its population that speaks a language other than English at home at 82 percent; and 37 percent of Miami/Hialeah's city population reports not speaking English well or at all (Andrulis et al. 2003).

Figure 2. *Percentage of Population with Limited English Proficiency, 2000*

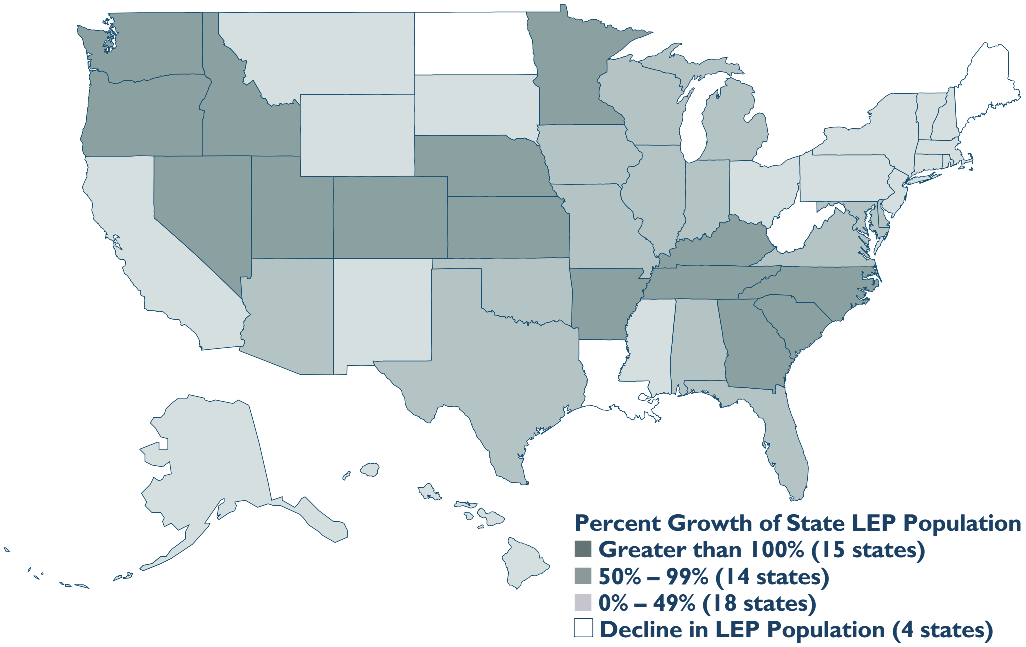


Source: Chen 2003.

While the highest foreign-born population rates are concentrated in California, Texas, and northeastern metropolitan areas, the greatest rates of growth occurred in the South and Midwest, with many cities experiencing triple-digit increases between 1990 and 2000 (Figure 3). During this period, Augusta, Georgia experienced the largest growth, with a 766 percent increase in its foreign-born population. The three largest cities in North Carolina (Raleigh, Greensboro, and Charlotte) had increases in their Hispanic population well over 450 percent. Grand Rapids, Michigan and Des Moines, Iowa also saw high rates of foreign-born growth at 167 percent and 151 percent, respectively (Andrulis et al. 2003). These changes present significant challenges for health and other social programs as policymakers and communities struggle with how to serve this influx of newcomers.

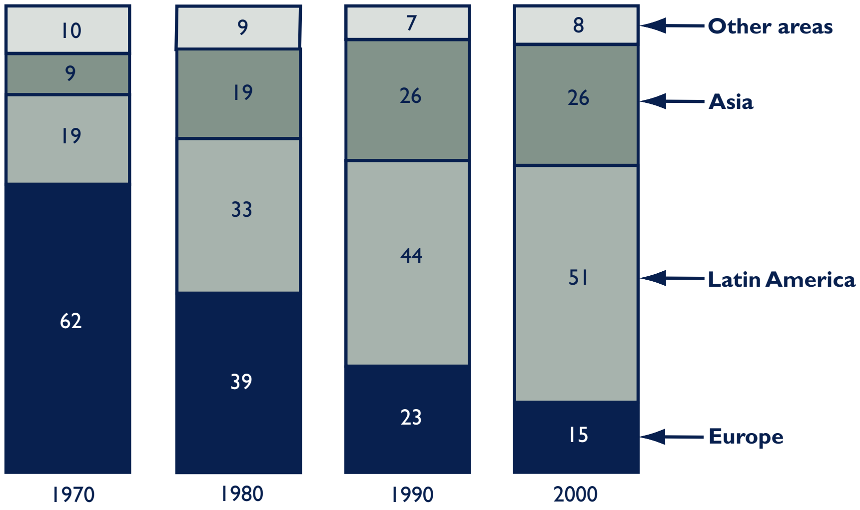
The composition of the nation's foreign-born population is also changing. Since 1970, the number of immigrants from Europe has steadily declined, whereas populations from Latin American and Asia have both increased (Figure 4) (U.S. Census Bureau 2002c). Latin American countries constituted half of the foreign-born population, with countries such as Mexico, Cuba, El Salvador, and the Dominican Republic leading the way. In fact, Mexico alone accounted for over half of the foreign-born population from this region and more than one-quarter of the total immigrant population (U.S. Census Bureau 2002a). Immigration from Asian nations comprised 26 percent of the foreign-born population and was distributed relatively evenly among the five largest contributors: China, the Philippines, India, Vietnam, and Korea (U.S. Census Bureau 2002b).

Figure 3. *Growth in Limited English Proficiency, 1990-2000 (Percentage)*



Source: Chen 2003.

Figure 4. *Foreign-Born Population by Region of Birth: 1970 to 2000 (Percentage)*



Source: U.S. Census Bureau 2002c.

Broadly categorizing immigrants according to the continent or even the country of their birth does not tell the whole story of linguistic and cultural diversity. Significant variations exist within categories with respect to primary language, religious beliefs, and cultural practices. Although the primary language of most Latin American countries is Spanish, each Asian country has a different national language and multiple dialects. In the Philippines, for example, over 70 different dialects are spoken, even though the national language is Tagalog. Furthermore, individual countries or subgroups within countries may have specific health beliefs and practices that are not broadly shared. Traditional Mexican culture, for example, includes the "hot-cold" theory of disease, where illnesses, food, and medicines are classified as hot or cold. Prevention or treatment is then based on restoring the hot-cold balance, where "hot" diseases are treated with "cold" foods and vice versa. This practice is not common in other Latin American countries (Families USA Foundation 1995).

Health Consequences of Language Barriers

A consistent body of research points to the extent of language barriers in health care settings and its implications for health. Moreover, the personal stories of those who have encountered these barriers illustrate the reality of the system. The following sections describe the ramifications of poor linguistic access, including: decreased access to health services, compromised patient comprehension, low patient satisfaction, reduced quality of care, and an increase in health care costs.

Access

Language barriers have been shown to impede access at several entry points, from having health insurance to receiving basic and preventive care to accessing specialty services. In a study of the effect of English language proficiency on enrollment of Medicaid-eligible children in publicly funded health insurance programs, most families with eligible children reported not knowing eligibility guidelines and difficulty translating enrollment forms as reasons for not enrolling in the program (Feinberg et al. 2002). In a nationwide telephone study of insured adults, Spanish-speaking Latinos were significantly less likely than non-Latino whites to have had a physician visit, flu shot, or mammogram in the preceding year. To isolate the role of language, non-Latino whites were then compared to English-speaking Latinos. No difference in utilization was found, which points to language as the driving force for this disparity in access to preventive services (Fiscella et al. 2002).

Patient Comprehension

Once LEP patients get into the system, language barriers may compromise comprehension of diagnosis, treatment instructions, and plans for follow-up care (Crane 1997). At the same time, language concordance —when the physician and patient speak the same language —has been associated with better patient self-reported physical functioning, psychological well-being, and health perceptions, as well as lower pain (Perez-Stable et al. 1997).

Patient Satisfaction

Patients are more satisfied when they have access to a trained and qualified interpreter. In one study, 32 percent of those who needed an interpreter, but did not get one, said they would not return to the hospital if they became insured, while only 9 percent of those who did receive an interpreter said they would not return (Andrulis et al. 2002). Another study comparing LEP versus English-speaking Asian and Hispanic patients found significantly worse reports of care on multiple domains, including timeliness of care, provider communication, staff helpfulness, and plan service (Weech-Maldonado et al. 2001). Oftentimes, satisfaction with care at a particular institution determines whether a patient will return for subsequent care at the same institution, if given a choice (Chen 2003).

Quality of Care

Language barriers diminish quality of care and can lead to serious complications and adverse clinical outcomes. One study found that patients with a language barrier were more likely to have self-reported outpatient drug complications. They were also more likely to have a number of other medical problems, such hospitalizations and lower medication compliance. When a prescribing physician is unable to communicate effectively with his/her patient, serious side effects may occur if an accurate history is not taken (Ghandi et al. 2000).

Costs to the Health Care System

Language barriers can escalate costs to the health care system by increasing inefficiencies and unnecessary testing. When treating LEP patients, providers often order additional tests and other costly, and sometimes invasive, procedures for fear of missing a diagnosis when a good history would have sufficed. The practice is so common it has come to be characterized as “veterinary medicine.” In the absence of verbal communication, test results, visual assessment of symptoms, and hand

A CLOSER LOOK AT LANGUAGE BARRIERS

A Vietnamese-speaking patient is unable to schedule a follow-up appointment for an abnormal mammogram because the receptionist speaks only English. As a result, treatment and necessary procedures are delayed.

……

A Chinese-speaking woman visits her primary care physician complaining of a mass in her wrist. Luckily, this physician is able to speak the patient's language and communicate effectively. She is referred for a biopsy and returns to the same physician several weeks later for a follow-up appointment. The patient tells her physician that the surgery was performed, but she did not know what the surgeon found. She also mentions that she was prescribed medications, but has stopped taking them because she felt fine. Her physician examines the bottles and discovers the medications are for tuberculosis. The patient was not aware of this diagnosis. More alarming, she was not aware the disease could be spread easily to others and that effective treatment includes taking her medications for one year.

……

A Mien-speaking man with chronic hepatitis is referred to a gastroenterologist for a biopsy of his liver. Through a Mien interpreter, he reported back to the referring physician that he was yelled at by a staff member for not bringing his own interpreter. After multiple frustrating encounters, he asked to be referred to another doctor, a bold act for someone whose culture does not normally allow for questioning of a physician's authority.

……

A patient presenting with shortness of breath that was attributed to hyperventilation after an earthquake was later found to have diabetic ketoacidosis, a severe complication of diabetes requiring aggressive treatment to avoid coma or death. Language problems prevented a discussion of the patient's history.

……

A call from the mother and sister of a Spanish-speaking man reported that he was "intoxicado." Paramedics and the hospital personnel incorrectly interpreted this as intoxicated or drunk and, therefore, left him alone, offering no treatment. It turned out the man was actually having a stroke, and this mistake resulted in him being paralyzed. After settling out of court, the health care institution was required to pay $71 million.

……

A Spanish-speaking patient presenting chest pain, unrelated to coronary artery disease, is scheduled for multiple unnecessary diagnostic procedures, due to the inability of the medical team to get a good history.

motions must form the basis of a diagnosis (Chen 2003). These add up to unnecessary costs to the health care system. A study in a Chicago pediatric emergency department documented the cost of language barriers. After controlling for severity of illness, vital signs, tests, and insurance status, the investigators found that visits that had a language barrier were on the average $38 more expensive and required more time, on the average 20 minutes more, than those without language barriers (Hampers et al. 1999).

Taken together, this body of research and cases show that speaking a language other than English puts a patient at risk for adverse health outcomes and reduced quality of care. The landmark Institute of Medicine (IOM) report, *Unequal Treatment*, suggested that factors within the health care system may exert different effects on patients, resulting in negative consequences for those with limited English proficiency. It further stated that "language mismatches are a fertile soil for racial and ethnic disparities in care" (IOM 2002). Many of these findings suggest a strong need for improving oral and written communication about the importance of preventive physician visits and medication instructions. Additionally, enhanced patient-provider communication may lead to more effective diagnosis, reducing the need for unnecessary testing and more aggressive treatment. Lastly, improved communication about publicly funded programs may improve access to care for eligible patients, as well as provide new funding streams for hospitals and health systems treating these patients.

More Than Words: The Role of Culture

Language access is only part of the answer in effectively addressing the health care needs of the LEP population. Culture plays a critical role in an individual's approach to health and healthy living. Cultures vary in perceptions of illness and their causes; beliefs with respect to health, healing, and wellness; adoption of health behaviors; and attitudes toward the health care system (National Center for Cultural Competence 1999). Consider the example of an elderly, first-generation Laotian man who was prescribed four teaspoons a day of an oral antibiotic. Although the gentleman was able to get his prescription filled, when a public health nurse visited his home, she realized he was not taking his prescribed medicine because he had no idea what a teaspoon was; he had only used chopsticks and large soup spoons (Families USA Foundation 1995). Hmong culture provides another illustrative example.
In the Hmong language, there is no word for cancer or even a concept of it. In trying to explain radiation, inexperienced interpreters or family members used language translated as "we're going to put fire in you," which obviously deters patients from agreeing to treatment (Morse 2002).

There are numerous examples of how culture plays a role in the health care encounter. In many cultures, patients are reluctant to raise issues they deem as insignificant with their providers. For example, a persistent cough in the early hours of the morning is typically an indication of asthma in a child. Some parents may not mention this problem if not specifically asked about it by the provider because they may deem it as unimportant, particularly if the problem has persisted for some time. A survey of three schools in one California community—one with predominantly white students, another with predominantly Hispanic students, and a third with predominantly Vietnamese students—found high levels of asthma in the Hispanic and Vietnamese children, even though many children were undiagnosed. Providers in the community commented that these indicators were rarely brought up during office visits (Kieu 2003).

Political nuances can also creep into the interpretation process. Some immigrants come to the U.S. from countries or regions experiencing political unrest. Many times language is directly related to political affinities. In Farsi, for example, there are dialects used by particular regional or religious groups that may be offensive to others.

Laws and Policies for Ensuring Language Access

There is a legal and policy framework that supports access to language services. This section describes federal laws and policies, recommended federal guidelines, and public financing for language access services. While some states have specific laws related to language access, a discussion of these is beyond the scope of this Issue Brief.

Federal Civil Rights Policy

The legal basis for a patient's right to language access has existed for some time. Title VI of the Civil Rights Act of 1964 states,

> 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.

The courts have interpreted national origin to include individuals with limited English proficiency. Recipients of federal funding, such as Medicare and Medicaid providers, may be held liable for discrimination if they fail to provide access to language services.

In August 2000, President Clinton reiterated this policy by issuing Executive Order (EO) 13166, *Improving Access to Services for Persons with Limited English Proficiency*, which applied to all federal agencies, not just those focused on health. The EO required each federal agency to develop and implement guidance, specifically tailored toward its grantees, for improving access to programs and services for individuals with LEP. It also required all federal agencies to meet the same standards as their grantees by developing policies for ensuring linguistic access within their own agencies (U.S. Department of Justice 2000).

"The cultural attitude of the patient is very important and must be factored into any diagnosis and treatment recommendations."

QUYNH KIEU,
THE HEALTHCARE
FOUNDATION FOR
ORANGE COUNTY

As the lead federal agency funding most health and social services programs, the U.S. Department of Health and Human Services (HHS) issued its guidance immediately after the EO, applying these long-standing provisions of Title VI to the health care setting. The guidance was drafted by the HHS Office of Civil Rights (OCR), the agency responsible for enforcing federal civil rights laws in the health care context, including Title VI. The OCR guidance did not impose any new requirements, but did reaffirm the expectation that health care entities receiving federal funds were required to offer meaningful access to linguistic services, including interpreters. Entities that are responsible for complying with the guidance include: hospitals, nursing homes, home health agencies, and managed care organizations; universities and other entities with health or social service research programs; state, county, and local health agencies; and physicians and other providers receiving federal assistance from HHS. The guidance explained the legal requirements of Title VI, provided a roadmap to compliance, identified best practices, and explained the process for handling complaints and enforcing the law (Office of Civil Rights 2002).

The LEP policy guidance explained the obligations of federal grantees for ensuring linguistic access and outlined several broad strategies for accomplishing this. It states:

> The key to providing meaningful access to benefits and services for LEP persons is to ensure that the language assistance provided results in accurate and effective communication between the provider and LEP applicant/client about the types of services and/or benefits available and about the applicant's or client's circumstances (Office of Civil Rights 2002).

Although HHS recipients have considerable flexibility in fulfilling this obligation, OCR's policy guidance identified four elements common to effective language assistance programs (Office of Civil Rights 2002):

- *Assessment:* Providers should assess the language needs of the population to be served by determining the languages and number of LEP persons in the service area, identifying and recording language needs of each client/patient served, recognizing possible points of contact where language services are needed, and identifying and obtaining resources needed to provide timely language assistance.
- *Development of Comprehensive Written Policy:* Providers should develop and implement LEP policies and procedures that include: furnishing notice to LEP persons in their language of the right to free language assistance; offering competent oral language assistance, particularly avoiding the use of the patient's friends, family members, or children; and translating written materials.
- *Training of Staff:* Providers should train their staff to ensure that staff understand and implement LEP policies and procedures. Training is essential to bridging the gap between policies and actual practices.

- *Vigilant Monitoring:* Providers should ensure that LEP persons can meaningfully access their services. At least annually, providers should assess: the current LEP makeup of its service area, the current communication needs of LEP persons, whether existing assistance meets LEP needs, whether staff is knowledgeable about policies and procedures and how to implement them, and whether sources of and arrangements for assistance are still current and viable.

Enlisting family, friends, and other patients as interpreters is strongly discouraged by the OCR guidance. Using children as interpreters, in particular, is discouraged because of potentially damaging psychological effects when translating sensitive physical or sexual matters for their elders (Downing and Roat 2002). Materials from the National Health Law Program (NHeLP) provide an example of such a situation: A provider performing an ultrasound on a pregnant LEP patient instructed the patient's seven-year-old daughter to tell her mother that the baby was stillborn. Only when the daughter became upset and refused to translate was a professional interpreter called (NHeLP 1998). This practice is allowable by the OCR's policy guidance only when a patient insists on using the trusted individual, even after being informed of their right to an interpreter free of charge. In any other case, the OCR guidance has made it clear that the practice of "requiring, suggesting, or encouraging" a patient to bring his or her friends, minor children, or family members to serve as interpreters infringes on the patient's civil rights and is unacceptable (Office of Civil Rights 2002).

Legislation has been introduced in California that would prohibit children from being used as interpreters. This bill (AB 292) would prohibit a state or local governmental agency, or a public or private agency, organization, entity, or program that receives state funding, from using any child, or permitting any child to be used, as an interpreter. It would further require that they have in place, and available for inspection, an established procedure for providing competent interpretation services that does not involve the use of children (Huang 2003).

Some communities are enlisting bilingual youth for limited interpreter roles, a practice that has both benefits and ramifications. Often referred to as heritage speakers—people who were either born in the U.S. to an immigrant family or who immigrated themselves at an early age and speak English—are seen as an untapped resource in many immigrant communities. Since there are a variety of circumstances in which interpretation is needed, they can play valuable roles as patient greeters and/or navigators (Beltran Avery 2003). Such roles also help these speakers to retain rudimentary language skills and offer them the opportunity to develop these skills further. This can be a valuable asset, particularly for some of the rarer languages. Yet, caution must be exercised so that their services are not extended beyond these duties to the clinical encounter. Merely being bilingual does not qualify someone as an interpreter and, therefore, it is essential that providers know "where to draw the line, so that they don't pull these people into the encounter" (Chen 2003).

> *"Oftentimes family members build their own agenda for the patient. The health encounter eventually becomes a conversation between the provider and the person that speaks English, while the patient gets sidelined and left out."*
>
> MAREN GRAINGER-MONSEN, STANFORD UNIVERSITY'S CENTER FOR BIOMEDICAL ETHICS

CLAS Standards

To help providers and advocates respond to the needs of the LEP population, the HHS Office of Minority Health (OMH) issued national standards for ensuring culturally and linguistically appropriate services (CLAS) in health care (Figure 5).[1] These standards are organized by themes: culturally competent care (Standards 1-3), language access services (Standards 4-7), and organizational supports for cultural competence (Standards 8-14). Including cultural competence with linguistic access strengthens the notion that interpretation and translation require knowledge of culture (California Primary Care Association 2002). The standards concerning language access reiterate the obligations of federal fund recipients outlined in Title VI of the Civil Rights Act (and enforced by the Office of Civil Rights). Other standards include practices recommended by OMH for adoption by federal, state, and national accrediting agencies and suggested activities for health care organizations. The standards are intended for use by policymakers, providers, patients, advocates, purchasers of health care, accreditation and credentialing agencies, and other health care organizations (IQ Solutions, Inc. 2001).

Public Financing Mechanisms

Although federal laws and policies require recipients of federal funds to provide language services, there is no well-established funding mechanism. Major sources of federal funding include categorical grants and matching funds under Medicaid and the State Children's Health Insurance Program (SCHIP). The recently enacted Community Health Centers Reauthorization Act includes authorization for linguistic access grants to community health centers to provide translation, interpretation, and other such services, but funding has not yet been determined (The Access Project and National Health Law Program 2003). The Office of Minority Health developed the Bilingual/Bicultural Service Demonstration Program in 1993 to test models of culturally and linguistically competent services and help LEP patients navigate managed care systems. This grant program provides funding for a three-year period and is currently funding 20 sites nationwide. OMH anticipates issuing a new request for proposals for another round of grants in 2003.

Currently, the Centers for Medicare and Medicaid Services (CMS) provides the primary source of federal funding to help states and health care providers pay for language services. Through the Medicaid/SCHIP program, language

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[1] Development of the CLAS standards was a multistep process to create a consistent framework from an existing patchwork of independently developed definitions, practices, and requirements. The first stage of the project involved a review and analysis of existing cultural and linguistic competence standards and measures, the development of draft standards, and revisions based on a review by a national advisory committee. The second stage focused on obtaining and incorporating input from organizations, agencies, and individuals that have a vital stake in the establishment of CLAS standards. The final standards reflect input from a broad range of stakeholders, including hospitals, community-based clinics, managed care organizations, home health agencies, providers, policymakers, and professional organizations (IQ Solutions, Inc. 2001).

Figure 5. *National Standards for Culturally and Linguistically Appropriate Services in Health Care*

Standard 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.
Standard 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.
Standard 3:	Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
Standard 4:	Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
Standard 5:	Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
Standard 6:	Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on the request of the patient/consumer).
Standard 7:	Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
Standard 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 culturally and linguistically appropriate services.
Standard 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.
Standard 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.

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National Standards for Culturally and Linguistically Appropriate Services in Health Care

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Standard 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 their service area.
Standard 12:	Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formats and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
Standard 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.
Standard 14:	Health care organizations are encouraged to regularly make available 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.

Source: Office of Minority Health 2000.

services are an optional service. In 2000, CMS reminded states that they could obtain federal matching funds for language services provided to Medicaid and SCHIP enrollees. According to a letter to state health officials,

> Federal matching funds are available for States' expenditures related to the provision of oral and written translation administrative activities and services provided for SCHIP or Medicaid recipients. Federal financial participation is available in State expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service.

Currently, only nine states directly reimburse for language services. The reasons states do not take advantage of federal funding vary, from lack of awareness of its existence to tight state budgets (The Access Project and National Health Law Program 2003). It is important to note that while these services are covered under Medicaid, the Medicare program, a source of coverage for a growing number of elderly LEP individuals, does not offer separate reimbursement for language access services (Katz 2003).

The nine states that have adopted the Medicaid/ SCHIP option currently use one of three models for paying for language services (Figure 6). Some states require providers to hire interpreters and then pay the providers for the costs. Other states pay interpreters directly. In New Hampshire, interpreters are required to enroll as Medicaid providers through a special process. These interpreters can bill the state directly for their services. Finally, some states use brokers or language agencies. Providers contact these designated organizations to schedule an interpreter; the state then pays the organization, which in turn pays the interpreter (The Access Project and National Health Law Program 2003). Rates paid by each state vary. The exact cost of providing language services in a given area depends on several factors, such as the number of different languages spoken, the organization and types of services offered, and the language ability of current providers (Office of Management and Budget 2002).

The determination of federal matching funds varies by state and depends on several factors. A state can claim its federal share as either a covered service or an administrative expense. In order for a state

Figure 6. *State Mechanisms for Paying for Language Services Under Medicaid and SCHIP*

State	Payment Model	Rate Paid by State	Claim Method	Federal Match (percentage)
Hawaii	Language agencies	$36/hour (in 15 minute increments)	Covered service	Medicaid: 58.77 percent SCHIP: 71.14 percent
Idaho	Providers	$7/hour	Covered service	Medicaid: 70.96 percent SCHIP: 79.67 percent
Maine	Providers	$30/hour (business hours) $40/hour (nonbusiness hours) $7.50/15 minutes after first hour	Covered service	Medicaid: 66.22 percent SCHIP: 76.35 percent
Massachusetts	Providers	varies for each health care facility	Unknown	50 percent
Minnesota	Providers	$12.50/15 minutes lesser of $50/hour or usual and customary fee	Administrative expense	50 percent
Montana	Interpreters	lesser of $6.25/15 minutes or usual and customary fee	Administrative expense	50 percent
New Hampshire	Interpreters (who are Medicaid providers)	$15/hour $2.25/15 minutes after first hour	Administrative expense	50 percent
Utah	Language agencies	$22/hour (phone) $39/hour (in-person)	Covered service	Medicaid: 71.24 percent SCHIP: 79.87 percent
Washington State	Public entities	50 percent of allowable expenses	Administrative expense	50 percent
	Brokers, interpreters, and language agencies	Brokers receive an administrative fee Interpreters/language agencies receive up to $28/hour	Administrative expense	50 percent

Source: The Access Project and National Health Law Program 2003.

to claim language services as a covered service, it must submit a request to CMS to have it added to its Medicaid state plan. States can also choose to claim language services as an administrative cost, which may offer a lower matching rate,[2] but require no prior approval (The Access Project and National Health Law Program 2003).

Strategies for Improving Language Access in the Health Care Setting

There are several broad approaches to improving access to language services, including strengthening service delivery, promoting advocacy and policy change, and advancing research. Specific practices related to these approaches are discussed in this section, along with ways in which foundations are supporting and furthering these activities.

Improving Access in Delivery Settings

Health care organizations and providers have used various methods of service delivery to reduce linguistic and cultural barriers between patients and providers who do not speak the same language. Different practices are appropriate in different settings and communities. Oftentimes a combination of several methods is most effective at ensuring equal access to linguistic services for all populations. The following section describes current practices for addressing language barriers in the health care setting, opportunities for improvement, and ways in which grantmakers have supported these various strategies and programs. Current practices include:

- relying on the language skills of providers and patients;
- in-person, third-party interpretation, both ad-hoc and professional;
- remote, third-party interpretation using technology; and
- the translation of written materials.

Improving Language Proficiency of Providers

The lack of diversity in the health care workforce often emerges as the broad issue relevant to language access. While there is a need to increase the availability of trained medical interpreters, there is the dual need to increase the representation of bilingual/bicultural providers. There are several advantages to having a provider who can speak the same language as the patient. Bilingual/bicultural providers are ideal because insight into the patient's culture and the ability to speak to the patient directly help create a connection between provider and patient. When the patient and provider are from the same culture, mutual understanding of cultural beliefs and health care practices enable some providers to pick up on subtle cultural nuances that can influence health behaviors and attitudes.

Health care organizations must be able to ensure the accuracy of self-declared language proficiency of bilingual providers (Green 2003). While both native and

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[2] While the match for covered services ranges from 50 to 84 percent, all states receive a standard 50 percent federal match for both Medicaid and SCHIP for administrative expenses.

nonnative speakers may be familiar with the language in social settings and/or an academic context, they may lack the terminology specific to the medical encounter, particularly if their medical training was in English. While several health plans now publish the language of their providers in their provider directories, there is no standardization as to the accuracy of those self-declarations. Providers may list the languages they speak or those spoken by anyone employed in their office, oftentimes without further questioning. In efforts to enhance its services and accountability, the Alameda Alliance for Health completed a detailed survey of its provider network. The six-page survey not only asked for self-declared language(s) for each person employed in the office, but also, "Where did you learn the language? Are you a native speaker? Did you learn it in high school? Did you learn it in college? Did you enter medical/professional school speaking that language?" Although the survey cost the health plan considerable time and money, it achieved a fairly high response rate (Quan 2003).

Practical limitations prevent use of bilingual/bicultural providers from being the sole strategy for any one health care setting. Developing the language skills of others in the health care organization is also important, as language needs extend beyond the examination room. During their visits and when navigating the health care system, patients interact with administrative and other staff, including receptionists, orderlies, lab technicians, and pharmacists. Ensuring that the entire health care organization is linguistically accessible can be a costly and complex task in large settings with multiple language needs (Downing and Roat 2002).

Foundations have played an important role in supporting the bilingual training of both providers and staff. Grantmakers are also helping educational institutions enhance the linguistic ability of current students. For example:

- The Assisi Foundation of Memphis, Inc. funded the Christ Community Medical Clinic, Inc. to help the clinic fund participation in Spanish language training for clinic employees.
- The Blue Cross Blue Shield of Massachusetts Foundation has sponsored a number of activities to train both providers and their staff to be both linguistically and culturally competent through its *Pathways to Culturally Competent Health Care* initiative. It funded the Lowell Community Health Center, Inc. for a comprehensive training initiative to serve its Brazilian and African immigrant communities through interpreting and cultural competence for physicians and staff. It also established the Latino Consult Service to build the bilingual skills of staff at Beth Israel Deaconess Medical Center by teaming them with bilingual and bicultural providers. It also funded the Health Access Collaborative of Southeastern Massachusetts, Inc. to support the development and delivery of advanced cultural competence and interpreter training for professional and clinical staff and basic medical interpreter training for administrative and reception staff at the New Bedford and Fall River hospitals,

neighborhood health centers, and community-based organizations that make up this collaborative.

- The Helene Fuld Health Trust in New York supported a grant to Lee College to provide nursing faculty and students language instruction in medical Spanish to improve their ability to perform health assessments for Spanish-speaking patients.

The advantages of having providers who speak their patients' languages have raised questions about how to take advantage of the skills of immigrant health professionals. A group of Latino health care advocates in Georgia, for example, is pushing for the state to adopt a new licensing process for health care providers that would help alleviate the shortage of bilingual physicians and nurses. Under current state law, it can take foreign-trained nurses up to three years and foreign-trained doctors up to seven years to receive their licenses. Groups are asking Georgia's Professional Licensing Boards Division to review a plan that would give foreign-trained medical professionals a limited license and require them to work alongside licensed doctors and nurses while they learn English, undergo credential reviews, and complete follow-up classes or tests required for formal licenses. Providers would be able to provide needed services to Spanish-speaking patients in their language, while they become proficient in English (Dodd 2002).

In response to the growing number of immigrants, consisting of both those who need health care and professionals in search of meaningful job opportunities, The California Endowment has funded a $1.4 million project to create an International Health Care Workers Assistance Center for the Los Angeles and Southern California area. The first year of the three-year grant included planning, and the center officially opened in 2002. The purpose of the center is to help physicians, nurses, radiology technicians, respiratory technicians, and others trained in the health field from other countries obtain appropriate licenses and credentials to work in the U.S. health care system. It will also offer orientation and job placement services. By helping these workers transition to the U.S. health care system, the center will help meet the demand for highly trained professionals in communities that desperately need their skills, as well as their linguistic and cultural competency. Additionally, the project addresses the need for racial and ethnic diversity in the health care workforce.

Similarly, The HealthCare Foundation for Orange County was able to inititate funding in the area of interpretation by addressing the broader issue of the ethnic diversity of the workforce. The foundation funded a project to train, as interpreters, foreign-educated physicians who were unable to practice medicine in the U.S. because of their limited English language competency. The ultimate goal of the program is to enable these physicians to gain the skills necessary to become licensed health professionals.

Improving Language Proficiency of Patients

Another approach for improving language access is promoting English proficiency among patients so they can effectively navigate the health care system and communicate with providers. Some organizations, like Arlington, Virginiabased ProEnglish, actively promote the use of English and oppose multilingualism. California's Little Hoover Commission, an independent state oversight agency, issued a report in 2002 on the rights and responsibilities of immigrants in California—a group that currently comprises one-quarter of that state's population. The commission called for increased efficiency of public services, as well as a California Residency Program that would give immigrants preferential access to public benefits, including health care, if they agreed to certain responsibilities. Among those responsibilities are the ability to speak English or the enrollment in English-language training. In presenting the general concept behind the program, the commission suggested that immigrants who commit to the residency program would be given priority over other immigrants to receive benefits, such as Medi-Cal, the California Medicaid program. Those who choose not to make this commitment would receive lower priority to access public sector services (Little Hoover Commission 2002).

Although promoting self-sufficiency and improving the effectiveness of public programs are noteworthy goals, assuming that all LEP populations can become fluent is probably unrealistic, particularly when it comes to health. First, immediate health needs make it impossible to wait for linguistic competence and cultural assimilation. While most immigrants arrive in good health, many refugees—especially those fleeing from violent situations and/or persecution in their homeland—may arrive with complicated medical and psychological health problems (National Council on Interpreting in Health Care 2001). Secondly, English as a Second Language (ESL) courses may not be sufficient preparation for navigating the health care system. These classes generally emphasize practical communication for survival and employment, rather than developing higher-level language skills needed to understand explanations of disease, bodily processes, and treatment alternatives (Downing and Roat 2002). Moreover, for most working adults, learning a new language is time-consuming and may take a backseat to supporting and caring for their families. Many immigrants also fear that ESL classes and other venues that cater to immigrant populations are too often frequented by Immigration and Naturalization Service officers. Latino immigrants tell of being recruited into English-language classes by local community colleges, while simultaneously being targeted by law enforcement officers who wait for them to drive to work or class (Little Hoover Commission 2002). Finally, the use of a priority system may cause further divide among immigrant communities, as some groups may find it easier to assimilate, such as those that come from countries with high exposure to American culture. Immigrants that come from less developed nations and/or those fleeing from persecution may be less likely to succeed in the program, yet be the most vulnerable and in need of public assistance.

There are positive steps that can be taken to improve language skills and understanding of American customs and institutions. The Colorado Trust has employed a two-pronged approach by initiating its grantmaking on both positive acculturation and language access to health care services. In response to a needs assessment focusing on immigrants and refugees in Colorado, the foundation launched the *Supporting Immigrant and Refugee Families Initiative* in the fall of 2000. This five-year, $7.5 million effort has two program components. The first component addresses mental health and acculturation by strengthening community-based organizations throughout the state that provide direct mental health and acculturation services to newcomers. Such services include counseling, ESL classes, support groups, and parenting classes.

The Colorado Trust's second component aims to increase language access services in the health care setting. The foundation convened interested stakeholders, such as interpreters, health care providers, the regional HHS Office of Civil Rights, and immigrant and refugee organizations from the Denver area; the group emerged as the Coalition for Language Access. With the help of a facilitator, the coalition identified the critical issues in providing high-quality language interpretation. One priority was the need to train health care providers on how to effectively work with medical interpreters. A curriculum was created in response, and presentations were made to interested providers. Another need identified as critical was the creation of a high-quality interpreter bank in the Denver area. Through an RFP process, the foundation selected a local organization to create and manage the interpreter bank. One year into implementation, the interpreter bank has successfully recruited a cadre of interpreters, provided health care interpretation training, focused on interpretation ethics, and continues to explore ways to constantly assess language skills and provide ongoing professional development for interpreters. Marketing interpreter bank services and educating the community about the need for high-quality, professional interpreters are ongoing challenges (Downs-Karkos 2003).

Expanding Access to Third-Party Interpretation

Third-party interpretation, both in-person and through the use of advanced technology, is gaining increased attention and scrutiny and is being adopted in many forms. Interpretation services have been shown to effectively reduce language barriers and improve access to care for LEP patients. Implementation of an interpreter program in a large health maintenance organization was highly associated with an increase in the number of physician office visits, receipt of preventive care, and the amount of prescriptions filled for LEP patients. This trend was not seen in the cohort of health plan members that did not use the interpreter services, suggesting the effect was due to the implementation of these services (Jacobs and Goldin 2002).

Ad-hoc Interpreters

Ad-hoc interpreters are individuals whose primary job function in the health care setting is something other than interpretation and includes the patient's family members, friends, clinic staff, or even fellow patients. These individuals are bilingual, but not formally trained as interpreters. The danger in using family members as interpreters was explained in a previous section of this report and, therefore, will not be described here as a strategy, although this was perhaps the most common method in use at one time. Instead, this section focuses primarily on other ad-hoc interpreters, including bilingual clinical or nonclinical staff members.

In most instances, the quality of the health care encounter is compromised with ad-hoc interpreters whose job functions may range from a bilingual physician or nurse to a janitor, receptionist, or an orderly. The interpreter may have only slightly better English skills than the patient, lack knowledge of appropriate health-related translations, or be likely to minimize the provider's diagnosis and instructions to alleviate emotional distress. It can also hinder the organizational effectiveness of the health care setting if employees are being pulled away from their normal duties to interpret.

A recent study found that mistakes committed by ad-hoc interpreters were significantly more likely to have potential clinical consequences than those made by hospital interpreters. At Boston Medical Center's outpatient pediatric clinic, researchers found that medical visits of Spanish-speaking patients had an average of 31 errors in medical interpretation and that more than 50 percent of these mistakes had the potential to adversely affect the patient's health. The most common mistakes included omitting information, substituting words or expressing personal opinions, and adding information (Flores et al. 2003).

For organizations with rare and minimal language needs, ad-hoc interpretation can serve as an effective solution when employees are adequately trained and given support. For example, some organizations have implemented "Interpreter for a Day" policies where bilingual employees are relieved of their primary job functions to interpret for that day and are then rewarded through pay differentials. It is important to note, however, that these solutions must be augmented by appropriate access to and requirements for formal interpreter training (Downing and Roat 2002).

Recognizing the need to increase the number of bilingual personnel in local physicians' offices, The Health Foundation of Greater Cincinnati developed a mini-RFP to increase the number of bilingual personnel in local primary care offices. The greater Cincinnati area has seen a rapid influx of non-English speaking populations, specifically Hispanic and West African immigrants. Some local organizations that work closely with undocumented immigrants estimate that there may be close to 30,000 Hispanic immigrants in the area. As a result, several safety net primary care providers within the foundation's service area have reported a dramatic increase in the number of Hispanic and West African patients seeking medical and dental care. Unfortunately, these sites are minimally staffed and oftentimes have no bilingual personnel. In most instances, providers have resorted to using nonclinical bilingual staff to assist with translation and interpretation, pulling these individuals away from their primary job functions. In rare cases, area providers have prearranged for an interpreter to accompany the patient, but the hourly rate for interpreters has been cost-prohibitive for those providers with smaller practices.

To address this need, the foundation announced the availability of $200,000 for grants to assist primary care providers to the poor in hiring bilingual employees

> *"The primary tool that providers use to diagnose a patient is language. Interpretation is a diagnostic tool."*
>
> MARIA-PAZ BELTRAN AVERY, EDUCATION DEVELOPMENT CENTER

for direct service jobs. Individual grants of $50,000 were awarded for a one-year period to assist provider organizations with the following:

- the recruitment and training costs for bilingual personnel who would be responsible for providing direct services (allowable costs included advertising, certification or licensure fees, and/or remedial training for clinical support positions); or
- support for salary and benefits for up to six months that is matched by the organization for another 12 months. The expectation would be to retain the employee, based upon a satisfactory performance review and compliance with the organization's personnel guidelines.

Eligible applicants included public or private nonprofit organizations that offer direct medical and/or dental services to low-income, uninsured, or underinsured patients. Providers also had to show that their non-English speaking population comprised at least five percent of the total active patients served or document that the practice site was located in an area with a high concentration of non-English speaking residents. After distributing the grants under these specifications, the foundation found that grantees wanted to use a portion of the funding for a spin-off training program for medical interpreters. Recognizing the need for appropriate training, a three-day class at local hospitals was designed (Warren 2003).

Dedicated or Professional Interpreters

Professional interpreters are those individuals whose sole function in the health care setting is to interpret. The IOM recommends that "professional interpretation services should be the standard where language discordance poses a barrier to care" (IOM 2002). Health care organizations have employed a variety of strategies, including hiring interpreters, contracting for their services on a per diem basis, contracting with a language agency, and/or using volunteer agencies that help place volunteer bilinguals (Downing and Roat 2002). There are trade-offs for each strategy, and often a combination of strategies works best (Figure 7).

Foundations have supported a variety of activities and promising practices that provide qualified third-party interpreters for LEP populations:

- The Consumer Health Foundation in Washington, DC supported La Clinica del Pueblo to improve and increase access to quality and specialized medical care for the Latino community through interpreter services. The project trained patient care coordinators, as well as community medical interpreters for on- and off-site interpretation.
- The United Hospital Fund in New York funded the Queens Hospital Center to train linguistically and culturally diverse volunteers to serve as advocates for patients being treated in one of the center's facilities that specializes in cancer, women's health, and diabetes. The fund also supported the Greater New York Hospital Foundation and the New York Task Force on Immigrant Health to work jointly on a project to develop a business plan and a related research agenda that would create centralized medical interpretation services for New York City

Figure 7. *Strategies for Using Professional Interpreters*

Strategy	Description	Advantages	Disadvantages
Staff Interpreter	• employed part-time or full-time by health care organization • usually recruited in most common language(s) of patient population	• interpreter is familiar with provider and patient population • interpreter has most likely received formal training and has high incentives for continuing education • contributes to operational effectiveness for an organization because providers do not have to use ad-hoc interpreters	• productivity of interpreters depends on language needs of patient population • rarely cost-effective to employ interpreters in all language combinations
Contract Interpreter	• interpreters are not employed by health care organization, but available per diem or on-call • can be scheduled in advance or contacted on short notice when needed	• interpreter has most likely received formal training and has high incentives for continuing education • can be more cost-effective than staff model when demand is low	• requires an entity at the health care organization to coordinate screening, contracting, dispatching, and payment of interpreters • hourly rate can be more costly than staff model (although organization may save costs on benefits, etc.)
Language Agency	• health care organization contracts with language agency that recruits, contracts, and dispatches interpreters on demand • agencies can be for-profit companies, community interpreter pools, nonprofits, or community-based organizations	• takes responsibility for recruiting, screening, training, and paying interpreters • agencies concentrate solely on interpreting and are more likely to build relationships with bilingual residents in the community • may have access to a wider variety of languages	• may be prone to hiring unqualified interpreters in times of high demand • health care organizations have no direct oversight for quality and performance of interpreter
Volunteer Organization	• resembles contract interpreters, but are not compensated for work	• cheap way to provide language services and promote volunteerism in the community	• few are trained or held accountable to minimum standards

Source: Downing and Roat 2002.

hospitals. The project would also develop related cultural competency programs for medical staff.

- Several foundations in California, such as the Alliance Healthcare Foundation, The California Endowment, and The California Wellness Foundation, are funding Pacific Asian Language Services (PALS) for Health, a nonprofit, community-based organization offering free verbal interpreting services to health care providers serving limited English speaking Asian and Pacific Islander clients. PALS also works in training providers on the benefits of using interpreters and how to effectively use interpreters.
- Mount Zion Health Fund in San Francisco, California has made a number of grants to reduce LEP barriers to care

for recent Russian and Bosnian immigrants. One and two-year grants have funded the International Institute's Newcomers Health Program to provide patient interpretation and one-to-one counseling at the Refugee Clinic of San Francisco General Hospital.

Remote, Third-Party Interpretation

Health care organizations are turning to a variety of technological innovations to reduce language barriers in the health care setting. The use of telephone language lines has been increasing rapidly, while a few institutions have been experimenting with alternative methods, such as video links and other remote systems. Providers often prefer these methods to in-person interpretation because they do not have to wait for an interpreter to be physically present. With remote systems, however, the interpreter is not privy to facial expressions and/or nonverbal cues.

In 1995, New York University's Center for Immigrant Health (CIH) received a planning grant from the United Hospital Fund to examine projects nationwide that address delivery systems for interpreter services. The objective was to uncover models that could effectively be replicated in the New York area, where diverse language needs and geographically scattered hospitals presented logistical challenges. Their research uncovered a pilot project that was applying translation technology used by the United Nations to the health care setting. Remote simultaneous medical interpreting (RSMI) uses highly trained simultaneous medical interpreters who sit in a remote location as they interpret for doctors and patients through wireless headsets. Both patients and providers wear headsets during the encounter; their conversation is transmitted to a nearby receiver and then digitally over a fiber-optic line to a central switching station 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; since the interpretation is simultaneous, it resembles a language concordant encounter. With this technology, only the patient and provider are present in the room, thereby avoiding the tendency for them to relate to the in-person interpreter rather than to each other (Gany 2003; Youdelman and Perkins 2002).

With subsequent funding from the New York City Health and Hospitals Corporation, CIH implemented a pilot project to test RSMI at Gouverneur Diagnostic and Treatment Center in 1999. The hospital is a public facility located in a New York City neighborhood with a predominantly Chinese and Hispanic immigrant population. Over 50 percent of its patients are LEP. Implementation of RSMI continues to operate with trained interpreters who have been screened for bilingual aptitude and have undergone rigorous training in simultaneous interpreting. The interpreters are monitored for quality by a language coach and engage in continuing education exercises to enhance their knowledge base. The initial success of the program has led to expansion of the technology to Bellevue Hospital. Available languages include Spanish, Mandarin, Cantonese, Fuzhao, and Bengali (Gany 2003).

CHANGING PROVIDER ATTITUDES

Lack of funding is often identified as the primary obstacle to the use of professional medical interpretation. As one health plan found, however, the real issue may be provider attitudes and habits. The Alameda Alliance for Health (the Alliance)—a nonprofit health plan with 90,000 members, of which 45 percent are LEP—not only pays for the full cost of professional medical interpreter services (face-to-face and telephonic), but also compensates its physicians and providers who take advantage of these services. Despite this rich array of benefits, the Alliance found that interpreter services were severely underutilized (Quan 2003). In this case, finances were not the only reason providers were not embracing these services.

There are several nonfinancial reasons why providers do not use interpreter services, even when readily available. First, many physicians may believe that their own language skills are adequate, despite evidence to the contrary. Others think that patients can be diagnosed and treated without direct communication if hand signals and clinical tests can be used. Still, many believe that the use of family and friends for interpretation is adequate and that it is more culturally appropriate and less distant than third-party interpretation. Finally, a good portion continue to believe that English is the official language of the U.S., and patients should be expected to know or learn it (Quan 2003).

Negative experiences and logistical challenges can also dampen providers' willingness to use these services. Some providers are not used to working with interpreters, and learning this skill is yet another burden to an already busy workday. The logistics are significant and may include: arranging for an interpreter, waiting for an interpreter, lacking equipment in exam rooms, an insufficient supply of qualified interpreters, and not being able to find or evaluate qualified interpreters.

There are several approaches for getting providers on board. *Hablamos Juntos*, a national program of The Robert Wood Johnson Foundation, is conducting focus groups with physicians to learn how they view language barriers and third-party interpretation. This information will help determine the best method for presenting this issue to other physicians (Partida 2003). The Alliance continues to educate its providers on the benefits and availability of professional interpreters. A rigorous awareness campaign targeting physicians more than quadrupled its utilization of interpreters in one year (Quan 2003).

More can be done to create opportunities for educating and training providers, from the early stages of medical school to advanced practice. Starting early by engaging medical students in these issues could shape who they become as physicians (Hernandez 2003). Once in practice, providers should have access to continuing medical education that focuses on issues related to language and culture. Modules, where providers and interpreters are taught to work together, would demonstrate the benefits of working with a qualified medical interpreter. For some providers, one positive experience with an interpreter is enough to make them demand these services in subsequent patient encounters.

"It's a very ambiguous line at times and a very thin line that you have to walk when you're making a translation that is appropriate culturally and linguistically to your entire population."

CAROLA GREEN,
VISTA COMMUNITY
CLINIC

Translation of Written Materials

Written materials serve multiple purposes in health care settings, including relaying health education and prevention guidelines, surveying a patient's medical history, stating dietary restrictions, giving pre- and post-operative instructions, approving advanced directives, and other important tasks. The translation of certain documents, when done thoughtfully, can be a valuable means of relaying important health messages to LEP individuals and their families. It is important to recognize, however, that translation from English to another language is more complex than simply changing one text into another. Particularly with health and medical information, appropriate translation involves cultural considerations and understanding the situation in light of one's cultural background and beliefs (Anderson 2002).

For example, an American Academy of Pediatrics project to translate the index for child development into Vietnamese illustrates how language cannot be separated from culture. In describing indications of child development, parents were instructed to observe how many blocks a child is able to stack. It is possible to translate this statement literally. In Vietnam, however, children do not play with blocks; consequently, many children would fail that measure. An equally valid measure of fine motor skills and a more culturally appropriate observation would be the child's ability to handle chopsticks (Kieu 2003).

There are numerous challenges and difficulties when trying to translate culturally appropriate materials. First, the diversity of one language alone can create nightmares in translation. In one small Rhode Island community, one can find tremendous diversity in the Latino population, consisting of Dominicans, Puerto Ricans, Colombians, and Mexicans, all with a slightly different twist on the Spanish language. Some groups are more familiar with common colloquialisms, while others use academic Spanish. The Vista Community Clinic in San Diego, California addresses this issue by using the majority usage for a specific term and in its absence, defaulting to proper Spanish (Green 2003). Secondly, in a variety of languages and dialects, an equivalent word does not exist in the non-English language, particularly for medical procedures and body parts. In response, Kaiser Permanente has been trying to gather a group of medical interpreters to create a common lexicon of terms (Quan 2003). Lastly, translation involves finding a balance between ensuring an appropriate reading level and not assuming a patient is uneducated. Translated materials can often become so simplistic that it becomes offensive to the reader (Green 2003).

The HHS Office of Civil Rights policy guidance set forth the following guidelines for ensuring access to written materials and documents for LEP patients served by recipients of federal funding:

- translation of *all* written materials for each LEP language group that equals the lesser of 10 percent or 3,000;
- translation of at least *vital* documents for each LEP language group that equals the lesser of 5 percent or 1,000; and
- translated notice of right to competent oral interpretation of written documents for LEP populations below the above thresholds (Office of Civil Rights 2002).

Even populations above these thresholds will sometimes need oral interpretation of written documents because of low literacy levels in their primary language. For example, the Canby Family Practice Clinic in California, a rural community health center, has a large Spanish-speaking population above the 10 percent threshold, but many patients are illiterate. The clinic's staff has been careful to translate vital health forms, such as advanced directives, informed consent forms, financial materials, and discharge information, in a private and confidential manner. Typical medical history forms ask extremely sensitive questions, including ones regarding reproductive and sexual health. When translated in busy waiting rooms, with the presence of other patients, the LEP individual may not be comfortable answering certain questions. To address this problem, the clinic created a translation room, where patients who need assistance completing forms can go and meet with a trained, bilingual interpreter (California Primary Care Association 2002).

The Alameda Alliance for Health spends approximately $300,000 a year to translate all its marketing materials, grievance materials, legal documents, and provider directory into all of its threshold languages. The health plan makes a point of creating high-quality original documents that contain both English and the target language, so that if there are family members who speak English, they can read through the materials with one another (Quan 2003).

A number of foundations have funded the translation of health documents. Several foundations, for example, have supported the translation of a variety of important patient education materials:

- Missouri Foundation for Health supported the expansion of a gestational diabetes education program to Bosnian and Hispanic women through the translation of patient handbooks and materials to their respective languages.
- The HealthCare Foundation for Orange County supported a Vietnamese version of the popular *Guide for New Parents*, produced and distributed by Prevent Child Abuse–Orange County.
- Hogg Foundation for Mental Health supported the translation into Spanish and printing of the Texas Department of Mental Health and Mental Retardation's publications: *Taking Care of Your Mental Health* and *What is Mental Retardation?*
- The Annie E. Casey Foundation funded the National Health Law Program to produce a consumer guide to help low-income persons understand and choose among managed care plans. Support included translation into Spanish and Chinese.

Many screening tools used by providers, particularly those for mental illnesses, appear as questionnaires and self-administered surveys. Accurate and culturally appropriate translation of these documents is essential to proper and timely diagnosis. The following foundations have worked to provide these important tools:

- William T. Grant Foundation funded the University of Puerto Rico to create a carefully crafted Spanish version of the *Child and Adolescent Psychiatric*

Assessment tool, an interiew-based survey that allows a trained interviewer to make developmental and cultural judgments about psychiatric symptoms.

- Hogg Foundation for Mental Health awarded the University of Texas Health Science Center in Houston funding for the Spanish translation and field testing of various questionnaires concerned with anxiety and related disorders. The purpose of the surveys is to aid in the diagnosis and treatment of such disorders among Hispanic adult populations. The foundation also supported the translation of brief, standardized, self-reported procedures to identify and monitor mental health problems among a variety of ethnic populations in the Houston area. The measures were used to identify new refugees with potential disorders and to monitor their symptoms until mental functioning is restored. Refugees in the program speak Arabic, Serbo-Croatian, Spanish, and Vietnamese.

When translating written materials, communities can work together to identify and disseminate existing resources, rather than continuously re-creating the wheel. One valuable resource may be health-related materials in foreign countries, if they are applicable to the target community. Similarly, materials developed for one project may have a life beyond their original audience. For example, the Paso del Norte Health Foundation developed a poster of the food pyramid that was translated into Spanish and illustrated with foods specific to the Mexican or Latino diet. After seeing the poster at a meeting, another foundation was able to pass it along to some of its grantees and clinics. Foundations can facilitate this collaboration among communities by providing supplementary funding to their grantees for wider dissemination of relevant materials (Pulley 2003).

> *"When you are talking about a medical encounter with an LEP patient, there are actually four languages present—English, the medical language in English, the second language, and the medical language in the second language . . . very few people have that whole repertoire at their disposal."*
>
> ALICE CHEN,
> ASIAN AND PACIFIC
> ISLANDER AMERICAN
> HEALTH FORUM

Improving Training

Bilingual skills do not automatically make an individual an effective interpreter. Quality interpretation includes sufficient proficiency in both languages, including mastery of the medical terminology in both languages (Chen 2003). Additionally, trained interpreters have critically important memory skills, the ability to negotiate a three-way conversation, and basic knowledge of cultural attributes that can influence health.

Because interpretation in the health care setting is a specialized skill and requires formalized training, uniform standards for both training and practice are prerequisites for high-quality translation. There are currently no minimum requirements for training programs, and many communities lack access to medically specific interpreter training programs.[3] This lack of training not only compromises the quality of the health care encounter, but it may also tarnish the reputation of qualified, properly trained interpreters when errors are made in translation. Standards for interpreter training and practice may help reduce the incidence of ad-hoc and second-rate interpretation and ultimately reduce costly medical errors and complications. Development of these standards may lead to certification requirements that support the recognition of health care interpreting as a respected profession and an integral part of the health care team.

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[3] Court and conference interpretation are the focus of the majority of training/certification programs.

Currently, medical interpreter training programs are being offered by hospitals, community-based organizations, language agencies, and a few institutions of higher education. These programs have no consistent standards for training or certification and vary widely in structure and quality. Training programs run the gamut and seem to fall into one of the following categories:

- eight hours of instruction without testing;
- a language proficiency test followed by less than one day of instruction;
- two days of instruction, occasionally accompanied by a practicum;
- 40 hours or more of instruction with a practicum and a final exam (with or without a preceding language proficiency test);
- a combination of medical and court interpreter training;
- one semester at the community college level with a practicum;
- more than one semester at the college level; and
- advanced degrees in interpreting.

The National Council on Interpreting in Health Care (NCIHC) emphasizes the importance of establishing minimum criteria for a standardized medical interpreting training program. There is some consensus that training programs should consist of a minimum of 40 hours of instruction and include the following topic areas: medical terminology, interpreting skills, code of ethics or ethical issues, role play, and cultural awareness. Training should culminate in an oral final test and, ideally, a practicum where interpreters can actually practice what they learned (NCIHC 2002).

Several challenges crop up when trying to develop standards and certification for interpreters. With the diversity in languages, creating proficiency tests for all languages is a daunting task, particularly for some of the rarer languages. Research is needed to determine what the average level of proficiency is for speakers of a certain language (Green 2003). On a cautionary note, the use of common protocols and frameworks may adversely affect speakers of languages who come from disrupted educational systems and/or rely on oral, rather than written, communication. Rigid standards might reduce or eliminate the pool of qualified people available to serve as interpreters (Beltran Avery 2003).

Some organizations, like the Massachusetts Medical Interpreters Association and the California Healthcare Interpreters Association (CHIA) have issued standards of practice for their states (Figure 8). CHIA embarked on the development of such standards with funding from The California Endowment. CHIA's Standards and Certification Committee reviewed and analyzed existing practice standards and combed both academic and health care interpreter training literature. After a collaborative process of public review and feedback from numerous stakeholders, CHIA released *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention* in the fall of 2002. This document, also known as *Standards of Practice*, is meant to serve as a reference for all health care interpreters and those who

Figure 8. *CHIA's Standards of Practice*

CHIA's *Standards of Practice* consists of three main sections that guide interpreters through the complex task of health care interpreting. The sections include:

Section 1: Ethical Principles	This section consists of six ethical principles that guide the actions of health care interpreters. Each principle has an underlying value description followed by a set of performance measures that demonstrate how the interpreter's action follows the principle.
Section 2: Protocols	This section describes procedures standardizing how interpreters work with patients and providers in the health care encounter before, during, and after their interaction or session.
Section 3: Complex Roles	This section describes four roles interpreters can play in the health care encounter and highlights strategies for setting appropriate boundaries.

Source: CHIA 2002.

work with them. It should serve as the basis for the development of interpreter training curricula; job descriptions, performance evaluations, and organizational policies and procedures; and tests for California state accreditation, certification, or licensure. Ultimately, the goal of the *Standards of Practice* is to contribute to the acceptance of health care interpreting as a recognized profession, subsequently leading to sustainable financing mechanisms and satisfactory reimbursement policies (CHIA 2002).

The California Endowment has invested over $15 million to ensure equal access for LEP consumers. One of its various strategies focuses on improving the training and professionalization of medical interpreters. In addition to funding CHIA for the creation of the *Standards of Practice*, it has supported the development of interpreter training curricula for community colleges and community-based organizations and a compendium of interpreter training programs in California, which includes an analysis of trends in the state.

The Endowment for Health worked with the New Hampshire Minority Health Coalition to develop a pilot project to implement the following: the ongoing training of qualified medical interpreters, the development of a program to broker interpreter services, the development of a training program to educate health professionals on cultural competency and use of a medical interpreter, and education and outreach to health care consumers with limited English proficiency about medical interpretation. This grant will also help create a formal medical interpretation advisory committee that will oversee activities related to intepreter services.

Promoting Advocacy and Policy Change

Despite evidence linking language barriers and disparities, there is not universal agreement on the role interpreter services should play. An example of this skeptism can be found in the words of Dr. Yank Coble, president of the American Medical

Association, who has stated, “without a body of scientific evidence to establish its worth, or government money to pay for it, medical interpreting is an unfunded and unaffordable frill” (Kaiser Family Foundation 2003). In stark contrast, the IOM recommends that “greater resources should be made available by payors to provide coverage for interpretation services for limited-English proficient patients and their families” (IOM 2002). To promote acceptance of interpretation in health care, foundations are working to create awareness among providers and the general public about its necessity in delivering high-quality care and the importance of developing sustainable financing mechanisms.

Convening Stakeholders to Advance Policy

In 2002, The California Endowment developed the Medical Leadership Council for Language Access, a collaborative of 25 local medical societies, physician specialty associations, ethnic physician organizations, health systems, and health plans working to create solutions that will improve the provision of interpreter and translation services to LEP patients.[4] The California Endowment convenes the council biannually to discuss how organized medicine and health care providers can support increased language access in California. Topics thus far have included models for providing language assistance services (including the use of technology) and the policy issues involved with public financing for these services. Council member organizations also engage in education and information dissemination among their organizations’ membership, through discussions at member meetings, writing member newsletter articles, soliciting member surveys, and promoting continuing medical education and training opportunities. Council members are paid a stipend for their participation and involvement.

In response to rising numbers of non-English speaking county residents, The Horizon Foundation in Howard County, Maryland, convened a multidisciplinary team of health and human service providers to explore the issue of language barriers to health services. These discussions led directly to a joint initiative of local community-based organizations and the foundation to address language and cultural barriers to health and wellness in their community. The project will include: a major outreach to the county’s ethnic communities; focus groups and surveys to clarify language and cultural barriers to health; the coordination of the local nonprofit community to generate expertise; and the investigation of best practices in translating health material, creating new lines of communication for health issues, and expanding overall access to care for those with the greatest needs.

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[4] Council members include: American Academy of Pediatrics, District IX; California Association of Public Hospitals and Health Systems; American College of Obstetricians and Gynecologists, District IX; American College of Physicians-American Society of Internal Medicine, California Chapter; California Medical Association; Fresno-Madera Medical Society; Los Angeles County Medical Association; San Francisco Medical Society; St. Joseph Health System; Sutter Health; Scripps Health (invited guest); Catholic Healthcare West; California Academy of Family Physicians; Association of American Indian Physicians; California Association of Health Plans; Asian and Pacific Islander American Health Forum; California Healthcare Association; California Latino Medical Association; California Primary Care Association; Golden State Medical Association; San Diego County Medical Society; Sierra-Sacramento Valley Medical Association; Santa Clara County Medical Association; Wellpoint Health System; and Kaiser Permanente (invited guest).

In spring 2002, the Blue Cross and Blue Shield of Minnesota Foundation commissioned a statewide survey on the use of interpreters in Minnesota. The foundation surveyed health and human service organizations located in 44 Minnesota counties and received a 90 percent participation rate. In November 2002, it convened an invitational forum to share the findings of the survey and generate action to promote the use of interpreters in Minnesota's health care system. The foundation worked with the Lao Assistance Center of Minnesota, and the forum was attended by 75 policymakers, college educators, and health care representatives. Both the survey and the forum uncovered that interpreters were widely used in Minnesota (78 percent of respondents use interpreters on staff, on a contract basis, or via a language agency) and considered "extremely effective" in meeting the cultural and linguistic needs of LEP patients. Organizations highlighted several challenges for expanding the use of interpreters, including unstable or inadequate funding, a shortage of qualified interpreters, and being able to effectively and efficiently respond to smaller pockets of LEP populations. The foundation is currently aligning its existing grantmaking activities to respond to these challenges.

With funding from The Commonwealth Fund, The Robert Wood Johnson Foundation, and local foundations, The Access Project and the National Health Law Program (NHeLP) are collaborating on a project to help communities advocate for the adoption (or enhancement) of Medicaid/SCHIP funding for interpreter services in their states. The project includes:

- conducting legal and policy research,
- fostering the development of coalitions that include providers and advocates,
- developing a network among the coalitions in various states, and
- developing an action kit to assist coalition participants in changing state policies for funding interpreter services.

Each coalition will work to educate opinion leaders and policymakers on the importance of providing interpreter services and explore the feasibility of implementing the federal reimbursement option in their state. Local foundations in each of the first three pilot sites have been invaluable components of the coalitions, providing funding as well as identifying key stakeholders, convening meetings and conference calls, and working with immigrant rights coalition and community groups.

The first in a series of local meetings took place in October 2002, with support from the Mid-Iowa Health Foundation. Representatives from the foundation, The Access Project, and NHeLP met with interested stakeholders, including the Bureau of Refugee Services, Iowa Department of Public Health, Mercy Medical Center, Central Iowa Health System, State Public Policy Group, and Broadlawns Medical Center. The foundation played a key role in organizing the meeting and enlisting community members.

In New Hampshire, with the help of the Endowment for Health, over 100 individuals attended a November 2002 meeting to explore expanding interpreter services, since the state already takes advantage of federal matching funds. Organizers of the meeting included the New Hampshire Minority Health Coalition, Southern New

Hampshire Area Health Education Center, and the New Hampshire Hospital Association. The Endowment for Health began its coalition building prior to working with The Access Project and NHeLP, but efforts have since strengthened as a result of this newer collaboration. The coalition is currently identifying its key goals and planning its strategic direction.

Upcoming meetings are being planned for Palm Beach, Florida, with the help of the Quantum Foundation. In a recent needs assessment, the foundation identified language access as a priority for its service population. Many of the individuals interviewed for the survey expressed frustration with the lack of bilingual health care services in many area hospitals (The Access Project 2002). While specific activities are still being planned, the work will focus on implementing Medicaid/SCHIP funding for language services in Florida.

Raising Awareness and Advancing Knowledge

The California Endowment has recently embarked on a public engagement campaign in partnership with California's ethnic media. The project will support the development, placement, and tracking of an integrated advertising and editorial campaign targeting LEP groups. Specific campaign activities include:

- informing consumers about the issue of language access through 200 print, radio, television, and on-line ethnic media outlets that target 12 linguistic groups;
- administering pre- and post-surveys monitoring the level of awareness of these issues among the top 12 linguistic groups; and
- forming linkages to ongoing advocacy and systems change efforts.

There is a delicate balance to be struck in efforts to stimulate demand for interpretation services by informing patients of their rights, since the availability of these services is still so limited, especially in the area of rare or indigenous languages.

The Commonwealth Fund also funded NHeLP, along with the Summit Health Institute for Research and Education, Inc., to examine the legality of collecting data on race, ethnicity, and primary language—an activity most health plans and providers view as illegal. The report firmly stated that collecting such information was indeed legal. It further noted that no federal statute required the collection and reporting of primary language data. The report called upon the federal government to support access to quality care for LEP populations by promoting the collection of primary language in the health care setting.

Advancing Research

The IOM recommends that "future research should identify best practices where the availability of interpretation services is limited" (IOM 2002). Foundations can play an important role in helping communities determine which strategies are most effective in addressing the language needs of their populations. While the evidence documenting the need for language services is substantial, information about which solutions have been most successful and cost-effective is needed. For this reason, several foundations are working to increase this knowledge through supporting research, evaluations of current practices, and demonstration programs.

THE POWER OF FILM

Viewing the real-life experiences of families and the intersection of their cultures with the culture of medicine can be a powerful means for conveying the importance of services to overcome language and cultural barriers. Funded by The California Endowment, The Commonwealth Fund, the Greenwall Foundation, and the Arthur Vining Davis Foundation, the medical education project and documentary films *Worlds Apart* provide an intimate view of patients and physicians struggling across science and religion, language, culture, generation gaps, and family customs to come to grips with life and death decisions.

For participants at the Issue Dialogue, the films illustrated the inherent complexity of medical conditions and their consequences for patients and their families. In the case of Justine, a four-year-old Laotian girl with a hole in her heart, the family was forced to weigh the need for open-heart surgery against their belief that a surgical scar would damage her next reincarnation. In another example, Mohammad, an elderly man from Afghanistan, refused chemotherapy following surgery for stomach cancer. The chemotherapy treatment recommended by his physician was by continuous infusion, which would have prohibited Mohammad from attending Muslim prayer services, because of the requirement to be completely clean before each prayer. His physician was unaware of the reason for his refusal until his daughter accompanied him on a visit to inquire about her father's deteriorating condition—six months later. By then, it was too late.

Another point that emerged from the films is the effect of medical decisions on family dynamics and structure. Justine's mother was not the sole decisionmaker for the child, and, in fact, her grandmother had a strong role in the decision to refuse surgery. When her mother finally consented to the surgery, she was ostracized from the family for going against their cultural beliefs. In Mohammad's case, his more-assimilated daughter was blamed for hastening her father's death by using the word cancer to explain his illness.

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Demonstration Programs to Discover Innovative Models

The Robert Wood Johnson Foundation has launched *Hablamos Juntos: Improving Patient-Provider Communication for Latinos*, a $10 million dollar national program to help improve access to quality health care for Latinos with limited English proficiency. The goal of the program is to explore cost-effective ways for providers to use interpretation and translation in delivering services. Specific activities are to:

- grow capacity for medical interpreters in regions with new and fast-growing Latino populations;
- develop technologies that will enable cost-effective and accurate interpretation in the health care setting;
- create and distribute resources to build on what is known about medical interpretation;
- link relevant experts nationwide in order to unify the field and explore the science base for medical interpreting;

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Other family members wanted to protect him and described his diagnosis as "the problem" or "the dark spot on the x-ray." In both cases, the generation gap between older, less-acculturated family members and younger, more-assimilated ones resulted in painful and disruptive familial relationships.

The issues involved with medical decisions are emotionally and intellectually challenging and speak to extraordinary communication challenges in health care encounters. When explaining treatment recommendations, physicians must remember to respect, as well as fully explore, the patient or family's reluctance to choose certain procedures. Often open dialogue with the patient could uncover alternative treatments that would result in favorable clinical results while remaining sensitive to the patient's beliefs. Alternatively, communication could be further enhanced if materials were available to educate patients about the right kinds of questions to ask a physician, for example, to ask whether there are any other alternatives to the particular type of treatment being proposed. Interpreters can be of enormous help in these situations. Well-rounded interpreter training programs address issues related to cultural mediation or brokering, as well as other sensitive, multilevel considerations. Interpreters learn to consider factors such as the patient's level of education, the extent of familial involvement, and the role of religion.

The *Worlds Apart* films offer tremendous opportunity for discussion about addressing the health care needs of a pluralistic society. A study guide will accompany the films and be used to teach medical students and health care professionals about cross-cultural communication and cultural sensitivity. Foundations could use the materials to engage board members and as inspiration for exploring solutions to the problem of linguistic and cultural barriers to care.

The Worlds Apart films and a companion facilitator's guide will be available for distribution in the fall of 2003. Please contact Maren Grainger-Monsen, M.D., producer and director, at mmonsen@stanford.edu or Raina Glazener, project coordinator, at rglaze@stanford.edu or 650.725.9564 for details.

- advance an understanding of the business implications of medical interpreter services in health care;
- expand the ability of plans and providers to track care by race and ethnicity; and
- explore how technology can assist in improving language access.

Three screening criteria were used to select proposals from interested organizations. Applicant organizations were required to: serve a catchment area home to "a new and fast-growing" Latino population; serve the majority of Latinos in a given community; and have access to a range of delivery sites, including the emergency room, the inpatient care setting, outpatient and primary care sites, and the pharmacy setting or the settings where other ancillary services are provided. In its first year of funding, the program awarded 10 sites nationwide with planning grants of $150,000 each. Grantees have conducted needs assessments and are taking inventory of their existing resources. Next steps include developing their implementation plans and associated program requirements.

The Commonwealth Fund is working to improve communication and quality of care through its *Patient Communication and Quality of Care for Underserved Populations* initiative. Announced in March 2003, the initiative is designed to identify causes and consequences of poor communication in medical settings and to evaluate methods to address communication barriers for underserved patients, including minorities, those with limited English proficiency, and patients with low health literacy. As many as five grants of up to $125,000 each for two years will be awarded under this initiative. The grants will focus on communication and improved quality of care for underserved patients, with projects that include:

- finding the root causes of communication problems at both the individual and systems levels;
- identifying the consequences of poor communication in areas such as patient compliance, health outcomes, access, health service utilization, and medical errors;
- developing or evaluating the best methods for addressing communication problems; and
- supporting or analyzing policies to improve health communication for the underserved.

Project activities may include research to generate new knowledge, work to develop solutions to currently known problems, evaluations of interventions, identification of best practices, policy analyses, bringing together experts in the field to forge consensus or meet specific objectives, or a combination of such activities.

Evaluation of Interpretation Models

There is little research comparing different methods of technological interpretation with one another and with in-person interpretation. Recognizing this need for more research and evaluation on effective models, The Commonwealth Fund and The California Endowment are jointly funding an evaluation of Center for Immigrant Health's remote simultaneous medical interpretation project. A randomized controlled study will compare the cost of using the service at full capacity to the cost of more common interpreter services, such as in-person interpretation and telephonic interpretation. The study will also examine associated health outcomes and patient satisfaction (Gany 2003).

Initial studies have seen some marked success with RSMI, including a high level of physician and patient satisfaction with this technology. Physicians have reported an improved ability to communicate with patients and a corresponding improvement in their ability to diagnose illnesses, including those that rely heavily on patient-physician communication, such as depression. RSMI has increased accuracy and the exchange of information, without extending the time the physician spent with the patient; therefore physician efficiency was enhanced. RSMI also appears to be cost-effective, as compared with both in-person interpreting and telephonic interpreting.

The Robert Wood Johnson Foundation has conducted focus groups with its *Hablamos Juntos* grantees to test a device known as a phraselater—a small, handheld device developed in the military that is preprogrammed with phrases. The provider speaks into the device, which can identify the phrase closest to it and say it in the language to the patient. The testing is still in the early phases, and although it is probably inadequate for complex encounters, it may have utility in certain parts of the health care setting (Dickson 2003).

A BUSINESS MODEL FOR PROVIDING LANGUAGE SERVICES

Particularly in today's economic environment, businesses make tough choices in balancing their social agenda with their business interests. There are four different motivating factors that can shape how an organization interprets its corporate responsibility. Some factors may be more compelling than others, such as compliance with legal requirements, but each has its own unique considerations. These factors can be illustrated in a matrix for calculating the return on corporate responsibility (Figure 9). In applying this model to the provision of language services, Kelvin Quan, J.D., M.P.H., CFO and general counsel at Alameda Alliance for Health, demonstrated how health care organizations and providers could examine this issue in light of their own business practices.

Figure 9. *The Virtue Matrix: Calculating the Return on Corporate Responsibility*

FRONTIER

STRATEGIC Profit making; Results in positive reaction from owners/constituencies	SOCIAL JUSTICE May be contrary to owners' interests
CHOICE Dictated by norms and customs of industry/society	COMPLIANCE Required by laws, regulations or contracts

CIVIL FOUNDATION

Source: Martin 2002.

The bottom portion of the matrix comprises the civil foundation of corporate behavior. These practices promote socially responsible behavior and business interests, but do not extend beyond meeting society's baseline expectations. In the compliance quadrant, health care organizations and providers must adhere to certain federal and state laws that

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promote language access. Compliance with legal requirements as the sole motivating factor, however, is a reactive rather than proactive approach to addressing language barriers. When organizations think only in terms of compliance, there is the risk of creating a "race to the bottom" mentality that stifles creativity and innovation and resists further expansion. From the choice quadrant, an entity may choose to undertake a new initiative that is spurred by industry norms, such as offering health care benefits to employees' dependents. By not meeting industry norms, the entity suffers competitively by its omission. Unfortunately, language services are not the industry standard in the current health care market, as reflected in the relatively few health care organizations and providers that offer them.

The top portion of the matrix represents the broader frontier. It encompasses practices companies engage in because they consider them the right things to do. In the social justice quadrant, these initiatives benefit society, but they may have negative consequences for the organization or no apparent value to business interests. While language services may promote quality of care and ultimately contribute to the elimination of health disparities, organizations may not see them as producing greater efficiency or cost savings. Such conclusions often provide justification for not initiating language services. Some organizations may be motivated by social justice considerations and respond to the value placed on certain services by the community. These organizations are in the minority when it comes to language access. Where practices may not appear to be in the organization's interests but are motivated by social values, as can be the case for language services, organizational leadership is essential to their successful and sustained implementation.

In the most ideal circumstances, a business case can be made for practices that are also consistent with corporate social responsibility, by either improving the bottom line or helping to capture a greater market share. When considering language services in the strategic quadrant, some organizations believe that these services will reduce unnecessary testing and may reduce medical errors that can result in misdiagnosis, suboptimal care, and lawsuits. Linguistic services may also promote patient satisfaction and the willingness to return to facilities that provide interpreters, resulting in a favorable public image and increased corporate value. This motivating factor has the greatest potential for growth and creativity as organizations develop new ways to attract consumers and offer the best services.

Philanthropy can play a role in promoting language access in each of these four quadrants. They can support and inform the development and implementation of sound laws and regulations; promote the concept of social justice; and work to make language services an industry standard. Foundations can also support efforts to document the business case for providing language services, including studies to determine the cost-benefit of linguistic services and to strengthen the evidence base showing that language access can have a positive return on investment.

Conclusion

The growth of populations with limited English proficiency and the creation of related legal requirements and guidelines have increased consciousness of the issue of language access. As providers and communities struggle to care for these populations, the field is ripe with opportunities for foundations to get involved and contribute to the growing body of knowledge around these issues. Philanthropy can take a significant leadership role in these efforts by partnering with local community groups, educating policymakers and health care organizations, and reaching out to immigrant and minority populations. As this report points out, there are a variety of activities that foundations could choose to pursue, including:

- promoting awareness among providers about the importance of language services and their obligation to provide them, as well as equipping them with resources, such as medical education and experiential learning opportunities, to enable them to better serve their patients;
- facilitating agreements among health plans to create an industry standard for covering the costs of professional interpretation;
- developing and broadly disseminating high-quality health education materials in multiple languages;
- tapping into resources outside of the U.S., such as materials already translated in other countries, to strengthen the work done here;
- increasing public awareness of the availability of interpreter services and empowering patients with information on what types of questions to ask in the health care encounter;
- building the field of professional medical interpretation through enhanced educational opportunities, standards development, and recognition of interpreters as integral to the health care team;
- developing an agenda for long-term sustainable funding and for greater utilization of existing funding, such as federal matching grants for state Medicaid programs;
- building the business case and encouraging the development of new financing mechanisms that could lead to the establishment of standard reimbursement policies;
- creating awareness within communities about the issue of language access and working with community members, policymakers, and government officials to support policies that guarantee equal access to linguistic services;
- supporting financial incentives that encourage the use of interpreters, both at the policy level and at the institutional level;
- helping communities explore systems change and policy development to ensure the sustainability of initial investments, including seed money provided for interpreter training and certification;
- supporting research to identify and evaluate the most effective modes of delivering language services in specific communities, including technological advancements;

- using grants as a mechanism for advancing the field by putting stipulations into awards that grantees must incorporate cultural competence into their projects; and
- working with nontraditional partners, such as anthropologists and arts councils, to better understand how cultural practices influence health.

By filling this needed leadership role, foundations can help shape the language access agenda to ensure that all patients have equal access to quality health care and thus take important steps toward eliminating racial and ethnic disparities in health.

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