Improving Care for Individuals with Limited English Proficiency:

Facilitators and Barriers to Providing Language Services in California Public Hospitals

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Executive Summary

Evidence shows that effective communication between patients, clinicians, and other health care professionals is a critical component of providing high quality care. Providing individuals with limited English proficiency (LEP) the means to communicate effectively with their health care providers is critical to improving their experience in the health care setting, the quality of care they receive, and their health outcomes. ("LEP" is the acronym for both "limited English proficiency" and "limited English proficient." The U.S. Census Bureau's operational definition of LEP is a patient's self-assessed ability to speak English less than "very well.") Yet, health care providers throughout the country have reported challenges, such as inadequate funding of language services, to be major barriers in providing LEP patients with high-quality care.

Our objective was to better understand the impact of the efforts undertaken by California public hospitals to improve language access to all Californians, and ultimately to identify strategies that engage hospitals in facilitating organizational change to address the provision of language services. According to the 2000 Census, 12.4 million people in California speak a primary language other than English at home, with 6.2 million being identified as LEP. These numbers resonate with health care providers and clinicians, as several studies have found that patients who cannot speak English well receive less than optimal health care.

Our collaborators on this project included the 12 California public hospitals that graciously opened their doors to us, the Safety Net Institute, and The California Endowment. We developed an evaluation design that combined degrees of flexibility and fluidity, which enabled us to work with diverse stakeholders throughout the evaluation process. We conducted site visits to the 12 hospitals between April and November 2007 and held 186 key informant interviews with hospital leaders, clinical staff, and administrative staff. We also conducted a hospital-level Readiness to Engage in Language Services analysis (results of this analysis will be presented in a separate document). As part of a formative evaluation process, we provided structured summary feedback reports to each hospital after our visit. In this summative report, we provide a synthesis of our findings across all hospitals focusing on the following domains:

- Policies and procedures for providing language services
- Indicators of organizational commitment to provide language services
- Strategies to improve language services
- Staff training
- Changes in language services over time
- Evaluation of language services
- Effectiveness of language services
- Facilitators and barriers to providing language services

Our findings suggest that systems for providing language services in California public hospitals are continuing to evolve, but it should also be noted that despite environmental challenges and ongoing financial and budget constraints, California public hospitals are making great strides. For example, all

12 hospitals had organizational policies and procedures in place and provided components of staff training that focused on the provision of language services. Eleven hospitals reported collecting patient primary language data. California public hospitals may serve as models of promising practices that can be adopted by other hospitals and health systems across the country as they focus on providing language services to their LEP populations. In the domain of staff training, a nationwide study of hospitals found that 79 % indicated that their staff would like to receive training about how to respond to family members who do not speak English[1] and only 38% of hospitals reported tracking patient primary language in a database.

Because public hospitals in California are willing to systematically examine their provision of language services, identifying both strengths and weaknesses, they are well poised to share their experiences as well as make improvements. For example, a number of hospitals indicated that though they had policies and procedures in place and staff received training, they needed to be more effective in communicating information about language services to staff at all levels. Staff at all hospitals acknowledged that additional training was necessary to reinforce the importance of using trained and qualified interpreters rather than untrained individuals or no interpreters. Additionally, many hospitals reported that, despite collecting primary language data from patients, they needed to incorporate better systems and procedures for collecting this information and tracking it over time. All hospitals indicated a commitment to providing high quality language services and this commitment was explicitly stated in 11 of the 12 hospitals' mission statements. Eleven of the 12 hospitals indicated that they had an executive-level staff member for overseeing hospital language services, and half the hospitals had a specific department dedicated to language service provision. However, only four hospitals indicated that language services were incorporated as a separate line item in the general budget. All 12 hospitals were able to articulate goals and strategies for improving the provision of language services, but only two hospitals indicated that their goals and strategies were written into a formal plan. Ten of the 12 evaluation hospitals had participated in at least one Safety Net Institute (SNI) improvement initiative and had found that this participation helped facilitate language services. Hospitals participating in these initiatives had made system-level changes to improve the access and quality of language services on multiple domains, relative to the two hospitals that did not participate in these initiatives.

Hospitals that commit to providing high-quality language services to their patients likely will be rewarded with greater patient and staff satisfaction, which can provide them with a competitive advantage as the demographic trends in California and across the country continue to point to increased linguistic diversity. State and national resources should monitor and improve language services for all patients with LEP to support high-quality health care for all.

Introduction and Background

Environment

Effective communication between patients, clinicians, and other professionals in a health care setting is a central component of providing high quality care. Language barriers in health care can compromise the provision of high-quality care.[2,3,4] Consequently, providing individuals with limited English proficiency (LEP) with the means to communicate effectively with their health care providers is critical to improving the quality of care they receive and their health outcomes. ("LEP" is the acronym for both "limited English proficiency" and "limited English proficient." The U.S. Census Bureau's operational definition of LEP is a patient's self-assessed ability to speak English less than "very well" based on a scale of "very well," "well," "not well", "not at all." Assessment of English-language ability is widely used in studies evaluating the effects of language proficiency on disparities in the quality of health and health care. The Census proficiency question has been tested to correlate with understanding of content.) As the racial, ethnic, and linguistic diversity in the United States continues to increase, so does the demand for the provision of appropriate and effective language services. Almost 52 million people—over 19% of the U.S population—speak a language other than English at home. The Census Bureau's 2005 American Community Survey documented that over 29% of all Spanish speakers, 22% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English "not well" or "not at all." Nationally, estimates of the number of people with LEP range from a low of about 12 million, or 4.5% of the U.S. population (who speak English "not well" or "not at all") to over 23 million people, or 8.6% of the U.S. population (if one includes those who speak English less than "very well"). The impact of these demographic trends in hospitals throughout the country is evident. A national study of hospital language services found that 80% of hospitals in the United States encountered patients with LEP frequently, with 63% of hospitals reporting either daily or weekly encounters, and an additional 17% reporting monthly encounters.[5, 6]

There has been considerable national and state-specific focus in California related to improving language access in health care. The Joint Commission has been leading a study since 2004 entitled "Hospitals, Language, and Culture: A Snapshot of the Nation," which focuses on the challenges, activities, and perspectives of 60 hospitals across the nation examining the domains of leadership, quality improvement and data use, workforce, patient safety and provision of care, language services, and community engagement. The study found that hospitals had made greater progress in addressing language issues than in addressing broader cultural issues, but that challenges were still evident.[7] The first national study of hospital language services, "Hospital Language Services for Patients with Limited English Proficiency," was published in 2006[8] with the goal of better understanding the processes and resources available to hospitals in providing language services to patients with limited English proficiency. The study identified both challenges and opportunities for improving hospital language services, and it informed policymakers, practitioners, and providers about key issues that hospitals face, such as the lack of reimbursement for language services. California is at the forefront

of addressing hospital language services through initiatives implemented by way of the Safety Net Institute (described in more detail in the next section of this report), the Medical Leadership Council, and a recent California Department of Health Care Services task force on financing language assistance services.

The issue of language services is particularly relevant in California given its very diverse population. An article dated May 27, 2007 in the *Los Angeles Times* reported that as the nation's diversity continues to increase, California leads the way as home to the largest numbers of two of the fastest-growing racial groups, Latinos and Asians. Minorities now account for one-third of the nation's 300 million U.S. residents, with the largest share of them—21%—living in California. They now constitute 57% of the state's population and include 13.1 million Latinos, 5 million Asians, 2.7 million blacks, and 689,000 Native Americans and Alaska Natives, according to population estimates taken between July 1, 2005 and July 1, 2006. With this racial and ethnic diversity, there is a concurrent increase in language diversity. According to the 2000 Census, 12.4 million people in California speak a primary language other than English at home, with 6.2 million being identified as LEP. These numbers ring true with health care providers and clinicians, as several studies have found that patients who cannot speak English well receive less than optimal health care.

Safety Net Institute

Originally established in 1987, the California Health Care Safety Net Institute (SNI), an affiliate of the California Association of Public Hospitals, strives to fulfill the potential of public hospitals and health systems by promoting quality improvement and system innovation to improve the health of communities in California. SNI implemented several initiatives to understand and improve language services in California public hospitals starting in 2002, first by providing educational forums to public hospital staff about language access mandates and best practices. SNI subsequently published a report entitled *Straight Talk: Model Hospital Policies and Procedures on Language Access* http://www.calendow.org/uploadedFiles/straight_talk_model_hospital_policies.pdf. Two of SNI's initiatives include:

The Language Access Continuum Program

The California Health Care SNI received funding from The California Endowment to improve 10 public hospitals' policies and procedures on language access using SNI's publication *Straight Talk: Model Hospital Policies and Procedures on Language Access.* In partnership with Paras & Associates, a nationally known expert on improving hospital-based language services, and with SNI's Language Access Advisory Committee, the program included (1) a language access policy and procedure review that offered an opportunity for hospitals to conduct a review of their policies, procedures and real practice; (2) a language access implementation component, which allowed hospitals that participated in the policy and procedure review process to gain additional consulting and financial support for proposed language access improvements.

LEADing Organizational Change: Advancing Quality through Culturally Responsive Care.

With funding from The California Endowment and in partnership with the University of California, San Francisco Center for the Health Professions, SNI worked with eight public hospital teams to improve language access and integrate cultural competency principles into administrative and clinical practice. Using

four change strategies (leadership, education, accountability and dissemination: LEAD), the program asked teams to focus on a single project to improve language access and/or cultural competency for their patients. Several teams focused on training hospital staff to provide interpreter services. Another team focused on improving cultural competency in palliative care settings and another on culturally effective approaches to diabetes care for African Americans. One LEAD program participant engaged pregnant Latina women in their community. They trained female Latina community leaders to promote prenatal care. The program combined language access and cultural competency. The results of the study reinforced the need for continued education among staff regarding cultural issues and ethnic groups.

Our goal was to understand the facilitators and barriers that California's public hospitals encounter in providing language services to their LEP patients and family members. We worked with SNI to understand the efforts of California Association of Public Hospitals members as they relate to the provision of language services. In 2006, the population of 24 public hospitals was divided into three groups based on engagement in prior or current SNI language access initiatives. The 24 hospitals were divided into the following groups:

1) Prior Engagement: nine hospitals that have already successfully engaged in an SNI language access improvement initiative
2) Current Engagement: nine hospitals selected for SNI's language initiatives and is made up of two cohorts:
   - Cohort 1 consists of five "review hospitals" that have not yet focused on improving language services but have been reviewing their policies and procedures related to language services
   - Cohort 2 consists of four "implementation hospitals" that have demonstrated previous language services improvement and are currently implementing at least one change to their existing system.
3) Not Yet Engaged: six hospitals that have not yet engaged in any language access improvement initiative

We selected the 12 hospitals we worked with during this evaluation from the 24 hospitals described above.

Evaluation Goals

The overall objective of the evaluation was to better understand the impact of the work by California public hospitals to improve language access for Californians, and ultimately to identify strategies that engage hospitals in facilitating systems change to address the provision of language services.

Evaluation Methodology

Participating Hospitals

We conducted site visits at 12 of the 24 originally identified California public hospitals. We were unable to visit the other hospitals for a number of reasons, including hospital closure; perceived burden that would make study participation difficult; and environmental stressors on hospitals, such as threat of closure due to insufficient funds. Of the 12 hospitals that participated in the evaluation, nine had participated in at least one SNI improvement initiative focusing on language services. The site visits to the 12 participating hospitals were conducted between April and November 2007.

Combining a Formative and Summative Evaluation Approach

Working with culturally diverse hospitals, staff, and communities required a degree of flexibility and collaboration in our evaluation approach. Collaboration with a variety of stakeholders—including hospital leadership, clinical and administrative staff, SNI, and The California Endowment—throughout the entire evaluation process (design, implementation, analysis, and dissemination) ensured that the information we gathered and distributed had value and utility. The overall objective of the evaluation was to better understand the impact of the work by California public hospitals to improve language access for Californians with LEP, and ultimately to identify strategies that hospitals use to improve language services. The knowledge and lessons gleaned from this evaluation can be applied by hospital leaders, clinicians, and policymakers nationally.

We developed a rigorous evaluation design, coupled with a degree of flexibility and fluidity, enabling us to work with diverse stakeholders (e.g., hospitals, communities, demonstration/program staff, funders) throughout the evaluation process. We strove not to be prescriptive or rigid in designing and implementing this evaluation project. Our evaluation was formative in nature. After each site visit by evaluation team members, we provided formal (and confidential) feedback to each hospital in a summary report that covered our assessment of the following areas:

- Commitment to providing quality language services
- Evolution of language services over time
- Policies and procedures for providing language services
- Self-evaluation of language services
- Strategies used to improve language services
- Strengths and weaknesses of language services
- Recommendations for improvement

We received feedback from a number of hospital staff stating that they found the summary feedback reports very helpful in that the reports gave them a comprehensive picture of their language service programs, what they were doing well, and what they needed to target for improvement. From our individual assessment of each hospital, we focus now in this summative report on key findings and lessons learned across all hospitals. Our findings are summarized in the following domains:

- Policies and procedures for providing language services
- Indicators of organizational commitment to provide language services
- Strategies to improve language services
- Staff training

- Changes in language services over time
- Evaluation of language services
- Effectiveness of language services
- Facilitators and barriers to providing language services

Qualitative Research Methodology

The evaluation design was intended to capture data from a variety of language access stakeholders within California's public hospitals. To achieve this goal, we conducted key informant interviews with individuals from the following areas within each of the 12 hospitals using interview protocols developed by the evaluation team:

- Leadership [chief executive officer (CEO), chief operating officer (COO), chief medical officer (CMO), chief nursing officer (CNO), chief financial officer (CFO)]
- Clinical staff
- Administrative staff (e.g., financial counselors, registration/admissions staff, patient advocates)
- Directors of multicultural affairs and language services (or equivalent)

A total of 186 staff members were interviewed across all 12 hospitals, for an average of 15.5 staff per hospital (range: 9 to 23). The breakdown of staff interviewed is as follows:

- **Leadership.** We targeted up to 5 staff per site, preferably the CEO, COO, CMO, CNO and CFO. A total of 46 individuals representing leadership were interviewed across 12 sites. The average per site was 3.8 leadership interviews (range: 3 – 5).

LEADERSHIP STAFF	
CEO	9
COO	6
CMO	9
CNO	8
CFO	9
Other*	5
Total	*46*

* Head of ambulatory services/associate administrator, director of ambulatory community health services, assistant director of the health and hospital system, director of ambulatory care, director of ambulatory services

- **Clinical staff.** We targeted up to six clinicians per site, preferably a physician and a nurse from three different departments such as the emergency department (ED), critical care unit/intensive care unit (CCU/ICU), and primary care. A total of 49 clinicians were interviewed across 12 sites; the average number of clinical interviews per site was 4.1 (range: 1 to 7).

CLINICAL STAFF	
Physicians	16
Nurses	29
Other*	4
Total	*49*

* Director of occupational therapy and recreation therapy, director of physical therapy

- **Administrative staff.** We targeted up to six staff per site, preferably from registration/admissions, social services, patient relations, financial services, or quality improvement. A total of 36 staff were interviewed across 12 sites; the average administrative staff interviews per site was 3.0 (range: 0 to 4).

ADMINISTRATIVE STAFF	
Patient advocate/representative	11
Financial counselor	5
Registration/admissions staff	3
Social worker	11
Quality manager	2
Other*	4
Total	*36*

* ER patient supervisor, associate hospital administrator of professional services, administrative supervisor, utilization manager

- **Language services staff.** We targeted two staff members per site, preferably the department director and a staff interpreter. A total of 23 staff were interviewed across 12 sites; The average language services staff interviews per site was 1.9 (range: 1 to 5).

LANGUAGE SERVICES STAFF	
Department head/director	9
Department supervisor/coordinator	4
Staff interpreter	3
Other*	7
Total	*23*

* Cultural competency leader, coordinator of refugee services, director of patient care services, compliance coordinator/privacy officer, quality management analyst, county human resources director, assistant hospital administrator

Data Collection

Construction of Protocols

Using a rigorous qualitative methodology for data collection, we developed semi-structured interview protocols to conduct key informant interviews with individuals from the following groups in each hospital: executive leadership, clinical staff, administrative staff, and staff responsible for language services or multicultural affairs (e.g., director of language/multicultural services, staff interpreter). The domains and specific questions under each domain were based on a systematic review of the literature as well on consultation with The California Endowment and the Safety Net Institute. The evaluation team members brought expertise in conducting national evaluations to this project, and many of the lessons learned from the team members' prior work were also incorporated into this evaluation project. Dr. Romana Hasnain-Wynia served as a senior advisor to the Joint Commission project "Hospitals, Language, and Culture: A Snapshot of the Nation,"[9] which was also funded by The California Endowment, and many of the questions related to language services from the project were incorporated into our interview protocols. In addition, Dr. Hasnain-Wynia and Ms. Julie Yonek conducted the first national study of hospital language services in collaboration with the National Health Law program, which was also funded by The California Endowment. The results from the study provided a national context for understanding what was taking place in hospitals' provision of language services across the country, which helped our team formulate questions for this evaluation project. Finally, Dr. Hasnain-Wynia has led many studies examining race, ethnicity, and primary language data collection in hospitals, which informed the development of the protocols we used in this project.

Dr. Alan B. Cohen and Dr. Joseph D. Restuccia are national experts in evaluation research and both have worked actively with hospitals (including public hospitals) and hospital administrators in various ways and on diverse topics throughout their careers. They have conducted several waves of site visits to 12 different health care systems across the country and have interviewed hundreds of hospital managers, clinicians, and other staff members at each institution over four years. The collective expertise of the team enabled us to develop questions and interview protocols that elicited rich, pertinent, and timely information during our site visits in an efficient manner.

Questions were designed to obtain staffs' overall perspectives about key topics related to language services as well as more specific information on the following topics:

- Current approaches to providing language services
- Mission and organizational culture
- Leadership commitment to promote and improve language access
- Staff sensitivity to and knowledge of the language needs of patient populations
- Staff sense of urgency around providing language services
- Facilitators and barriers to providing and improving quality language services
- Implementation of system-level strategies to improve access and quality of language services.

To allow for capturing diverse perspectives and varying levels of knowledge and expertise on issues, we developed separate protocols for each key informant group. Although the questions or wording of certain questions varied between protocols, the protocols were standardized to a sufficient degree to enable identification of areas of overlap, agreement, or disagreement between respondents.

Interview Process

Evaluation team members conducted site visits at each of the 12 California public hospitals between April and November 2007. Nine of the visits were conducted by the evaluation team's field research coordinator, who was based in California, and the remaining three were conducted by the project director. For the first four site visits, two project team members were present, one of whom took notes. One-on-one interviews were conducted with hospital executives (leadership), and group interviews were conducted with clinical staff, administrative staff, and language/cultural services staff. The interviews were digitally recorded and transcribed. Participation in the interviews was voluntary, all interviewees were consented, and the study was approved by the Health Research and Educational Trust (HRET) Institutional Review Board and the Boston University Institutional Review Board.

Data Analysis

Coding Qualitative Data

Data for the evaluation were obtained from key informant interviews conducted during site visits. A professional service was used to transcribe the recorded interviews for each site visit. Once all transcriptions for a given site were completed, data were checked for accuracy and clarity. In some cases, it was necessary to return to the tapes to clarify or correct what had been transcribed. The coding strategy was developed by the evaluation team members. Because the project team member responsible for conducting the majority of the site visits was not involved in the coding process, the potential for introducing personal bias was not a major concern.

To develop the coding scheme, transcripts were selected from two of the 12 site visits, the first of which occurred at the beginning of the data collection period and the second toward the end. The codes were derived directly from the interview questions. The project director and an HRET staff member then independently coded the information from both site visits, after which discrepancies in coding were discussed and resolved jointly. Once complete, the coded information was reviewed by project investigators to ensure consistent and accurate use of the coding scheme. A Microsoft Access database was created to facilitate data entry, management and analysis of coded information.

Results

We present the results of our key informant interviews from all 12 hospitals focusing on eight primary domains:

Domain 1: Policies and procedures for providing language services
Domain 2: Indicators of organizational commitment to provide language services
Domain 3: Strategies to improve language services
Domain 4: Staff training
Domain 5: Changes in language services over time
Domain 6: Evaluation of language services
Domain 7: Effectiveness of language services
Domain 8: Facilitators and barriers to providing language services

DOMAIN 1: POLICIES AND PROCEDURES FOR PROVIDING LANGUAGE SERVICES

We asked staff whether the hospital had policies and procedures for providing language services to LEP patients. We asked specifically about the policies and procedures for identifying patients' language needs, acquiring an interpreter, providing translation of written materials, and collecting and documenting patients' primary language and use of interpreter services.

All 12 hospitals indicated having policies and procedures for providing language services to LEP patients, and many of them have had these policies and procedures in place at least 10 years. A number of the hospitals have updated their policies and procedures over this time period. One hospital indicated that it explicitly conducted a review of its polices and procedures as part of its participation in the SNI initiative "Advancing Public Hospitals Along the Language Access Continuum." It compared its policies and procedures for providing language services with the "best practices" identified in the report *Straight Talk: Model Hospital Policies and Procedures for Language Access*, and as a result of this review, it revised its existing policies and procedures as a foundation for providing high quality language services.

Policies and procedures for language services were most commonly included in the employee handbook or the administrative manual of the hospital. Two of the hospitals indicated that the policies and procedures were also available electronically either on the hospital intranet or on the hospital language services department Website.

Almost all of the hospitals (nine) indicated that they followed procedures for identifying patients' language needs at the point of registration or admission. If registration/admission staff cannot determine a patient's language through verbal communication, they then use language determination cards—most of which list up to 20 languages—which a patient could then point to. One hospital indicated that if this process does not work, staff then use an interpreter through a telephone language line to determine the primary language of the patient. A few hospitals indicated that they do not have established procedures to identify language needs but do employ various means for doing so. One hospital indicated that it uses a combination of the language card and "guessing" based on the patient's surname to determine the primary language. Another hospital indicated that staff try to determine the patient's language either through the last name or by asking an accompanying family member or friend. One hospital stated that they need to establish

procedures for determining primary language of patients during registration. At the time of the interview, this hospital did not have such a standard procedure and stated that sometimes registration uses a "language sign"; they also reported that staff may try to deduce language from race/ethnicity or by physical appearance.

All 12 hospitals indicated that they have procedures in place for getting an interpreter, and 11 had signage notifying patients of their rights to an interpreter. The most common procedure cited was to first try to get a bilingual staff interpreter from within the department or through a bilingual staff roster, and then a hospital interpreter. When these attempts are not successful, the last resort is to turn to a telephonic interpreter service.

A common theme in all 12 hospitals is that formal policies state that trained medical interpreters should be used during the clinical encounter with LEP patients. However, resource, time, and staff constraints prohibit this practice from consistently taking place. For instance, staff reported that in several instances, family members are allowed to interpret general questions, though this is not preferred and staff understand that this does not comply with stated policies and procedures. Staff also indicated that family members and friends are more likely to interpret in the emergency department, where time constraints are the most prevalent. Finally, a number of staff reported that though bilingual staff have been trained and qualified to interpret, they are not considered trained medical interpreters. However, it is important to note that the majority of hospitals indicated that their policies and procedures support using trained bilingual staff.

Ten hospitals had procedures in place for translating written materials. Most used a mix of in-house bilingual staff translators as well as outside vendors for more complicated or technical forms, such as informed consent. The most commonly translated language is Spanish, followed by Vietnamese. One hospital reported having a forms committee, which is responsible for overseeing all in-house translation of documents.

Two hospitals reported not having a standard procedure and use a much more ad hoc approach, involving bilingual staff translators as needed or outside vendors for translating informed consent forms. However their policies and procedures for doing so are not established or standardized.

Eleven hospitals indicated that they had standard policies and procedures for systematically collecting and documenting patients' primary language during registration and all 12 hospitals reported collecting this data. However, seven hospitals indicated that this information was inconsistently and sometimes inaccurately obtained and documented. Only three hospitals indicated that staff received regular training about how to ask patients to provide primary language information. Three hospitals reported documenting and tracking the use of interpreter services for patients.

DOMAIN 2: INDICATORS OF ORGANIZATIONAL COMMITMENT TO PROVIDE LANGUAGE SERVICES

To assess whether hospitals place a high value on providing language services to LEP patients, we asked interviewees to describe how hospital leaders demonstrate their commitment, capacity, and efforts to meet the communication needs of LEP patients. For example, interviewees discussed whether:

- the hospital's mission statement and/or strategic plan includes a commitment to providing high-quality, accessible language services
- there is a designated, executive-level staff member responsible for overseeing the hospital's language services
- the hospital has goals and strategies for providing quality language services, including initiatives to improve these services

- the hospital allocates identifiable resources (e.g., funds, personnel) to ensure effective communication with LEP populations
- the hospital has policies and procedures that address the communication needs of LEP patients
- the hospital's workforce is knowledgeable about hospital policies and procedures for communicating with LEP patients
- the hospital has a strategy for disseminating and integrating relevant information about meeting the needs of LEP patients across its workforce
- language access is a priority of the board of trustees and is a regular agenda item at board meetings

Mission statement. A commitment to language access is implied in 11 of the 12 hospitals' mission statements, typically expressed as a commitment to providing services to a culturally diverse population/in a culturally sensitive environment.

Executive oversight and accountability. Eleven of 12 hospitals have an executive-level staff member who is responsible for overseeing the hospital's language services program or department. Six hospitals have a separate department dedicated to providing language services. Each department is directed by a staff member responsible for coordinating the delivery of services as well as various types of staff trainings related to providing language services (e.g., training on policies and procedures for language services, interpretation skills training, diversity/cultural competency training). Five of the six remaining hospitals without a separate department have at least one individual who coordinates the provision of language services.

Goals and strategies. All 12 hospitals reported having goals and strategies for appropriately meeting the communication needs of LEP patients, but only two of these hospitals indicated that their goals and strategies are written into the hospital's overall strategic plan.

Engagement in language access improvement initiatives. Eleven hospitals have participated in at least one initiative aimed at improving quality and/or accessibility of their language services within the past three years. Such initiatives include those funded by SNI: eight hospitals participated in "Straight Talk," and seven participated in LEAD. In addition to these initiatives, six hospitals have implemented remote interpretation technology, specifically video medical interpreting technology (health care interpreter network [HCIN] or video medical interpreting [VMI]). Three hospitals indicated that they plan to introduce the technology within the next year. Two hospitals were considering implementing the technology at the time of the site visit.

Policies and procedures. All 12 hospitals indicated having policies and procedures for providing language services.

Resources and funds. Four hospitals reported that language services are included as a separate line item in the general budget. The remaining eight hospitals divert funds from the general budget and/or use grant money to support language services. Although bilingual staff members serve as the primary resource for providing interpretation in each of the 12 hospitals, seven indicated that they have full-time staff interpreters who are professionally trained and qualified in medical interpretation.

Training. All 12 hospitals provide staff members with some level of training on policies and procedures for providing language services; and 11 of these train staff on the specific process for obtaining an interpreter. These include training on how and when to obtain an interpreter; hiring professionally trained medical interpreters; and providing multiple options (i.e., in-person, video, telephone) for accessing interpreters. Seven hospitals have full-time, professionally trained staff interpreters in addition to bilingual staff members.

We also asked about tools and training focused on improving the quality of communication with LEP patients, such as testing bilingual staff members' linguistic competency, professional medical interpreter training for bilingual staff, training for providers on how to work with interpreters, and training for all staff members on how to interact with culturally and linguistically diverse patients. All hospitals require that bilingual staff members be tested and qualified in conversational linguistic competency prior to serving as interpreters. Nine responded that they provide professional interpreter training; however, two of nine offer this training only to their full-time interpreters and not to all bilingual staff who interpret. Eight hospitals offer training on how to work with interpreters; 11 offer diversity/cultural competency training.

Leadership communication to staff at all levels. Although each hospital uses common strategies such as all-staff meetings to convey general information, only eight hospitals use this strategy to communicate specifically about language services and language access goals. At each of the 12 hospitals, communication occurs between leaders and staff through a "top-down" approach: staff members typically receive information from leaders at new employee orientation, mandatory staff meetings, training sessions, and via e-mail and/or hospital intranet. Among the eight hospitals where goals and strategies specific to language services are routinely discussed, two hospitals reported that informal, CEO-led small group discussions are a commonly used forum for these discussions.

DOMAIN 3: STRATEGIES TO IMPROVE LANGUAGE SERVICES

We asked hospital leadership to identify their hospital's goals for improving the provision of language services and whether these were written into a strategic plan. We asked specifically if there were current initiatives aimed toward improving language services or whether such initiatives were in the process of being developed. We also asked whether funds were designated to support language services provision (i.e., is language service provision a line item in the budget).

All the hospitals were able to identify a number of goals and strategies for improving the provision of language services, however only two hospitals indicated that their goals and strategies are defined and written into a plan. The strategies for improving language services fell under the following categories: (1) investment in infrastructure; (2) offering tools and training to staff; and (3) other, which included a number of diverse initiatives that could not be categorized under infrastructure or tools and training.

Strategies that focus on investment in infrastructure included:

- Funding a new language services department
- Adding signage in different languages throughout the hospital
- Developing a database of bilingual employees who are tested and qualified in medical interpretation
- Requiring bilingual skills for more job positions in order to increase the number of employees who speak the languages spoken by patients
- Investing in technology enhancements such as computerized telephone integration, HCIN, and wireless phones
- Ensuring that interpretation and translation services has its own budget (a line item in the overall budget)
- Collecting race/ethnicity and primary language data routinely and systematically
- Hiring staff interpreters in high-volume languages as well as American Sign Language interpreters
- Centralizing language services under one department or center within the hospital

Strategies that focus on tools and training for staff included offering:

- Training in medical interpretation to bilingual staff members
- Interpreter training to ED staff as part of the LEAD program, to be rolled out throughout the hospital (taking lessons and training implemented in one department and offering it throughout the hospital)
- Training to new employees about how to access an interpreter from the Language Services Department
- Training to clinic staff on how to use VMI
- Sessions to staff (e.g., medical and nursing interns and residents) on working with patients with limited English proficiency
- Training to clinicians on how to work with interpreters
- Monetary rewards to bilingual staff who demonstrate linguistic competency (through formal testing) and who serve as interpreters
- Cultural competency training to staff

Four hospitals indicated that they had a line-item budget for language services within the general budget, which most often was designated for interpreter and translation services and bonuses for staff that provide language services.

DOMAIN 4: STAFF TRAINING

We asked about the types of training provided for language services, such as training on the hospital's policies and procedures for providing language services, including how to access an interpreter; how to work with interpreters; how to work with culturally and linguistically diverse patient populations; health care interpreter training; and training on the collection of primary language data. All 12 hospitals provide staff members with training on policies and procedures for providing language services. This training is provided during general orientation. Six hospitals reported that new staff members are also trained within their respective departments. Five hospitals provided additional training during annual refreshers, reorientation sessions, or whenever policies are updated and when remote technologies are first implemented (e.g., HCIN or VMI). Training of new staff members was typically provided by staff who run the hospital's language services program or department (e.g., the director of interpreter services, an LEP administrator, or an interpreter services supervisor/coordinator). These same individuals or nursing supervisors provide training at the department level. Eleven hospitals reported training staff on the process for obtaining an interpreter. Eight hospitals offered training on how to work with interpreters. Eleven hospitals offered diversity/cultural competency training. One hospital indicated that it offered formal training on how to collect primary language data from patients or family members. Nine hospitals provide professional training in medical interpretation to bilingual staff members, and of these nine, two offered the training only to their full-time interpreters and not to all bilingual staff who interpret.

Of the eight hospitals that offer training on how to work with interpreters, three reported that more training of frontline clinical staff—especially physicians—is needed; two responded that such training has been limited in scope, e.g., offered to only a few departments rather than hospital wide.

Five hospitals reported that ongoing training is necessary to maintain staff awareness regarding the importance of providing language services to LEP patients as well as the availability and accessibility of these services; two said additional training of clinical staff is needed on procedures for accessing an interpreter.

Although all 12 hospitals report collecting primary language data, six responded that regular training on how to appropriately and systematically obtain

and record this information is needed to overcome issues of inconsistency and inaccuracy. Hospitals acknowledged that additional training is necessary to reinforce the importance of using a trained and qualified interpreter rather than untrained individuals or no interpreter. Each of the three hospitals that do not provide interpreter training to bilingual staff stated that this is needed.

DOMAIN 5: LANGUAGE SERVICES CHANGE OVER TIME

We asked how language services have evolved over time and about the types of changes that have been made to improve and expand these services throughout the hospital. All 12 hospitals have been providing some form of language assistance to LEP patients for at least 10 years; six hospitals have had services in place for 20 years or more. However, until fairly recently (2001 and later) these services were limited in scope and tended to be ad hoc in nature; providers tended to use any bilingual staff member or family members—including children—available for interpretation. Additionally, the language proficiency of the interpreters and their knowledge of medical terminology were largely unknown. To systematize the provision of language services, hospitals made specific changes, which included:

Redesigning and formalizing policies and procedures for the use of interpreters and written translation. Nine hospitals have revised their policies and procedures to improve access to language services. These hospitals have transformed their policies and procedures from a basic statement that "interpreters are provided" to a comprehensive set of specifications regarding when an interpreter should be present, how to access an interpreter, signage to notify patients in multiple languages of their right to an interpreter, informed consent procedures (a qualified interpreter must be used), and prohibition under any circumstance of the use of family members as interpreters. The remaining three hospitals were currently undergoing this revision process at the time of the site visit.

Centralizing services by establishing a separate department or designating an existing department within the hospital. Seven hospitals established a separate department to facilitate coordination and delivery of language services. Five hospitals designated a specific area of the hospital such as human resources, the nursing office, or patient relations for this purpose.

Increasing the options available for providing language services to patients, usually by implementing remote interpretation technology. At the time the site visits were conducted, seven hospitals had implemented remote interpretation technology (video and/or telephone conferencing), and three were planning to implement it within the next six months to one year. Of these seven hospitals, five responded that they have increased access to both the number of interpreters and the languages available through remote interpretation technology. Four hospitals responded that this technology also improved quality of language services, because their remote interpreters are professionally trained in medical interpretation.

Hiring full-time, trained medical interpreters. Seven hospitals have full-time medical interpreters.

Testing linguistic competency of bilingual staff members. All 12 hospitals require bilingual staff who serve as interpreters to be tested and qualified in language proficiency (conversational only). Four hospitals stated that language access has improved over time due to an increase in their numbers of qualified bilingual staff.

Establishing interpreter training programs for bilingual staff members. Seven hospitals offer medical interpreter training to bilingual staff members who serve as interpreters; one hospital indicated that this training is mandatory. Training bilingual staff interpreters in medical interpretation has contributed to improvement in the quality of language services.

DOMAIN 6: EVALUATION OF LANGUAGE SERVICES

We asked interviewees whether there is a process in place for routine evaluation of language services, and if so, what it entails. Specifically we asked whether formal or informal surveys are conducted to gather feedback from patients and staff regarding their experiences with the hospital's language services, whether leadership reports back to staff on how this information is used to improve language services, and the degree to which this information is used to shape policies and procedures for the provision of language services.

Patient and staff satisfaction with language services. All 12 hospitals administer general patient satisfaction surveys. Six of the 12 hospitals reported that this survey includes questions gauging patient satisfaction with language services. Four hospitals administer supplemental, department-specific patient satisfaction surveys that include questions about the use of language services. The remaining two hospitals do not currently assess patient satisfaction with language services. Two hospitals formally survey frontline clinical and administrative staff members about their perceptions of language services. In one of these two hospitals, this survey is administered annually. For the other hospital, interviewees were uncertain how frequently staff members are surveyed.

In seven hospitals, frontline staff members are not routinely or formally surveyed about their experiences and perceptions of the hospital's language services. Instead they are more likely to provide feedback informally to managers during staff meetings or one-on-one discussions. They also provided feedback during one-time surveys or focus groups connected with specific improvement initiatives such as LEAD or HCIN. In four hospitals, no feedback from staff members was solicited, either formally or informally. The only source of feedback these four hospitals receive from staff members is through complaints.

DOMAIN 7: EFFECTIVENESS OF LANGUAGE SERVICES

All hospitals reported that language access and the effectiveness of language services have improved over the last five years. The number of staff training programs related to provision of language services has increased substantially. Staff interpreters and bilingual staff are effective and responsive, and multiple options are in place for providing language services, including video, telephone and in-person conferencing. A number of staff stated that remote interpretation has increased the efficiency and effectiveness of language services by reducing the number of full-time staff interpreters required and by increasing access to professionally trained interpreters in a wide array of languages. From a hiring perspective, almost all hospitals indicated that many point-of-entry positions now require bilingual skills, increasing the linguistic and cultural diversity of the staff.

DOMAIN 8: BARRIERS AND FACILITATORS TO PROVIDING LANGUAGE SERVICES

We asked staff to identify the main strengths of the language services offered in their hospitals. We also asked staff about the challenges they face in providing language services to patients with limited English proficiency and to identify the main weaknesses related to offering language services in their hospitals. The most commonly cited strengths were the commitment of the CEO and hospital leadership to language services, and the cultural and linguistic diversity of the hospital staff. Other commonly cited strengths included the availability of qualified bilingual staff at the hospital.

A number of hospitals said that having policies and procedures for language services was a strength. A few hospitals said that the ready availability of professionally trained hospital staff interpreters was a clear strength within their hospitals. Three hospitals said that having a language services administrator or department for language services

within the hospital was an important facilitator to keeping language services high on the priority list for providing quality health care.

The most commonly cited barriers to providing language services were lack of bilingual staff and trained hospital interpreters in less common languages, especially in the emergency department. Staff also said that it was quite challenging for bilingual staff to meet interpretation demands along with their full-time jobs. The lack of continuity of language services during an individual's entire hospital visit or stay was also cited as a barrier.

A number of hospital staff said because their hospitals do not systematically collect data on patients' primary language, it is difficult to plan for provision of language services. Financial barriers and limited dollars for language services were also cited as common barriers. A small number of hospitals reported that goals and strategies for providing language services are not well communicated and that staff do not always comply with policies and procedures.

The table below summarizes the key findings by domain for the full hospital cohort.

TABLE: COMMONLY REPORTED PRACTICES IN LANGUAGE SERVICES PROVISION

Domain 1: Policies and Procedures for Providing Language Services

- All have policies and procedures for providing language services to LEP patients
- All have an established process in place for obtaining an interpreter; bilingual staff members serve as the primary resource for interpretation in each of the 12 hospitals
- All have policies that specify the use of a trained and qualified interpreter during clinical encounters with LEP patients
- All collect primary language data
- Eleven hospitals had signage notifying patients of their rights to an interpreter

Domain 2: Indicators of organizational commitment to provide language services

- A commitment to language access is implied in 11 of 12 hospitals' mission statements
- Eleven hospitals have an executive-level staff member who is responsible for overseeing the hospital's language services program/department
- Eleven hospitals have specific goals and strategies for appropriately meeting the communication needs of LEP patients
- Eleven hospitals have participated in at least one initiative aimed at improving the quality and/or accessibility of their language services within the past 3 years
- All hospitals require bilingual staff who serve as interpreters to be tested and qualified in language proficiency (conversational only) prior to serving as interpreters

Domain 3: Strategies to improve language services

- Implementing or expanding video medical interpretation technology (e.g., HCIN or VMI)
- Recruiting additional bilingual employees, especially clinical providers
- Training staff on the process for obtaining and using an interpreter

Domain 4: Staff training

- All train staff members on policies and procedures for providing language services
- Eleven hospitals provide training on the specific process for obtaining an interpreter
- Eleven offer diversity/cultural competency training

Domain 5: Changes in language services over time

- Redesigning and formalizing policies and procedures for the use of interpreters and written translation
- Centralizing services by establishing a separate department or designating an existing department within the hospital
- Increasing the options available for providing language services to patients, usually by implementing remote interpretation technology (video or phone)
- Testing the linguistic competency of bilingual staff members

Domain 6: Evaluation of language services

- All 12 hospitals administer general patient satisfaction surveys
- Six hospitals reported that this survey includes questions gauging patients' satisfaction with language services
- Four hospitals administer supplemental, department-specific patient satisfaction surveys that include questions about the use of language services.

Domain 7: Effectiveness of language services

- The number of bilingual staff interpreters has increased, improving language access
- Hospitals report more training programs for staff on how to provide culturally and linguistically appropriate care to LEP patients
- More options are available for providing language services, including video medical interpreting and telephonic and in-person interpreting

Domain 8: Facilitators and barriers to providing language services

Commonly cited facilitators to providing language services include:

- The commitment of the CEO and hospital leadership to language services
- The cultural and linguistic diversity of the hospital staff
- The availability of qualified bilingual staff
- Use of remote interpretation technology to supplement in-house staff translators

Commonly cited barriers to providing language services include:

- A lack of qualified interpreters in less common languages, especially in the emergency department.
- Limited availability of qualified bilingual staff to interpret; their full-time job responsibilities compete with the demand for interpretation
- Financial barriers and limited dollars to support language services

Discussion:

A Synthesis of the Facilitators and Barriers to Providing Language Services in California Public Hospitals

Ten of the twelve evaluation hospitals had participated in at least one SNI improvement initiative and had found that this participation served as a facilitator in providing language services. Seven of the 10 hospitals participated in the LEAD program, and eight participated in the "Straight Talk Policies and Procedures" reviewers and/or implementers initiative. Hospitals participating in these initiatives had made system-level changes to improve the access and quality of language services relative to the two hospitals that did not participate in these initiatives.

For example, all hospitals who participated in one or more SNI initiatives have an established process for identifying LEP patients' primary language. At points of entry such as admissions/registration, signage and printed information is used to inform patients of their right to an interpreter and the availability of interpreter services. Signs are posted in the predominant languages spoken in the surrounding community.

All hospitals have an established procedure for accessing interpreters. When multiple options exist for providing an interpreter (video, telephone, and in-person conferencing), policies clearly indicate when it is appropriate to use each option. One hospital, for example, has a policy which states that an interpreter should be physically present when obtaining informed consent. All hospitals who participated in an SNI initiative have a process in place for translating written documents. Patient education materials, informed consent forms, and other vital patient documents are translated by trained and qualified interpreters, usually bilingual staff. At one hospital, several Asian languages such as Vietnamese have become increasingly common within the last 20 years. In response to this trend, the policy on written translation was changed to include translation of vital patient documents into Vietnamese, indicating that the hospital had been tracking the increase of this language in its patient population.

In regard to tools, training, and resources for providing language service, hospitals who participated in one or more of SNI's initiatives provide staff members with training on policies and procedures—including the process for obtaining an interpreter—during new hire orientation. Ongoing training for staff members is typically incorporated into other trainings, such as diversity trainings. At one hospital, training is offered during biannual Joint Commission patient safety fairs, which staff members are required to attend. Staff members at two of the hospitals are able to access these policies online. Several hospitals offer professional training in medical interpretation to bilingual employees who serve as interpreters. Such training improved the quality and accuracy of the interpretation provided and also raised staff awareness of the importance of providing accurate interpretation. There is also less reliance on untrained staff and family members for interpretation in these settings.

Many hospitals indicated that they test the linguistic competency of their bilingual staff members who serve as interpreters. One hospital

offers two different tests depending on the type of interpretation performed: employees interpreting medical terminology received more advanced training and tests than staff members who were responsible for interpreting nonmedical information (e.g., registration staff, financial counselors). At the time of our visit, none of the hospitals required bilingual staff members to be retested or requalified after a specific period of time; however, a few indicated that they are setting up systems to monitor the quality of interpretation.

All hospitals have focused on recruiting staff members that speak the predominant languages of the patient population, especially clinical providers. At two hospitals, many frontline clinical and administrative positions are designated as "bilingual required."

Technology has played a substantial role in improving access to interpreter services. For hospitals that use remote video medical interpreting (via HCIN or VMI), the wait time to access an interpreter has been reduced significantly, from one hour or longer to just minutes. Remote interpreting has also significantly increased the number of interpretations that can be provided per day because interpreters do not have to be physically present in the room with every patient. At one hospital, interpreter productivity notably increased since introducing HCIN; each interpreter now provides approximately 40 interpretations per day, compared to 12 in the past. At another hospital, interpreter productivity increased significantly as a result of implementing an interpreter services call center (the ACD system). Prior to using this system, 50% of an interpreter's time was spent interpreting and the other 50% spent in transit. Now 90 to 95% of an interpreter's time is spent performing interpretation.

Before options such as HCIN and contracted telephonic interpreters were available, family members and untrained bilingual staff members were often relied upon to interpret. Also, with remote interpreter technology in place at a number of California public hospitals, it is now possible to access interpreters for approximately 20 different languages, including American Sign Language. This point is important because sparse availability of interpretation in less common languages was cited as one of the most recurring barriers by hospital staff.

There are also key areas for improvement. We were able to identify barriers and challenges to providing language services. For example, few hospitals formally evaluate their provision of language services to determine whether they are successfully meeting the language needs of their patient populations. We found that although most hospitals routinely collect and record primary language data from patients during registration, few use it to inform decisions about improving language services, which is consistent with national trends. California public hospitals, because they are far ahead of national trends in many areas, can lead the way with this particular strategy as well. One specific area that requires focus is the systematic collection of primary language data. Although hospitals are collecting primary language data, they are not doing so systematically or consistently, and the data are often cited by hospitals as inaccurate. Without good data it is difficult to determine the true needs of the population, to quantify the impact of the work that has been done to improve language access, and to justify the need for additional resources to support further development.

Most hospital policies state explicitly that children are never to be used as interpreters, and the use of family members is generally discouraged. However, family members are still used for languages that are not commonly encountered. Though this is not standard practice and is plainly discouraged, this practice still takes place, particularly in the emergency department where time is often scarce.

It is sometimes even the case in hospitals that provide access to trained interpreters either remotely or in person. Clear and unambiguous staff training discouraging this practice should be incorporated into all staff education programs.

Currently, most hospitals stated that on a system level, there is no standard procedure in place for communicating patients' language needs across departments. Additionally there is no process for ensuring the availability of interpreter services to a patient through various points of contact within the hospital during all hours of operation. Staff members who serve as bilingual interpreters indicated that they find it challenging to meet the expectations of providing interpreter services and their primary job responsibilities. Because these individuals are not dedicated staff interpreters, it is often difficult for them to get away from their primary job duties to interpret. Despite having HCIN, in some hospitals there are still situations where staff members find it more convenient to rely on a patient's family members or any available bilingual staff member than to use a trained interpreter. We anticipate that as staff members become more familiar with HCIN this will change, but it may require a more focused investment in training of both clinical and nonclinical staff to ensure this happens.

Limitations

There are several limitations that should be noted when considering the findings of this report. First, the small size of our sample and our sampling methods do not allow for generalization of study findings to the larger range of hospitals in California or nationally. Second, the data are self-reported and subject to variation based on each respondent's level of knowledge, position within the hospital, and individual perceptions, which may be biased. We cannot exclude the possibility that respondents may have provided information in areas where their knowledge of the subject may have been limited. However, because we interviewed an average of 15 individuals per hospital, enabling us to obtain a wide array of perspectives, we hope that we have minimized the potential bias that this limitation may impose. Finally, while this report provides information about the perceptions of hospital leadership and staff, it does not reflect the perspective of patients who receive care at California public hospitals.

Despite these limitations, we believe that the observations described in this report are noteworthy and offer a descriptive assessment of system-level facilitators and barriers related to providing language services in California public hospitals, which will be informative to hospital leadership, clinicians, administrative staff, and policymakers in California and throughout the country.

Conclusions

Our findings suggest that systems for providing language services in California public hospitals are continuing to evolve. The findings from our site visits show strong system-level support for language services in California public hospitals, but there are clear areas for improvement. The evolution of language services in California public hospitals points to progress across the board, especially over the last five years. The experience and lessons learned from California public hospitals can serve to inform hospitals nationwide as they implement and improve upon the provision of language services to their LEP populations. Hospitals that commit to providing high-quality language services to their patients will likely be rewarded with greater patient and staff satisfaction, giving them a competitive advantage as the demographic trends in California and the country continue to point to increased linguistic diversity. State and national resources need to be targeted toward monitoring and improving language services for all patients with LEP to support the provision of high-quality health care for all.

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