Talking With Patients

How Hospitals Use Bilingual Clinicians and Staff to Care for Patients with Language Needs



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Executive Summary

It is an exciting time for language services. Researchers, health plans and providers are focusing increased attention on the importance of effective communication between patients and their health care team. As the diversity of our country increases, many stakeholders are responding by developing or adopting policies designed to ensure that high-quality language services are available for individuals with language needs.

Bilingual staff and clinicians are frequently called on to provide health care or health care-related services to patients in languages other than English, particularly in communities with a significant concentration of patients speaking languages other than English. Little is known about hospital policy surrounding the role of bilingual clinicians in caring for patients with limited English proficiency (LEP). Less well understood is the extent to which bilingual clinicians and staff are being used at hospitals, or the mechanisms currently used to assess their qualifications to engage in health care encounters with LEP patients.

This report presents findings from a survey conducted by researchers at The George Washington University and supported by funding from The California Endowment to learn more about the individuals in a hospital setting who interact with patients who speak a language other than English. The study focuses in particular on the ways that bilingual clinicians and staff are used, how policies are developed, and how these practices affect the provision of language services. The report describes practices across the country, as well as policies and practices across hospitals located in the state of California.

We gathered information from three primary sources: (1) a national survey of over 800 hospitals, targeting human resource directors; (2) an oversample of California hospitals to develop a base of information about language services and use of bilingual clinicians and staff across the state; and (3) interviews with selected survey respondents to gain in-depth knowledge about policies and practices. By increasing and sharing knowledge about how bilingual clinicians and staff can be effectively utilized, health systems will be able to modify and improve strategies for meeting the needs of their linguistically diverse communities.

Key Findings

- Many hospitals across the country are in frequent contact with patients requiring language services; 74 percent of hospitals serve patients whose primary language is not English. Of these hospitals, nearly three-quarters reported seeing LEP patients on a daily or weekly basis.
- More than 8 out of 10 hospitals offer language services training, but 27 percent of these hospitals indicate that this training is optional. Hospitals are more likely to require language services training for nurses and registration staff and less likely to require it for physicians and medical residents.
- Half of the hospitals use volunteer interpreters, while only three out of ten hospitals hire interpreters as staff. Hospitals that encounter LEP patients on a daily basis are significantly more likely to hire interpreters as staff than hospitals reporting encountering LEP patients once a month or less.
- Almost nine out of ten hospitals report that bilingual doctors and nurses provide health care services at their hospitals, although the languages spoken by these clinicians may not correspond to the needs of the patients and the languages that they speak.
- Fewer than half of hospitals with volunteer interpreters require language assessments and only one in four hospitals require volunteer interpreters to have experience or require volunteer interpreters to have gone through interpreter training or an educational course about medical interpreting.
- Only 18 percent of hospitals with bilingual doctors or nurses offer any assessment of fluency; of these, half require the assessment for bilingual doctors and nurses.
- Fifteen percent of respondents indicate that they offer incentives for bilingual ability. For most of these 123 hospitals, incentives take the form of an add-on to base pay.
- Less than half of hospitals have formal policies regarding the use of minors, friends or family, or non-trained staff as interpreters. Only 28 percent of hospitals have policies related to the use of bilingual doctors and nurses serving as interpreters.
- Compared to the national sample of hospitals, California hospitals are more likely than hospitals nationwide to encounter LEP patients, offer training related to accessing language services, require specific qualifications of staff and volunteer interpreters, have bilingual staff and clinicians within the hospital setting, offer

a language assessment for bilingual clinicians to gauge their language skills, offer bilingual staff incentives for secondary language skills, have policies about the use of minors, friends or family, or non-trained staff as interpreters, and have policies about using bilingual doctors and nurses as interpreters.

Discussion

Effectively using the resources available through bilingual clinicians and staff can be challenging. Most hospitals have bilingual physicians and nurses but too few assess the language proficiency of these clinicians in languages other than English—creating a climate where errors and miscommunication can be commonplace.

Furthermore, our study reveals that many LEP patients may be receiving care with interpreters of unknown or questionable quality. Volunteers can provide high-quality and valuable resources for language services if they are appropriately trained and properly assessed for language fluency. However, our study shows that LEP patients receiving interpreter services from volunteer interpreters are likely to be served by interpreters whose qualifications or language proficiency have not been verified by the hospital. Hospitals appear to use volunteer interpreters differently than other volunteers in the hospital and essentially deputize often untrained individuals to assume a critical place on the health care team. The implications for safety and quality are enormous under this scenario, and emphasize the importance of ensuring the language proficiency and competency of volunteer interpreters.

Hospitals need better education about when and how to request interpreter services among physicians and residents in training. Given their role and the frequency with which they are trained in accessing language services, registration staff and nurses need to be advocates for LEP patients to access language services, both at the system and policymaking level, as well as at the individual patient encounter level.

Little information is known about the use of incentives related to language ability but some pioneers around the country assess the languages spoken by their physicians and nurses, and reinforce these skills with incentives. Much more information should be developed to determine what type and amount of incentives would be most effective in encouraging bilingual clinicians and staff to participate in training on medical interpreting, have their language skills in secondary languages assessed, and serve in the capacity of dual-role interpreters to fill the resource needs of their hospitals.

The state of California can serve as a model for other states interested in implementing innovative policies and practices to provide effective, high-quality language services to their patient populations. California hospitals are ahead of the nation in terms of setting formal policies around language services and using bilingual clinicians as interpreters. Still, across the country (including California), more hospitals must take steps to ensure language services are available and appropriately delivered.

Recommendations

We recommend the following strategies to strengthen hospital policies and programs designed to improve language services on behalf of patients with limited English proficiency:

- Hospitals should develop explicit policies or plans related to the provision of language services for patients with LEP.
- Bilingual clinicians and staff should be assessed for language proficiency if they provide direct services or care to patients with limited English.
- Volunteer interpreters should have their language proficiency assessed and be trained in medical interpreting.
- Hospitals should require that all staff, including clinical staff, receive education on the critical importance of language services to patient care and training on how to access language services.
- All hospitals should know who their patients and work force are and work to meet the language needs of all of their patients.
- Hospitals should take a proactive approach to learning more about the many ways that high-quality language services can be provided to their patients.

I. Introduction

It is an exciting time for language services. Researchers, health plans and providers are focusing increased attention on the importance of effective communication between patients and their health care team. As the diversity of our country increases, many stakeholders are responding by developing or adopting policies designed to ensure that high-quality language services are available for individuals with language needs. While many research studies have been conducted on the value of using trained, qualified interpreters to provide language services, there are fewer studies focusing on the use of bilingual staff and clinicians to care for patients with limited English proficiency (LEP).

Bilingual staff and clinicians are frequently called on to provide health care or health care-related services to patients in languages other than English, particularly in communities with a significant concentration of patients speaking languages other than English. Evidence from a survey conducted by The Health Research and Educational Trust (HRET) in 2006 indicates that bilingual resources are available at the majority of hospitals in the U.S., with more than four out of five hospitals reporting that bilingual clinical staff are available for providing language services, and nearly three-quarters of hospitals indicating that bilingual nonclinical staff are available for providing language services.[1] The HRET study also found that bilingual clinical and bilingual nonclinical staff are frequently used, with hospitals reporting use of these resources most frequently after staff interpreters and telephone services.

Bilingual staff and clinicians serve as an enormously valuable resource to hospitals and other health care organizations, offering a critical set of skills to interact with individuals who require care in a language other than English. Bilingual clinicians can serve a vital need for hospitals by providing high-quality health care, improving patient safety, and meeting organizational priorities to provide linguistically and culturally appropriate care for their patients. Research has shown the additional benefit of bilingual clinicians speaking directly to patients in their preferred language (also referred to as language concordance). Language concordance between physician and patient has shown a positive effect on appointment-keeping, improved medication adherence, and lower emergency room visit rates,[2] as well as better understanding of medical situations,[3] fewer instances of physical harm as a result of an adverse health outcome,[4] greater recall and asking more questions about care.[5] Patients with language concordant clinicians report receiving better interpersonal care and gave higher ratings to the doctor or nurse.[6, 7, 8, 9, 10] In addition, language concordance with their physicians has been associated with patients reporting better health status.[11]

While there are undoubtedly benefits to language concordance between a patient and clinician or staff, language *proficiency* of bilingual staff is an important consideration.[12] Many clinicians may be able to comfortably converse with their patients in languages other than English, but may lack proficiency in terms of providing medical care in another language. A recent study emphasized the importance of assessing second language skills of bilingual staff that serve in the role of interpreters ("dual-role interpreters").[13] This study found that one in five dual-role interpreters had inadequate bilingual abilities to serve as interpreters in medical encounters, and were more likely to make errors in interpretation. Another study found many errors with the potential for clinical consequences during a series of interpreted pediatric encounters, both by hospital and informal or untrained interpreters.[14] Inconsistency in describing and assessing language skills makes it difficult to determine how qualified someone is to communicate with patients in another language.[15]

This growing body of evidence demonstrates the importance of using *qualified* language resources to deliver high-quality care to patients with limited English proficiency, and is paralleled by the development of patient-centered standards by the country's leading accreditation and quality organizations.

National Standards: Patient-Centered Care and Communication

Over the past few years, three of the most influential standards-setting organizations have undertaken broad steps to articulate a new set of expectations around the quality of language services. In 2009, the National Quality Forum issued specific recommendations for ways for health care organizations to deliver clear patient-provider communication, "at all levels and at all times among patients, clinicians and support staff."[16] Seven of these preferred practices specifically address the provision of language services, from recommending that organizations plan for and provide language access at all points of contact to recommending that organizations translate *all* documents deemed essential for effective communication.

In December 2008, the National Committee on

Quality Assurance (NCQA) released a set of standards for public comment for assessing the quality of culturally and linguistically appropriate services in health care organizations.[17] Among these standards were specific targets associated with accessibility, availability and evaluation of language services provided by organizations. These standards may eventually be rolled into NCQA's core accreditation standards for health plans and other health care organizations.

The Joint Commission is also actively engaged in a process to develop new standards for culturally competent patient-centered care.[18] In early June, The Joint Commission released for public comment proposed accreditation requirements for hospitals to "advance effective communication, cultural competence and patient-centered care."[19] Four proposed standards include Elements of Performance that propose providing education about how and when to use language access services, communicating with patients via preferred access or language access services, translating vital documents and informing patients of their rights to language access services. These proposed hospital requirements may be implemented as early as January 2010.

Many of these standards or requirements are reflections of the "National Standards for Culturally and Linguistically Appropriate Services in Health Care" released by the Office of Minority Health in 2000, commonly referred to as "CLAS" standards.[20] Four CLAS standards specifically address language access, including the provision of language assistance to patients at all points of contact, providing written notices of their right to receive these services at no cost, ensuring the competence of language assistance and refraining from using family and friends, and providing materials and signage in the appropriate languages. The development of CLAS standards, as well as the current standards focusing on patient-centered communication, are based on legislation requiring federally-funded programs[21] to provide "meaningful" access to language services for people with LEP[22] and Federal guidance outlining principles on how to fulfill these requirements.[23, 24] With the current research and quality standards environment supporting provision of appropriate and effective language services, national and state policies have concurrently developed legislation providing financial incentives and in California, detailing specific requirements for hospitals providing language access services.

National and State Language Access Policies

Increasingly, national policies are addressing the need for effective language services in the health care setting, creating financial incentives for providing language services through the Children's Health Insurance Program (CHIP) and Medicaid. The CHIP Reauthorization Act of 2009 authorized enhanced federal administrative matching payments for providing language services through CHIP and Medicaid programs.[25] The enhanced matching rate is 75 percent of costs or the sum of the state's federal CHIP administrative matching rate plus 5 percent, whichever is higher. Also, under this provision, the federal matching rate for Medicaid programs is 75 percent of costs related to translation and interpreter services provided to children of families with limited English proficiency or Federal Medical Assistance Percentages (FMAP) plus 5 percent, whichever is higher.[26]

As part of health reform, proposed legislation includes provisions to strengthen the effective delivery of language services. America's Affordable Health Choices Act (H.R. 3200), the health care reform bill introduced in the House of Representatives on July 14, 2009,[27] includes recommendations related to ensuring effective delivery of language services and communication for patients with LEP. The bill also includes recommendations to review ways for Medicare providers to pay for language services, and also calls for a report through the Institute of Medicine on the impact of language access services on the health and health care of LEP patients.

State governments have also stepped up efforts to ensure access to effective language services on behalf of their residents. Thirteen states have set up programs to provide direct reimbursement to pay for language services (DC, Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Virginia, Vermont, Washington and Wyoming), and four other states are moving toward setting up reimbursement (Connecticut, California, New York, North Carolina).[28] In addition to reimbursement, four states require or are in the process of requiring state-based certification for interpreters,[29] which coincides with the ongoing process of developing national certification standards for interpreters.[30, 31]

The state of California has the most number of and most comprehensive laws related to language services in health care settings.[32] Demonstrating its support of language services and serving as a model for other states, CA Health and Safety Code Section 1259 (Kopp Act 1983)[33, 34] requires all general acute care hospitals in California to provide

language assistance services 24 hours a day for language groups that comprise 5 percent or more of the hospital's patient population or geographic service area. In addition, hospitals must:

1) develop and review policies on interpreter services or on using bilingual professional staff;

2) post notices about the availability of interpreters, how to obtain an interpreter and how to make complaints about interpreter services;

3) notify employees of the hospital's commitment to provide interpreters to all patients who request them;

4) prepare and maintain a list of qualified interpreters;

5) identify and record patients' primary languages in the patient's hospital records;

6) review standardized forms to determine which should be translated; and,

7) consider using picture and phrase sheets and establishing community liaison groups.

Research combined with national and state policies support the delivery of high-quality language services to patients with language needs but the extent to which these services are being provided, and the extent to which these national and state policies are enforced is unclear. Health care organizations have long provided language services to their patients, and the current legal and regulatory climate will strengthen and support ongoing efforts to deliver these services. Hospitals are using a variety of mechanisms to respond to the needs of their linguistically diverse patients—through in-person interpreters, telephone interpreters, contract interpreters, and remote or video technology.

Little is known about hospital policy surrounding the role of bilingual clinicians in caring for patients with limited English proficiency. Less well understood is the extent to which bilingual clinicians and staff are being used at hospitals, or the mechanisms currently used to assess their qualifications to engage in health care encounters with LEP patients. In May 2008, The Joint Commission released a report on findings from its *Hospitals, Language and Culture* study, emphasizing the importance of developing hospital policies and procedures to support cultural competence, and describing the importance of integrating a diverse work force, language services and interpreters into organizational systems.[35]

In 2008, researchers at The George Washington University conducted a survey funded by The California Endowment to learn more about the individuals in a hospital setting who interact with patients who speak a language other than English. This report presents the findings from the survey, which focused in particular on the ways that bilingual clinicians and staff are used, how policies are developed and how these practices affect the provision of language services. In this report we describe practices across the country, as well as policies and practices across hospitals located in the state of California. The findings presented in this report are timely given the substantial financial pressures hospitals face in today's economy, the increasing linguistic diversity of patient populations in the U.S., and the legislative activities on the national and state level. Understanding strategies and practices for using bilingual clinicians and staff is imperative to improve the quality of hospital-based language services.

Overview of Study

In order to learn about how hospitals are using physicians, nurses, and other staff and clinicians as resources for communicating with patients in languages other than English, we gathered information from three primary sources: (1) a national survey of over 800 hospitals, targeting human resource directors; (2) an oversample of California hospitals to develop a base of information about language services and use of bilingual clinicians and staff across the state; and (3) interviews with selected survey respondents to gain in-depth knowledge about policies and practices. Survey findings combined with case studies contribute to emerging knowledge about how health care organizations can provide high-quality and efficient language services and advance culturally competent providers and health systems. By increasing and sharing knowledge about how bilingual clinicians and staff can be effectively utilized, health systems will be able to modify and improve strategies for meeting the needs of their linguistically diverse communities.

The findings in this report are presented in two parts: an analysis of findings from the national survey of hospitals and a summary of survey results related specifically to California hospitals. In general, California hospitals have a more diverse patient population and health care work force compared to their counterparts across the country, and also appear to be leading the nation in several areas related to language services and bilingual clinicians and staff.

II. Characteristics of National Survey Respondents

A total of 899 human resources (HR) directors from non-federal, acute care hospitals completed the survey, representing nearly 20 percent of all non-federal, acute care hospitals in the U.S. We obtained a response rate of 39 percent. We oversampled California hospitals to enable analysis of California responses, and we present data from 159 California respondents. We also oversampled rural hospitals to provide sufficient information to understand hospital practices and policies related to language services in this sector of the industry.[36] The nationwide analysis was adjusted by ownership, teaching status, market, and geography (CA vs. not) to reflect the characteristics of the U.S. hospital industry.[37]

Little information has been published about hospital policies and practices specific to the use of bilingual clinical and nonclinical staff for providing language services. We were particularly interested in identifying practices and innovations related to language assessments and use of incentives related to bilingual ability, so hospitals active in these areas were asked several follow-up questions to gather in-depth information about these practices. As a result, some questions were asked of a portion of respondents (depending on their level of activity in these areas of interest) and the number of respondents is variable; the number of respondents for each question is noted in chart titles and labels.

The majority of hospitals that participated in the survey were investor-owned or non-government, not-for-profit organizations that did not operate teaching programs (Table 1). More than two-thirds of hospitals (69 percent) in our sample were not-for-profit and well over three-quarters of the sample (85 percent) were non-teaching hospitals. Hospital respondents were somewhat more likely to be small, in terms of bed size, compared to acute care hospitals across the country (54 percent of responding hospitals had fewer than 100 beds, compared to 46 percent nationwide). Approximately one-third of respondents (38 percent) self-identified their hospital as urban or suburban and two-thirds of respondents (62 percent) identified their market as rural. Because rural hospitals are less likely to have teaching programs, non-teaching hospitals are also overrepresented in our sample.

Table 1 **Characteristics of Survey Respondents Compared to U.S. Hospitals**

	Survey Respondents (%)	U.S. Hospitals (%)
Hospital Ownership Status		
Non-government, not-for-profit	69.1	61.3
Investor-owned, for-profit	13.7	14.8
Government, non-federal (city, county or state)	16.8	23.9
Teaching Status		
Non-teaching (community)	85.3	73.4
Teaching	14.7	26.6
Total Staffed Beds		
<20	8.9	4.8
20-99	44.7	41.9
100-249	21.8	30.5
≥250	21.1	22.9
Hospital Market		
Urban*	37.7	56.6
Rural	62.3	43.4

Source: George Washington University, 2008; U.S. Hospital data from AHA Annual Survey of Hospitals, FY2007
**Respondents that indicated their hospital is in a "suburban" market are categorized with "urban" for the purposes of this report*

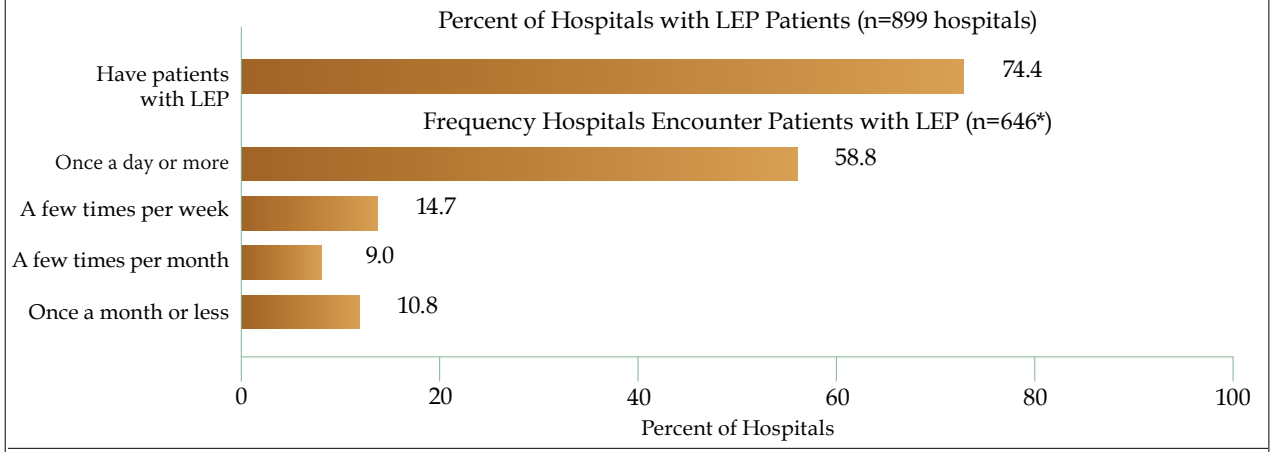
III. Findings from the Survey: National Results

Hospitals Caring for LEP Patients

We were interested in determining whether hospitals around the country perceive that they care for patients with limited English proficiency. Most hospitals reported caring for patients with LEP, although the frequency with which they encounter LEP patients varied. Nearly three-quarters (74 percent) of hospitals reported that they serve patients whose primary language is not English (Figure 1). Of those reporting that they have LEP patients as part of their patient population, nearly three-quarters (74 percent) reported seeing LEP patients on a daily or weekly basis, highlighting the large number of hospitals across the country that are in frequent contact with patients requiring language services. The remaining hospitals reported seeing LEP patients a few times per month (9 percent) or once a month or less (11 percent). Compared to the hospital survey conducted by HRET in 2006,[38] more hospitals in this study reported seeing LEP patients on a daily or weekly basis (74 percent vs. 63 percent, respectively). The difference in these findings may be partially attributable to the oversampling of California hospitals in this study.[39]

Respondents from urban and rural hospitals reported markedly different rates of encountering LEP patients. Not surprisingly, most urban hospitals reported having LEP patients (90 percent) and three quarters (75 percent) encountered LEP patients each day (Figure 2). While 6 out of 10 rural hospitals (61 percent) reported having LEP patients, only 39 percent of rural hospitals encountered LEP patients once a day or more, and nearly a quarter (24 percent) said they saw LEP patients once a month or less.

Figure 1 **Encounters with LEP Patients**



*Source: George Washington University, 2008; weighted data; *frequency estimates apply to hospitals with LEP patients*

Training Staff to Care for LEP Patients

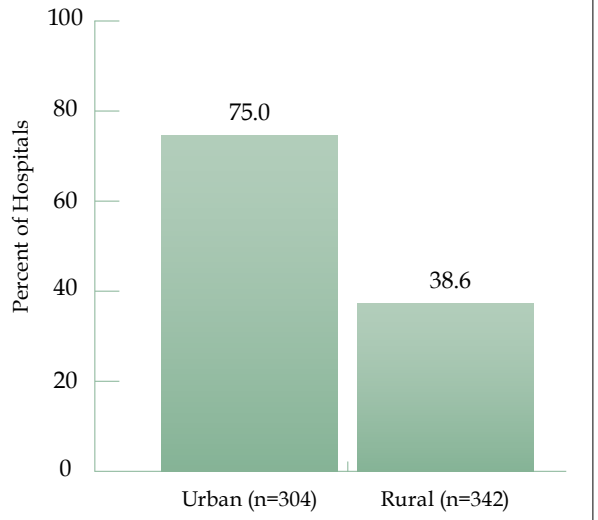
We asked human resources directors whether their hospitals provide training to help clinicians and staff understand the ways they can access language services. Most hospitals indicate that they offer training on how to use language services to prepare their staff for encounters with LEP patients. This training is designed to help prepare staff to serve culturally and linguistically diverse patients, as well as to learn when language services are needed and how to access them for LEP patients.

More than 8 out of 10 hospitals (83 percent) indicated that they offer language services training—a percentage higher than those indicating that they have LEP patients. Some hospitals with few or no LEP patients may include training related to language services in the event that a patient with language needs presents for services. Such training may also serve as a means to comply with legal requirements related to accessible language services.

While the majority of hospitals have training programs on how to access interpreter services, many do not require hospital staff to take this training. Most hospitals (69 percent) that have language services training require their hospital staff to go through this training, but more than one-quarter (27 percent) of hospitals with language services training indicate that this training is optional (Figure 3).

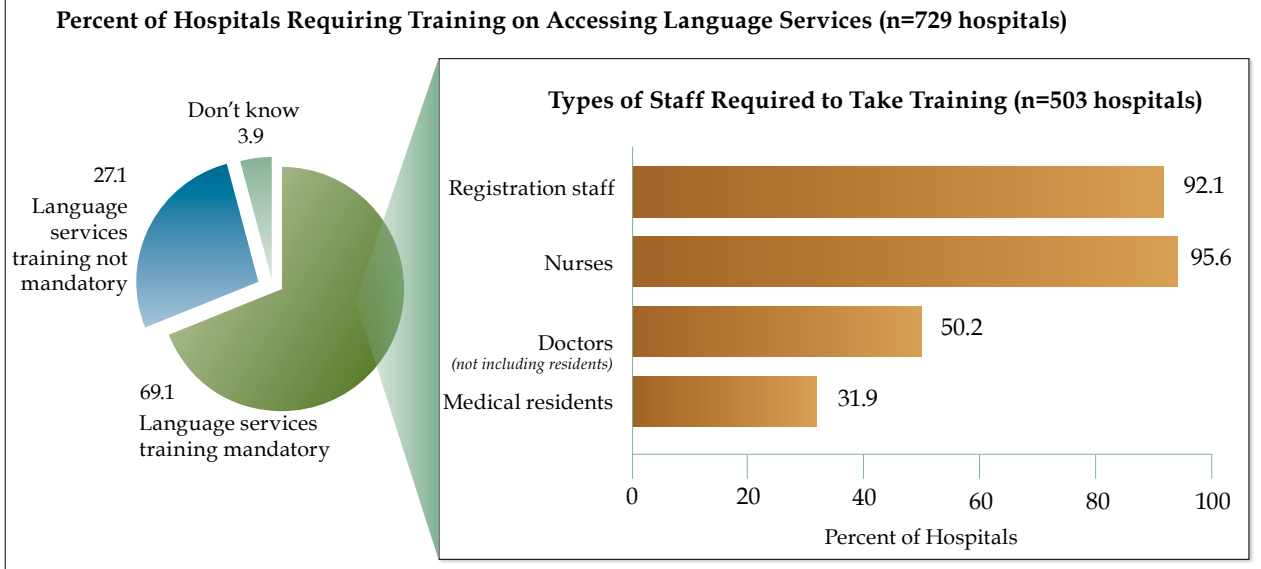
Even among hospitals that require language services training, these hospitals do not necessarily require language services training for *all* hospital staff. Hospitals are more likely to require language

Figure 2 **Percent of Urban and Rural Hospitals Encountering LEP Patients Once a Day or More**



Source: George Washington University, 2008

Figure 3 **Hospital Requirements for Training on Accessing Language Services**



Source: George Washington University, 2008; weighted data

services training for nurses and registration staff and less likely to require it for physicians and medical residents. Only one-third (32 percent) of the hospitals that offer language services training require it for medical residents and half (50 percent) require the training for doctors (Figure 3). In contrast, over 90 percent of hospitals that offer language services training require it for nurses and registration staff (96 and 92 percent).

Providing Language Services through Staff and Volunteer Interpreters

Findings from the survey indicate that hospitals rely on a mix of employed and volunteer interpreters, as well as informal "interpreters" who may be friends or family members of the patient. "Volunteer interpreters" include hospital staff that provide interpretation services but are under hospital employment to fulfill other, non-interpretation duties, as well as unpaid interpreters that are used by the hospital to provide interpretation services as needed.

The types of language services resources used to provide language services to LEP patients vary from hospital to hospital. Hospitals were asked about their use of two different types of interpreters, those hired as staff and those who serve on a volunteer basis. Hospitals were more likely to report that they use volunteer interpreters than paid staff interpreters; half (52 percent) of the hospitals said they use volunteer interpreters, while only three out of ten hospitals (30 percent) hire interpreters as staff (Figure 4).

More than one-quarter (27 percent) of the hospitals that reported hiring interpreters were unable to report how many interpreters they employ (data not shown). Even among the group of 244 hospitals that reported hiring staff interpreters, the level of staffing is relatively low. Looking at the subset of

hospitals that hire interpreters at all, 18 percent have one FTE and 10 percent have two FTE interpreters; only about one-third of respondents (35 percent) hire more than 2 FTE interpreters.

We found a strong relationship between frequency with which hospitals encounter LEP patients and their interpreter hiring practices. Hospitals that encounter LEP patients on a daily basis are significantly more likely to hire interpreters as staff than hospitals encountering LEP patients once a month or less (43 percent vs. 13 percent, data not shown). Similarly, hospitals that encounter LEP patients once a month or less are significantly more likely to use volunteer interpreters than hospitals encountering LEP patients on a daily basis (75 percent vs. 46 percent).

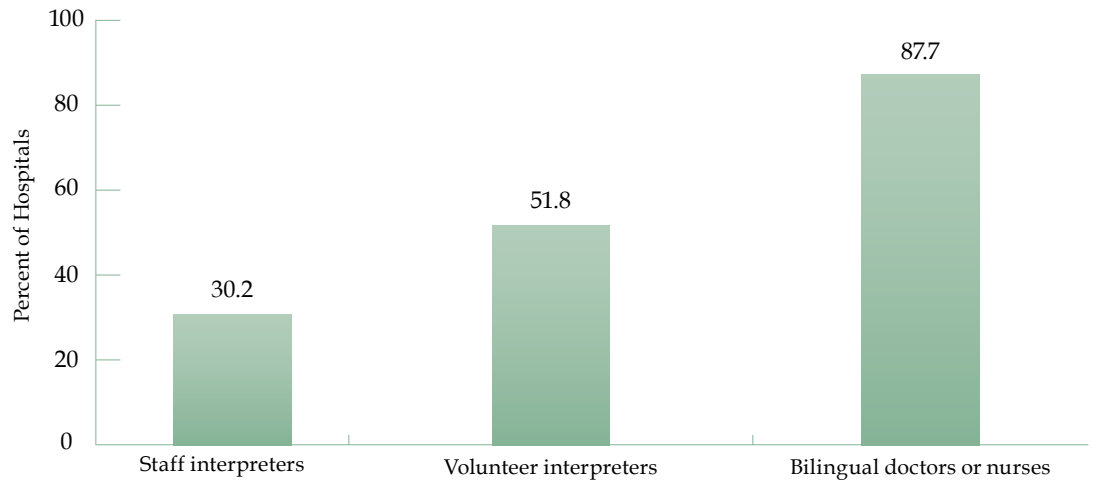
By far, the majority of hospitals report that bilingual doctors and nurses provide health care services at their hospitals (88 percent), although the languages spoken by these clinicians may not correspond to the needs of the patients and the languages that they speak. These data should be interpreted with caution as they do not reflect capacity to meet the language needs of patients via bilingual clinicians; the distribution of clinicians' bilingual language abilities does not necessarily match the language needs of patients in those communities.

Governance, teaching status, and region emerged as strong factors in whether hospitals hire interpreters as hospital staff. Nearly one-third of non-government, not-for-profit hospitals (29 percent) and government, non-federal hospitals (31 percent) reported that they hire staff interpreters; these hospitals were more than twice as likely as investor-owned hospitals to hire interpreters, with only 13 percent of investor-owned hospitals reporting that they hire interpreters as staff (Figure 5). Nearly half of teaching hospitals (48 percent) hire interpreters compared to only one-quarter (24 percent) of non-teaching hospitals. Also, more than one-third of urban hospitals (36 percent) hire staff interpreters compared to only 22 percent of rural hospitals. These variations may be a function of resources available toward hiring interpreters given different levels of demand for language services.

Significant variations were also seen by region and teaching status related to use of volunteer interpreters. Compared to rural hospitals, urban hospitals rely less on volunteer interpreters and more on staff interpreters for language services—a finding that should not be surprising given that rural hospitals are less likely to have the large volumes of LEP patient encounters (Figure 6).

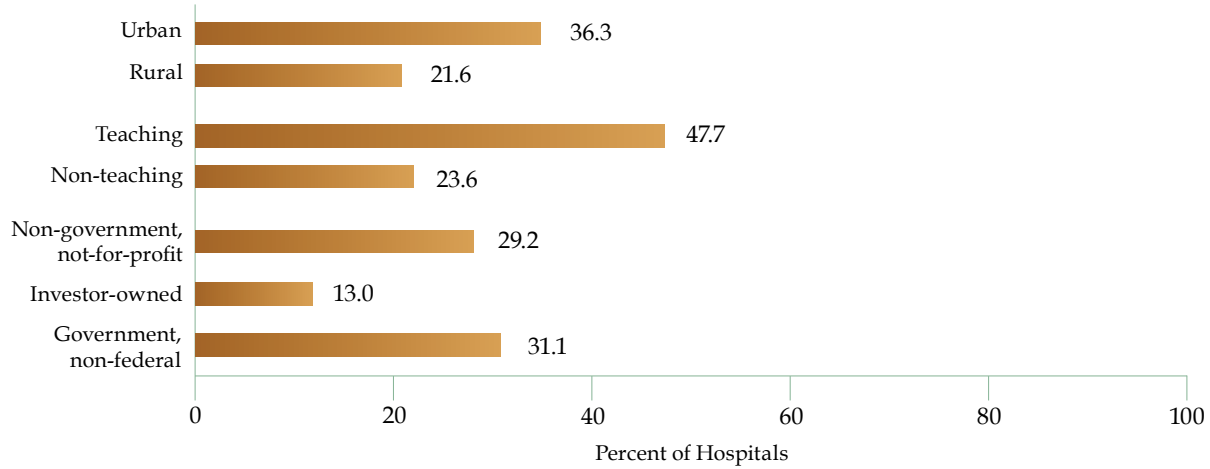
Compared to urban hospitals, rural hospitals rely more on volunteer interpreters and less on staff interpreters for language services—a finding that should not be surprising given that rural hospitals are less likely to have the large volumes of LEP patient encounters.

Figure 4 **Bilingual Hospital Resources (n=899 hospitals)**



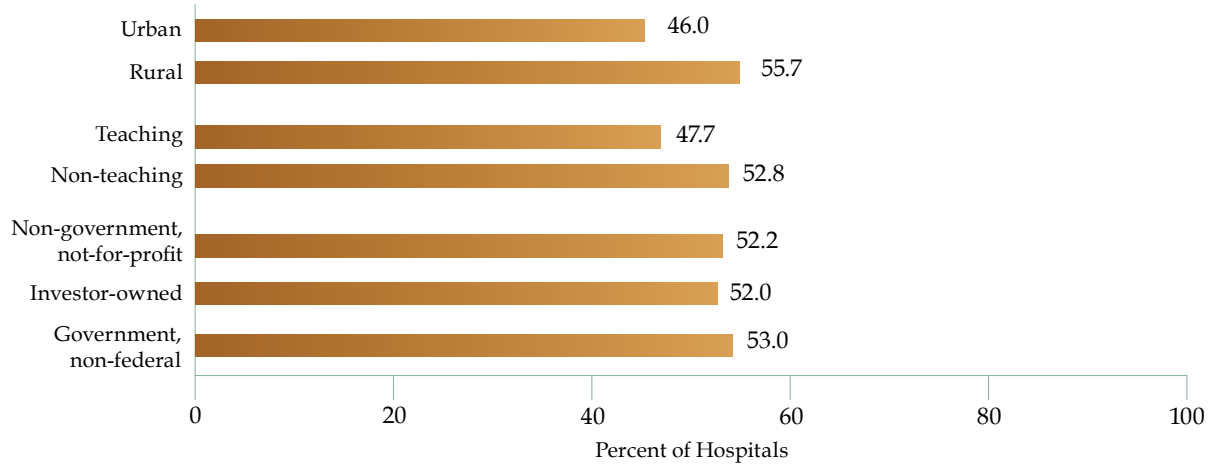
Source: George Washington University, 2008; weighted data

Figure 5 **Characteristics of Hospitals Hiring Staff Interpreters (n=244 hospitals)**



Source: George Washington University, 2008

Figure 6 **Characteristics of Hospitals Using Volunteer Interpreters (n=468 hospitals)**



Source: George Washington University, 2008

Teaching hospitals, which are also more likely to be in urban areas, also rely less on volunteer interpreters than non-teaching hospitals, and are significantly more likely than non-teaching hospitals to hire staff interpreters. Interestingly, there were no significant differences in the use of volunteer interpreters for hospitals with different ownership, with about half of hospitals using volunteer interpreters, regardless of governance.

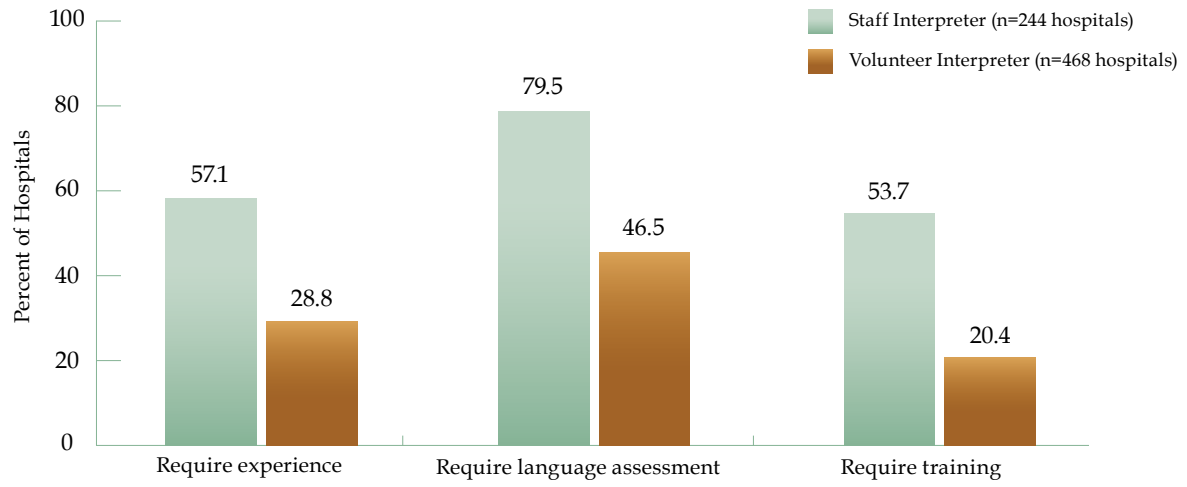
Qualifications of Staff and Volunteer Interpreters

The survey included several questions about the types of qualifications required of staff and volunteer interpreters, such as training and experience as an interpreter. Across the board, requirements or qualifications are less rigorous for volunteer interpreters than staff interpreters. While nearly 80 percent of hospitals require an assessment for hired interpreters, fewer than half of hospitals (47 percent) with volunteer interpreters require language assessments (Figure 7). Even fewer require volunteer interpreters to have experience or training; only about one in four hospitals require volunteer interpreters to have experience (29 percent) or require volunteer interpreters to have evidence of having gone through interpreter training or an educational course about medical interpreting (20 percent).

Providing Language Services through Bilingual Doctors and Nurses

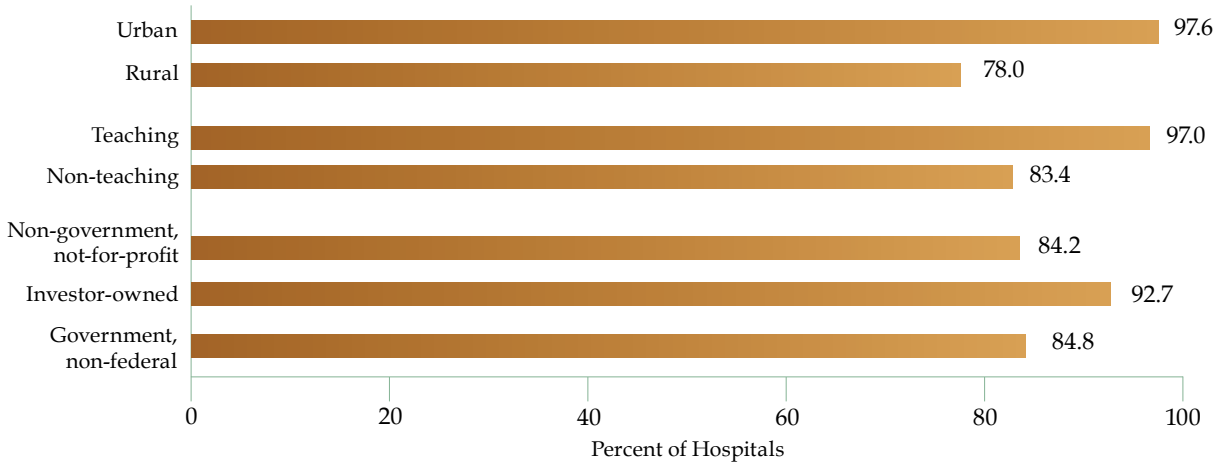
We asked hospitals several questions related to the bilingual ability of their clinicians and staff, as well as incentives associated with the use of their language skills. For some of the questions, we were

Figure 7 **Requirements for Staff and Volunteer Interpreters**



Source: George Washington University, 2008; weighted data

Figure 8 **Characteristics of Hospitals with Bilingual Doctors and Nurses (n=768 hospitals)**



Source: George Washington University, 2008

particularly interested in policies and practices related to clinicians who interact with LEP patients in medical encounters.

Survey responses indicate that most hospitals (88 percent) have at least some bilingual doctors or nurses working at the hospital (Figure 4). Nearly all teaching hospitals, investor-owned hospitals, and urban hospitals reported having bilingual doctors or nurses at their hospital (97 percent, 93 percent, and 98 percent, respectively), significantly more than non-teaching hospitals, not-for-profit or government hospitals, and rural hospitals (Figure 8). However, these data do not address capacity to meet patients' language needs via bilingual clinicians. These data reflect general bilingual abilities among doctors or nurses at hospitals without addressing whether the language abilities of clinicians matches patients' language services needs.

Our survey did not elicit information about the numbers of bilingual clinicians who practice at the hospital site. We assumed that hospitals are interested in bringing bilingual clinicians onto clinical staffs to interact with patients who speak languages other than English; for this reason, we were particularly interested in learning about challenges with recruiting bilingual doctors and nurses. Only 16 percent of respondent hospitals reported difficulty recruiting bilingual doctors and nurses (data not shown). These findings were consistent across markets and teaching status. Surprisingly, rural hospitals were not that different from urban hospitals in reporting difficulty recruiting. Similarly, there were few differences between teaching hospitals and non-teaching hospitals with regard to recruiting

bilingual doctors and nurses. Approximately 15 percent of rural and urban hospitals (17 and 14 percent, respectively) reported difficulty recruiting bilingual doctors and nurses, and approximately 16 percent of teaching and non-teaching hospitals (17 and 16 percent, respectively) reported difficulty recruiting bilingual doctors and nurses.

Assessments of Language Fluency

Assessments of language fluency for bilingual doctors and nurses are important in order to verify that they are able to accurately communicate with patients in another language. Doctors and nurses who self-identify as bilingual may have varying skill levels and may unknowingly jeopardize patient safety if their fluency is not assessed.[42, 43]

Hospitals that reported having bilingual doctors or nurses were asked a series of questions about assessment of language fluency for doctors and nurses. Only 18 percent of hospitals with bilingual doctors or nurses offer any assessment of fluency; of the 120 hospitals that offer an assessment, only half require the assessment for bilingual doctors and nurses (Figure 9). Most respondents did not know how many of their bilingual doctors or nurses had been assessed for language proficiency. Fifty hospitals were able to provide an estimate of the number of doctors or nurses who had been assessed—a number that ranged from having no doctors or nurses assessed, to hospitals having over 100 doctors or nurses assessed for language proficiency. The survey did not address the adequacy of the assessment; in some cases, the assessment would likely fall short of a comprehensive review of bilingual ability or fluency.

Implementing New Technologies: The Role of Leadership

Alameda County Medical Center is a not-for-profit community health system including three hospitals and three freestanding clinics spanning more than a 40-mile area in the East Bay region of the Bay Area. Twenty-one percent of the population in Alameda County is Hispanic,[40] and 41 percent of the population over the age of 5 speaks a language other than English at home.[41] Alameda County Medical Center employs almost 30 full-time interpreters. In order to increase efficiency in the use of these interpreters yet maintain an emphasis on customer service, hospital leadership negotiated a partnership with San Francisco General Hospital to use remote video interpretation.

The use of remote video interpretation was initially met with some resistance by both physicians and interpreters at Alameda County Medical Center. Physicians were accustomed to requesting their favorite interpreter and having him or her physically present. They were also accustomed to waiting for the interpreter, who was often finishing up an encounter with another patient somewhere else in the system or traveling some distance to the physician's location. With the availability of video interpretation, the push of a button results in an interpreter appearing on a screen in a matter of seconds. The addition of video interpreting has increased the efficiency of interpreters, with elimination of travel time between encounters. According to Medical Center representatives, resistance from physicians has largely disappeared with the accessibility and efficiency of the new system.

The move to use video interpreting to enhance existing language services could not have occurred without a strong system administrator at the helm. Alameda County Medical Center has long been known for its commitment to interpreter services as a component of patient safety; that commitment was in evidence by the administration maintaining its interpreter staff despite deep budget cuts hospital-wide and now integrating the operational costs of video interpretation after external grant funding for the equipment and initial implementation has ended. From a business perspective, video interpretation provides a key strategic advantage when marketing services to the community around Alameda County Medical Center – being able to attract a diverse population is an important growth strategy. Partnering with San Francisco General Hospital and using cutting edge technology has enabled Alameda County Medical Center to make the best use of its language services resources.

Source: George Washington University, 2008

Providing High-Quality Language Services in a Rural Community

Ukiah Valley Medical Center is a nonprofit, 78-bed community hospital located in Mendocino County, California. Located in a rural area, nearly 20 percent of the population of 86,000 is Hispanic.[44] Nearly 20 percent of residents over age 5 speak a language other than English at home.[45]

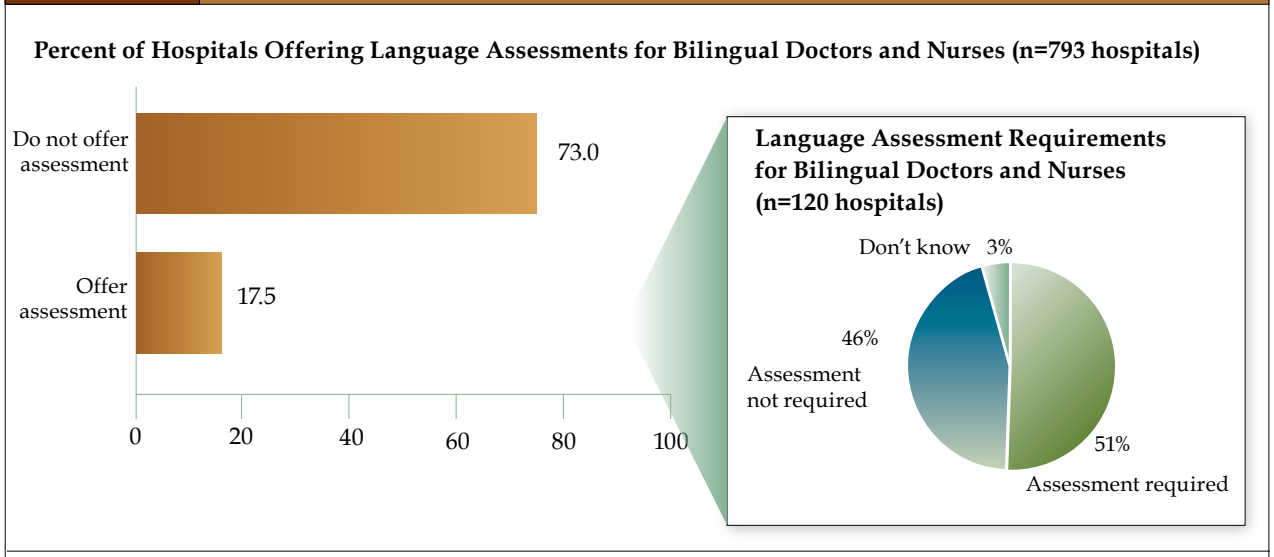
Ukiah Valley Medical Center recently began to develop a list of staff that have been assessed for language fluency and are able to provide interpretation assistance. Verbal assessments are performed by phone through the hospital's vendor for telephone interpretation. Each director in the hospital may recommend staff members from their department to be assessed. If staff members take the 30-minute assessment, they receive a one time $50 stipend if they pass the assessment at either a non-medical or medical level. Those at the non-medical level are able to interpret in non-medical interactions and to assist a physician in situations without medical terminology.

The hospital hopes to have at least two employees in each department assessed; these employees will be able to be called on to interpret within their own clinical or administrative area. Until this goal is reached, staff members who are available and willing can interpret in another area of the hospital. According to hospital representatives, these staff members stepped up to the task because of their strong desire to help patients.

The list of assessed bilingual staff members is posted on the intranet where most hospital staff have access. Bilingual staff members who have not been assessed are asked not to interpret. All hospital employees have been trained to access interpreter services by phone when an in-house interpreter is unavailable. Currently, the hospital does not provide training for assessed staff members that focuses on interpretation skills and protocol but hopes to add it at some point in the future. Ukiah's model is an example of how a hospital can maximize use of staff language skills to provide language services for a rural community.

Source: George Washington University, 2008

Figure 9 **Language Assessments for Bilingual Doctors and Nurses**



Source: George Washington University, 2008; weighted data

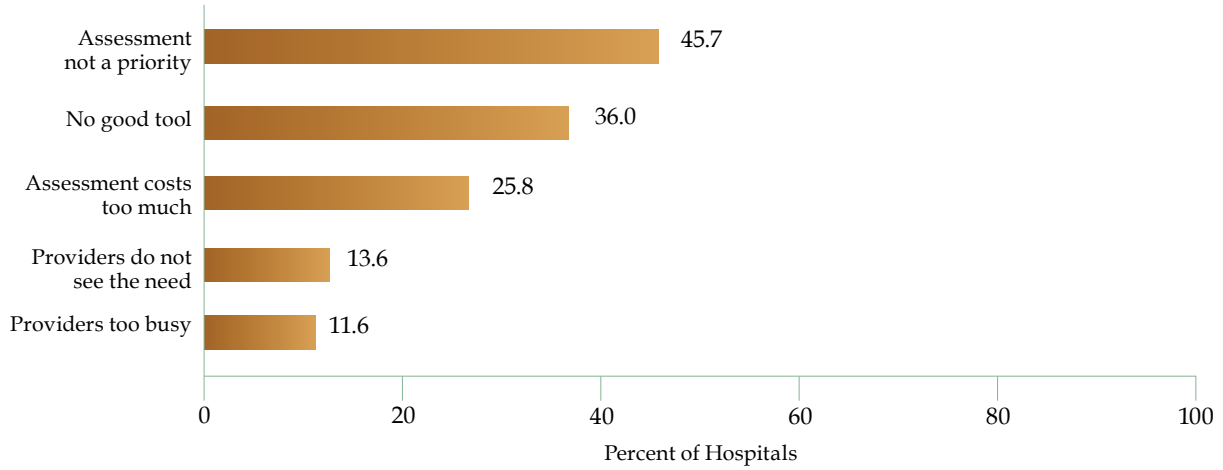
Hospitals stated several reasons why they did not offer language assessments for bilingual doctors and nurses. The most common reason, reported by 46 percent of hospitals, is simply that it is not a priority for the hospital (Figure 10). Over a third of the hospitals said they do not provide an assessment because they have not identified a good tool to use. Just over one quarter said the assessment costs too much; this percentage rises to over one third for rural hospitals. Other reasons hospitals do not offer an assessment are because doctors or nurses do not see a need for one or because they are too busy.

Hospitals in rural regions and non-teaching hospitals may require additional support and assistance in order to prioritize and implement language assessments for bilingual doctors and nurses. Rural and non-teaching hospitals were more likely than urban and teaching hospitals to cite cost of assessment as a barrier to offering language assessments to bilingual doctors and nurses, and were also more likely to indicate that assessments were not a priority for their hospital.

Incentives for Bilingual Ability

The survey asked whether hospitals offer incentives or compensation for bilingual ability on the part of clinicians and staff in the hospital. Fifteen percent of respondents indicate that they offer incentives for bilingual ability (Figure 11); these 123 hospitals offer a range of incentives and

Figure 10 **Reasons Hospital Do Not Offer Language Assessments to Doctors and Nurses (n=597 hospitals)**

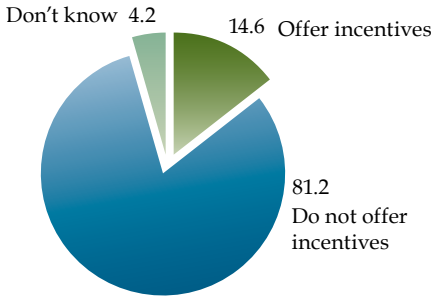


Source: George Washington University, 2008; weighted data

strategies for using bilingual staff and clinicians to care for LEP patients.

We were particularly interested in the types of incentives hospitals offer and the amount that actually accrues to the employee. Interestingly, most financial incentives were very low additions to an hourly rate or involved adding a relatively small percentage of salary for bilingual skills. Most hospitals used the same incentive, regardless of the position of the employee; only a handful of hospitals reported varying the incentive for different staff or clinicians. For about three-quarters of the 123 hospitals offering incentives, incentives take the form of an add-on to base pay (data not shown). The range of incentive was

Figure 11 **Percent of Hospitals Offering Incentives for Bilingual Ability (n=793 hospitals)**



Source: George Washington University, 2008; weighted data

Patient Safety as an Incentive for Assessment and Training

Lincoln Medical and Mental Health Center is a 347-bed, municipal teaching hospital in Bronx County, New York. The Bronx borough of New York City has a population of nearly 1.4 million, over half of whom are Hispanic;[46] 56 percent of the population 5 years and over speak a language other than English at home.[47]

In 2006 the hospital instituted a campaign to emphasize the use of employees validated as proficient in language(s) other than English. New employee orientation now includes a video demonstrating patient safety implications of using employees for language services, as well as an emphasis on the hospital's requirement that all hospital employees that communicate with patients in another language must first be assessed and validated as proficient. The assessment is also promoted in a newsletter that employees receive with every paycheck. To date, 327 hospital employees have been assessed for language proficiency.

Some of these 327 employees have gone through a rigorous training program to prepare them to serve as interpreters, and have spent one full day a week for six weeks being trained in interpreter methodologies and protocols. Most of the employees who have been trained are nurses, social workers, patient care associates, client navigators and patient representatives. As of May 2009, 52 employees had been trained and are deemed qualified to serve as Medical Interpreters. These employees interpret within their respective assigned units, but occasionally are pulled to help in another area of the hospital.

While no financial incentive is offered for assessment, training, or serving as an interpreter, employees have been encouraged to participate in the program because they believe it enhances patient care services and patient safety. Hospital leadership emphasizes language services at leadership meetings and the need for improved language services. The support by leadership on access to quality language services has resulted in a highly successful language assessment and interpreter training program for bilingual employees.

Source: George Washington University, 2008

very large, ranging from less than or equal to one dollar per hour, to over 20 dollars an hour. Fifteen percent of hospitals with incentives provide a one-time payment for bilingual skills, ranging from 25 to 500 dollars.

A number of hospitals use reward programs or recognition as an incentive for bilingual skills; one-third of hospitals offering incentives (32 percent) provide recognition from senior management, such as a certificate, special breakfast or award. Examples of rewards include meal tickets, employee advancement, bonuses, paid language classes, pins, certificates and performance reviews reflecting a contribution to the organization. Very few (2 percent) offered additional leave or comp time.

Some hospitals compensate clinicians and staff for the interpreter service itself. One-third of the hospitals offering incentives (30 percent) give some form of compensation for delivery of interpreter services, where clinicians or staff serve as the interpreter during an encounter between a clinician and patient. Forty-two hospitals indicated that they provide this type of compensation, which typically takes the form of a payment per encounter or payment for a block of time interpreting. Payments per encounter range from a low of 1 dollar to a high of 30 dollars. This compensation is in addition to the employee's regular compensation.

Language Services Policies

Even though the majority of hospitals have bilingual clinicians, few have developed policies related to using this language resource in providing language services to patients. In order

Fifteen percent of hospitals offer a range of incentives and strategies to encourage using bilingual staff and clinicians to care for LEP patients.

to assess the extent to which hospitals have policies regarding language services, we asked human resource directors two questions regarding policies: a) does your hospital have formal policies about using minors or children, friends or family, or non-trained staff as interpreters, and, b) does your hospital have policies about bilingual doctors and nurses serving as interpreters? Less than half of respondents (40 percent) reported having formal policies regarding the use of minors, friends or family, or non-trained staff as interpreters, and markedly more teaching (55 percent vs. 35 percent for non-teaching) and urban hospitals have formal policies in this area (53 percent vs. 28 percent rural, data not shown). Even fewer hospitals have *any* policies addressing bilingual clinicians as interpreters—only 28 percent of hospitals have policies related to the use of bilingual doctors and nurses serving as interpreters. Of these 211 hospitals, 40 percent indicate these policies address training on how to interpret, half (49 percent) indicate these policies address assessment of language fluency, and 38 percent report these policies address relief of a clinician's other responsibilities in order to interpret.

Incentives & Assessments: The Role of Collaboration

Sutter Medical Center is a not-for-profit, community hospital located in downtown Sacramento. Its campus includes two acute care hospitals, a psychiatric facility and a convalescent facility. One quarter of the population in the city of Sacramento is Hispanic,[48] and 35 percent of those 5 years and over in Sacramento speak a language other than English at home.[49]

As a strategy to meet the needs of a growing population with language needs, interpreter services worked with nursing to create a process for using bilingual staff certified for language fluency to provide interpretation. A 40-minute assessment is given over the phone by Language Line University, with two possible levels of certification—medical or basic. Those at the medical level are assessed in English on medical terminology as well, and can interpret for consents for medical procedures, while those at the basic level can assist with registration, gathering insurance-related information, and help in interactions without critical medical terminology.

Interpreter services also worked with human resources to develop a pay incentive. Medically certified bilingual staff members are paid $2 extra per hour for each patient they care for in a different language, whether interpreting for someone else or providing direct patient care in a language other than English. When bilingual staff members are called to interpret, they must submit a log sheet to the Interpreter Services Coordinator showing how many times they interpreted each day per patient, helping the coordinator to manage the incentive as well as to collect data. As of October 2008, 115 staff members passed the assessment and all but a few were certified at the medical level.

As a result of the initial success, these policies have been adopted system-wide at Sutter Health. The success of this strategy was largely dependent on language services working with nurses at every step, understanding their concerns about demands on bilingual nurses' time acting as interpreters given their nursing responsibilities, and providing additional compensation for direct care in another language.

Source: George Washington University, 2008

IV. Findings from the Survey: A Closer Look at the California Experience

We oversampled California hospitals in order to allow for robust analyses and a focus on California responses. A total of 159 California hospitals participated in the survey. The California sample closely resembles the distribution of the California hospital industry in terms of ownership and teaching status and, like the national sample, over-represents rural hospitals (Table 2). The California analysis was adjusted by market to reflect the make-up of the hospital industry in California.

California hospitals were surveyed on the same set of questions as were hospitals nationwide. Compared to the national sample of hospitals, California hospitals are more likely than hospitals nationwide to (Figure 12):

- encounter LEP patients
- offer training related to accessing language services
- require specific qualifications of staff and volunteer interpreters
- have bilingual staff and clinicians within the hospital setting
- offer a language assessment for bilingual clinicians to gauge their language skills
- offer bilingual staff and clinicians incentives for secondary language skills
- have hospital policies related to language services, specifically around using untrained interpreters and using bilingual clinicians as interpreters

Table 2 Characteristics of California Survey Respondents Compared to CA Hospitals

	CA Survey Respondents (%)	CA Hospitals (%)
Hospital Ownership Status		
Non-government, not-for-profit	59.1	57.8
Investor-owned, for-profit	25.2	22.5
Government, non-federal (city, county or state)	15.1	19.7
Teaching Status		
Non-teaching (community)	83.7	73.2
Teaching	16.4	26.8
Total Staffed Beds		
<20	1.9	2.3
20-99	23.9	25.9
100-249	35.9	39.0
≥250	30.8	32.8
Hospital Market		
Urban*	71.1	90.3
Rural	28.9	9.7

Source: George Washington University, 2008; U.S. Hospital data from AHA Annual Survey of Hospitals, FY2007
**Respondents that indicated their hospital is in a "suburban" market are categorized with "urban" for the purposes of this report*

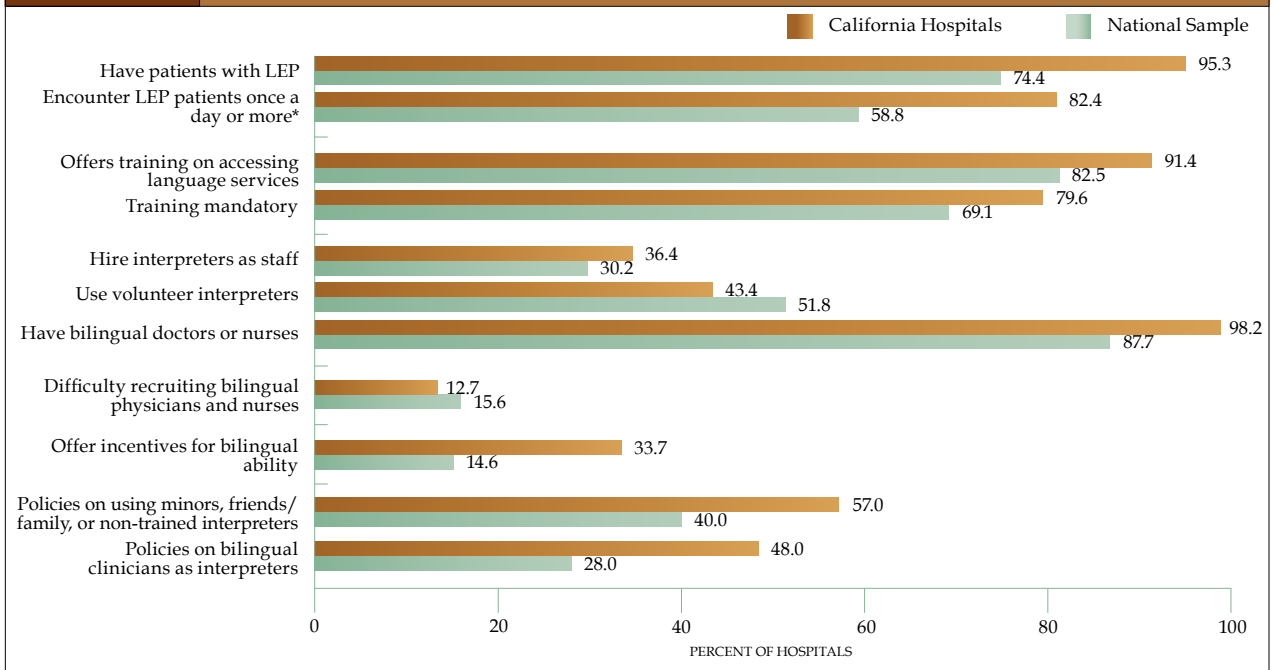
Caring for LEP Patients

California hospitals are more likely to have patients with LEP and encounter them more frequently than the country as a whole. Around 95 percent of the California hospitals reported having patients with LEP, compared to 74 percent of the national sample. In addition, 82 percent of California hospitals reported they encounter patients with LEP on a daily basis, compared to 59 percent of the national sample.

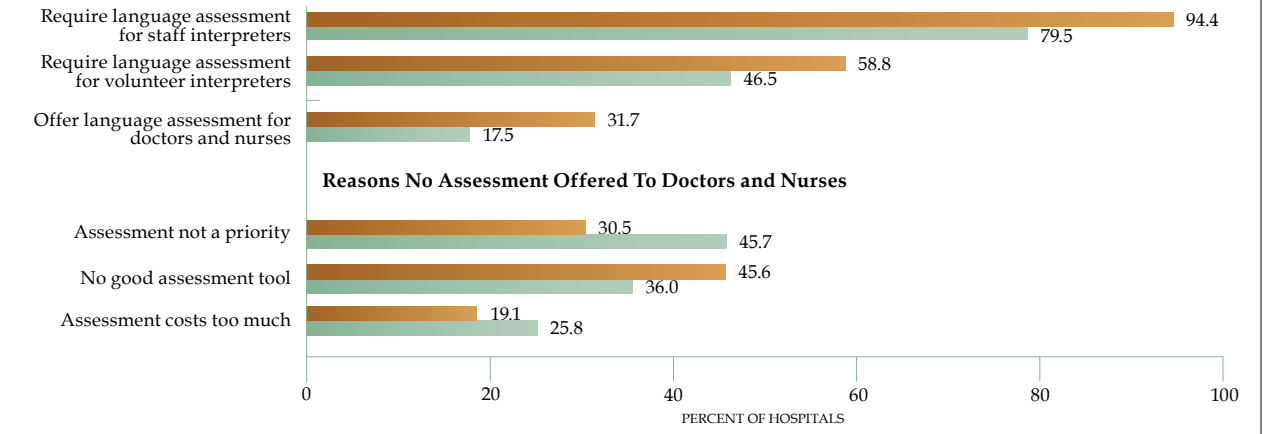
Training on Accessing Language Services

California hospitals are more likely to offer training on accessing language services than the national sample of hospitals (91 percent compared to 83 percent). However, they are less likely to require this training for doctors; one-third of the California hospitals reported requiring training for doctors, compared to one half of hospitals in the national sample. Notably, all California hospitals that offer training on accessing language

Figure 12 **Survey Responses, California vs. National Sample**



Language Assessments: Policies and Barriers



*Source: George Washington University, 2008; weighted data; *frequency estimates apply to hospitals with LEP patients*

services require it for nurses and nearly all (99 percent) require it for their registration staff.

Staff and Volunteer Interpreters

Like the national sample, California hospitals are more likely to use volunteer interpreters than staff interpreters. One-third of California hospitals (36 percent) reported hiring staff interpreters and 43 percent reported using volunteer interpreters. For California hospitals that hire staff interpreters, 14 percent have one FTE interpreter and 14 percent have two. One in five California hospitals (22 percent) reported more than 5 FTE interpreters.

Overall, California hospitals had more requirements related to training and experience for interpreters than hospitals in the national sample. Most California hospitals (94 percent) require a language assessment for staff interpreters and two-thirds (67 percent) require training. A little over half of California hospitals require experience for staff interpreters (52 percent). There were fewer requirements for volunteer than for staff interpreters in California hospitals, with 59 percent requiring an assessment, 33 percent requiring training and 27 percent requiring prior experience for volunteers.

Bilingual Clinicians

Nearly all hospitals in California reported having bilingual doctors and nurses. California hospitals are similar to the national sample in their difficulty recruiting bilingual doctors and nurses. Only 13 percent of California hospitals said they have difficulty recruiting bilingual doctors and nurses. Nearly two-thirds of the California

As the hospital industry moves towards providing linguistically appropriate care for all patients, California hospitals have the opportunity to lead the way in improving the care provided for diverse populations.

hospitals (63 percent) that reported they had difficulty recruiting bilingual doctors and nurses indicated that their location has a lot of impact on recruiting (reported 4 or 5 on a scale of 1 to 5).

Assessments

Nearly one-third (32 percent) of California hospitals offer an assessment of language fluency for their bilingual doctors and nurses, compared to 18 percent of hospitals in the national sample. More than half (56 percent) of California hospitals that offered an assessment required it for bilingual doctors and nurses.

California hospitals most frequently reported having no good tool for assessment as the reason (46 percent) for not offering an assessment. This differs from the national sample, which indicated a lack of priority for assessments not being offered. Still, 30 percent of California hospitals said that assessing bilingual skills was not a priority and therefore not conducted. One in five (19 percent) California hospitals say they do not offer an assessment because it costs too much; an additional 15 percent cite a lack of need among clinicians and staff, and another 12 percent say that clinicians are too busy.

Incentives

California hospitals with bilingual doctors and nurses were more than twice as likely to offer incentives for bilingual ability than the national sample (34 percent and 15 percent, respectively). In two-thirds of the hospitals that provide such an incentive, it takes the form of an add-on to base pay for bilingual ability. Similar to the national sample, the range of the incentive was broad, from less than one dollar per hour to over 20 dollars an hour. A small number of California hospitals provide a one-time payment for bilingual skills ranging from 25 to 500 dollars.

Language Services Policies

California hospitals that participated in the survey had more language services policies than the national sample. For example, California hospitals were more likely to have formal policies about using minors or children, friends or family, or non-trained staff as interpreters (57 percent vs. 40 percent in the national sample). Also, California hospitals were more likely to report having policies addressing the use of bilingual clinicians as interpreters (48 percent vs. 28 percent in the national sample). As the hospital industry moves towards providing linguistically appropriate care for all patients, California hospitals have the opportunity to lead the way in improving the care provided for diverse populations.

V. Discussion

Our study reveals that many LEP patients may be receiving care with the assistance of interpreters with unknown or questionable quality. Volunteers can provide high-quality and valuable resources for language services if they are appropriately trained and properly assessed for language fluency. However, our study shows that LEP patients receiving interpreter services from volunteer interpreters are likely to be served by interpreters whose qualifications or language proficiency have not been verified by the hospital. Hospitals generally apply less rigorous requirements for volunteer interpreters than staff interpreters with regards to assessment of language proficiency, with less than half of hospitals requiring volunteer interpreters to have their language assessed. This occurs even with volunteer interpreters often serving in the same capacity as staff interpreters.

Hospitals appear to use volunteer interpreters differently than other volunteers in the hospital and essentially deputize often untrained individuals to assume a critical place on the health care team. For example, volunteer interpreters are expected to provide essential information in critical communication with patients, such as taking a patient's medical history or providing discharge instructions. The implications for safety and quality are enormous under this scenario, and emphasize the importance of ensuring the language proficiency and competency of volunteer interpreters.

Similar concerns are raised with the use of non-interpreter staff for communicating with patients in languages other than English. Effectively using the resources available through bilingual clinicians and staff can be challenging for hospitals. Most hospitals have bilingual physicians and nurses but too few assess the language proficiency of these clinicians in languages other than English—creating a climate where errors and miscommunication can be commonplace.

Recruiting bilingual clinical staff also appears to be a low priority area for hospitals. Few hospitals reported difficulty with recruiting bilingual doctors and nurses, regardless of their market or their teaching status. Recruiting bilingual clinical staff may not be a priority for hospitals around the country, who are struggling just to maintain staffing levels in the midst of nursing and physician shortages, especially in rural areas. As a result, our findings that recruiting bilingual clinicians is not difficult for most hospitals may reflect that most hospitals are not actively trying to recruit bilingual clinical staff.

Hospitals need better education about when and how to request interpreter services among physicians and residents in training. The need for better training is emphasized by The Joint Commission's recent *Hospitals, Language, and*

All states have much work to do to ensure that all their patients with language needs are effectively communicating with clinicians and staff, but California appears to be several steps ahead in this process.

Culture study, recommending that hospital staff undergo ongoing in-service training on how and when to access language services.[50] Also, NQF-endorsed practices[51] specifically recommend clinicians receive training on how to work effectively with language services. With so few hospitals requiring physicians or medical residents to take training on accessing language services, many clinical encounters with LEP patients may be conducted without the support of interpreter services. Hospitals are more likely to require language services training for registration staff and nurses, supporting anecdotal information that nurses are frequently the decision points for whether or not to request interpreter services in a clinical encounter. Given their role and the frequency with which they are trained in accessing language services, registration staff and nurses need to be advocates for LEP patients to access language services, both at the system and policymaking level, as well as at the individual patient encounter level.

Most hospitals do not have formal practices or policies that have been implemented around the assessment, use of, and incentives for bilingual ability. Little information is known about the use of incentives related to language ability and we were surprised to learn that 123 hospitals have implemented incentive programs. These programs are complex to manage and track but some pioneers around the country assess the languages spoken by their physicians and nurses, and reinforce these skills with incentives. These hospitals can serve as examples as more hospitals develop strategies to using bilingual staff and clinicians to care for LEP patients. More information should be developed to determine what type and amount of incentives would be most effective in encouraging bilingual clinicians and staff to participate in training on medical interpreting, have their skills in secondary languages assessed, and serve in the capacity of dual-role interpreters to fill the resource needs of their hospitals.

The majority of hospitals in the country do not have formal policies regarding the use of family, friends, or minors to provide language assistance. CLAS Standards[52] and recently NQF-endorsed practices[53] recommend that minors, children, family members and friends are not used to provide interpreter services, except in life-threatening situations. California hospitals are ahead of the nation in terms of setting formal policies around language services and using bilingual clinicians as interpreters. Nevertheless across the country (including California), more hospitals must take steps to ensure language services are available and appropriately delivered.

All states have much work to do to ensure that all their patients with language needs are effectively communicating with clinicians and staff, but California appears to be several steps ahead in this process relative to the nation. California hospitals are more likely to have organizational policies related to language services, have a diverse health care work force, have stringent requirements related to qualifications of interpreters and encourage appropriate use of language services through training and education. Many California hospitals are engaged in innovative strategies designed to improve the quality of language services, such as assessing language proficiency of bilingual clinicians and offering incentives for secondary language skills. Other states can learn from California's challenges and successes to use bilingual clinicians and staff to care for patients with language needs.

VI. Recommendations

We recommend the following strategies to strengthen hospital policies and programs designed to improve language services on behalf of patients with limited English proficiency:

- **Hospitals should develop explicit policies or plans related to the provision of language services for patients with LEP.** Delivery of high-quality language services includes many components, including training of staff to access language services, medical interpreter training and language assessments for interpreters, the use of language assessments and incentives for bilingual clinicians and staff, and policies around how different types of interpreters or individuals may or may not provide language services given clinical circumstances and variations in qualifications. Careful consideration of policies related to these components will help hospitals in their preparations to meet the linguistic needs of their patients, and comply with federal and state laws and regulations and emerging hospital accreditation and quality standards.
- **Bilingual clinicians and staff should be assessed for language proficiency if they provide direct services or care to patients with limited English.** Assessing language proficiency of individuals providing care and other services is essential to address patient safety concerns and improve quality of care for patients with limited English.
- **Volunteer interpreters should have their language proficiency assessed and be trained in medical interpreting.** A large number of hospitals across the country use volunteer interpreters, whether employed in other hospital positions and serving as dual-role interpreters or part of the volunteer work force. Requiring volunteer interpreters to have their language proficiency assessed and be trained in medical interpreting will help improve the quality of language services, and ultimately, the quality of patient-provider communication.
- **Hospitals should require that all staff, including clinical staff, receive education on the critical importance of language services to patient care and training on how to access language services.** A significant number of hospitals in the U.S. do not require their staff and clinicians to undergo training on how to access language and interpreter services. Increased staff education and training about the impact of language services on quality and safety could encourage physicians, nurses, medical residents and other hospital staff to embed the effective use of language services into routine patient care.
- **All hospitals should know who their patients and work force are and work to meet the language needs of all of their patients.** Hospitals should take inventory of their current capacity, and create a plan to use resources effectively, creatively and efficiently to deliver language services to patients with LEP. Hospitals across the country are using a variety of strategies and resources to address the language needs of their patients. Some hire staff that are trained medical interpreters; others assess and train their own in-house cadre of language specialists, employing innovative strategies to make the most of the talents of their own clinicians and staff and create avenues for improved communication between patients and their care team.
- **Hospitals should take a proactive approach to learning more about the many ways that high-quality language services can be provided to their patients.** Learning more about experimentation and successful strategies from hospitals around the country can spur innovation and create opportunities for greater use of bilingual clinicians and staff to support language services. The state of California can serve as a model for other states interested in implementing innovative policies and practices to provide effective, high-quality language services to their patient populations.

VII. Methods

1. Survey

We developed a brief survey for human resources directors that was reviewed by external experts, including researchers, legal experts, and policy-makers. Human resources directors were targeted for this survey because their department has the authority to hire, and the extent to which they are purposeful in seeking bilingual staff may indicate a hospital's prioritization and allocation of resources to provide linguistically appropriate care. The human resources department also plays an active role in shaping and enforcing hospital policy. Survey questions and topics were included based on literature reviews, online forums addressing language services, and interviews with directors of human resources, diversity and recruiting, and language services.

From a series of conversations with human resources and language services experts, we selected five topics to explore in the survey: the role of diversity in training and recruitment practices, the availability of language services provided to patients and training requirements of staff providing language services, the use of bilingual staff to care for patients, and practices related to assessing language proficiency and providing incentives for language skills.

A mailing list was purchased from the American Hospital Association's Annual Survey Database, including names and contact information for over 4,000 non-federal, acute care hospitals' human resources directors (or if unavailable, contact information for the hospital's executive office). Hospitals were targeted by governance, teaching status and urban-rural status to ensure a representative sample of the hospital industry's distribution. Prior to fielding the survey, 10 hospitals were randomly selected as pilot test sites, and revisions were made to the survey instrument based on their responses.

A total of 899 HR directors from non-federal, acute care hospitals completed the survey, representing nearly 20 percent of all non-federal, acute care hospitals in the U.S. Prior to fielding the survey, we set targets (or quotas) for completed surveys by governance, teaching status, and urban-rural status in order to achieve a sample representative to the nation's hospital industry. We obtained a response rate of 39 percent. An oversample of California hospitals was surveyed, with 159 respondents from California. The nationwide analysis was adjusted by ownership, teaching status, market and geography (CA vs. not) to reflect the make-up of the hospital industry. Aggregate findings for the national sample are weighted by ownership, teaching status, market and geography (CA vs. not). The California analysis was adjusted by market to reflect the make-up of the hospital industry in California.

2. Interviews

In addition to the hospital survey, four survey respondents were selected to participate in case study interviews, with the goal of learning about operational, organizational, and financial challenges, barriers and strategies to provide care to patients in language(s) other than English. These case studies provided detailed information about policies and procedures, and profile promising practices and strategies around the country that will be helpful to hospitals building high-quality language services programs. Case studies of hospitals that are using their resources to meet the language needs of their patient population in an innovative way are highlighted throughout the report in text boxes.

3. Limitations

Weighted estimates are presented throughout the report for aggregate findings. We weighted aggregate findings due to over-representation of rural hospitals, and oversampling of hospitals in California. We deliberately oversampled California hospitals in order to allow for state-specific analyses.

There is an association between teaching status and market, with non-teaching hospitals more likely to be in rural markets, and teaching hospitals more likely to be in urban markets. Some variations in survey responses may be understated due to confounding between market and teaching status.

Another potential limitation is the response rate. We are confident that the analyses and findings are reliable and generalizable given the large sample size, as well as the extensive development and review of the survey instrument.

Some questions were only asked of specific respondents depending on their responses to previous questions, although the findings are generally robust due to the large sample size. As a result, some questions were asked of a very small number of respondents. These responses provide interesting information to the field in learning about innovative practices but do not permit in-depth analyses.

Finally, there may be variation in how respondents interpreted survey questions for which we did not provide definitions. For instance, we did not define "hospital staff" and respondents may have included different personnel in responding to questions related to hospital staff. Even so, we are confident the findings present valuable and reliable information given the extensive review process for the survey, as well as the large number of completed surveys.

Notes

[1] Hasnain-Wynia R, Yonek J, Pierce D, Kang R, Greising CH. *Hospital language services for patients with limited English proficiency: Results from a national survey.* Health Research and Educational Trust, October 2006.

[2] Manson A. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. *Medical Care* 1988;26(12):1119-28.

[3] Wilson E, Chen AH, Grumbach K, Wang F, Fernandez A. Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine* 2005;20:800-806.

[4] Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: A pilot study. *International Journal for Quality in Health Care* 2007;19(2):60-67.

[5] Siejo R, Gomez H, Freidenberg J. Language as a communication barrier in medical care for Hispanic patients. *Hispanic Journal of Behavioral Sciences* 1991;13(4):363-376

[6] Ngo-Metzger Q, Sorkin DH, Phillips RS, Greenfield S, Massagli MP, Clarridge B and Kaplan SH. Providing high-quality care for limited English proficient patients: The importance of language concordance and interpreter use. *Journal of General Internal Medicine* 2007; 22(Suppl2):324-330.

[7] Lee LJ, Batal HA, Maselli JH, Kutner JS. Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. *Journal of General Internal Medicine* 2002;17(8):641-6.

[8] Mazor SS, Hampers LC, Chande VT, Krug SE. Teaching Spanish to pediatric emergency physicians: Effects on patient satisfaction. *Archives of Pediatrics & Adolescent Medicine* 2002;156(7):693-5.

[9] Green AR, Ngo-Metzger Q, Legedza AT, Massagli MP, Phillips RS, Iezzoni LI. Interpreter services, language concordance, and health care quality. Experiences of Asian Americans with limited English proficiency. *Journal of General Internal Medicine* 2005;20(11):1050-1056.

[10] Jacobs EA, Sadowski LS, Rathouz PJ. The impact of an enhanced interpreter service intervention on hospital costs and patient satisfaction. *Journal of General Internal Medicine* 2007;22(Suppl 2):306-311.

[11] Perez-Stable EJ, Napoles-Springer A, Miramontes JM. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care* 1997;35(12):1212-1219.

[12] Fernandez A, Schillinger D, Grumbach K, Rosenthal A, Stewart A, Wang F, Perez-Stable EJ. Physician language ability and cultural competence. *Journal of General Internal Medicine* 2004;19:167-174.

[13] Moreno MR, Otero-Sabogal R, Newman J. Assessing dual-role staff-interpreter linguistic competency in an integrated healthcare system. *Journal of General Internal Medicine* 2007; 22(Suppl2): 331-335.

[14] Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 2003;111(1):6-14.

[15] Diamond LC, Reuland DS. Describing physician language fluency: Deconstructing medical Spanish. *Journal of the American Medical Association* 2009;301(4):426-428.

[16] National Quality Forum. *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report.* Washington, DC: NQF; 2009.

[17] National Committee for Quality Assurance. *Standards aimed at improving health care for diverse groups released for public comment.* December 1, 2008. Available online at http://www.ncqa.org/tabid/916/Default.aspx. Accessed January 1, 2009.

[18] The Joint Commission. *Developing proposed requirements to advance effective communication, cultural competence, and patient-centered care for the hospital accreditation program.* June 8, 2009. Available online at http://www.jointcommission.org/PatientSafety/HLC/HLC_Develop_Culturally_Competent_Pt_Centered_Stds.htm. Accessed July 16, 2009.

[19] The Joint Commission. *Proposed requirements to advance effective communication, cultural competence, and patient-centered care.* June 8, 2009. Available online at http://www.jointcommission.org/Standards/Field Reviews/field_ecccpc.htm. Accessed July 1, 2009.

[20] 65 FR 80865, December 22, 2000.

[21] Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d)

[22] 65 FR 50121, August 16, 2000.

[23] 65 FR 50123, August 16, 2000.

[24] 68 FR 47311, August 8, 2003.

[25] National Health Law Program. *The Children's Health Insurance Program Reauthorization Act.* March 27, 2009. Available online http://www.healthlaw.org/library/attachment.146440. Accessed May 14, 2009.

[26] Youdelman M. *Show me the money: Funding for language services.* April 1, 1009. Polyglot Webinar. Available online http://www.pgsi.com/Products/Resources/Webinars/Webinar6/Youdelman_slides.pdf. Accessed July 15, 2009.

[27] America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong., 1st sess. (introduced July 14, 2009). Available online http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3200ih.txt.pdf. Accessed July 16, 2009.

[28] Ibid.

[29] Perkins J, Youdelman M. *Summary of state law requirements addressing language needs in health care.* Washington, DC: National Health Law Program, January 2008.

[30] National Board of Certification for Medical Interpreters. *Testing for national medical interpreter certification to enter pilot phase.* May 14, 2009. Available online http://www.certifiedmedicalinterpreters.org/LinkClick.aspx?fileticket=mAppNHZlh4k%3d&tabid=69. Accessed May 18, 2009.

[31] National Coalition on Health Care Interpreter Certification. *National coalition surges ahead with national healthcare interpreter certification.* January 28, 2009. Available online http://data.memberclicks.com/site/ncihc/NCCRelease%20Final%201%2028%2009%20logo%20(2).pdf. Accessed May 18, 2009.

[32] Perkins J, Youdelman M. *Summary of state law requirements addressing language needs in health care.* Washington, DC: National Health Law Program, January 2008.

[33] Ibid. See Cal. Health & Safety Code § 1259.

[34] UCSF Center for the Health Professions. *Health care providers' language assistance responsibilities: Major federal and California requirements.* October 2003. Available online at http://www.medi-flag.com/about/pdf/CA_US_langasst_reqs1.pdf Accessed July 16, 2009.

[35] Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, Galvez E. *One Size Does Not Fit All: Meeting The Health Care Needs of Diverse Populations.* Oakbrook Terrace, IL: The Joint Commission; 2008.

[36] Due to study sampling methods, rural hospitals are overrepresented in the study sample.

[37] Weighted estimates are presented throughout the report for aggregate findings, and noted as such for applicable charts and findings.

[38] Hasnain-Wynia R, Yonek J, Pierce D, Kang R, Greising CH. *Hospital language services for patients with limited English proficiency: Results from a national survey.* Health Research and Educational Trust, October 2006.

[39] Ibid.

[40] U.S. Census Bureau, 2005-2007 American Community Survey. *Alameda County, California. ACS demographic and housing estimates: 2005-2007 American Community Survey 3-year estimates.* Available online.at http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812. Accessed May 18, 2009.

[41] U.S. Census Bureau, 2005-2007 American Community Survey. *Alameda County, California. Selected social characteristics in the United States: 2005-2007 American Community Survey 3-year estimates.* Available online http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812. Accessed May 18, 2009.

[42] Ferguson W. Un poquito. *Health Affairs,* 2008; 27(6): 1695-1700.

[43] Diamond L, Reuland DS. Describing physician language fluency: Deconstructing medical Spanish. *Journal of the American Medical Association,* 2009; 301(4): 426-428.

[44] U.S. Census Bureau, 2005-2007 American Community Survey. *Mendocino County, California. ACS demographic and housing estimates: 2005-2007 American Community Survey 3-year estimates.* Available online. http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812. Accessed May 18, 2009.

[45] U.S. Census Bureau, 2005-2007 American Community Survey. *Mendocino County, California. Selected social characteristics in the United States: 2005-2007 American Community Survey 3-year estimates.* Available online http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812. Accessed May 18, 2009.

[46] U.S. Census Bureau, 2005-2007 American Community Survey. *Bronx County, New York. ACS demographic and housing estimates: 2005-2007 American Community Survey 3-year estimates.* Available online. http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812

[47] U.S. Census Bureau, 2005-2007 American Community Survey. *Bronx County, New York. Selected social characteristics in the United States: 2005-2007 American Community Survey 3-year estimates.* Available online. http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812. Accessed May 18, 2009.

[48] U.S. Census Bureau, 2005-2007 American Community Survey. *Sacramento City, California. ACS demographic and housing estimates: 2005-2007 American Community Survey 3-year estimates.* Available online. http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812. Accessed May 18, 2009.

[49] U.S. Census Bureau, 2005-2007 American Community Survey. *Sacramento City, California. Selected social characteristics in the United States: 2005-2007 American Community Survey 3-year estimates.* Available online. http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2007_3YR_G00_&_lang=en&_ts=260718801812. Accessed May 18, 2009.

[50] Wilson-Stronks A, Galvez, E. *Exploring cultural and linguistic services in the nation's hospitals: A report of findings.* Oakbrook Terrace: The Joint Commission; 2007.

[51] National Quality Forum. *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report.* Washington, DC: NQF; 2009.

[52] 65 FR 80865, December 22, 2000.

[53] National Quality Forum. *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report.* Washington, DC: NQF; 2009.

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