CENTER FOR THE HEALTH PROFESSIONS

Considering Language Access Services for California Hospitals

The move toward "cultural competence" that responds to the diversity of California's population is reflected in efforts of California hospitals to provide linguistically appropriate care for their patients who have limited English proficiency. Legal mandates are underscoring this need (see box).

Health care providers do not always speak languages their patients understand, and research has confirmed that miscommunications can risk harm to patients. In 2007, the Center for the Health Professions interviewed representatives of 20 hospitals throughout California that are instituting interpretive language services to learn what services are being provided, the costs and benefits of the services, and the process by which they were established. The responses both provide information on what is being done and offer models for others to integrate into their own institutions.

KEY FINDINGS

Interviews with hospital personnel—from CEOs and CFOs to language access program staff—reveal the following key findings:

- Hospitals are tailoring language services to their patient population by offering a combination of language service options: telephonic, in-person, and video conferencing interpretation.
- Each language service option has benefits and challenges.
- Costs are significantly less than 1 percent of a hospital's operating budget, with salaries and benefits of staff interpreters accounting for the bulk of the costs.
- A useful four-step program-development process is to assess the situation, create and implement a plan, then evaluate and revise as needed.
- Successfully established programs have the following critical elements:

  Good information and data on patient needs and preferences

  An approach that is integrated throughout the institution

  Dedicated leadership from both executive offices and front-line language program directors

SELECTED LEGAL RESPONSIBILITIES

U.S. Title VI of the Civil Rights Act of 1964

Any program or activity (including hospitals and physicians) that receives federal funding (including payment for Medicare and Medicaid enrollees) must take reasonable steps to ensure meaningful access to their programs by persons with limited English proficiency.

California Health & Safety Code § 1259

California general acute care hospitals must provide language assistance services 24 hours a day for language groups that comprise 5% or more of the facility's geographic service area or actual patient population.

Language Service Options

Three main types of interpretive services are offered: telephonic, in-person, and video. Each has benefits and challenges (see chart, next page).

Telephonic services have the advantage of being able to access a large number of languages with minimal wait time and minimal training for hospital staff. Costs are lower than in-person service, but nonverbal cues and body language can be lost.

In-person services—whether by dedicated staff interpreters, contract or vendor interpreters, bilingual clinicians or other staff, or family and friends—are considered superior to telephonic services. They provide a higher potential for nonverbal cues and body language to be

Benefits and Challenges of Various Approaches to Language Services

LANGUAGE SERVICE	BENEFITS	CHALLENGES
ALL LANGUAGE SERVICES		
	▪ Improved quality of care ▪ Higher levels of safety ▪ Increased satisfaction of patients, clinicians, and hospital staff	▪ Costs can be significant ▪ Difficult to match all patient needs with language service availability ▪ Assessing quality services ▪ Clinicians and staff understanding benefits and how to use the service
TELEPHONIC		
	▪ Large number of languages can be accessed ▪ Less expensive than in-person services, with costs easily tracked ▪ Minimal waiting time and training for staff	▪ Possible loss of nonverbal cues and body language ▪ Limited hospital control over quality
IN-PERSON		
All In-Person Language Services	▪ Physical presence of interpreter means nonverbal cues and body language can be captured ▪ Quality and usage known and tested	▪ Assessing language proficiency ▪ Training clinicians how to work with interpreters
Dedicated and Tested Staff Interpreters	▪ Institutional control over training, quality, costs ▪ Better continuity of interpreters ▪ Lower cost than contract or vendor	▪ Costs for training, monitoring, and maintaining coverage ▪ Wait time while locating available interpreter ▪ Coverage for lower-demand languages
Contract or Vendor Interpreters	▪ Costs can be lower than with staff interpreters ▪ Multiple vendors can provide expanded language coverage ▪ Outsourcing eliminates training and testing	▪ Limited continuity of interpreters ▪ Wait time while locating available interpreter
Bilingual Clinicians	▪ Additional costs limited to testing and training ▪ No wait time ▪ Most privacy; no third party	▪ Difficult to track costs ▪ Must assess language proficiency, including medical terminology
Bilingual staff, non-clinicians	▪ Costs can be lower than with dedicated staff interpreters ▪ Wait time is limited	▪ Lost productivity to home department ▪ Must assess language proficiency, including medical terminology
Friends and Family	▪ No costs or wait time ▪ Level of comfort and trust may improve compliance	▪ Knowledge of medical terminology may be poor in both English and patient's language ▪ Topics may be inappropriate for family member, particularly if child is interpreter ▪ High risk of communication and medical errors
VIDEO		
	▪ Costs can be lowered if networked ▪ More personal than telephonic ▪ Higher quality control and interpreter continuity than with contract services ▪ Limited wait time ▪ Coverage of languages can be high	▪ Costs for investing in equipment ▪ For networks, must develop contracts or join existing system ▪ More impersonal than in-person service

captured, but in each case, language proficiency, especially medical terminology in the requested language, may be limited. In some instances, training, and in most instances, assessing the interpreter's language capability can be difficult. When the interpreter is a child, there are added difficulties of language sophistication as well as appropriateness of the subject matter. Given the impossibly high costs of having "24/7" in-person interpreter coverage for all potentially needed languages, hospitals usually try to strike a balance between in-person and telephonic services.

Video conference interpretive services are a newer option that can be available within a single hospital or networked across multiple sites. A video and sound monitor brings an interpreter's face and voice into the clinical interview. Initial equipment costs can be high, but technology development costs have already been covered.

A combination of these three approaches can provide wide coverage of language needs at all times. If an in-person or video interpreter is not available at a particular time or for a particular language, back-up telephonic interpretation can be used. To manage costs and coverage, hospitals may hire a limited number of interpreters to be on staff for the most commonly demanded languages at that site and then rely on networked or contract interpreters for the other languages.

Process and Infrastructure

To introduce a language access program, hospitals generally adopt policies to support and direct such a program, collect information about patient language needs, establish the program, then assess their impacts.

Policies cover such things as types of language services available and how they can be accessed.

Information about patient language needs is often collected at intake, reception, or registration and entered into databases accessible to the clinicians treating the patient.

Establishing language access programs involves locating authority and oversight for the program with a department or individual who coordinates scheduling and delivery of services.

Assessing the impact of the presence of language services has been mostly informal, with staff reporting satisfaction among patients. No hospitals reported having assessed impact on clinical outcomes.

A more detailed process for considering and expanding language services for patients with limited English proficiency is presented in the box at right.

Four Steps to Establishing or Expanding Language Services for Patients with Limited English Proficiency

1. ASSESS THE SITUATION

- Quantify language needs of the population being served, current efforts to meet those needs at what cost, and organizational assets.
- Assemble your language access team, including key personnel and executive leadership.
- Consider the environment through organized labor, community input, and risk management perspectives.

2. CREATE A PLAN

- Review current internal policies and any available external policies.
- Open channels with other hospitals and other providers for possible collaboration (such as video network interpretation) and general information sharing on community needs and wants.
- Adopt and/or modify current internal policies regarding services available, which interpreter modalities should be used when, use of bilingual clinicians, and whether any types of interpreters, such as children, should be used only as a last resort.
- Set up a system to track needs and outcomes, including costs and patient and provider satisfaction.
- Set up a system to test for competence, particularly if using in-house clinicians or other staff for interpretation.
- Set up system to monitor and enforce adherence to policies, including how to encourage, solicit, and respond to feedback.

3. IMPLEMENT THE PLAN

- Establish organizational buy-in and integrate in all systems: financial, legal, quality and patient safety, public relations, and clinical staff.
- Assign responsibilities, particularly for a primary, dedicated staff person.
- Identify, select, train, and monitor interpreters as appropriate for telephonic, contract, and in-person interpreters.
- Install or secure hardware, equipment, or technical services for video interpretation.
- Initiate tracking and analysis systems, including costs, competence, and feedback.

4. EVALUATE AND REVISE

- Review tracking and analysis systems.
- Investigate and resolve variations/violations of policies.
- Modify policies and efforts as needed.

For a more detailed version of this process, see the full report: http://futurehealth.ucsf.edu/hwtc/languageaccess.html.

Costs

Costs range from .06% to .78% of the study hospitals' operating budgets. Salaries and benefits of staff interpreters account for the bulk of the costs, including money spent on premiums for bilingual staff. For high volume and broad coverage, networked video interpretation can cost less than staff interpreters and telephonic services. Although reimbursement for language access services does not seem to be available from third-party payers, grant funding can support aspects of these services.

Rather than looking for a return on investment, hospitals come to providing language access services from a number of perspectives: they see it as the right or proper thing to do, as part of the hospital's mission, as a way to prevent lawsuits, and as a way to increase compliance and engagement in their own care among patients with limited English proficiency. Moreover, they see interpretive services as contributing to safety, patient satisfaction, and quality of care.

Moving the Institution

Leadership high in the hospital hierarchy is important to initiating language access programs. CEOs or vice presidents often bring the question of language services to the forefront of hospital care by forging appropriate partnerships, authorizing needed funding, naming committees, creating departments, and choosing effective individuals to direct language service programs. Departmental managers and coordinators of programs are involved in budgets, staffing, testing interpreters, training clinicians in how to work with interpreters, and developing useful policies and guidelines. Leadership within the executive suite or in another part of the hospital—someone with vision, the right network of people and resources, and the willingness to take that extra step—is critical to moving language access services from an auxiliary office to a fully respected and funded department capable of meeting the needs of patients with limited English proficiency.

Conclusion

The California hospitals that participated in this research have taken the lead in recognizing the need for language access services and pioneering their implementation. Their experiences offer guidance for others considering instituting such services for their patients. Leading hospitals are generally tailoring language services to their patient population by offering a combination of language service options. Key to finding the right balance of options is having good information and data, an approach that is integrated throughout the institution, and dedicated leadership from the executive offices as well as from frontline language program directors.

In the long run, interpretive services must become an integrated part of the overall strategic direction of any hospital or care delivery unit. For this change to occur, executive leadership must recognize the value of these services in providing high-quality, cost-effective, and consumer-responsive care. Those responsible for the financing of the institutions must be able to see that programs that provide language access create a set of services that are cost effective in the aggregate. Clinicians of all types will need to recognize the contribution that these services make to patient-care outcomes. Those who lead language access efforts will need to make an articulate case for each of these key leadership constituencies if programs are to receive the necessary support and be successful.

Resources

An increasing number of resources are available to health care providers seeking information and help regarding language access.You can find extensive lists of resources in the following articles available at http://futurehealth.ucsf.edu/publications/index.html:

Language Access Online Resources for California & the Nation

Improving Language Access in Hospitals—General References

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