THE CENTER
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Bilingual Proficiency among California's Health Care Professionals

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Speaking the patient's language

Californians speak a multitude of languages. In 2000, California ranked first in the U.S. in percent of the population speaking English less than "very well". With 20% of the general population[1] and 25% of school-age children[2] of limited English proficiency (LEP), concerns are rising that many Californians may not be receiving optimal health care.

This concern is clearly linked to the relationship between language access and the disparity of health care outcomes across the various populations in the U.S. Language cannot account for all of the disparity, but seems increasingly to be a driver for many populations.

California Population, 2000[3]

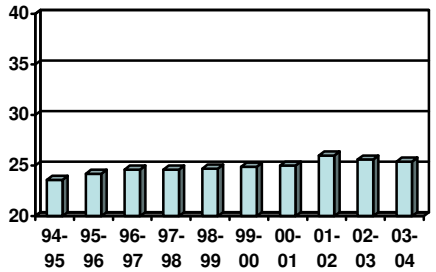
Number speaking a language other than English who reported speaking English less than "very well"	Total population Age 5+	Percent speaking another language who reported speaking English less than "very well"
6,277,779	31,416,629	**19.98%**

While interpreters – both family and professional – are often relied upon to bridge the communication gap, a more direct approach to meeting the health care needs of LEP patients is through bilingual practitioners. Language skills of physicians and other clinicians may improve access and mitigate health care disparities.

It is not unusual for health plans, medical groups,[4] medical societies[5] and even private reviewers[6] to now offer searches of practitioner by language skill. Online searches of seven health plans[7] in California found the number of languages searchable ranging from 38 to 225; the longest list runs from Achinese to Zulu and no two lists are identical.

Although the online databases are currently unclear as to whether it is the physician or an associated staff member who is bilingual, a 2001 survey of California physicians provides some additional information. In that survey, 28% of primary care physicians and 17% of specialists reported that they themselves were fluent in Spanish. Ten percent of primary care physicians and six percent of specialists reported fluency in Chinese.[8]

Percent of California K-12 Students who are "English Learners"*, 1994-2004[9]



* In the California education system, "English Learners" were formerly known as Limited-English-Proficient or LEP; see references for more.

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Assessing proficiency

The numbers of California doctors reporting bilingual skills are impressive. Missing from the current information on bilingual practitioners though are objective assessments of language proficiency. Assessments may range from a simple self-assessment to documentation of education to objective, third-party evaluations and examinations or credentialing. For the most part, however, the data available on language proficiency are based on physicians' own reports. Few impartial data exist regarding competency.

A 2004 survey of 24 heath plans (6 large commercial plans and 18 Medi-Cal health plans) by the California Office of the Patient Advocate found that, while virtually all of them reported the availability of bilingual practitioners based on reports from physicians, only a handful used assessment tools – their own or through contracted services – to validate the physicians' self-reports.[10]

In employment settings, we are more likely to see some actual assessment of language proficiency but standards across the industry are absent. Some employers require bilingual skills for specific positions and some may offer premiums to providers who are bilingual. Others may be interested in the capacity of workers to provide care in the patients' languages or to serve as interpreters. In employment settings, testing usually is done to determine whether the practitioner meets the needs of the employer. It is up to the employer to decide whether to develop and use its own test or to contract the testing out to a service, which use a variety of assessment tools.

Employers may start this process with a self-assessment tool such as the one developed by the Industry Collaboration Effort. ICE's Employee Language Skills Self-Assessment Tool, available online, can help employers identify language skills and resources among staff. The document provides employees with a structure (five-point scale) for assessing their fluency in speaking, reading and writing a language.[11]

Moving beyond self-assessments to more objective methods, some employers may turn to third-party language testing. Depending on the organization's needs, options might include:

- Language Testing International (the official testing arm of the American Council on the Teaching of Foreign Languages)[12]
- One of the telephonic interpreting service companies that offers language assessment
- One of the tests offered by an organization focused on a particular language. For example, the Ministry of Education and Culture of Spain offers an internationally recognized certification examination, *Los Diplomas de Español como Lengua Extranjera*. [13]

With very few exceptions (e.g. Language Line Services and NetworkOMNI telephonic interpreting services), existing language proficiency tests have not had a specialized health care or medical component, severely limiting their usefulness to health care employers.

The paucity of language proficiency tests tailored to the medical professions has led some health care organizations to develop their own examinations. For example, Kaiser Permanente has used its own tool, developed in-house, to assess employees' bilingual skills. A recent environmental scan of the options available spurred the large HMO to improve and expand its own test. Working in partnership with the Alameda Alliance for Health on a project funded by The California Endowment, Kaiser Permanente will refine and pilot a test to assess physician language competence.[14]

Next generation of testing

Leaders in the field of improving language access to health care are moving towards more comprehensive testing or proficiency testing that goes beyond a series of questions and answers. For example, *Hablamos Juntos*, a project funded by the Robert Wood Johnson Foundation to develop models for language services in health care organizations, considered the elements that would be appropriate in testing health care interpreters.[15]

While these six components were developed with health care interpreters specifically in mind, they may also be useful in testing proficiency in bilingual providers:

1. Basic language skills – including speaking and understanding.
2. Ethical case study – including knowledge of code of ethics and decision-making.
3. Cultural issues – including ability to respond to cultural misunderstandings brought on by language and culturally based beliefs, values and assumptions.
4. Health care terminology – including terminology and concepts such as anatomy, symptoms, illnesses, procedures and tests, equipment, treatment, and medications.
5. Integrated interpreting skills – including ability to interpret a simulated cross-linguistic review with accuracy and completeness.
6. Translation of simple instructions – including application forms, signage, notices, surveys, brochures, invoices, bills, discharge instructions, appointment cards, and medication labels.

Certifying health care professionals in a second language

Should policy makers choose to go beyond comprehensive proficiency testing, the next logical step would be to develop and recognize a formal credentialing mechanism to certify health care professionals in a second language. The development of a recognized credential with standards that professionals and patients could rely upon would be a significant contribution in this arena.

Elements of certification as a bilingual health care professional could include:

- Documentation of education, training and coursework in both languages.
- Passing scores on oral examinations in both languages, including conversational fluency and medical/health care terminology.*
- Training and testing in bilingual ethics including issues of cultural competence and knowing when and whom to ask for help with interpreting.
- Passing scores in both languages and in translation capabilities on basic written competence relevant to the care being provided (e.g. instructions, medications).*

*Competence in a native language might be demonstrated through other documentation.

Ongoing maintenance of certification as a bilingual practitioner might include:

- Documentation of continuing proficiency in both languages as evidenced by regular testing or ongoing employment (with review) as a bilingual provider.
- Maintenance of a clean certification record free from findings of misconduct or violations of a code of ethics.
- Maintenance of state licensing and other board certification as appropriate in one's profession.

Setting up a Certification program

Certification programs could be administered by government or private entities. In either case, similar steps would be followed. After determining a need and audience for such a program, an analysis would have to be conducted to determine the skills that should be tested. A psychometrically sound test – one that is valid and reliable – would be constructed and testing security measures would be implemented. Certification protocol would be developed and an organizational infrastructure to administer the test(s), issue certifications and maintain credentials would be established. Organizations such as the National Organization for Competency Assurance are available to offer guidance for and accreditation of certifying agencies.

Training practitioners in a second language

Policy makers and employers considering requiring or rewarding second-language skills would want to consider the costs of training. Because of the variable involved, there are no fixed estimates of how much time or money would go into training an adult health care provider in a second language. Models to assist the decision-making process would be a welcome addition. The resources that would go into training health care professionals in a second language might depend on at least five variables:

1. ***Pre-training skills and aptitude,*** including competence in one's first language (vocabulary, sentence structure); any experience and competence in non-native languages; age; and natural aptitude, which could be assessed by existing tools such as the Modern Language Aptitude Test[16] or through new tests using existing models such as the US Military Defense Language Aptitude Battery.[17]

2. ***Degree of difficulty of language*****.** For example, a common perception among teachers of Americans is that romance languages can be taught in a shorter amount of time than other languages.

3. ***Intensity of training –*** Program intensity can range from one hour per week to full immersion programs running all day every day for a week, a month or more, a choice some nurse practitioners and certified nurse-midwives currently are opting for.[18]

4. ***Desired level of proficiency*** in language. Proficiency in a second language can range from competence in using the one-sheet guides developed by the Industry Collaborative Effort's Cultural and Linguistic Workgroup[19] to conversational competence to full fluency including health care terminology.

5. ***Motivation*** to learn the language. An individual's own enthusiasm, incentive and reasons for wanting to learn a new language will play a role in how quickly and how well that language is mastered.

The components of non-native language training would likely include an initial assessment to determine existing skills; education and training in the new language including medical terminology; and a final test, recognized by employers and certifying agencies, to determine post-training competence.

Policy options

As the questions and concerns about second-language competencies among health care professional evolve, California policy makers – both public and private – might consider several options. Legislators and regulators could consider laws or regulations that would apply to all licensed practitioners, with waiver programs possible for specific individuals or groups. Administrative leaders of hospitals,

medical groups, health plans and government health programs could adopt policies and standards applicable to their employees, members or participants. Finally, market forces might be brought to bear in one of two ways. First, by actions of organized purchasers such has been the case in the Leapfrog Group effort to improve quality.[20] Another option would be to depend upon individual consumer preference for language-competent health care which might be more readily expressed in a more consumer driven system and be informed by state credentialing of language competence.

Clearly policy does make a difference. In this arena for example, recent information collected by the California Office of the Patient Advocate show variances by line of service[21] that could be correlated with regulations affecting the various lines of service. In other words, if organizations are required by law to do something, they are often more likely to comply than if no law or regulation exists.

The California State Personnel Board Bilingual Services Program offers a bilingual oral fluency exam for state employees using verbal skills on the job. However, at this time, the test is offered only in Spanish, is limited to conversational skills and does not include medical terminology.[22] Other states have resources and models to review. The State of Washington Department of Social and Health Services runs a Language Testing and Certification program that provides bilingual certification and testing services in numerous languages to ensure quality services to DSHS LEP populations.

In another example, New Jersey now requires physicians to complete a course in cultural competency to obtain a license or be re-licensed in an effort to counter race- and gender-based disparities in health care.[23]

In considering possible policies, leaders in this state might entertain some of the following:

1. Supporting the development of standard, recognized certification programs for health care professionals with second- language competence.

California Population Speaking English Less Than "Very Well" by Language, 2000[24]

Language Spoken at Home	Number	Percent of Total	Cumulative Percent
Spanish	4,303,949	69%	69%
Asian Language*	1,438,588	23%	92%
Other Indo-European**	453,589	7%	99%
Other Language	81,653	1%	100%
Total	6,277,779	100%	

* "Asian Language" includes languages indigenous to Asia and Pacific Islands areas.
** "Other Indo-European" excludes English and Spanish

Number of English Learners in California Schools K-12 by Language, 2003-2004[25]

Language by Rank	Number	Percent of Total	Cumulative Total
Spanish	1,359,792	85%	85%
Vietnamese	34,444	2%	87%
Hmong	23,423	2%	89%
Cantonese	22,867	1%	90%
Other (n=53)	158,009	10%	100%

"English Learners" were formerly known as Limited-English-Proficient or LEP; see references for more.

2. Requiring competence in one of the most common non-English languages in California to be licensed as a physician or any of a select group of health care professions. The top four non-English languages spoken at home in California are Spanish, Chinese, Tagalog and Vietnamese. People who speak these four languages, in aggregate, make up

about 80% of the individuals who speak a foreign language at home. Adding another six languages (Korean, Armenian, Japanese, Persian, German, and French) brings the aggregate percent to about 90. If policy makers wanted to better ensure that all Californians had access to health care practitioners who spoke their language, policy could be introduced requiring practitioners to be proficient in at least one of these top ten foreign languages in addition to English.

A variation on this option that might be more meaningful would be requiring competence in either Spanish or an Asian language*, speakers of which together make up the vast majority – 92% –of the population speaking English less than "very well".[26]

3. Requiring language skills as a requirement of continuing professional education. Depending on one's proficiency and/or patient population, the requirement could be met from a range of choices including learning how to use the single-page guides that ICE and others have issued and actual language training. For a certain period of time, continuing education courses in this topic could carry a "double credit"

4. Requiring minimal competence in using the cards or single-page charts of common sentences in multiple languages that have been developed by various organizations; competence could be demonstrated by testing in health professions' schools and/or on the licensing examinations.

5. Proactively seeking candidates for medical, nursing and other health professions schools who are proficient in English and at least one other language identified as high priority for California. For example, California State University at Bakersfield's Family Nurse Practitioner program gives admissions preference to applicants with bilingual skills, especially Spanish.[27]

6. Offering school loan repayment subsidies or other financial incentives or rewards for practitioners who meet established proficiency standards in languages identified as priority languages for California's LEP population

7. Providing public information about language competence of practitioners – individual or aggregated – to consumers to inform their decisions.

In developing education and certification programs to better equip California's health care workers with linguistic skills, policy makers will have to struggle with the challenge of setting standards high enough to meet Californians' needs while not so high that training time and costs are unreasonable. Finding the balance point may be difficult but worth the effort.

* The US Census group "Asian and Pacific Island languages" includes Chinese, Japanese, Korean, Mon-Khmer/Cambodian, Miao/Hmong, Thai, Laotian, Vietnamese, Other Asian languages, Tagalog, and Other Pacific Island languages. Of the people who speak API languages at home who speak English less than "very well", those speaking Chinese make up the highest percentage (33%). LEP speakers speaking Chinese, Korean, Vietnamese and Tagalog together make up over 80% of the total LEP Asian-speaking population.

Speaking English

A related topic is English proficiency for health care workers. Most U.S. health care workers are trained and/or tested in English. With one exception, all health care professionals licensed in California are required to take their licensing test in English.[28] In addition, federal law requires non-US citizens coming to the United States for employment as a health care worker in specific professions to obtain health care worker certification, which includes demonstration that English language requirement has been met.[29] State boards may rely on a standard examination such as the Test of English as a Foreign Language (TOEFL) for practitioners who did not attend health care professional school in the United States or an English-speaking country.

Health care workers who are not required to be licensed – ranging from receptionists to many of the allied and auxiliary workers – generally are not required by state or federal law to speak English although individual employers may of course require any level of proficiency.

References

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[2] California Department of Education, Educational Demographics Unit: http://dq.cde.ca.gov/dataquest.

[3] US Census 2000. Ability to Speak English by Language Spoken at Home: 2000. Table 6a California – Ability to Speak English by Language Spoken at Home for the Population 5 Years and Over: 2000. http://www.census.gov/population/cen2000/phc-t37/tab06a.pdf

[4] See e.g. Hill Physicians http://www.hillphysicians.com

[5] See e.g. http://www.healthcenterworldwide.com/sfms/phyloc/search.aspx. A January 2005 search of the San Francisco Medical Society produced 97 language options ranging from Ainu to Yoruba.

[6] See e.g. "Health Grades", which offers consumer reports on searches by language: http://www.healthgrades.com/consumer/index.cfm?fuseaction=mod&modtype=content&modact=SHOP_Report_ForceExample&type=PhysQual&subact=results

[7] Aetna, Blue Cross of California, Blue Shield of California, Cigna, HealthNet, PacificCare, Western Health Advantage.

[8] Grumbach K, Dower C, Mutha S, Yoon J, Huen W, Keane D, Rittenhouse D, Bindman A. *California Physicians 2002: Practice and Perceptions*. San Francisco, CA: California Workforce Initiative at the UCSF Center for the Health Professions. Dec 2002.

[9] California Department of Education, Educational Demographics Unit. Original table prepared from data from searches of enrollment and English Learners. http://dq.cde.ca.gov/dataquest. "English Learners" (formerly known as Limited English Proficient or LEP) is the term used by the California Department of Education to describe those students for whom there is a report of a primary language other than English on the state-approved Home Language Survey and who, on the basis of the state approved oral language (grades K-12) assessment procedures and including literacy (grades 3-12 only), have been determined to lack the clearly defined English language skills of listening comprehension, speaking, reading, and writing necessary to succeed in the school's regular instructional programs.

[10] Reifman, Cori. *Rating HMOs on Linguistic Services: Lessons Learned*. American Public Health Association. November 8, 2004; Washington, DC.

[11] Industry Collaboration Effort. *Better Communication, Better Care: Provider Tools to Care for Diverse Populations*. October 2004. Available online at http://www.iceforhealth.org/library/

[12] Language Testing International: http://www.languagetesting.com

[13] Instituto Cervantes offers Los Diplomas de Español como Lengua Extranjera: http://diplomas.cervantes.es/

[14] Personal communication from Sunny K. Pak, Project Manager, National Linguistic & Cultural Programs, National Diversity, Kaiser Permanente. March 15, 2005.

[15] Hablamos Juntos: Improving Patient-Provider Communication for Latinos. *Language Testing Options*. Claremont CA: September 27, 2002. http://www.hablamosjuntos.org/resourcecenter/pdf/Language_Testing_Options.pdf.

[16] The Modern Language Aptitude Test is offered by Second Language Testing, Inc. See http://www.2lti.com/news.htm#7

[17] Powers R. Defense Language Aptitude Battery: All About the DLAB. http://usmilitary.about.com/cs/joiningup/a/dlab.htm.

[18] See e.g. the Interamerican University Studies Institute http://www.iusi.org/professional/health_care.htm

[19] http://www.iceforhealth.org/home.asp
[20] The Leapfrog Group for Patient Safety: http://www.leapfroggroup.org/
[21] California Office of the Patient Advocate: www.opa.ca.gov
[22] California State Personnel Board http://www.spb.ca.gov/bilingual/InterpreterCert.htm
[23] New Jersey Senate Bill S144 (2005).
[24] CensusScope. Source: Census 2000 analyzed by the Social Science Data Analysis Network (SSDAN) http://www.censusscope.org/us/s6/chart_language.html. Note that ability to speak English "very well" is based on the self-assessment of those responding to Census questions, not on a test of language ability.
[25] California Department of Education, Educational Demographics Unit. Number of English Learners by Language 2003-2004. http://dq.cde.ca.gov/dataquest/
[26] Census Scope. California. Language. Ability to speak English among those speaking a language other then English, 2000. http://www.censusscope.org/us/s6/chart_language.html; US Census 2000 PHC-T-37. Ability to Speak English by Language Spoken at Home: 2000. Table 6a. California – Ability to Speak English by Language Spoken at Home for the Population 5 Years and Over: 2000. http://www.census.gov/population/cen2000/phc-t37/tab06a.pdf
[27] http://www.csubak.edu/nursing/grad_fnp_index.htm accessed February 17, 2005.
[28] The one exception is acupuncture; the California Acupuncture Board permits licensee applicants to take the licensing test in English, Mandarin or Korean. There is no English proficiency requirement for licensed acupuncturists in California.
[29] Section 343, Illegal Immigration Reform and Immigrant Responsibility Act of 1996; Pub Law 104-208.

Additional Resources

Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members. Sponsored by the California Academy of Family Physicians and CAFP Foundation. Supported by a grant from The California Endowment. 2005

Perkins, Jane. *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities.* Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation. August 2003.

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