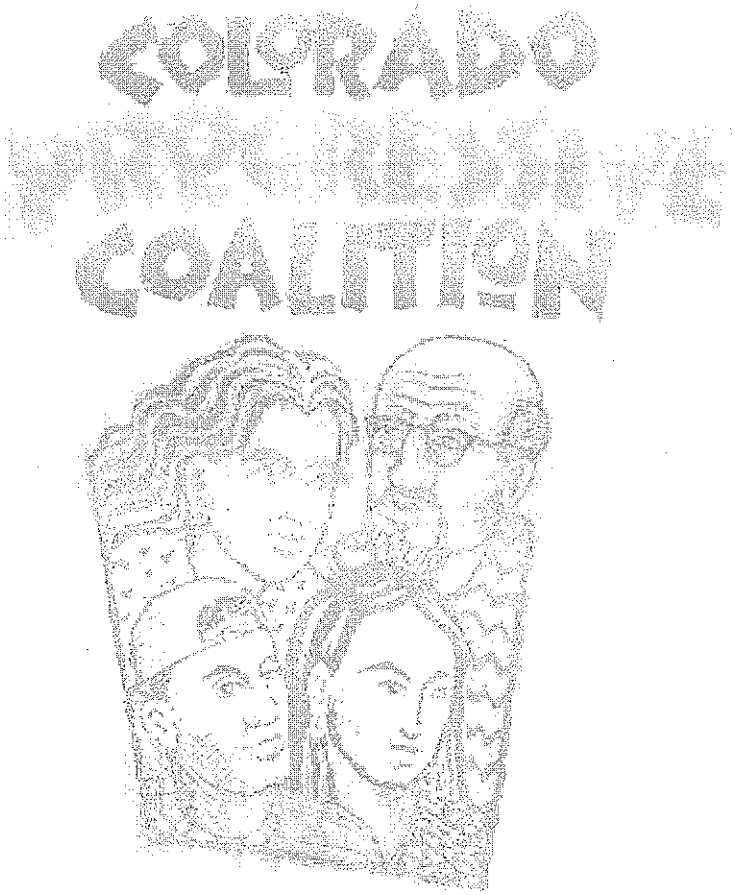
SPEAKING OF HEALTH CARE:

Ensuring the Quality and Safety of Care for Limited English Proficient Patients in Colorado



THE COLORADO PROGRESSIVE COALITION
HEALTH JUSTICE ORGANIZING PROGRAM
1600 Downing Street, Suite 210
Denver, CO 80218
303-866-0908 (phone)
www.progressivecoalition.org
e-mail: cpc@progressivecoalition.org

ACKNOWLEDGEMENTS:

This report would not have been possible without coalition partners conducting over a thousand hours of surveys in the community, meeting with coalition partners, local and national research, and identifying and interviewing those who have experienced challenges because of lack of access to high quality and culturally competent health care. The Colorado Progressive Coalition's Health Justice Organizing Program (CPCHJOP) is grateful to many that helped produce this well-rounded and vivid report. We are especially grateful to the following people and organizations that helped make this report a success:

- The report's primary authors and editors: Francoise Mbabazi, CPC Health Justice Program Director; Susan Downs-Karkos, Director of Integration Strategies at Spring Institute for Intercultural Learning; Leah Bry, CPC Lead Health Justice Organizer; Sujata Massey, M.D., former CPC Health Justice Intern; James Skay, CPC Volunteer; and Bill Vandenberg, CPC former Executive Director.

- The community outreach staff, interns, volunteers and coalition partners who spent hundreds of hours collecting stories and conducting 870 surveys at local community events, congregations, clinics, and migrant worker housing facilities and work sites: Elsa Banuelos, former La Clinica Tepeyac staff member; Becca Farley, former CPC Intern; Cheyenne Hughes, CPC Racial Justice Organizer; Francoise Mbabazi; Miriam Pena, CPC Development Director; Nisar Nikzad, CPC Technology Director; Victoria Voronkov, CPC Intern from the Graduate School of International Studies at the University of Colorado; and Nick Ernster, CPC Intern from Creighton University.

- Community partners who facilitated survey collection, community outreach, and identification of people facing great health care challenges: Central Baptist Church, Empowerment Program, La Clinica Tepeyac, Plan de Salud Family Health Centers, and St. Dominic's Catholic Church.

- Organizational endorsers of the Language Access Coalition/Stop Health Care Discrimination Campaign include: 9 to 5 National Association of Working Women, the African Community Center, the American Diabetes Association, American Friends Service Committee, Asian Pacific Development Center, Brother Jeff Cultural Center, Colfax Community Networks, Colorado Access, Colorado Coalition Against Sexual Assault, Colorado Consumer Health Initiative, Colorado Foundation for Families and Children, Colorado Foundation for Medical Care, Colorado Jobs with Justice, Colorado Minority Health Forum, Cross Community Coalition, Cultura Business Communications, Denver Area Labor Federation, Denver Justice and Peace Committee, Dignity Through Dialogue and Education, Front Range Economic Strategy Center, Jewish Family Services, Latin American Research And Service Agency (LARASA), Latino Research and Policy Center, Padres Unidos, Pueblo Catholic Charities Dioceses, Project Wise, Rights for All People, Rocky Mountain Survivor Center, Safehouse Progressive Alliance for Nonviolence, SEIU Local 105, Sisters of Color United for Education, University of Colorado at Denver and Health Sciences Center UCDHSC: Asian Studies Department, Western States Baptist Convention.

- All of Colorado Progressive Coalition's members and funders, including these health care program and general support funders: the Bamboo Fund, the Brett Family Foundation, the Colorado Health Foundation, the Gay and Lesbian Fund for Colorado, the Philanthropic Community Organizing Collaborative, the Rose Community Foundation, the General Service Foundation, the State Strategies Fund, the Stern Family Fund, the Theodore and Chandos Rice Charitable Foundation, and the USAction Education Fund.

EXECUTIVE SUMMARY

Language interpretation plays a critical role in providing high quality health care to Limited English Proficient (LEP) patients in Colorado. From 2004-2006, the Colorado Progressive Coalition launched a comprehensive study to examine how Colorado hospitals were implementing the certification standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Title VI of the Civil Rights Act of 1964.

While all health care providers struggle with providing high quality language interpretation to their patients, perhaps no where is having an interpreter as critical as in the hospital. Many patients enter the hospital facing urgent health care situations, and for those who are LEP, interpretation services in those circumstances can mean the difference between life and death.

By collecting 870 community surveys, conducting community forums and hospital interviews and gathering personal testimonies, the Colorado Progressive Coalition set out to document the state of language interpretation from both the hospital and patient perspectives.

Study results indicate that hospitals are increasingly aware of Colorado's changing demographics, the national guidelines for providing language interpretation and the link to patient safety and quality care. Many have taken incremental steps to increase the amount of language interpretation provided by trained interpreters. However, it is clear that much more work remains in this arena. Hospitals recognize that there are still inadequate resources allocated for interpretation, much of what is provided is ad-hoc, and that the state's growing diversity requires more deliberate, systemic action.

At the same time, many Limited English Proficient patients continue to experience challenges with the most basic interactions, including making appointments, as well as receiving and understanding accurate diagnoses, treatment and ongoing care. Significant gaps in understanding still exist between hospitals and LEP patients. Many patients also feel that there is a lack of respect for their language and culture in some interactions.

Clearly, with Colorado's growing diversity, unless language interpretation needs are more systemically addressed, the risks will increase of costly medical errors and declining health care quality. There are models from across the country emerging that make the business case for increased language

interpretation resources and services. This report explores the model from the University of Massachusetts Memorial Medical Center and provides a series of recommendations for hospitals and a series of recommendation for policymakers interested in improving language access.

Recommendations for Hospitals and other health care providers. In order to provide high quality, linguistically appropriate care, hospitals and other health care providers need to commit to a comprehensive approach. This includes:

- Committing to change as an organization
- Systemically collecting and analyzing data
- Supporting the development of staff champions
- Outreaching to and ongoing engagement of newcomer communities and patients
- Developing a diverse and skilled workforce
- Spreading awareness throughout the organization of cultural diversity
- Providing high quality language assistance services
- Tracking performance over time

Recommendations for Policymakers. Enacting state policies that support expanded access to high quality language interpretation is an important next step for Colorado. This includes:

- Addressing language access issues as part of state health care reform efforts
- Using state Medicaid dollars to pay for interpretation, as in other states
- Developing a statewide certification program for medical interpreters
- Establishing a system for monitoring and enforcing the law
- Expanding workforce initiatives that promote career ladders and a diverse and culturally competent medical workforce

The Colorado Progressive Coalition welcomes the opportunity to work with Colorado's health care providers and policymakers to improve the quality of care for all patients, including those not yet English proficient.

SPEAKING OF HEALTH CARE:

Ensuring the Quality and Safety of Care for Limited English Proficient Patients in Colorado

2009

BACKGROUND OF THE PROBLEM

Health care providers recognize the critical importance of providing high quality health care services to all patients. With Colorado's growing emphasis on improving the quality of patient care, providers are more focused than ever on implementing ways to minimize clinical errors and promote patient safety.

One key component of high quality care is patient-centered care. According to the Institute of Medicine, patient-centered care is "respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions." In order to provide patient-centered care, language needs of the patient must be addressed. Indeed, the needs for language interpretation in the health care setting are steadily increasing each year, with a growing number of families from across the globe settling in Colorado.

While all health care providers struggle with providing high quality language interpretation to their patients, perhaps no where is having an interpreter as critical as in the hospital. Many patients enter the hospital facing urgent health care situations, and for those who are LEP, interpretation services in those circumstances can mean the difference between life and death.

This report explores the consequences of not providing language interpretation in hospitals. From simple miscommunications to misdiagnoses and incorrect treatments, too often language interpretation needs are ignored, or when they are provided, the quality of the interpretation is sub-standard at best. Such practices run the very real risk of massive, costly clinical errors occurring, errors that are devastating to both families and providers.

COLORADO'S CHANGING DEMOGRAPHICS

In 2006, Colorado ranked 16th out of the 50 states in the number of the foreign born, with the population now representing 10.3 percent of Colorado's total. The top three countries of birth of the foreign born in Colorado are Mexico (52%), Korea (4%) and Vietnam (3%). Nearly 31% of the foreign born are U.S. citizens. In terms of educational levels, 23% of the foreign born in Colorado have a college degree, while 38% have not completed high school.

Any person age five or older who reports speaking English less than "very well" on the U.S. census survey is considered Limited English Proficient (LEP). In 2006, 56.6% of the foreign born population was LEP. Of all Colorado households in 2006, 4.6% were considered to be linguistically isolated where all people aged 14 and over in the household are LEP. It is estimated that over 325,000 people in Colorado, ages five and above, are LEP.

Many efforts exist in Colorado to help immigrants learn English, so that they can successfully navigate the health care system, understand the educational system, advance in careers and integrate into Colorado's communities. Indeed, English is the language of business and health care in the United States, and newcomers have an obligation to learn the language. However, English classes are massively underfunded, and many report long waiting lists. In addition, learning to speak a new language fluently often takes years of practice and study. And, even in the best of circumstances, native English speakers can experience trouble comprehending complex medical diagnoses and terminology. Therefore, while it is critical to help immigrants learn English, there is at the same time a very real need to provide language interpretation in the health care setting, in order to prevent clinical errors and promote high quality care.

It should also be noted that a significant percentage of the foreign born population in Colorado is undocumented, and currently there are no legal avenues for them to become authorized. While immigration policy remains a serious national problem, hospitals are required to screen all patients arriving in the emergency room for emergency conditions, regardless of their status. This report attempts to help health care professionals meet their charge of providing high quality care to all of their patients.

STUDY DESCRIPTION

Given Colorado's significant population of Limited English Proficient speakers and health care's increasing interest in improving the quality of care for all patients, this study seeks to understand the degree to which LEP patients have access to high quality language services in hospitals and how such efforts could be strengthened.

The Colorado Progressive Coalition (CPC) is a non-profit organization that conducted research from 2004 through 2006 to investigate language related health care issues at the grassroots, community, and institutional levels. The CPC conducted research assuming patient services are guided by the hospital certification standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Title VI of the Civil Rights Act of 1964 which makes it illegal for publicly funded institutions to allow a language barrier to prevent delivery of adequate health care services. As an organization, the CPC understands there are many complexities inherent in the health care system in the United States. The CPC also realizes that, in general, health care consumers face many challenges. The purpose of this study is to focus attention on the needs of those with Limited English Proficiency who may be especially at risk of not receiving linguistically and culturally sensitive health care particularly in critical or life threatening circumstances.

In the preparation of this report, the CPC conducted 870 surveys with LEP patients in an attempt to identify specific issues they struggle with in acquiring adequate levels of health care. CPC conducted more than 30 follow-up conversations with persons participating in the survey. It also interviewed 10 Denver-metro area hospitals to learn more about their interpreter services and conducted a review of the literature to understand the current research on providing language interpretation. This report attempts to offer insight regarding the health care experiences and perspectives of LEP persons and the quality of services they received. It describes practices commonly used and some of the challenges faced by hospitals attempting to meet the needs of LEP persons. The report concludes with recommendations for health care providers and policymakers.

In 2004, CPC introduced a campaign called STOP Health Care Discrimination. STOP sought to increase public awareness of the difficulties LEP persons faced when seeking health care services. The

A recent immigrant from Russia living in Arapahoe County visited a hospital and was treated without an interpreter. The caregiver at the hospital prescribed medication and the woman was sent home. She subsequently visited a clinic to get a second opinion. Not only did she find out she was pregnant, she was also informed the prescribed medication could have resulted in a miscarriage.

campaign's goals included seeking policy changes to ease the burden on LEP persons. In the summer and fall of 2003 through 2004, organizers collected over 870 STOP surveys at local clinics, migrant worker housing facilities, community events, and congregations. The surveys were designed to gather opinions of a target audience possibly experiencing difficulties acquiring adequate health care services because of limited English language skills. 80% of persons who felt their limited skills in English constituted a language barrier also said they felt they did not receive the respect they deserved when seeking medical care. 47% of persons reporting a language barrier reported they also encountered discrimination affecting their ability to attain health care services. This initial project and its results identified language as a source of great sensitivity and an obstacle for many to the best possible health care. CPC considered it an urgent issue needing further investigation.

CPC developed a Language Access Campaign in the summer of 2005 providing a deeper analysis of issues revealed by the STOP surveys. The campaign worked in coalition with 48 different community organizations including the African Community Center, the American Diabetes Association, the Colorado Consumer Health Initiative, Cultura Business Communications, Jewish Family Services, the Latin American Research and Service Agency (LARASA), Rights for All People/Derechos Para Todos, and Sisters of Color United for Education as well as others to collect 30 personal testimonies from LEP individuals at community clinics, hospitals, and health care forums.

In 2006, the Coalition held 12 forums in various communities of immigrants including people from Ethiopia, Somalia, Uganda, Rwanda, Russia, and Bosnia. CPC and coalition partners interviewed French, Germans, and Spanish speakers as well as others from East Asia, Central Asia, Southeast Asia, and Latin America. The coalition also collected surveys from LEP persons at refugee resettlement agencies. Health care workers were interviewed including representatives from metro-Denver hospitals and employees of a managed health care organization agreed to take part in the interviews.

STUDY FINDINGS

"The biggest issue is the staff. [Providers] are not trained well enough how to interact with their patients in a culturally and linguistically comfortable way."

Matthew Riley, Senior Manager Pacific Interpreters

The efforts of the CPC to learn about issues and challenges facing both LEP patients and hospitals reveals a complex web of requirements, interactions, and sentiments. Clearly, all stakeholders face exceptional challenges.

Both patients and providers recognize that a language barrier can inhibit LEP persons from making initial contact with health care providers. Once contact is made, the lack of interpretation services can make proper care a complicated proposition for both. The quality of interpretation services is also often questioned. Interviews reveal problems with diagnoses and treatment from the simple to the life threatening. The failure of institutions to meet legal requirements for interpretation services to LEP persons is a significant problem and a huge obstacle to patients receiving high quality care. Ultimately, LEP patients too often express enormous frustration with the difficulties they have acquiring initial diagnoses and treatment as well as maintaining ongoing care. These frustrations feed feelings of discrimination and, whether justified or not, can make actions as seemingly simple as setting up an appointment exceedingly complex. The following feedback from both patients and hospitals presents a picture of a system in need of significant change.

FINDINGS FROM PATIENTS ON LANGUAGE INTERPRETATION

Many patients experience obstacles early on in their health care experiences and end up not seeking the treatment they need. The following stories describe some of their problems with just seeking health care in general. A Laotian woman reported, "Making appointments is [my parents'] worst nightmare. They were transferred many times and asked many questions and were unable to understand and therefore can't respond. The fact that they can't communicate in a language that is most familiar to them and that we have to accompany them...and read their prescribed notes causes them great concern. As a result, asking for help becomes less likely." The daughter of two Vietnamese-speaking parents says, "My parents' inability to communicate and fear of seeking care makes me feel like there are some problems that are difficult [for them] to disclose. They prefer to stay home and when things get worse they opt to [see] their under-qualified Vietnamese doctor." A Spanish-speaker trying to get an appointment to investigate a lump in her breast says, "If you don't speak English they have to keep transferring you and disconnect a million times. It took me three months to make an appointment!"

"If you don't speak English they have to keep transferring you and disconnect a million times. It took me three months to make an appointment!"

Spanish Speaking Respondent

The single greatest issue for LEP persons seeking health care is the need for reliable interpreters.

"Between 0-21 years of age immigrants are eligible for dental treatments, check-ups, and cleanings but most of the time we have no access to interpreters to get appointments. When we do [get appointments], we are asked to pay for our own interpreting services which most of us are unable to do and so we go without."

–LEP Person seeking healthcare in Denver

Often qualified professional interpreters are simply unavailable. Many are forced to use ad-hoc interpreters. These are persons who may be family members or others who are present and available, often by coincidence, and speak the native language of the patient. Use of ad-hoc interpreters can be problematic due to the lack of training and because they may feel they have no obligation to protect medical privacy. Though institutions receiving federal funding are required to provide interpretation services under Title VI, LEP patients too often rely on other patients, their own children, hospital visitors, and even support staff or custodians for communications fundamental to effective medical care.

Other complaints included obstacles in attaining accurate and timely information, often related to medication. Respondents also reported concerns about confidentiality, accessing preventive care, and having to take children out of school to translate for their parents at doctor's visits.

A patient in the emergency room of a local hospital reported she overheard a nurse asking the 15-year old son of a woman who spoke only Spanish to "stick around" because "we don't have any bilingual nurses today." When required to assist by asking his mother questions about her urination, he told the nurse it made him very uncomfortable. Nevertheless, the nurse also enlisted him to help collect a urine sample from his mother.

Another Spanish speaking patient reported, "My daughters always had to accompany me every time I had a doctor's appointment. One of the days, I was in the hospital while my daughter was at work. I was alone. I couldn't get up because I was still hooked up to all the machines and it was very hard to walk. I rang the buzzer to call for a nurse. No one ever came. When they would ask what I needed over the intercom, I would say 'bathroom.' I guess they never understood because they never came. My daughter finally got there after work about an hour and a half later. She helped me get up to use the restroom."

"I asked my grandmother whether she had ever asked strangers to interpret. The answer was 'numerous times.' Usually this would happen at hospitals. Random people and cleaning ladies, volunteers or even people who were having blood taken would help translate when she would end up in ER, for instance. They would help her out before I arrived."

Russian Speaking Respondent

Another LEP respondent reported reliance on so few professional interpreters prevents interpreters from having enough time to dedicate to each patient leading to errors in diagnosis and medication. Respondents also reported concerns about confidentiality. One LEP person uses a professional

interpreter but says she always hears the interpreter pass around stories about other clients' problems. She says she can't be sure if her personal health issues are being kept confidential.

Sometimes a lack of interpretation services and reliance on ad-hoc interpretation causes misunderstandings that have disastrous effects on families and their health care benefits. A survey respondent reports that a Russian family with two children aged seventeen and eleven depended on social security supplemental income and Medicaid. The seventeen year-old usually acted as interpreter for her parents but one day the father answered a phone call while his daughter was at school. The caller asked many questions and the father always answered "yes" because he did not understand the caller, was anxious, and just wanted to get off the phone. The call was from Social Services. Misunderstandings resulting from the call caused the family to lose their social security, food stamps, and health care coverage.

A Chinese-speaking tuberculosis patient who saw a provider at a hospital without an interpreter present reports she came away having no idea the disease could be spread. The provider also failed to explain it was important for her to complete her medications in order for the treatment to be effective. She did not understand why she was asked to take medicine for a whole year when, at the time, she had no symptoms. Such examples not only have potential dire consequences for the patient but also for the community.

FINDINGS FROM HOSPITALS

Hospitals report concerns similar to those of LEP individuals. Health care providers at all levels struggle to find and effectively apply the resources necessary to provide effective interpretation services. "The demand is so high for interpreters we don't have enough interpreters to cover the needs of the whole hospital. We work with what we have," states the Interpretation Coordinator at a Denver area hospital.

Top 10 Requests for Interpretive Services at Denver Health:

1. Spanish
2. Somali
3. Russian
4. Vietnamese
5. Amharic
6. Arabic
7. Cantonese
8. Oromo
9. Mandarin
10. Burmese

www.denverhealth.org

The single biggest challenge reported by hospitals surveyed was a general lack of resources dedicated to interpretation services. Institutions struggle with meeting demand and recruiting bilingual staff and language interpretation professionals. Though four of ten hospitals surveyed had established institutional guidelines for

interpretation, not all managed to effectively train staff for use of the available resources or concerning policies already in place.

Some agencies and institutions recognize the dangers and inequities of relying on ad-hoc translators. Only one local hospital actively discourages the practice, requiring patients to sign a waiver if they insist upon using an ad-hoc interpreter. Other institutions apply a range of policies including: use of ad-hoc interpreters only in emergency situations; only when the patient prefers the use of an ad-hoc interpreter and the interpretation appears adequate to the health care provider; or the reliance on support staff such as nurses, clerks, and technicians who are bilingual but not formally trained. Another hospital counts on ad-hoc interpreters to perform most of its interpretation services yet offers no incentives to staff for training or additional benefits for those able to interpret at a professional level.

The use of ad-hoc interpreters is widespread and helps fill in many gaps where professional services are scarce. However, the need to apply professional services to avoid misunderstandings and dangerous mistakes is clear. Yet there are complexities inherent in the access to and use of professional interpretive services.

Most health care providers and all health care institutions interviewed for this report stated they use telephone interpretation services. Every institution contacted relied on "language line" telephone interpretation to some degree. The caregiver holds one telephone headset and connects with a call center of interpreters. The patient holds another headset. The caregiver, patient, and interpreter then conference as an examination occurs or treatment is administered. The interpreter simultaneously translates for the doctor. Based on accounts given for this report, it appears to be the most widespread source of professional interpretive services available to LEP patients.

Advantages of this system include the opportunity for telephone interpretation services to concentrate interpreters speaking a wide range of languages at one location. Health care providers and institutions requiring interpreters speaking many different languages can reach out for native speakers available to help with their patients. While the system has advantages and may be the best option in many cases, this CPC report discovered both practical and emotional difficulties experienced by LEP communities.

In many cases LEP persons are unaware that telephone interpretive services exist. If a patient does not request the service, it may go unused. And even when the service is utilized, reports by both patients and providers indicate that each suffer a discomfort level with this method of interpretation. A Senior

Many LEP patients reported that they would rather rely on untrained family members, even children, for interpretation rather than the phone services.

Implementation Manager with a company providing interpretation services interviewed for this report stated, "[the] language line is not a face to face interaction, and I have had complaints about that. There is definitely an issue in use of interpreters over the phone that scares people. You have a patient in front of you that speaks a language different from yours and you have a barrier which is the phone that you have to pick up and start to talk. I think the biggest issue is the staff. [Providers] are not trained well enough on how to interact with their patients effectively in a culturally and linguistically comfortable way." Many LEP patients echoed this critique, frequently expressing a lack of trust in phone interpretation.

FINDINGS FROM LEP PATIENTS ON RESPECT AND CULTURAL SENSITIVITY

While not intended to be a focus of this study, interviews and surveys with LEP patients also found a strong concern with the level of respect and cultural sensitivity in their interactions with hospitals and other health care providers. Certainly there are also many native-born, fluent English speakers who have concerns with health care delivery. With the potential for frustration high for all health care consumers, it may be no wonder that LEP patients feel disrespect and discrimination at times while seeking and receiving medical attention. It may or may not be true that in the following cases discrimination or intentional neglect were directly responsible for gaps in communications and care, but based on the fact so many expressed these types of feelings, it seemed important to give those who commented a voice.

Many LEP patients reported receiving inadequate or inattentive care. A former doctor from Russia reports that she has waited four to five hours in line in the ER before being helped. She felt discriminated against on many occasions and waited long hours as she observed English speaking patients never waiting as long. She is convinced hospitals are more concerned with how much money they get out of patients and their insurance than helping patients resolve their problems.

"We are the very few educated Somali-Bantu. Most of us have no education and we are grateful to be here but the price is way too high. All we ask is that healthcare providers make an effort to understand our cultural values and beliefs. For example the Somali tribe and Somali-Bantu don't even share the same dialects. We speak two different languages. We are the voices of our communities and have to voice their concerns. Often times I get calls from refugee clinics to come interpret. Never once have I been compensated for my time or asked if I have any medical background or knowledge of the medical terminologies."

—A leader in the Somali-Bantu community

Some respondents reported what they thought was negligence on the part of doctors or nurses who could not understand them. Other respondents reported feeling a lack of respect

and cultural sensitivity due to language barriers. A common complaint was that procedures were not fully explained or were performed without the patient's full knowledge or permission. A Somali-Bantu community leader describes an experience of his and his wife, "We were expecting a baby and had an emergency. [We] rushed to the hospital and I was told to wait as my wife was being examined. Soon after that, she was rushed to the surgery room. Not once did the nurse or the doctor inform me of any surgery procedures. My wife was taken into the surgery room without any information. She didn't have an interpreter. I spoke some English by then but was never consulted. When I tried to ask what was going on, I was ignored for a couple of hours and when they finally decided to talk to me the doctor said, 'We are professionals and we know what we are doing.' I was ignored and didn't have a say or any support from the health care providers. I was denied a right to see my son the moment he was born. If I spoke English fluently and with no accent my life would be different and I would be treated with respect."

In other cases, the system did not take patients' cultural values and priorities into account. A patient from Uganda writes, "I am a mental health patient of African descent seeking mental health services. All I ask for is access to quality care that is culturally competent: a therapist that I trust, relate to, and feel comfortable with." She relates the story of making repeated requests to see a therapist "familiar [with] Ugandan culture whom I trust." Her petition was denied with the following explanation, "[The patient] was offered the opportunity to see one of the [managed care organization's] mental health professionals but her preference is to pay an outside therapist with experience with Ugandan culture." [Her] doctor told her she would have to be a [managed care organization's] member for at least ten years to get a referral outside of the network.

"Sometimes the way they look at you different, treat you, respond when you ask a question, you just don't feel comfortable at the end."

Spanish Speaking Patient

RESEARCH ON QUALITY CARE AND LANGUAGE INTERPRETATION

Nationally, health care leaders, associations and researchers increasingly understand the critical importance of clear communication in providing high quality, patient-centered care. One study conducted by the Ethical Force Program and Health Research and Educational Trust examined eight hospitals to better understand the critical components of patient-centered communication. They found that one of the core components of patient-centered communication is effective language assistance, which the participating hospitals found led to better quality care, fewer unnecessary tests and a likely

decrease in errors and potential lawsuits. The leading hospitals in this arena had the following in place:

- Coordinated interpretation and translation services, often through a department or staff person
- Assessed and trained interpreters
- Assessed and trained bilingual staff

The need for highly trained interpreters is particularly acute, because even when a professional interpreter is available, correct and appropriate interpretation is not guaranteed. A Pediatrics Encounters study in 2003 found errors by interpreters to be common. When statistics for ad-hoc and professional interpreters were combined, they made an average of 31 language errors per encounter. Of the 31, 19 were found to have potential clinical consequences. Professional interpreters in the study fared somewhat better than those interpreting ad-hoc. Of errors committed by interpreters, 77% of those made by ad-hoc interpreters were found to have potential clinical consequences. 53% of errors made by professional interpreters were found to have potential clinical consequences. The most common types of errors as a percentage of the total made were omission (52%), false fluency (16%), substitution (13%), editorializing (10%), and addition (8%).

RESEARCH ON COST AND LANGUAGE INTERPRETATION

Few studies have comprehensively explored the true financial costs and benefits of providing language interpretation in health care settings. However, simply by comparing the costs of a contract interpreter with the cost of diagnostic tests and hospital charges, it becomes clear that there are large potential cost savings with interpreter usage. For instance, a common negotiated bulk rate in Denver for an interpreter is about $80 per hour, whereas in 2007 an average CT scan was $1,462; an average MRI was $949; an average 2007 Emergency Room charge was $1,260; an average outpatient surgery room (hospital) charge was $6,822, and an average outpatient surgery room charge was $5,776. Good patient-provider communication can prevent unnecessary tests and potentially bring significant savings to hospitals.

Other research is available that makes the case for expanding language interpretation in Colorado. The following are examples of studies from other states that have explored the benefits of providing interpretation.

Medicaid

Focusing on the Limited English Proficient Medicaid population in Connecticut, a study commissioned by the Connecticut Health Foundation and conducted by Mathmatica found that providing all LEP Medicaid patients with interpreters would cost the Medicaid program $4.7 million per year. The state would bear a cost of $2.35 million per year, with an additional $2.35 million matched by the federal government. (Connecticut Health Foundation, Policy Brief, August 2006). It is worth noting that both Connecticut and Colorado have a total of about 8% of the state population that is LEP.

Other states are using Medicaid dollars to pay for some of the costs of language interpretation. Colorado should also seriously explore how the Medicaid program could fund interpretation and improve the quality of care for those not yet fluent in English.

Managed Care

Another recent study examined the impact of interpreter services on the cost and utilization of health care services among LEP patients within a health maintenance organization in Massachusetts. The study recognized that many health care providers do not provide interpretation because of the initial cost; yet they often forget the benefits of clear communication with patients and the potential negative health consequences of miscommunication.

The study found that compared to a comparison group, Limited English speakers who received an interpreter had significantly greater: percentage of recommended preventive services received; number of office visits; number of prescriptions written; and number of prescriptions filled. Use of the emergency room was small for both groups; however, those receiving interpretation did experience a net reduction in ER use. In addition, the use of an interpreter suggests that it improved the ability of LEP patients to access primary and preventative care, for a relatively small cost.

The interpretation model used in the study was for full-time, staff interpreters available in person or by telephone 24 hours a day, for all points of contact within the HMO. Over a one-year period, the cost of providing an interpreter averaged $79 per interpretation, with the estimated total cost per person being $279 over the year.

As the study notes, these costs are quite reasonable when compared to annual Medicaid expenditures (in 1996) for conditions such as mood disorder ($1,957), diabetes ($1,563) or heart disease ($2,328).

In addition, because the $279 per year for interpretation improved health care utilization, there are also potentially longer- term health care cost savings from increased prevention efforts and fewer longer-term complications, though tracking these was beyond the scope of this study. The prevention of such chronic diseases, through improved patient-provider communication and improved adherence to medical advice and medication has the potential to save a significant amount of money. The study does suggest that language interpretation may lower the cost of care in the long-run. (Jacobs, E. Donald S. Shepard, etc "Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services, American Journal of Public Health, May 2004.)

HOSPITAL CASE STUDY - A POWERFUL PRECEDENT FOR CHANGE

In 2006, JCAHO issued requirements for hospitals to ensure provision of culturally and linguistically appropriate health care. These recommendations were based on a 30-month research project titled "Hospitals, Language, and Culture." The project investigated how hospitals across the nation are providing health care to diverse populations and motivated 40 states to implement an Emergency Room Interpreter Service Law. The most respected of these reforms were implemented in Massachusetts and Rhode Island demonstrating an effective precedent for improving health care for LEP populations.

The University of Massachusetts Memorial Medical Center (UMMMC) has developed an Interpreters Services program to "promote equal access to health care, facilitate effective communication, facilitate cross-cultural understanding, create trust and rapport, increase quality of care, reduce costs, enhance satisfaction, pursue excellence and follow the Massachusetts Medical Interpreters Association (MMIA) Standards of Practice." The program incorporates an in-depth training program for interpreters and staff including 91 training hours in interpreting skills, cross-cultural communication skills, and working knowledge of anatomy, physiology, and medical terminology. The program also trained for medical interviewing, the health care system in general, hospital policies and procedures, and the interpreter services code of ethics, policies, and protocols.

UMMMC trains all staff on the internal procedures for serving LEP populations, discourages the use of ad-hoc interpreters

> "The hourly rate of an interpreter is much more cost efficient than the least expensive diagnostic test in the Emergency Department and the number of medical errors caused by miscommunication are much greater when ad-hoc interpreters are used instead of trained professionals."
>
> Martha Benitez
> Interpreter Services Coordinator - UMMMC

(patients must sign a disclosure if they insist), and prohibits the use of minors as interpreters. Included in the policy is a directive that interpreter services must be provided at no cost to the patient. A computerized scheduling system ensures an interpreter is present at every single appointment with an LEP person. The Interpreter Services Office (ISO) also provides telephone interpretation services to patients needing prescription refills or any type of follow-up care. The UMMMC also developed a formal plan to identify languages new to the community and provide resources and improved access to the speakers of those languages.

The cost of the Massachusetts program is cited at $480,000 per year for approximately 40,000 interpreted encounters including 16,000 face to face interventions. Connie Camelo, Interpreter Services coordinator for the UMMMC notes, "The hourly rate of an interpreter is much more cost efficient than the least expensive diagnostic test in the Emergency Department and the number of medical errors caused by miscommunication are much greater when ad-hoc interpreters are used instead of trained professionals." The success of programs at the institutional level like the one at UMMMC demonstrate effective reform is possible and can serve as a model for Colorado institutions. This would provide better health care services for LEP patients while saving money for health care facilities and providers, a "win" for both patients and providers.

STATE-LEVEL PUBLIC POLICIES THAT SUPPORT LANGUAGE ACCESS

While there has been little federal activity in recent years on language access issues, many states have addressed language access through state-level policy changes. These have occurred primarily through:

- Reimbursement for interpretation for Medicaid/SCHIP
- Certification of interpreters
- Continuing education for providers

Medicaid Reimbursement

Both Medicaid and SCHIP are federal programs that are eligible for federal matching funds. Many states are including language interpretation as a reimbursable service under their state Medicaid and/or SCHIP programs. There are 12 states that allow for some type of reimbursement for these public insurance programs, though the amounts they reimburse for and the mechanisms used vary significantly.

Certification of Interpreters

There are currently no federal standards for health care interpreter certification. However, efforts are underway to create a national health care interpreter certification. Some states have developed their own program, with Washington being the first. Colorado does not have a certification program, though Bridging the Gap, a medical interpreter training, is offered in Colorado, but is not mandated.

Continuing Education

Mandated training for health care providers on cultural competency and/or language access has been legislated in three states: New Jersey, California and Washington. Rather than making it a one-time requirement, weaving cultural and linguistic issues throughout medical topics for ongoing provider education is more likely to help create long-lasting change.

IMPLICATIONS FOR THE FUTURE

The CPC conducted this study to bring attention to the difficult circumstances facing Limited English Proficiency persons seeking hospital care in the state of Colorado. Clearly, access to quality care for LEP patients remains uneven at best. Health care institutions clearly acknowledge many problems serving a growingly diverse population. Yet for some hospitals, better services for LEP patients may have been a low priority. Meeting the challenge of providing equitable and effective health care regardless of language is essential for the well being of all Coloradans. The State of Colorado, hospitals, and other health care providers must invest in strategies and take actions to minimize communication barriers regardless of spoken language. The recommendations outlined below are based on findings from LEP patients, hospitals and the growing body of research that specifies the practices and policies that can effectively improve the accessibility and quality of language interpretation services.

RECOMMENDATIONS

FOR HOSPITALS AND HEALTH CARE PROVIDERS

While the recommendations below are based on hospital experiences, they are very much applicable to other providers, including clinics, managed care and private providers. Recent health care research suggests a variety of ways that hospitals and health care systems can begin to address the communication needs of newcomers. These include:

- **Committing to change as an organization**, by examining how meeting the language and cultural needs of patients fits within the mission, values, policies, programs and budget. A foundation of policies and procedures must be built to support language access in the health care setting.
- **Systemically collecting and analyzing data** on community demographics and the language needs of patients across services. This includes collecting data on the needs of both patients and staff, using the data in an ongoing way to build support for expanding language services and tracking health care facility performance.
- **Supporting the development of staff champions** to advocate for language programs. Leaders in effective health care organizations recognize and prioritize the need for high quality language services in order to provide high quality care. Often they drive the continual advancement of language services throughout the organization. Language and communication efforts should be integrated throughout the hospital setting and expand over time.
- **Outreach and ongoing engagement of newcomer communities and patients**. Being proactive about understanding and building relationships with existing ethnic groups in the community is an important starting point for these efforts. Finding mechanisms, such as community advisory boards, to give communities avenues for input and to learn about emerging needs will help providers remain proactive in their programs and can lead to longer-term, meaningful collaborations. In addition, opportunities to educate patients, through health literacy efforts, for example, should be emphasized, and feedback from diverse patients about their health care experiences should be compiled and disseminated throughout the facility, providing opportunities for program enhancements.
- **Developing a diverse and skilled workforce** by recruiting and hiring multi-lingual, multi-cultural staff members helps reduce language and cultural barriers. Partnering with local educational institutions, ethnic community groups and other intermediaries can help provide new opportunities to build a diverse workforce, including opportunities for professional development and medical career ladders. Training existing providers on how to access and use an interpreter is critical. This includes training for staff to understand current policies and how to effectively use available resources such as face-to-face interpreters and phone interpretation services. It also includes ongoing opportunities to learn about the cultural norms of diverse ethnic groups, in an effort to help promote care that is culturally competent. Providing materials that reflect the health literacy level of populations and using them in oral and written communications is important.

- **Spreading awareness throughout the organization of cultural diversity** includes creating a welcoming environment and educating all staff about the importance of culture in health care. This includes encouraging an environment that is respectful of diverse cultures and one that helps staff understand the common health beliefs and backgrounds of different ethnic groups.
- **Providing high quality language assistance services** by coordinating language assistance services within a specific department with dedicated staff. Contracted interpreters should be required to have received medical interpreter training and should be assessed on their skills. Bilingual staff should also be trained and assessed. Certification and monitoring may be necessary to ensure a high quality of interpretation services. The practice of using ad-hoc interpreters without forethought or planning should be eliminated.
- **Tracking performance over time** by collecting quantitative and qualitatative data for program improvements and assessing the strength of the language program, including potential cost savings of providing higher quality care to newcomer populations.

FOR POLICYMAKERS

- **State health care reform and efforts to expand health care services** should also address language access issues, where appropriate. From enrolling in programs, understanding services and receiving quality care, the perspectives of LEP populations should be included in health care reform strategies.
- **Begin to use Medicaid dollars** and maximize federal funds to pay for some of the costs of language interpretation. As in other states, the Colorado Department of Health Care Policy and Financing and policymakers should study how the Medicaid program could fund interpretation and improve the quality of care for those not yet fluent in English.
- **Address the quality of interpretation** by developing and phasing in over time a statewide certification program for all medical interpreters, ensuring culturally and linguistically competent and quality services to LEP patients.
- **Legislate continuing education on language access for health care providers** in order to continue to strengthen how providers interact with patients from various linguistic and cultural backgrounds.
- **Establish a system for monitoring and enforcing the law** regarding linguistic access in hospitals and have the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment publish a report on its findings for public and legislative review.

- **Expand workforce initiatives** that promote career ladders and a diverse and culturally competent medical workforce willing to engage with diverse communities in meaningful ways. Such initiatives could also explore certain medical credentialing for the foreign born.

CONCLUSION

Since the 1996 U.S. Office of Civil Rights ruling on Title VI, providers and community members have seriously grappled with how to address the growing language access needs across Colorado communities. Competing with other higher profile quality improvement priorities over the past 12 years, improvements in language access have at times been incremental at best. Providers are committed to high quality health care and community-based organizations want to see systemic change. Together, policymakers, hospitals, other health care providers, community groups and patients can help make Colorado truly a leader in this field. We at the Colorado Progressive Coalition welcome this opportunity to work together in a positive spirit to support community change.

SOURCES

- American Hospital Association (AHA). Improving Communication: Improving Care. An Ethical Force Program Consensus Report. (2006).
- Chen, Alice Hm, Mara Youdelman and Jamie Brooks, "The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond," Journal of General Internal Medicine 22 (Suppl 2); (2007): 362-367.
- Colorado. Colorado Census Bureau. 2000 Colorado Census. (2000).
- Colorado. Colorado Census Bureau. 2005 Addendum to the 2000 Census. (2005).
- Connecticut Health Foundation, Policy Brief. (August 2006).
- Denver Health. 15 May 2007. <http://www.denverhealth.org>.
- Diversity RX, Models and Practices: Interpreter Services Program University Of Massachusetts Medical Center, Worcester, MA. 9 December 2006. 17 May 2007. http://www.diversityrx.org/HTML/MOBISB1.htm
- Flores, Glenn and M. Barton Laws, Sandra J. Mayo, Barry Zuckerman, Milagros Abreu, Leonardo Medina, Eric J,. Hardt. "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters" Pediatrics 111.1 (2003): 6-14
- Migration Policy Institute. www.migrationpolicy.org, American Community Survey. (2006).
- National Health Law Program. www.healthlaw.org
- United States. U.S. Census Bureau. Dynamic of Economic Well-Being: Health Insurance. (1996-1999).
- United States. U.S Census Bureau, Population Division, State Population Database. State estimates by Demographic Characteristics – Single year of Age, Sex, Race, and Hispanic Origin. (2002).
- Wynia, M. and J. Matiasek, Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals, The Commonwealth Fund, (2006).
- 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).

APPENDIX

List of Interviewed Hospitals

- Boulder Community Hospital (BCH)
- Children's Hospital
- Denver Health
- Exempla St. Joseph's
- Kaiser Permanente
- National Jewish Hospital
- Presbyterian St. Luke's
- University Hospital
- Colorado Acute Long Term Hospital
- The Medical Center of Aurora

Communities where Patients were Surveyed

Surveys were completed at four health clinics serving the low-income in the Denver Metropolitan area. Additional surveys were conducted at immigrant-serving Catholic congregations and congregations of other denominations. Migrant worker housing facilities, shopping areas in low-income neighborhoods, and various community events were also targeted for survey. Word-of-mouth was a powerful tool, as people heard about the survey and telephoned to share their stories

Interview Guide for Hospitals

1. Do you have a translation/interpreting program? If so, please generally describe how the program works.
2. If so, why has the hospital put resources into this program in the last few years?
3. What are the pros and cons of the program? Please explain
4. Where does the funding come from? Is there a budget set aside for translation/interpreting program?
5. Is there a system of monitoring the performance of interpreters in the hospital? What do you think would be an effective way to monitor the system?
6. What do you think the hospital has done different in comparison with other hospitals?
7. What additional resources will be needed to address gaps between current practices and newly identified needs?
8. What resources are currently available in the local community?
9. What resources will need to be developed internally?
10. What specific steps need to be taken to best obtain and utilize these additional resources?
11. Do you feel there is just a lesser demand for many different languages at your hospital in comparison to other hospitals?
12. What is the language of highest demand at your hospital?
13. Are there any hospital association groups that are giving trainings to facilities on how to implement the LEP requirements?
14. How are the LEP persons being identified?
15. Who is currently being used to interpret, under what conditions, and how often?
16. What types of information are being translated, into which languages?
17. What types of interpreter services, at what frequency, are needed to serve the hospitals patient population?
18. Would you be willing to share your model with other hospitals?

Survey Questions for LEP Patients

Which of the following has happened to you in your health care interactions:

- Have you ever been asked to bring your own translator?
- Have you had to take your child out of school to translate/Interpreter for you for a doctor's appointment or for other medical assistance?
- Have you ever had a janitor or a stranger translate for you because there was no qualified translator nearby?
- Have you had to wait a long time for a translator/Interpreter? If so, how long_____
- Have you ever felt discriminated because:
  [] English is not your primary language?
  [] You felt information provided to you was not timely and accurate?
  [] Your confidentiality was not protected?
- Have you ever been given the wrong translation?
- Because of mistranslation have you been misdiagnosed or given the wrong medication?
- Are you willing to share your experience regarding language barriers? OR Do you know someone else who is willing to share their experience?