CE

Ensuring Language Access at Sutter Health

Assessing and Training Dual Role Interpreters

Maria Moreno, MPH[1]
Regina Otero-Sabogal, PhD[2]
Christy Soto[1]
Traci Van[1]
Jeffrey Newman, MD, MPH[1, 2]

Sutter Health
With You. For Life.

Sutter Health Institute for Research and Education[1]
Institute for Health and Aging, University of California, San Francisco[2]

This paper highlights the Language Access program at Sutter Health in Northern California, a not-for profit hospital system of 26 affiliated hospitals and 9 medical foundations. The objective of this program is to improve language access to limited English proficient patients served by Sutter Health hospitals and physicians through two services:

1) Assessing bilingual staff that serve a dual role as ad-hoc interpreters.
2) Providing interpreter skills training for ad-hoc interpreters through a Web-based, interactive course.

This program was funded by The California Endowment.

Approximately 33 percent of the population in the Sutter Health coverage area is are considered limited English proficient (LEP).[1] Nationally, 49.6 million U.S. residents cannot speak the same language as their medical provider. Meeting the language needs of these patients is a practical necessity, and an integral component of providing patient-centered care. The literature associates language barriers with increased medical errors, misdiagnoses and decreased access to acute

care and preventive services. When appropriate interpreter services are not provided to LEP patients including the use untrained ad-hoc interpreters, the potential for medical errors increases while quality of care decreases.

Sutter Health's Commitment to Language Services

Sutter Health is addressing language access barriers by (1) establishing a process to accurately and completely test language competency of bi-lingual staff that serve as ad-hoc interpreters (2) developing and instituting an efficient and cost-effective system of training bilingual staff with interpreter skills. Implementing these processes in our hospitals, as well as the medical foundations and ambulatory settings, can reduce the cost of care and increase the quality of patient care, fulfilling the Sutter Health mission of enhancing the well-being of people in the communities we serve through compassion and excellent health care services.

Language Access for LEP Patients in US and California

In a 2006 national survey, 80% of hospitals reported frequent encounters with LEP patients, of which 43% reported doing so on a daily basis.[2] California has some of the most racial, ethnic, and linguistically diverse communities in the U.S., with 26% of its residents foreign-born; the highest percentage of any state.[3] Moreover, about 40% of Californians speak a language other than English at home. In 2000, the US Census found that 48% of the 815,000 native Chinese speakers in California considered themselves LEP.

Sutter Health's communities are even more diverse than California as a whole. For example, 37% of Santa Clara County's population is identified as LEP, and more individuals in the County report Spanish than English as their primary language.[4] Similarly, 47.5% of the residents of the City and County of San Francisco are not native English speakers, while 25% report speaking English "less than very well."[5] (See Table 1)

Impact of Communication Barriers in Health Care

Health care provider's ability to communicate across language barriers and understand socio-cultural circumstances is critical to deliver healthcare quality to racially and ethnically diverse patient populations.[6-8] Often clinicians turn to bilingual staff for ad-hoc interpretation, serving as dual-role staff interpreters. Commonly, these staff are untrained in interpretation protocols, lack medical terminology, and rarely are tested in language competency for English or the second language. Ad-hoc interpreters may themselves be limited English proficient or lack adequate vocabulary, and can ultimately serve as "language brokers" who informally mediate, rather than relay accurate information between the patient and provider.[9]

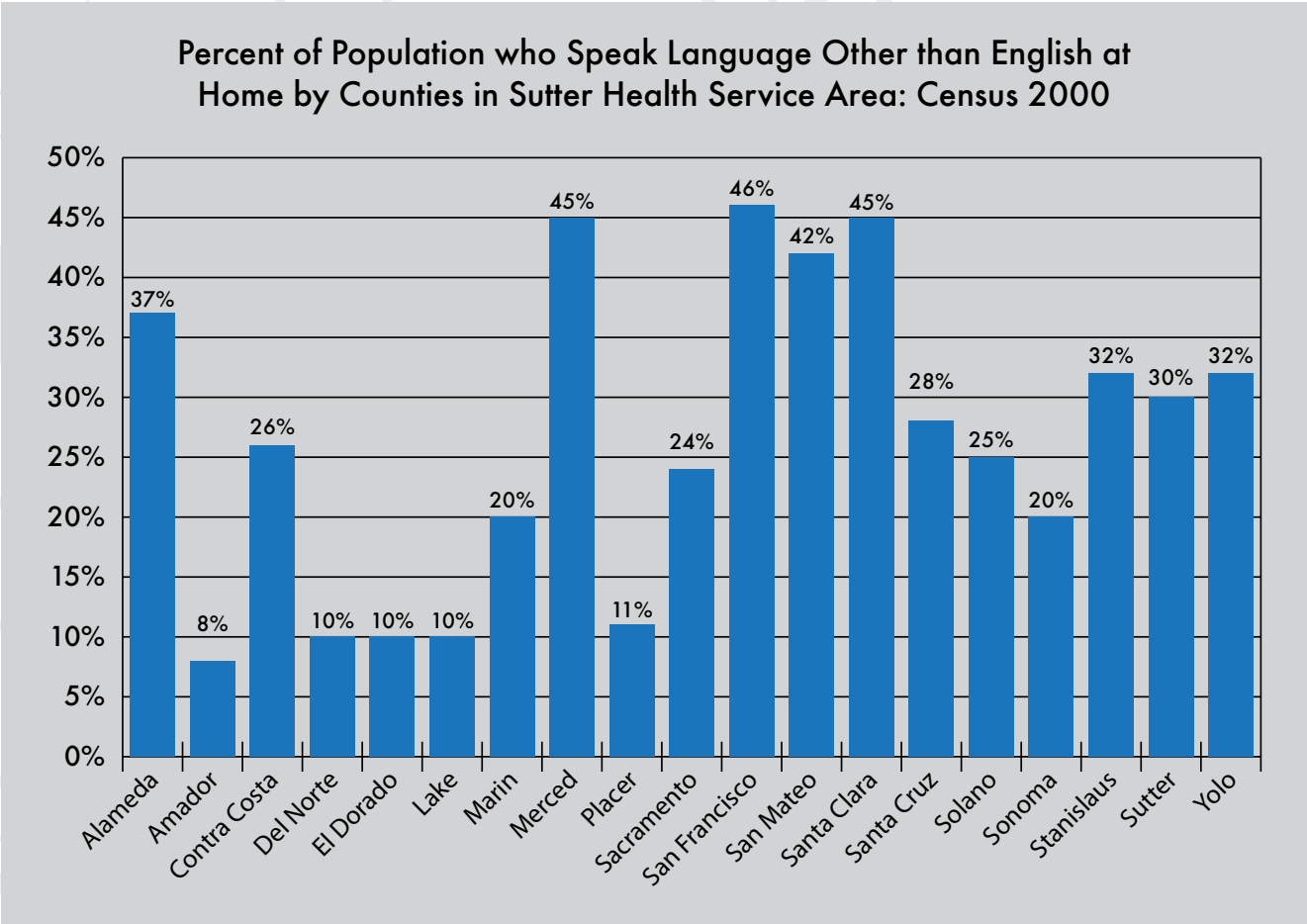
> *"The single most important component needed to improve the quality of care for patients is having an 'informed' patient. Language and cultural barriers impede this process."*
>
> —Gordon Hunt, M.D.,
> Senior Vice President
> Chief Medical Officer
> Sutter Health

Language barriers can diminish quality of care and lead to serious complications and adverse outcomes. Studies have shown that LEP patients are less likely to have a regular source of primary care, less likely to receive preventive care, and are more likely to experience medical errors.[10-11] Ultimately these barriers may result in poorer clinical outcomes[6] and increased medical errors[8] due to LEP patients' inability to describe their symptoms, understand their diagnosis, make informed decisions about treatment options, and follow through with recommended treatments. A recent study revealed that while interpretation errors of potential clinical consequence occurred in 12 percent of encounters using trained interpreters, they occurred in 22 percent of encounters using untrained interpreters.[12]

Use of Interpreters to Address Language Barriers

Although the federal and state governments have imposed numerous requirements for interpretive services to address LEP patient issues, The Joint Commission reports that only 3% of responding hospitals receive direct reimbursement for provision of interpretive services, with 78% of those reimbursements coming from Medicaid.[13] California does not receive matching funds for interpretive services

Table 1



for Medicaid and the State Children's Health Insurance Program (SCHIP) programs.[13]

Although many organizations, including The California Endowment, American College of Physicians, American Academy of Family Medicine, the American Medical Association, and the National Alliance for Hispanic Health have called for the Medicare program to pay for interpretive services, those calls have so far gone unheeded.[14] The Joint Commission reported in 2007 that fifty-four of sixty hospitals surveyed identified financial stressors related to providing language services. Many reported difficulty in staffing to meet the required cultural or linguistic competency.[15] On Jan. 1, 2009, California implemented SB 853 which mandated that HMOs provide interpretive services to their enrollees. The implementation of this law is an ongoing project within the state's health plans, however, it has had limited impact on the struggles that providers face in providing appropriate interpretive services.

Despite the fact that the literature demonstrates the benefits and need for competent interpreter services, current policies are limited and unclear.

Federal Regulations for Medical Interpreting

Numerous state and federal laws require health care providers to provide language assistance to patients who do not speak English. At the federal level, both Title VI of the Civil Rights Act of 1964 ("Title VI") and the Emergency Medical Treatment and Active Labor Act ("EMTALA," 42 USC 1395dl) require language assistance to be provided without charge to all LEP patients. These laws apply to Sutter Health because we receive federal funds from Medicare, Medicaid and SCHIP. Additionally, the Americans with Disabilities Act ("ADA," 28 CFR 36.303) require Medicare providers to accommodate persons with hearing disabilities by providing ASL interpreters at no cost

to the patient.

At the state level, California Government Code Section 11135 is the state counterpart of Title VI. In addition, California Health and Safety Code Section 1259 ("Section 1259") requires acute care hospitals to have, publicly post, and annually submit to the state Department of Public Health (DPH) a policy describing the availability of language interpretation services for non-English speaking patients. In addition, services must be provided for ASL patients and for any non-English language spoken by 5% or more of (a) the general population in the area served by the hospital or (b) the actual patient population. Interpreters must be available 24 hours a day, in person or telephonically, and procedures must try to make this availability actual. Patient records must include patient's primary language, a list of interpreters must be maintained, and all standard forms must be reviewed to determine which patients need translation. Section 1259 also recommends (but does not require) that hospitals should provide non-bilingual staff with standardized pictures and phrase sheets for communication, and/or develop community liaison groups to ensure adequate interpretation services.

As part of Title VI Executive Order 13166 was issued entitled "Improving Access to Services for Persons with Limited English Proficiency" [65 FR 50121- August 16, 2000], stating that every federal agency providing financial assistance to non-federal entities were required to publish guidance on how their recipients could provide meaningful access to LEP persons and thus comply with Title VI requirements. Consistent with that order, HHS developed its own guidance document on August 30, 2000 [Section VI. A.], which addresses the considerations relating to competency of interpreters and translators, which reads:

> *"Any health care provider that receives federal financial assistance from HHS (i.e. participating in the Medicare and Medi-Cal programs) must have a process in place to demonstrate fluency of speaking, reading and writing in both English and a second language, including the ability to translate the names of body parts and to competently describe symptoms and injuries in both languages to be considered a "competent interpreter."*

Existing guidelines are not clearly defined and a "formal certification" process to demonstrate interpreter competence does not exist. Dual-role staff interpreter testing and training is left to individual facilities nationwide resulting in varied quality assurance, which demonstrates the need to assess best practices and set a standard for all dual-role staff interpreters.

Sutter Health: An Integrated Health Care System

Sutter Health was initiated as a group of independent health care providers, but rising costs and declining payment for services made it difficult for hospitals and physicians to continue operating on their own. In the last decade, more than 100 Northern California hospitals have had to close their doors, and the majority of the State's physician groups are facing significant problems. In January 1996, the merger of Sacramento-based Sutter Health and Bay Area-based California Healthcare System created the current Sutter Health hospital system serving Northern California.

Sutter Medical Centers care for more inpatients than any other network in Northern California and leads the market in infant deliveries, cardiology, cancer and internal medicine. Sutter Health affiliates serve more than twenty Northern California counties, from the Oregon border to the San Joaquin Valley, and from the Pacific coast to the Sierra foothills, delivering services to approximately 18.4 percent of inpatients in Northern California, which encompasses all counties north of Fresno County.

Sutter Health is comprised of twenty-six hospitals, nine medical foundations, and over 3000 physicians. According to Census 2000 data, 1.5 million residents within the communities our affiliates serve can be categorized as LEP and speak languages other than English at home. Of the total LEP population, 49 percent speak Spanish, 12 percent speak Indo-European, and 39 percent speak Asian languages at home.

Methods

Sutter Health addresses language access needs through two programs:

1) Assessing language proficiency of bilingual staff serving as ad-hoc interpreters.
2) Training bilingual staff interpreters

to improve interpreter skills, knowledge and confidence.

1. Assessing Dual-Role Interpreters Language Competency

In 2004, Sutter Health began assessing dual-role staff interpreter's language competency using an external vendor.

Approximately 1,200 Sutter Health bilingual employees throughout the system have completed the language competency test. The exam tested accuracy, comprehension, communication, and medical terminology in English and the second language. Dual role staff interpreters at Sutter Health have been tested in 16 different languages.

Language Competency Test

The test consists of a thirty minute language competency evaluation done over the phone. Staff must score at least a 75% on the four sections (foreign language, English, significant interpreter errors, and medical vocabulary) to pass. The evaluation process assesses staff language competence at one of three levels: **a)** no pass, **b)** basic, or **c)** medical-level. Language Line University (LLU) provides certifications for 149 different languages and allows us to comply with federal guidelines to test medical interpreters.

The assessment exam consists of an oral component in English and the second language. LLU provides analysis of various skills used during an interpretation session. They are divided into 2 main areas and then into sub-categories: communicative skills (interpreter skills and customer service skills) and significant errors (content, proficiency, and interpreter protocol).

Table 2

Certification Results	Appropriate Use/Role
No certification	The staff member did not pass the language-competence test and is informed what language and skill areas to strengthen before attempting to take the test again. Meanwhile, staff must work with a certified or professional interpreter when caring for LEP patients.
Basic Dual-role Interpreter Certification	If a staff member passes at this level, they should be able to speak the language fluently and has some knowledge of basic medical terminology. This staff is best used for interpretation that DOES NOT include medical dialogue regarding health conditions, symptoms, diagnosis, or discharge instructions.
Medical Dual-role Interpreter Certification	If a staff member passes at this level, they should be able to speak the language fluently and has command of medical terminology. This staff member is best used for direct dialogue regarding health conditions or symptoms, diagnosis and discharge planning.

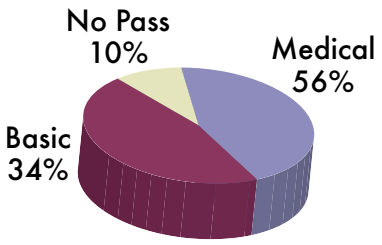
The vendor applies a Likert scale (1-5) to measure the skill level of each staff person in each interpreter skill categories. (see Table 2)

Results

Among the 1,200 bilingual staff tested, the majority passed at the Medical level (56%) with approximately one third (34%) passed at the Basic level. One of out of ten staff members tested for language competence did not pass the exam in either English or the second language spoken.

The most frequently tested language

Chart 1



is Spanish with 76% of the staff evaluated in this language. 6% of the staff were evaluated in Cantonese and 4% in Mandarin (Chinese dialects). Less than 5% of the staff evaluated were tested in other languages. (See Chart 2 on opposite page)

Language Competency Tested Categories

The testing vendor uses a Likert scale to measure skills in language competence. Overall, staff at Sutter Health demonstrate good language skills with the best area being speed and pace. (See Table 3 on opposite page)

The areas of improvement where staff are making significant errors include omissions and deletions of critical information during an interpretation session. (See Table 4)

2. Skills Training for Bilingual

Chart 2

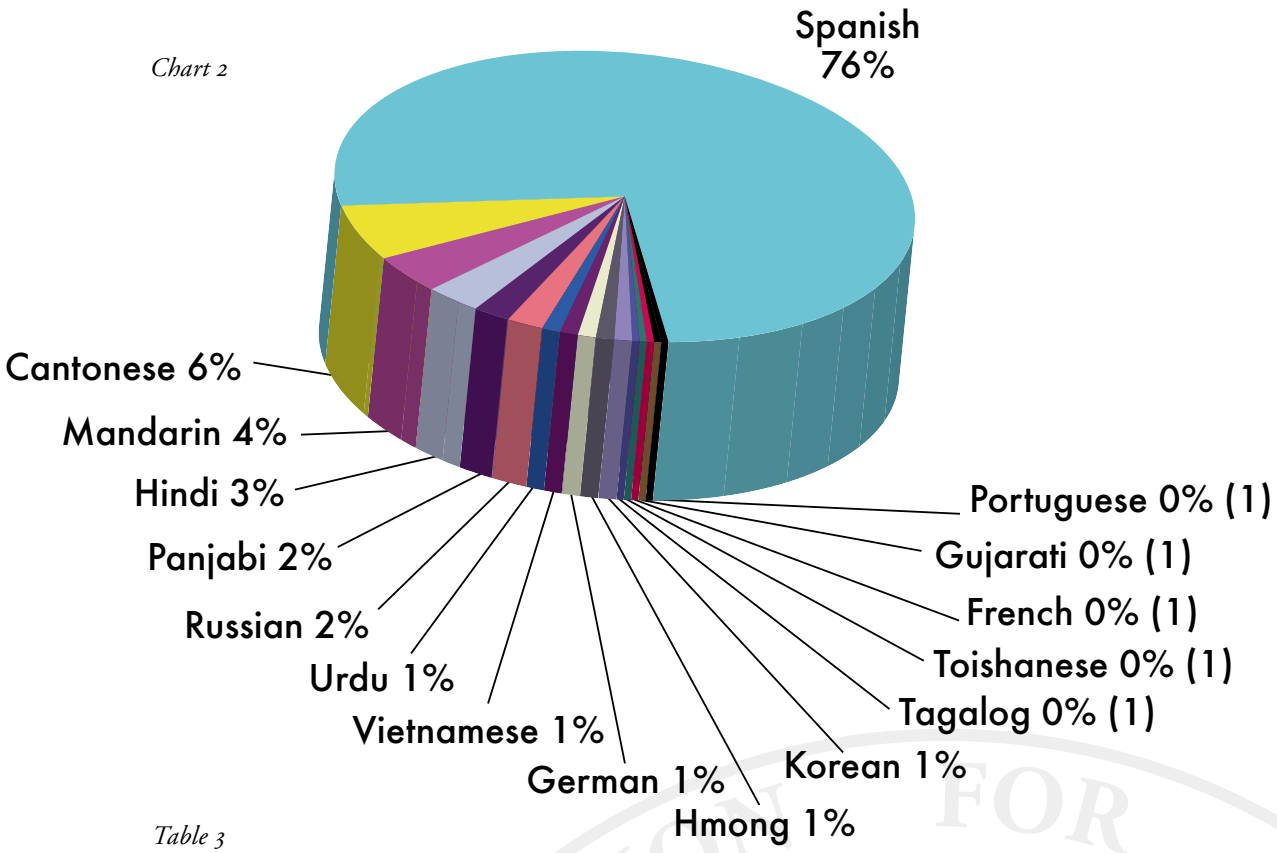
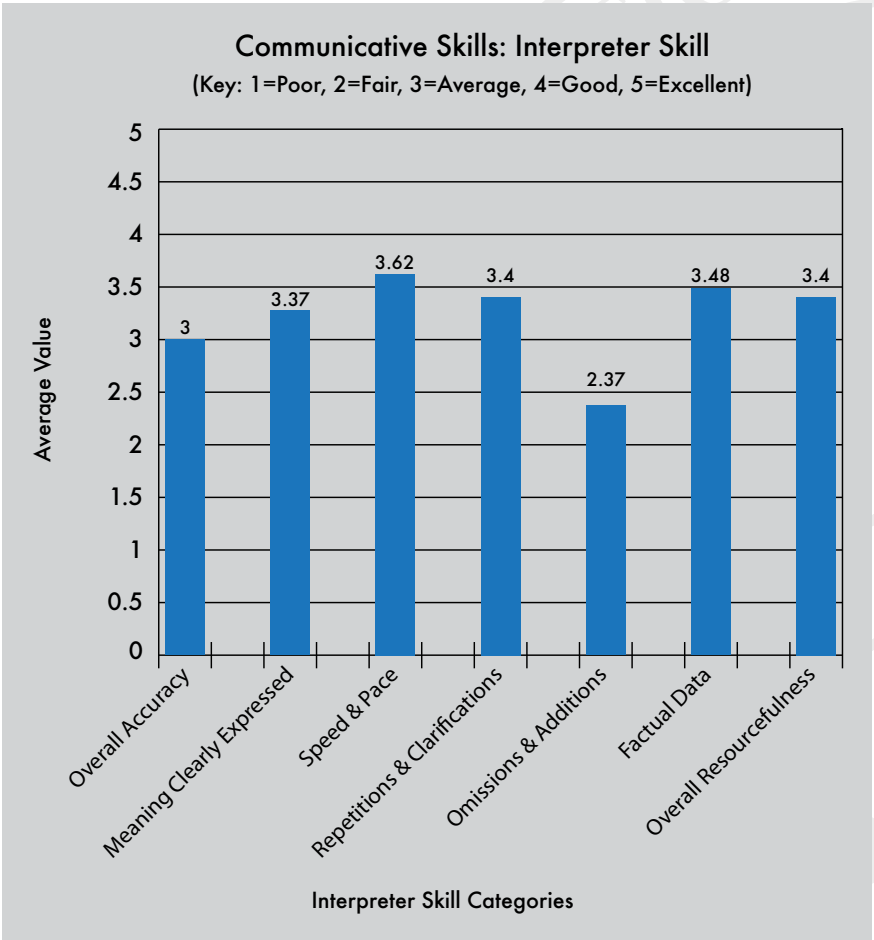


Table 3



Staff Ad-hoc Interpreters

Interpretation in a medical context requires very specific skills. Merely being "bilingual" does not automatically make an individual an effective interpreter. Quality interpretation requires not only proficiency in both languages, including specialized medical terminology, but also "critically important memory skills, the ability to negotiate a three-way conversation, and basic knowledge of cultural attributes that can influence health."[1] The Health and Human Services' Office of Minority Health (HHSOMH) has developed national cultural and linguistic standards addressing culturally competent care, language access services and organizational supports for cultural competence.[2] Following HHSOMH's lead,

Table 4

Interpreters' Areas of Improvement	Recommendations for Improvement
• Omitting words or phrases • Adding words or phrases • Overall accuracy • Changed or misinterpreted utterance • Medical terminology • Not using the "first person" as it was originally stated	• Medical terminology- read, practice, use medical glossaries when necessary • Exposure to media sources in second language (newspaper, TV, speak conversationally) • Take conversational classes in second language • Practice with colleagues or friends using your second language to improve grammar, pronunciation, and vocabulary

the California Healthcare Interpreters Association (CHIA) has also developed standards of practice, which "serve as the basis for the development of interpreter training curriculum."[3]

Web-based Interpreter Training

The objectives and content for the HealthStream Web-based, on-the job training for dual-role medical interpreters was designed based on needs assessment using focus groups with ad-hoc interpreters, Sutter Health training policies, content, evaluation and consultation with technical experts. The HealthStream Web training is interactive, self-paced, easily accessible, targets interpreters with different levels of knowledge and skills, provides learning aides using audio and video to reinforce learning objectives, and provides individual feedback throughout the course. The course has end-result measurable objectives. We expect significant improvement on post measures of knowledge, skills and interpreter's confidence when compared with pretest scores and with a comparison group of interpreters who did not take the course.

This five module Web training is designed for Sutter Health bilingual staff who serves as ad-hoc interpreters to improve their interpreting skills, knowledge, and confidence when interpreting in a healthcare setting. Each module takes an average of 30 minutes to complete. The total course takes approximately 2.5 hours to complete. After each module, the interpreter completes 10 true –false and multiple-choice post-test questions to assess knowledge and skills improvement. If the interpreter does not pass, he or she completes the post-test as many times as needed; the test questions are randomly pulled from a pool of 20 questions. Each one of the post-test answers provides feedback of why it is correct or incorrect providing further opportunity for learning. The training should be completed over the course of three months. After completion the interpreter receives a certificate as an incentive.

All staff members that have completed the language competence language testing can take the training online through HealthStream, a Sutter Health web-based training resource, and are encouraged to do so. Approximately 250 staff members have begun the Interpreter Skills Training. Since it was made available to all staff at Sutter Health in 2008, over 300 bilingual staff have started the training on HealthStream.

Sutter Health implemented a clinical trial of 49 staff that took the pre and post-test without completing the training and compared it to 150 staff members that completed the pre test, took the five-module training, and completed the post test.

Data analysis is under way. We expect the intervention group will improve their interpreter skills, knowledge, and confidence compared to the control group.

Conclusions

These studies document Sutter Health's effort to test and train dual-role interpreters and provide an initial step toward developing an organizational model for improving language access among LEP patients.

The first study found that about 1 out of 2 dual-role interpreters passed at the Medical level with approximately one third passing at the Basic level. One out of ten staff members tested for language competence did not pass the exam in either English or the second language spoken. These results indicate that staff interpreters at a large health care system are not sufficiently competent in their bilingual language skills to serve

as interpreters in a medical encounter, stressing the importance of language competence testing and training. Staff interpreters who passed as basic interpreters did not demonstrate the ability to sufficiently speak, read, or write English or the second language and had insufficient knowledge of medical terminology. Interpreting errors in a medical setting can result in misinformation, prescription errors, poor treatment adherence, and less patient satisfaction among limited English proficient patients. Not reading or writing a language can also lead to serious errors, especially in circumstances when staff are asked to translate consent forms, treatment regimens, or follow-up instructions.

The second study will demonstrate the effectiveness of the web training in improving interpreters' knowledge about their role as interpreters, their ethical dilemmas when performing their job, and their communication skills.

Sutter Health's effort to test and train interpreters support the Joint Commission report on the importance of assuring adequate language services to ensure quality care and patient safety in health care.

Further efforts are necessary to guide legislation and to demonstrate whether assessing and training interpreters' language competence within the health care setting can impact the quality of care and patient satisfaction.

References

1. *The federal government considers Limited English proficient individuals to be individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English*
2. *Hospital Language Services for Patients with Limited English Proficiency: Results from a Natural Survey. Health Research and Education Trust, Romana Hasnain-Wynia, October 2006.*
3. *In the Right Words: Addressing Language and Culture in Providing Health Care. Issue brief No. 18, Aug 2003, Grant Makers In Health*
4. *California Speaks. Language Diversity and English Proficiency by Legislative District. A report from the Asian Pacific American Legal Center of Southern California and the Asian and Pacific Islander American Health Forum, Daniel Ichinose*
5. *Health In Brief…Policy Issues Facing a Diverse California. The California Endowment, April 2003.*
6. *In the right words: addressing language and culture in providing health care. Grantmakers in Health. 2008 Aug; 18.*
7. *http://www.iom.edu:Confronting Racial and Ethnic Disparities in Health Care.*
8. *Hornberger JC, Gibson CD Jr., Wood W. et al. Eliminating language barriers for non-English speaking patients. Med Care. 1996; 34(8):845-6.*
9. *Language Services Resource Guide for Health Care Providers. National Health Law Program and National Council on Interpreting in health Care. 2007.*
10. *Jacobs E, Shepard D, Suaya J, Stone E, "Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services," American Journal of Public Health: Vol. 94, No. 5, May 2005.*
11. *Kaplan SF, Greenfield S. Ware JE. Assessing the effects of physician on the outcomes of chronic disease. Med Care. 1989;27 (7):679 (Jul).*
12. *Health in Brief…Policy Issues Facing Diverse California. The California Endowment, April 2003.*
13. *Paying for Language Services in Medicare: Preliminary Options and Recommendations. Leighton Ku. The Center on Budget and Policy Priorities. October 2006.*
14. *Hospitals, Language and Culture: A Snapshot of the Nation. Wilson-Stronks A, Galvez E. 2007*
15. *Wilson-Stronks A., Galvez E.: Hospitals, Language, and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings. The Joint Commission, 2007.*

CE Application page 28
CE Post Test page 29