Wisconsin Coalition for Linguistic Access to Healthcare

Resource and Needs Assessment
Report of Findings

October 11, 2004

By
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EXECUTIVE SUMMARY

Over the past fifteen years, Wisconsin's changing demographics have had a significant impact on our health care system. Census data indicate that the proportion of Wisconsin's total non-White or Hispanic/Latino population rose from 7.8% in 1990 to 11.1% in 2000 and now represents 3.6% of the total population. The Asian population also grew rapidly and by 2000 Asians represented 2% of Wisconsin's population with most of the growth due to an influx of Hmong refugees beginning in 1975. .

Language barriers affect multiple aspects of health care and studies have demonstrated that individuals with limited English proficiency (LEP) experience disparate health outcomes in comparison to those who speak English. Wisconsin's changing demographics have created a rapidly growing need for language interpreters who can enable limited English proficient patients to access health care services. Studies have suggested that untrained bilingual volunteers and staff who provide *ad hoc* interpretation commit more serious errors than trained professional interpreters and these errors could potentially result in negative clinical consequences. Federal laws mandate that health care organizations provide linguistic access for LEP patients and although they strive to provide quality language services to diverse population groups, health care organizations are challenged to achieve this goal.

The Wisconsin Coalition for Linguistic Access to Healthcare (WCLAH) was created in 2003 to improve the quality of health services for LEP populations. The coalitions' members represent many diverse organizations and share the vision of a future *statewide system that leads to positive health care outcomes for populations with limited English proficiency*. Components of this ideal system will include a sufficient supply and distribution of qualified medical interpreters; healthcare systems that value/demand access to qualified interpreters; oversight to assure quality, provide a means to link interpreters with health care organizations and identify/address unmet needs; and policies and resources that support the system. One of the coalition's major first year initiatives was to quantify issues related to the provision of health care services to Wisconsin's limited English proficient populations by surveying a sample of the state's health care organizations on existing needs and resources. The goal of the study was to address the following questions:

1. How are health care organizations providing interpreter services to non-English speaking people?
2. Is the current supply of qualified interpreters adequate to meet the needs of health care organizations?
3. How are health care providers and staff prepared to work effectively with interpreters?

The study sample included 214 organizations; 103 general hospitals, 96 local public health departments, and 15 federally qualified health centers. They were surveyed by mail using a tool developed for the study. It consisted of a written, 21-item, structured, self-administered questionnaire with a combination of open-, closed-ended and fixed alternative questions. The following is a summary of the study results:

- There was a 62% response rate overall, with returns from 57 hospitals, 66 health departments and 10 health centers.
- Nearly half of respondents need interpreters fewer than five times per week and 14% never need them, but 23% need interpreters more than 20 times per week.
- Most hospitals have written policies related to services for LEP patients, most health departments do not.
- Well over half of all respondents indicated that they *sometimes or usually* have difficulty providing services. Most use national telephone interpreter services or reschedule visits to a time when an interpreter is available, but 20% provide care to LEP patients without any interpreting at times.
- Among respondents approximately 30% of hospitals and community health centers, and 12% of health departments employ people to work exclusively as interpreters.
- Fifty-three percent of hospitals and 70% of community health centers have bilingual health care providers who are capable of providing services to LEP patients in their own languages.

- Over 70% of hospitals and health departments responding to the survey utilize independent or contract interpreters, and 51% of hospitals use the services of agencies that employ interpreters.
- Over half of all respondents indicated that they use family and friends as interpreters.
- Organizations listed 28 different languages that they encounter, with the most common being Spanish (89%), Hmong (32%), Chinese/Mandarin (23%), and Russian (19%).
- Most, but not all organizations require or prefer their hired interpreters to be proficient in English and a second language.
- There was a wide range of responses regarding costs of providing interpreter services, but almost all indicated that their costs must be included in the organization's budgeted overhead expenses because cost recovery options are not available.
- Training of providers and staff on how to work effectively with interpreters is not being provided by the vast majority of organizations surveyed.
- There is a need for more information about translation of written documents and the reliable resources available.

Results suggest that a number of barriers exist, limiting the ability of Wisconsin's hospitals, health departments and community health centers to consistently provide quality care to their patients with limited English skills. These barriers include the following:

- Organizations do not have easy access to resources and information on the provision of care to LEP patients.
- Many organizations currently have only occasional need for interpreter services.
- Periodic and/or standardized training opportunities for interpreters are not readily available.
- Most organizations do not have a process in place to determine the level of skills of their interpreters.
- Providers and staff are generally unaware of best practices in providing care to LEP patients.
- There are high costs associated with providing interpreter services and limited reimbursement is available.

The Wisconsin Coalition for Linguistic Access to Healthcare is developing several exciting projects to further its vision of a statewide system leading to positive health outcomes for populations with limited English proficiency. Planned for development during the next year are:

- Creation of a web site to serve as the Wisconsin health care interpreting information and resource center. It will contain information on interpreter standards, roles, and training opportunities; related laws, advocacy, and best practices; training opportunities for health care providers and advocates; model community collaborations that improve access; sample policies and procedures; and resources for high quality translated materials.
- Delivery of a regular series of continuing education offerings for interpreters.
- Development, testing and distribution of training materials for health care providers on working effectively with medical interpreters.
- Support for development of local or regional interpreter services consortia.

The statewide dissemination of findings from the Resource and Needs Assessment is one of the coalition's strategies to raise awareness about unequal access to quality health care services for those with limited English skills and to inform everyone about available resources that can help reduce disparities in access. The WCLAH members will share the study report by offering to bring presentations and displays to health care-related meetings or workshops and by submitting articles to professional publications and other media outlets.

INTRODUCTION

Over the past fifteen years, Wisconsin's changing demographics have had a significant impact on our health care system. U.S. census data indicate that the proportion of Wisconsin's total non-White or Hispanic/Latino population rose from 7.8% in 1990 to 11.1% in 2000. The Hispanic/Latino population more than doubled and now represents 3.6% of the total population. The Asian population also grew rapidly. By 2000 Asians represented 2% of Wisconsin's population with most of the growth due to an influx of Hmong refugees beginning in 1975. The impact of these changes on certain communities is much greater than these numbers imply. There are also many smaller ethnic populations located in Milwaukee and other parts of Wisconsin (Wisconsin Department of Health and Family Services, Division of Public Health, Minority Health Program, 2004). Residents with limited English proficiency (LEP) face major barriers to full and equal access to health care when they do not speak the same language as their health care providers.

Language barriers affect multiple aspects of health care and studies have demonstrated that individuals with limited English experience disparate health outcomes in comparison to those who speak English (Wisconsin Department of Health and Family Services, Healthiest Wisconsin 2010). Health care interpreters can reduce the impact of language barriers on access to care by facilitating effective communication between limited English proficient patients and health care providers. However, studies have shown that untrained bilingual volunteers and staff who provide *ad hoc* interpretation commit more serious errors than trained professional interpreters and these errors could potentially result in negative clinical consequences (Flores, et al., 2003). Federal laws mandate that health care organizations provide linguistic access for LEP patients. Although they strive to provide quality language services to diverse population groups, health care organizations find this to be a challenging goal to achieve (Anderson, 2002). In addition, organizational initiatives to make positive changes must be viewed as a long-term, on-going commitment to developing and maintaining cultural and linguistic competence (US Department of Health and Human Services, 2001).

The Wisconsin Coalition for Linguistic Access to Healthcare (WCLAH) was created in 2003 to improve the quality of health services for LEP populations. WCLAH members represent many diverse organizations and share the vision of a future *statewide system that leads to positive health care outcomes for populations with limited English proficiency*. Components of this ideal system will include a sufficient supply and distribution of qualified medical interpreters; healthcare systems that value/demand access to qualified interpreters; oversight to assure quality, provide a means to link interpreters with health care organizations and identify/address unmet needs; and policies and resources that support the system. One of WCLAH's major first year initiatives was to quantify issues related to the provision of health care services to Wisconsin's LEP populations. This was accomplished by surveying a sample of the state's health care organizations on existing needs and resources. The goal of the study was to address the following questions:

1. How are health care organizations providing interpreter services to non-English speaking people?
2. Is the current supply of qualified interpreters adequate to meet the needs of health care organizations?
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METHODS

Sample and Setting

Wisconsin AHEC Program Office conducted the survey on behalf of WCLAH. The sample included a total of 214 organizations: 103 general hospitals, 96 local public health departments, and 15 federally qualified health centers (Community and Migrant Health Centers and Health Care for the Homeless Programs).

Instrument Development and Pilot

In November of 2003, the WCLAH membership determined the importance of quantifying health care interpretation needs, resources, and issues throughout the state. Action committees of WCLAH focusing on interpreter training, health care provider training and organizational issues met in December to draft questions for inclusion in a survey tool. The interpreter training committee (WCLAH's *Workgroup A)* reviewed a survey tool created by Waukesha County Technical College (WCTC) for a labor market needs assessment (Waukesha County Technical College, 2004). The committee selected several questions from the WCTC survey tool for use in the WCLAH survey. The health care provider/organizational committee (WCLAH's *Workgroup B)* reviewed Anderson's Organizational Evaluation of Linguistic Access self assessment tool (Anderson, 2003). The committee decided that selected items from this assessment tool could also be adapted for use in the WCLAH study. Permission from the authors of both tools was requested and granted.

Draft survey questions were brought before the coalition in January of 2004 members provided ideas and suggestions. During the March coalition meeting, a revised draft survey tool and cover letter were distributed. AHEC Program Office staff piloted the survey in early May with five individuals, who were employed by WCLAH member organizations, but who were not involved in development of the survey tool. The final version of the survey tool and sample were approved during the May coalition meeting. AHEC hired a University of Wisconsin student hourly employee in June to work on the survey and planned to have the results and report ready by early fall.

The study design was a written, structured, self-administered questionnaire in English with a combination of open-, closed-ended and fixed alternative questions. It included 21 questions and according to pilot respondents it took an average of 20 minutes to complete. To help respondents with potentially unfamiliar terms used in the survey we included the following definitions, adapted from *The Terminology of Health Care Interpreting: A Glossary of Terms* (NCIHC, 2001).

> ***Limited English proficient (LEP)*** *refers to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter.*
> ***Interpreting*** *is the process of understanding and analyzing a* ***spoken*** *message and re-expressing that message accurately and objectively in another language, taking the cultural and social context into account.*
> ***Translation*** *is the conversion of* ***written text*** *into corresponding written text in a different language*

Although they could submit the survey anonymously, we asked respondents to provide names, titles and employing organizations to enable us to later provide information and clarify responses. A written assurance of confidentiality of responses was provided with the following statement:

> *Only Wisconsin AHEC staff working on this project will have access to the raw data from this survey and when the study is over, the data will be destroyed. The results of the survey will be reported in aggregate form only and your individual responses will not be identified or released to anyone.*

Data Collection Strategies

Before the survey was sent out, databases were created for hospitals, public health departments, and community health centers which contained contact information for each organization and a numerical identifier. In order to ensure the highest return rate possible, each of the hospitals was contacted by phone to determine the name of the employee who should receive the survey. The identified employee was then contacted, provided with a brief explanation of the study and survey, and asked to complete the survey for the hospital. The surveys were mailed directly to these individuals rather than to a general department of the hospital. Because of the smaller size of the public health departments and community health centers,

the surveys were sent directly to the health officer or center director respectively, and it was assumed that these individuals would either complete the survey or delegate the task to someone else.

Upon contacting the hospitals, we discovered that many of them shared interpreter services with another hospital or through a hospital system. For groups of hospitals that shared interpreter services, the survey was sent to the person who coordinates these services for the group. Therefore, out of the 121 hospitals listed in Wisconsin, only 103 were separately surveyed. In contrast, public health departments and community health centers do not seem to share interpreter services, so surveys were sent to all 96 health departments and 15 health centers.

The surveys were mailed along with a cover letter and a return envelope. Each survey had the numerical identifier of the organization at the top of the first page. The mailings were staggered throughout the summer, beginning in June and ending in August. Each organization was given three weeks to complete the survey. If an organization had not returned the survey by the given deadline, the individual to whom the survey was sent was contacted via phone or email and reminded to complete it. Some individuals either did not recall receiving the survey or had misplaced it, in which case surveys were resent via mail, email, or fax.

Data Analysis

Completed surveys were mailed or faxed to the AHEC Program Office where data were collected and entered into a Microsoft Excel file (Microsoft, Redmond, WA). A WCLAH subcommittee met to review the data, with identifiers removed, and discussed analysis and reporting of results. Wisconsin AHEC staff performed simple numerical analysis of the closed-ended and fixed alternative questions. They analyzed the open-ended items first individually and then in pairs to identify major themes in the data. Items contained in the survey tool were rearranged into five categories based on Anderson's *Parameters for Evaluation* (Anderson, 2003) and the *Four Keys to Tile VI Compliance in the LEP Context* (US Department of Health and Human Services, 2001). The categories were:

- Organizational Overview
- Patient Demographics
- Quality Management & Monitoring
- Training of Staff and Providers
- Translation Services

RESULTS

Surveys were mailed to a total of 214 organizations, and 133 were completed, for a 62% response rate. Sixty-six (67%) health departments, 57 (53%) hospitals and 10 (69%) community health centers returned surveys. The distribution of the positions of employees who completed the survey at hospitals is as follows: 39% administration; 18% social services, 16% interpreter services; 11% human resources; 5% nurses; and 11% did not include a title. As for public health departments, the majority of surveys (67%) were filled out by the health officer; 17% nursing directors; 9% public health nurses; and 8% did not include a title. In community health centers, the following positions were given: 60% executive director, 20% assistant director, and 20% did not include a title.

Organizational Overview

Policy

Most of the hospitals (95%) reported having written policies in place related to the provision of services for LEP patients and families and 75% of them have a department within the hospital responsible for coordinating interpreter and translation services. Only 56% of health departments and community health centers reported having written LEP services policies and procedures. Several health departments share interpreter services with other county departments, such as law enforcement.

Provision of Interpreter Services

We asked respondents to tell us all the ways in which they provide language interpreter services. The following is a summary of the results:

- Approximately 30% of hospitals and community health centers, and 12% of health departments employ people to work exclusively as interpreters.
- 53% of hospitals and 70% of community health centers have bilingual health care providers who are capable of providing service to LEP patients in their own languages, while only 26% of health departments have that capacity.
- 80% of community health centers employ bilingual staff, who provide interpreter services in addition to their primary duties. In contrast, only 44% of hospitals and 32% of health departments employ bilingual staff in this manner.
- Over 70% of hospitals and health departments utilize independent or contract interpreters and 51% of hospitals use the services of agencies that employ interpreters.
- Although only 20-30% of all respondents use interpreters for outgoing telephone calls, 80% of hospitals and 44% of health departments have interpreter services available for incoming telephone calls.
- Over half of all respondents included use of the patients' families and friends as a way they provide language interpreter services.

Methods used to provide interpreter services for LEP patients, based on responses from 133 hospitals, health departments and community health centers.

Method of providing language interpreter services	**Number of Responses**	**Percent**
Individuals employed by your organization to work exclusively as interpreters	**27**	**20 %**
Bilingual health care providers *	**54**	**41 %**
Bilingual employees **	**54**	**41 %**
Independent or contract interpreters	**92**	**69 %**
Agencies that employ interpreters	**47**	**35 %**
Telephone interpreter services for outgoing calls	**27**	**20 %**
Telephone interpreter services for incoming calls	**76**	**57 %**
Volunteer interpreters (not family or friends of patient)	**56**	**42 %**
Family and friends used as interpreters	**69**	**52 %**
Other	**2**	**<1 %**

*Bilingual health care providers = Doctors, nurses, etc. who are proficient in more than one language, enabling them to provide direct care to LEP patients using their non-English language.
Bilingual employees = Other employees, such as housekeeping staff, etc. who are proficient speakers of more than one language and are called upon to interpret for LEP patients, but are **not specifically employed as health care interpreters.

Interpreter Employees

A set of survey questions pertained only to organizations that employ individuals to provide interpreter services, either exclusively or in conjunction with other duties. Thirteen of the hospitals (23%) employ

bilingual individuals exclusively to provide interpreter services, employing anywhere from 1 to 18 individuals (average – 4). Only 7 health departments (11%) and 2 community health centers employed exclusive interpreters, with health departments hiring 1-6 (average number – 2) and both community health centers hiring a single individual. It was more common for all organizations to use employees hired for other positions to provide interpreter services; 54% of hospitals, 27% of health departments; and 60% of community health centers do this. Of these organizations, hospitals reported a range of 1-30 (average – 6) employees, but one hospital reported having 87 bilingual employees. Public health departments use between 1 and 8 (average - 3) bilingual employees for interpreting. Community health centers depend more heavily on this resource and use between 1 and 23 (average – 10) bilingual employees to provide interpreter services.

For organizations that employ people to provide interpreter services, more than half of the interpreting employees are bilingual Spanish/English. In health departments and community health centers, the second most common employee language is Hmong. In hospitals however, the second language is German, which was not a language commonly encountered in patients, but this was closely followed by Hmong and Russian. Many other languages were also reported, however most are only spoken by single employees, and many were not listed as those encountered at that hospital.

Costs of Providing Interpreter Services

We asked survey respondents to estimate the cost to their organization of providing interpreter services and to describe how they recover those costs. There was a wide range of responses, with an average of approximately $50 per encounter and a range of $25 - $120. They also reported paying agencies or individual contractors an average of $35 per hour, often with a two hour minimum, but responses ranged from $20 -$150 per hour. For those organizations that employ interpreters, wages, excluding benefits were reported to be $9.50 - $27 per hour, with an average of approximately $16.75. Expenses for telephone interpreter services ranged from $1.59 to $8.00 per minute, but respondents did not provide sufficient detail about monthly services charges or contracts to allow accurate comparison of these costs.

Almost all indicated that their costs are included in their organization's budgeted overhead expenses, or in the case of health departments, the county's expenses. A few respondents have received limited-term grant funding to help cover the cost of providing services to LEP patients. However, one respondent indicated that costs are recovered indirectly through "better services to patients, better outcomes, and less liability exposure."

Patient Demographics

Volume of LEP Patients

Nearly half of all organizations require the services of an interpreter fewer than five times per week and 14% reported that they never need them. Less than 13% of the survey respondents need interpreters 6 – 20 times per week, but 23% need them more than 20 times per week. Two hospitals indicated that they use interpreters more than 200 times each month.

Languages of LEP Patients

Organizations were asked to identify the top six non-English languages that they encounter among their patients and list them in order of frequency. Spanish was listed as the most frequently encountered language for over 81% of respondents, followed by Hmong at 11%. Spanish and Hmong were also the second most frequently encountered languages at 14% and 22% respectively. The following table includes all languages identified in responses to this question and the number of times each language was listed.

Language	# of times listed	% listed
Spanish	118	89%
Hmong	43	32%
Chinese and/or Mandarin	30	23%
Russian	25	19%
American Sign	11	8%
Bosnian	7	5%
Albanian	6	5%
Laotian	6	5%
Somali	6	5%
Vietnamese	6	5%
Polish	5	4%
Serbian	4	3%
Arabic	3	2%
Cambodian	2	2%
French	2	2%
German	2	2%
Korean	2	2%
Burmese/Arabic	1	1%
Croatian	1	1%
Czech	1	1%
Farsi	1	1%
Greek	1	1%
Italian	1	1%
Japanese	1	1%
Norwegian	1	1%
Pakistan	1	1%
Turkish	1	1%

Monitoring LEP Patient Volume and Languages

Of the organizations that serve LEP patients, 85% indicated that each patient's primary language is *always* or *usually* documented in the medical record, and 75% *always* or *usually* documented the use of an interpreter during the patient encounter.

Quality Management

Overall Ability to Provide Interpreter Services to LEP Patients

Organizations were asked to assess the level of difficulty they experience providing health care interpreter services to their LEP patients. Forty-five percent of hospitals and 30% of health departments and community health centers reported that they *rarely or never* have difficulty. Conversely, between 64% and 70% of all respondents indicated that they *sometimes or usually* have difficulty and 7% of health departments and community health centers *always* do.

We asked organizations to describe what happens when a LEP patient arrives for care and they are unable to provide interpreter services due to the time of day, clinic location, unexpected primary language, or for other reasons. Some respondents reported that their organizations use several different strategies to address this situation. Thirty-eight percent of health departments and 77% of hospitals can utilize a national telephonic interpreting service to find an interpreter. Twenty-seven percent of health departments and community health centers reschedule appointments, while only 9% of hospitals reported doing so. Overall 20% of the respondents indicated that at least sometimes they "make do" using ineffective

methods of providing services to LEP patients. All themes that emerged in the analysis of this open-ended question are summarized in the table below.

Theme	Number of Responses	Percent of Organizations
Use national telephone interpreter service	73	55 %
"Make do" and provide care by attempting to communicate with simple phrases/basic questions or attempt to find an employee, family member, or someone who is bilingual	27	20 %
Reschedule visit	26	19 %
Ask an employee or a local agency or individual to come to organization or interpret by phone	20	15 %
Has never happened	17	13 %

Qualifications for Employee Interpreters

Two items on the survey relate to organizations' expectations regarding education, experience and skills of their employees who provide interpreter services. Thirty-nine percent *require* employees who provide interpreter services to have a combination of interpretation experience, formal interpreter education or training, and/or competency testing, while 59% of the organizations *prefer* similar qualifications. A total of 63 organizations reported that they employ interpreters and/or other staff to provide interpreter services. Skill proficiency expectations were fairly consistent across the three types of organizations. The following table summarizes the data.

Interpreter Skills Expectations	Required	%	Preferred	%
Demonstrated proficiency in English	53	84%	9	14%
Demonstrated proficiency in second language	40	64%	21	33%
Oral interpretation	45	71%	17	27%
Written translation	24	39%	30	48%
Interpretation of medical terminology	28	44%	34	54%
Ability to discern cultural differences in communication	20	32%	40	64%

Training of Staff and Providers

Although health care facility staff and providers often do not have expertise in communicating with LEP patients, 61 (46%) of the survey respondents reported that their organizations do not offer any training in this area. A checklist of related training topics was provided and the remaining 55% of respondents were asked to specify the topics they cover in trainings. The following table provides details on the combined results from all three organization types. The top four most frequently included topics are *how to arrange for an interpreter* (38%), *policies and procedures* (35%), *appropriate use of interpreters* (32%), and *cultural issues* (30%).

Training Topics	Number	Percent
How to arrange for an interpreter	51	38 %
Policies and procedures related to language interpretation services	47	35 %
Appropriate use of interpreters	42	32 %

Cultural consideration in providing care to your organization's LEP patients	40	30 %
Appropriate use of a telephonic interpreter	37	28 %
How to determine whether an interpreter is needed	33	25 %
How to work effectively with limited English proficient patients	31	23 %
When to call a face-to-face interpreter and when to call a telephonic interpreter	25	19 %

Only 13 (10%) of the organizations offer training that covers all of the suggested topics. A few organizations indicated that they offer training on additional topics, including *Spanish courses or basic Spanish phrases and questions* (4), *demographic issues*, *federal regulations*, and *Bridging the Gap* (Cross Cultural Health Care Program). Of the 73 organizations that offer training, 88% provide it periodically on an "as needed" basis, 56% deliver it during new employee orientation, and 16% of organizations provide training updates on an annual basis. Approximately 55% of the training is provided by *in-house staff* and 24% is through various *outside speakers or agencies*. Many organizations use *outside trainers* from technical colleges, local social service agencies, and interpreter service organizations.

Translation Services

Fifty-six percent of respondents have important documents and written materials translated by an individual or agency outside of their own organization and 33% have internal capacity to translate materials. Twenty-five percent indicated that they locate materials that have already been translated from a variety of sources. This appears to be particularly prevalent among health departments and they listed the Wisconsin Division of Public Health and the federal Centers for Disease Control and Prevention as their primary sources of translated patient information. However, several respondents listed sources that may or may not be reliable for health care related materials, such as *web sites, Spanish teachers, cue cards, and volunteers.*

DISCUSSION

The WCLAH Resource and Needs Assessment study provides a foundation and guide for further work of WCLAH and its partners. When the findings from all respondents are consolidated and reviewed, a number of important themes emerge regarding how health care organizations provide services to non-English speaking patients, the current availability of qualified interpreters, and preparation of providers and staff working with interpreters.

It is desirable for every health care organization to have written policies and procedures in place concerning the provision of services to LEP patients. Written policies express the intent of the organization and procedures provide the instructions and guidance employees need in order to implement the policies. Without these in place, expectations are likely to be unclear and practices somewhat inconsistent. According to our survey results almost all hospitals have policies and procedures in place, in contrast to just over half of the health departments and community health centers. Hospitals are generally larger organizations operating in a comparatively more regulatory environment and thus tend to be more geared toward policies and procedures. We asked respondents to indicate the types of documents and other materials they may be willing to share with other organizations and many listed their policies and procedures. WCLAH will likely collect these and make available sample policies and procedures that can be modified and adopted by individual organizations.

The largest number of survey respondents reported that they use the services of independent or contract interpreters. There are no universal standards or a certification for interpreters in Wisconsin. We do not know how the organizations that responded to the survey determine the qualifications of contracted interpreters. Using family members as interpreters, especially children, is not acceptable according to federal standards, but 52% of the survey respondents use patients' families and friends as interpreters. However, we can not tell from this figure how family and friends are used and WCLAH may consider additional studies to learn more about how they are used and under what circumstances. Specifically, are

they only used to assist in arranging for appointments or communicating information on the patient's need for interpreter services, or do family and friends accompany the patient throughout the health care encounter, serving as the primary interpreter?

WCLAH members are aware of the complexity and cost of providing high quality interpreter services and in Wisconsin, reimbursement or cost recovery options are a significant issue for health care provider organizations. There was a wide range of responses regarding costs of providing interpreter services, both in person and by telephone. Regardless of cost, in order to create and sustain the availability of appropriate interpreter services within organizations, there have to be strategies to fund this service, with reimbursement being one of the most apparent. Cost will become an even more important issue as the need increases with the anticipated future growth in Wisconsin's LEP population.

Over half of the organizations included in the survey never or infrequently encounter LEP patients. For this reason, the provision of interpreter services is not likely to become a priority issue for them to address. The challenges of providing interpreter services, paired with budget and time constraints could make it difficult to justify expending significant resources to address this issue, despite existing federal regulations. Census projections suggest continued rapid growth in the size and geographic distribution of Wisconsin's LEP population. Therefore, it is reasonable to assume that the need for health care interpreter services will also continue to grow. The proportion of health care organizations that rarely or never need interpreters will likely shrink accordingly.

Based on survey results we can conclude that Spanish is by far the most prevalent non-English language encountered in Wisconsin and Hmong is the second most commonly encountered language. However, 15% of the surveyed organizations do not consistently document each patient's primary language in the medical record and 25% do not document the use of an interpreter during patient encounters. Based on this information, unless other tracking procedures are in place, it may be difficult for organizations to accurately report the volume of need for interpreter services and the languages encountered.

The majority of organizations experience some degree of difficulty in providing interpreter services to all of their LEP patients. Although we can not tell from the data, difficulties could be related to availability of interpreters for all needed languages at all times of the day, costs that are not reimbursed or additional factors. Many organizations have managed to implement procedures in an attempt to overcome barriers to providing this essential service. However, 20% of our respondents reported that they provide health care services to LEP patients without interpreters at times. Although 20% is a significant figure, because respondents are aware of federal regulations regarding LEP services, this may be lower than the actual figure due to underreporting.

The expected qualifications for interpreters employed by organizations may reflect the lack of availability of formal interpreter training opportunities and standardized certification, along with organizations' inability to accurately assess interpreters' skills. At a minimum, one could reasonably expect all interpreters to demonstrate proficiency in English and a second language. The majority of, but not all respondents indicated that their organizations require or prefer their hired interpreters to have these skills. Also, we know that many organizations receive services through independent agencies or free-lance interpreters. We do not know how or if these interpreters' qualifications and skills are determined.

We do not know what Wisconsin's practicing health care providers learned about caring for non-English speaking patients during their initial health professions training. However, acquisition of specific knowledge and skills on the part of providers and staff can improve the effectiveness of interactions with LEP patients. Results of the survey demonstrate that comprehensive formal in-service training in this area is not being offered by the majority of organizations.

The provider and staff training topics listed in the survey included most of the key areas that are typically covered in a comprehensive curriculum. However, in hindsight it may have been interesting to include the option, *tips for working with an untrained interpreter*. In the past, many health professions educational programs and health care organizations have offered training on *cultural competence*, with varying degrees of success and acceptance by the audiences. A fresh approach to training on culturally competent health care delivery could be to focus on effective care of LEP patients. Comprehensive training in this area should include cultural competence issues, especially those that involve diverse health/illness beliefs and communication styles. This practical approach may seem more relevant and therefore acceptable to providers and staff of health care provider organizations and could be more comprehensive.

While oral interpretation and written translation are related, they are not interchangeable and an individual must possess different skills to be able to perform both tasks well. There is no reason to assume that if one is an excellent interpreter, he is also able to translate written documents accurately and vice versa. However, it seems that most people are not aware of this issue. Translated health related documents available from many reliable sources have undergone significant review for content, accuracy, and cultural implications. There are reputable companies or agencies that offer translation service and some individuals who are oral interpreters are also skilled at translation. On the other had, there are many unreliable sources of documents, translation agencies providing poor quality services, and false claims by software venders who sell computer programs that supposedly translate materials. Based on survey results, there is currently a need in Wisconsin for health care organizations to have better access to information about the issues surrounding translation and the reliable resources available.

CONCLUSION

In conclusion, findings from the 2004 WCLAH Resource and Needs Assessment will be widely distributed throughout Wisconsin and will provide a sound basis for the work of WCLAH and its partners over the next several years. The survey results suggest that a number of barriers exist that limit the ability of Wisconsin's hospitals, health departments and community health centers to consistently provide quality care to their LEP patients. They include:

- Organizations do not have easy access to resources and information on the provision of care to LEP patients.
- Many organizations currently have only occasional need for interpreter services.
- Periodic and/or standardized training opportunities for interpreters are not readily available.
- Most organizations do not have a process in place to determine the level of skills of their interpreters.
- Providers and staff are generally unaware of best practices in providing care to LEP patients.
- There are high costs associated with providing interpreter services and limited reimbursement is available.

WCLAH is developing a number of important projects to further its vision of a statewide system leading to positive health outcomes for populations with limited English proficiency. Planned for development during the next year are:

- Creation of a WCLAH website that will serve as the Wisconsin health care interpreting information and resource center. It will contain information on interpreter standards, roles, and training opportunities; LEP-related laws, advocacy, and best practices; training opportunities for health care providers and advocates; model community collaborations that improve access; sample policies and procedures; and resources for high quality translated materials.
- Delivery of a regular series of continuing education offerings for interpreters, building on a very successful conference, "Ethics for Medical Interpreters," held in September of 2004.

- Development, testing and distribution of training materials for health care providers on working effectively with medical interpreters.
- Support for development of local or regional interpreter services consortia, modeled after a successful program in Dane County.

The statewide dissemination of findings from the Resource and Needs Assessment is one of WCLAH's strategies to raise awareness about unequal access to quality health care services for those with limited English skills and to inform everyone about available resources that can help reduce disparities in access. WCLAH plans to share the study report by offering to bring presentations and displays to health care-related meetings or workshops and by submitting articles to professional publications and other media outlets.

ACKNOWLEDGEMENTS

The WCLAH Resource and Needs Assessment study was a true collaborative project. Nancy Sugden provided funding through the Wisconsin AHEC Program Office and supplied staff time and resources to conduct the survey, complete analysis, and prepare the final report. Members of WCLAH's *Workgroup B* provided oversight and valuable input throughout the project. They included Suzanne Strugalla, Ruby Dow, Char White, Kelli Jones, Judy Warmuth, and Maria Calarco. Many of the questions contained in the survey were borrowed, with permission, from two documents and modified to fit the purpose of our study. They included *Linguistically Appropriate Access and Services; An Evaluation and Review for Healthcare Organizations* by Charles (Mike) Anderson and the Waukesha County Technical College, College Advancement Unit's *Language Interpretation for Health Services; Labor Market Needs Assessment* tool. Members of WCLAH's *Workgroup A* also contributed to the development of our survey questionnaire. They included Lucia Francis, Evelyn Cruz, Elvira Craig de Silva, Elena Frishman, Sarah Sullivan, Saul Arteaga, Arturo Martinez, Juan Morales, Larry Stocks, and Mary Taugher. Five volunteers participated in the survey pilot. They were Brenda Gonzales, Karla Blackbourn, Ruby Dow, Rosanne McSherry, and Carlile Schneider.

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**WISCONSIN COALITION FOR LINGUISTIC ACCESS TO HEALTHCARE (WCLAH)
MEMBERSHIP (7/04)**

COLLEGES & UNIVERSITIES
Alverno College

Madison Area Technical College

Milwaukee Area Technical College
Office of Bilingual Education Health Occupations

Medical College of Wisconsin

UW Madison -- School of Nursing

UWM College of Health Sciences
Dept of Occupational Therapy

Waukesha County Technical College
Communication Skills & Social Science Department
Research and Evaluation Services

Wisconsin Technical College System
Office of Instruction

COMMUNITY BASED ORGANIZATIONS
Latino Health Organization

Special Needs Family Center

United Community Center of Milwaukee

HEALTH SYSTEMS, HOSPITALS & CLINICS
Aurora Medical Center-Kenosha

Children's Hospital of Wisconsin

Covenant Health Care

Dean Medical Center

Family Health La Clinica

St. Luke's Medical Center

UW Hospital & Clinics

Wingra Family Medical Center

Madison Community Health Center

Agnesian Healthcare

OTHER ORGANIZATIONS/INDIVIDUALS
Wisconsin AHEC System Program Office

Milwaukee AHEC

Northeast AHEC

Northern AHEC

Southwest Wisconsin AHEC

Centro Hispano

Wisconsin Office of Rural Health

Southern Wisconsin Interpreting & Translation Services, LLC

Language Source

STATE & LOCAL GOVERNMENTAL AGENCIES
Department of Workforce Development
Office for Refugee and Migrant Workers

Division of Public Health Dept. of Health and Family Services
Office of Minority Health
Affirmative Action/Civil Rights Office
Office of Strategic Finance

STATEWIDE & REGIONAL ASSOCIATIONS
WI Hospital Association

Wisconsin Nurses Association

Wisconsin Primary Health Care Association

Wisconsin Public Health Association

Wisconsin Coalition for Linguistic Access to Healthcare
Resource and Needs Assessment
Spring 2004

Definition of Terms Used in this Survey

The following definitions were adapted from *The Terminology of Health Care Interpreting: A Glossary of Terms.* The National Council on Interpreting in Health Care, Working Paper Series. October, 2001.

Limited English proficient (LEP) refers to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter.

Interpreting is the process of understanding and analyzing a **spoken** message and re-expressing that message accurately and objectively in another language, taking the cultural and social context into account.

Translation is the conversion of **written text** into corresponding written text in a different language.

1. Please estimate the number of times per week that your organization needs the services of a language interpreter.

____ none ____ 1 – 5 ____ 6 – 10 ____10 – 20 ____ > 20 ____ don't know

2. List the non-English languages that you encounter among your patients in the order of frequency.

 # 1 _____ **# 2** _____ **# 3** _____

 # 4 _____ **# 5** _____ **# 6** _____

3. Is there a department within your organization responsible for coordinating interpreter and translation services?

___ yes ___ no

4. Does your organization have written policies and procedures related to the provision of linguistically appropriate services for LEP patients and families?

___ yes ___ no

5. Is each patient's primary language identified and documented in the medical record?

____ Always _____ Usually _____ Sometimes ____ Never

6. Is the use of an interpreter during patient encounters documented in the medical record?

____ Always _____ Usually _____ Sometimes ____ Never

7. How does your organization provide language interpreter services? (mark all that apply)

___ Individuals employed by your organization to work exclusively as interpreters
___ Bilingual health care providers
Doctors, nurses, etc. who are proficient in more than one language, enabling them to provide direct care to LEP patients using their non-English language.
___ Bilingual employees
Other employees, such as housekeeping staff, etc. who are proficient speakers of more than one language and are called upon to interpret for LEP patients, but are **not specifically employed as health care interpreters**.
___ Independent or contract interpreters
___ Agencies that employ interpreters
___ Volunteer interpreters (not family or friends of patient)
___ Telephone interpreter services for outgoing calls
___ Telephone interpreting services for incoming calls
___ Family and friends used as interpreters
___ Other_____

Please complete questions 8, 9, 10 & 11 only if your organization employs:

1) Individuals who work exclusively as interpreters, or
2) Bilingual health care providers (doctors, nurses, etc.) and/or
3) Bilingual employees (housekeeping staff, etc.) who are called upon to interpret.

If not, skip to question number 12.

8. Approximately how many bilingual individuals are currently employed by your organization?
_____ Number employed exclusively to provide interpreter services
_____ Number employed in other positions, but also provide interpreter services

9. Which languages do your bilingual employees cover?

_____ _____

_____ _____

10. Please indicate the education and experience expectations for all employees in your organization who provide interpreter services. (Circle your responses)

Previous work experience as an interpreter Required Preferred Not Important

Bridging the Gap or other recognized interpreter training program Required Preferred Not Important

Other (please describe) _____ Required Preferred Not Important

11. Please indicate the skills expected of all employees in your organization who provide interpreter services. (Circle your responses)

Demonstrated proficiency in English Required Preferred Not Important

Demonstrated proficiency in second language Required Preferred Not Important

Oral interpretation Required Preferred Not Important

Written translation Required Preferred Not Important

Interpretation of medical terminology, procedures and instructions Required Preferred Not Important

Ability to discern cultural differences in communication among populations Required Preferred Not Important

Other (please describe):_____ Required Preferred Not Important

12. Do you have difficulty providing health care interpreter services to your patients?

___ yes, always ___ yes, usually ___ sometimes ___ rarely/never

13. Please estimate how much it costs for your organization to provide interpreter services, per patient
encounter if possible. Include hourly wage range for in-house interpreters and/or fees for purchased
interpreter services.

14. How does your organization recover the costs of interpreter services?

15. Please describe what happens when a limited English proficient patient arrives for care and your
organization is unable to provide interpreter services (due to time of day, clinic location, unexpected
primary language, etc).

16. Many people do not have expertise in communicating with limited English proficient patients. If your
organization offers its employees training in this area, which of the following topics are included?
(mark all that apply)

_____ We do not offer this training.
_____ Organization's policies and procedures related to language interpretation services
_____ How to determine whether an interpreter is needed

_____ When to call a face-to-face interpreter and when to call a telephonic interpreter
_____ How to arrange for an interpreter
_____ How to work effectively with limited English proficient patients
_____ Appropriate use of interpreters
_____ Appropriate use of a telephonic interpreter
_____ Cultural issues and considerations in providing care to your organization's LEP patient populations
_____ Other (please describe)_____

17. When is employee training provided? (mark all that apply)

_____ New employee orientation _____ Annual update _____ Periodically, or as needed

_____ Other_____ _____ Not applicable

18. Who delivers the training? (mark all that apply)

_____ In-house staff _____ Outside speakers or agency _____ Not applicable

Names of staff trainers, speakers, or agencies (optional)_____

_____

19. How does your organization provide translation of written materials? (mark all that apply)

____ In-house employees ____ External or contracted agency

____ Other (please describe)_____

20. Which non-English written materials does your organization have? (If you prefer, attach a list of materials to this survey instead of completing this survey item.)

Translated Materials	**Language: Spanish**	**Language: Hmong**	**Language: Russian**	**Language:**	**Language:**	**Language:**
Patient instructions						
Consent forms						
Patients' rights and responsibilities						
Patient satisfaction surveys						
Other:						
Other:						

21. The Wisconsin Coalition for Linguistic Access to Healthcare is compiling a free resource library for

health care organizations. Please indicate materials that you might be willing to share with other organizations.

_____ Policies and procedures related to services for LEP patients and families
_____ Health care interpreter training and assessment materials
_____ Health care provider and employee/staff training materials
_____ Health care interpreter position descriptions
_____ Data from a confidential health care interpreter salary survey
_____ Translated patient education materials and forms
_____ Other (please list)_____

AHEC Guarantees Confidentiality of Your Reponses

Only Wisconsin AHEC staff working on this project will have access to the raw data from this survey and when the study is over, the data will be destroyed. The results of the survey will be reported in aggregate form only and your individual responses will not be identified or released to anyone.

Name of Person Completing this Survey:_____

Title or Position:_____

Organization Name: _____

Please return completed survey to us by Friday August 20th

- **Fax: 608-265-5995, or**
- **In the enclosed envelope, or**
- **Email:** pore@wisc.edu

Acknowledgements

The survey tool was developed by Wisconsin AHEC for the Wisconsin Coalition for Linguistic Access to Healthcare. Many of the questions contained in the survey were borrowed, with permission, from the following documents and modified to fit the purpose of our study.

Anderson, C., *Linguistically Appropriate Access and Services; An Evaluation and Review for Healthcare Organizations*. The National Council on Interpreting in Health Care, Working Papers Series. June, 2002.

Waukesha County Technical College, Research and Evaluation Services. *Language Interpretation for Health Services; Labor Market Needs Assessment,* Pewaukee, WI. January, 2004.

Study Results

We plan to publish the results of the study on the Wisconsin Area Health Education Center (AHEC) Web site as soon as the report is completed. Visit www.ahec.wisc.edu and look for a link to the Wisconsin Coalition for Linguistic Access to Healthcare.

Thank you for completing this survey.

If you wish to join the **Wisconsin Coalition for Linguistic Access to Healthcare** and/or be added to our list serv, please contact Peggy Ore at 608-265-6323 or pore@wisc.edu