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Use of Student Interpreters to Serve Limited English Proficient Patients

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ABSTRACT

Changing patient demographics and recently expanded federal guidelines require healthcare organizations to provide improved interpreter services to limited English proficient (LEP) patients. Access to health services for LEP patients has become a controversial public policy issue in the absence of consistent payment mechanisms and policies for recipients of federal funds affected by the guidelines. The experience of one hospital in addressing these new market demands illustrates some of the administrative, policy and educational challenges inherent in healthcare service delivery to LEP patients today. This hospital uses bilingual and bicultural college

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students preparing for careers in health care administration as interpreters. Preliminary data indicate that this is a cost-effective arrangement that can serve as a model for other health care organizations serving LEP patients, and as an incremental, operational coping stratagem while the broader policy issues undergo further debate.

INTRODUCTION

Ensuring effective access to healthcare services for growing numbers of limited English proficient (LEP) patients is an administrative and financial challenge for healthcare organizations across the nation. Beyond procedural compliance, adherence to the new guidance for language access and culturally appropriate services involves a fundamental re-education effort for most healthcare organizations. The evolutionary experience of a large urban tertiary care hospital in providing interpreter services illustrates some of the administrative challenges facing healthcare providers attempting to respond to shifting market and payer demands in a cost effective manner. Significant institutional re-educational efforts are also needed to provide meaningful language access and culturally appropriate services to LEP patients.

CASE STUDY

Long Beach Memorial Medical Center (LBMMC), with 726 beds, is the second largest private hospital on the West Coast and is located in one of California's most ethnically diverse communities. As of February 2002, the City's population consisted of 37% Hispanics, 33% Non-Hispanic Whites, 15% Non-Hispanic Blacks and 13% Asian/Pacific Islanders.[1] An analysis of patients admitted during the first six months of 2001 indicated that 21% were non-English speaking and another 13% were classified as "language unknown." Spanish, Cambodian, Vietnamese, and Korean were the most common languages for which medical center staff requested interpreter services.[2]

Until 2002, LBMMC provided interpreter services using an in-house pool of volunteer employees, supplemented by contracted language agencies and a telephone language line service. As the community became more diverse, this system developed over time from an informal and ad hoc activity to a defined hospital function with a designated coordinator and specified procedures for hospital staff to request interpreter services.

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An administrative reorganization in late 2001 moved Interpreter Services to the jurisdiction of the Executive Director of Information Services, co-author Kevin Torres. Mr. Torres also serves as adjunct faculty in the Health Care Administration Program at California State University Long Beach, teaching a course in information systems management and serving as an intern preceptor for many students. During 2001, Mr. Torres was supervising a graduate student whose master's degree project was an analysis of the interpreter services function. By presenting the project to the medical center's senior management and clinical staff as an opportunity to contribute added value to the organization's ongoing quality improvement program, he gained both their interest and cooperation.

The student's analysis, that included a survey of 51 nursing staff, revealed a number of problem areas with LBMMC's in-house interpreter system. The primary problem was that even though approximately 120 employees had signed on as volunteer interpreters, only seven regularly provided services. The over-use of this small group of volunteers led to complaints from some of their supervisors and co-workers when these employees left their regular jobs, as they often did not return when expected. Survey respondents noted that the time commitment for interpreting was highly unpredictable and reported that 90% of requests exceeded initial estimates. Some hourly employees who were eager to work additional hours at overtime wages exploited the need for their services by arranging to interpret outside their regular working hours, or by working overtime after an interpreting assignment.

As LBMMC had not developed methods for assessing the competence or qualifications of its volunteer interpreters nor provided any extensive training, nursing staff survey respondents raised some concerns about the ability of some of the bilingual staff to understand and effectively translate complex medical information. For Spanish-speaking patients needing interpreter services, nursing staff most often called upon Patient Liaisons, most of whom were bilingual and bicultural. However, Patient Liaisons were not included on the list of volunteer employees in order to ensure a clear division of responsibility, since the Liaisons focused on expeditiously resolving patient complaints. For Cambodian-speaking patients, the most active interpreter was an unpaid community volunteer, who made himself available as a personal service commitment to the community. The majority of the nursing staff respondents (80%) stated that they first attempted to find a staff member within their department or network of contacts before contacting the interpreter services coordinator. Just 14% stated that the medical center's existing interpreter service met their needs.

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Other problems noted by the nursing staff reflected the inherent challenges of using untrained and primarily paraprofessional employees on an ad hoc, volunteer basis. First, the request process was time-consuming. Respondents noted that it was difficult to leave messages with interpreter services and they did not receive confirmation of their service request so could not be assured that an interpreter would be available. Second, the interpreter service coordinator only worked standard business hours, so staff had to contact another department on nights and weekends. Third, not all volunteer interpreters seemed happy to serve; some appeared rushed and nervous about leaving their regular jobs. Some interpreters were rude, behaved inappropriately (interjecting personal opinions) or were unable to translate effectively. Fourth, the nursing staff noted their need for interpreters not only at the medical center, but at other locations on and near the large medical center campus.

The job of the interpreter services coordinator was not an easy one. Upon receiving a request for service, s/he filled out a paper form and then proceeded to contact volunteers by telephone to find a suitable available interpreter. If unable to fulfill the request within a reasonable time, the program coordinator contacted local community organizations with bilingual/bicultural staff who were sometimes available as interpreters. If no volunteer employee or community group interpreter was available, the program coordinator contacted a language agency. This agency, contracted through a competitive bidding process and selected on the basis of the breadth and quality of its service capacity, offered translation services in the languages for which the medical center had the greatest need (Spanish, Cambodian, Tagalog, Vietnamese, Cantonese and Mandarin Chinese, Japanese, Korean, Armenian, Farsi and American Sign Language) at an hourly cost ranging from $97 to $300 with a 3 h minimum or $82–$250 with a 6 h minimum. For Spanish, the most commonly required language, the agency also offered a full day contract (8 h) at $44 per hour, with a three year agreement for three interpreters.

During the first nine months of 2001, LBMMC used the language service agency 28 times for a total cost of $9405 and an average cost per encounter of $336. In many instances, LBMMC paid more for interpreter services than it received in revenue for the clinical services provided. This agency's interpreters were generally very proficient interpreters, but anecdotal comments from clinical staff and the agency indicated that they were generalist interpreters and not all were comfortable interpreting in a medical setting. Also, the agency required at least 24 h advance notice to locate and schedule an interpreter.

The graduate student concluded her report by recommending that LBMMC employ full-time Spanish professional interpreters, as this

was by far the most commonly requested language, and a part-time Cambodian interpreter. For the remaining languages, the medical center was advised to contract with an Asian community social service agency that offers interpretation services in seven Asian languages (Vietnamese, Cambodian, Cantonese and Mandarin Chinese, Japanese, Korean, and Thai) at an hourly cost of $65–$75 with no minimum, and another agency that provides sign language at $90 per hour. For less commonly needed languages, the best option was telephonic language service, albeit at a high cost, ranging from $2.20 to $4.50 per minute depending on the language and the time of day.

The graduate student presented her study and recommendations in late 2001, during a time when LBMMC was experiencing some serious budget shortfalls and implementing a number of cost control measures. In spite of the pressure to control costs, the LBMMC executive team recognized the need to improve its interpreter services to better ensure clinical quality and to more effectively serve both patients and providers. However, the recommendations proposed by the graduate student were too costly to be undertaken all at once. Challenged by the need to do things both better and less expensively as the executive newly in charge of the interpreter services function, Mr. Torres devised a plan to begin improving the interpreter services with a pilot project to recruit and train young bilingual/bicultural health professional students from the health administration program where he taught.

The University represented a logical choice, because the undergraduate student population at California State University Long Beach reflects the ethnic diversity of the surrounding Southern California region. Students with identified ethnicities are 27% Hispanic, 25% Asian/Pacific Islander, 8% African–American, 39% White, and 1% American Indian/Alaskan.[3] For the last seven years, the University's Health Care Administration Program has operated a competitive scholarship program for Latino students intending to pursue a career in health. Up to 20 students selected for the Latino Health Professionals Project (LHPP) each year either major in health care administration or obtain a certificate, equivalent to a minor.

Many of the LHPP and other bilingual/bicultural students in the health care administration program at California State University Long Beach already had considerable experience as interpreters for their LEP family members in the general community and the health care system—and, for many, these experiences shaped their career choices. As students majoring or minoring in health care administration, they understood the health care system and medical terminology. As members of ethnic minority groups they understood the language and the culture of their

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communities. They were eager to gain relevant work experience in a leading healthcare organization like LBMMC and to use their bilingual skills to assist members of their ethnic/language group to navigate the health care system.

The pilot project began in June 2002 when LBMMC hired two dedicated part-time bilingual/bicultural Latino interpreters at an hourly rate of $15 for up to 20 h per week each. One was an undergraduate student and the other a recent graduate. Both had majored in health care administration and one had also completed a dual major in Spanish translation and interpretation. The Assistant to the Executive Director of Information Services now handles e-mail or telephone requests for interpreter services during traditional business hours, scheduling and dispatching the student interpreters for both advance and ad hoc/urgent requests. The central staffing office continues to handle evening and weekend interpreter service requests, which are far less common. The medical center continues to use volunteer bilingual/bicultural employees to provide interpreter services for other languages, as well as a telephone language line and a contracted agency. The interpreter services department also arranges for written document translations by in-house interpreter staff, volunteer bilingual employees or the contracted agency. For deaf and hard of hearing patients (who may or may not be LEP), a regional service center for the disabled is contracted to provide sign language personnel on a 24-h basis.

The transfer of responsibility for interpreter services to Information Systems resulted in more explicitly defined expectations for interpreters in terms of both abilities and behaviors. LBMMC published and disseminated this information through an informational brochure and also prepared a policy on interpreter services for its policies and procedure manual (all documents that students helped to prepare).

Required skills and abilities for interpreters include the following:

A broad knowledge of both the patient's language and culture and English.
The ability to readily grasp and comprehend what is said in either language.
The ability to speak in either language and be readily understood.
Good recall of conversation.
The ability to visualize equivalent means of expression in each language, and
A working knowledge of specialized concepts and medical terminology.

The informational brochure for providers identified the following interpreter core competencies as part of an explanation of what the providers can expect from an interpreter:

Introduces self and explains role.
Is positioned to facilitate communication.
Accurately and completely relays the message between patient and provider.
Uses an interpretation mode that enhances comprehension.
Reflects the style and vocabulary of the speaker.
Ensures understanding of the message to be transmitted.
Remains a neutral party.
Identifies and separates personal beliefs from those of the other parties.
Identifies and corrects mistakes, and
Is able to address culturally based miscommunication, when necessary.

Ethical standards for interpreters are also specifically identified:

Maintains confidentiality.
Interprets accurately and completely.
Maintains impartiality.
Maintains professional distance.
Knows own boundaries, and
Demonstrates professionalism.[4]

LBMMC worked closely with a number of other community organizations to provide training and enhance quality of interpreter services. Soon after hiring the students as dedicated interpreters, LBMMC provided two training opportunities for both its paid and volunteer interpreters. The dedicated interpreters attended a 40 h program called "Connecting Worlds." The California Endowment, the state's largest health foundation, funded this program with a major grant of $442,419 for a statewide collaborative project to promote more effective communication between healthcare provider staff and Latino patients. Five multicultural health and social service agencies throughout the state offered "train-the-trainer" workshops for interpreters working in community clinics, hospitals, and private provider offices.[5] It is based on probably the best known health interpreter training program in the United States, "Bridging the Gap," developed by the Cross Cultural Health Care Program of Seattle, Washington.[6] The volunteer interpreters attended

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an abbreviated (2.5 h) session conducted by the "Connecting Worlds" program manager. The California Healthcare Interpreters Association, also with funding from The California Endowment, has published standards for healthcare interpreters and is developing a certification exam that LBMMC interpreters will be encouraged to take.

During the first six months that LBMMC employed student interpreters, demand for their services steadily grew. In calendar year 2001, there were 140 requests for interpreter services; in 2002, this number had nearly quadrupled, to 591, with a huge surge occurring in the second half of the year (420 of the 591 requests occurred from June through December).

In December 2002 a third Spanish-speaking interpreter was hired, and LBMMC is also recruiting a Cambodian-speaking interpreter. Anticipating that the demand for interpreter services will continue to grow and that LBMMC will need to continue to track and analyze interpreter service activities, the Executive Director of Information Services has proposed hiring or appointing a manager or coordinator to administer interpreter services as a defined service unit function within the Medical Center.

A number of providers, medical center staff, and community agencies have submitted unsolicited, positive feedback about individual interpreters' competence and ability to handle difficult situations (e.g., interpreting for parents of terminally ill children) as well as the benefits of having dedicated, skilled and personable interpreters readily available. The next phase of the Medical Center's customer satisfaction survey will also include a question on use of interpreter services to elicit patient feedback in a more systematic way.

The increased volume of interpreter services requests has resulted in increased monthly costs for providing interpreter services overall since the dedicated interpreters were hired, because the availability of dedicated interpreters has stimulated additional awareness of and demand for interpreter services. The average monthly costs for the two in-house interpreters were a modest $2000. However, monthly costs for outsourced (contract agency) interpreters averaged $5500. While demand continued to be greatest for Spanish and Cambodian interpreters, the increased visibility and availability of the in-house interpreters and LBMMC's efforts to promote their use had a "spillover" effect on requests for interpreters in all languages, including those for which a contracted agency was the only resource.

Long Beach Memorial Medical Center viewed the increase in interpreter service requests as a positive indicator for patient service and quality, and considers providing interpreter services a necessary cost of

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doing business in a diverse community. Intangible benefits include enhancing service quality, increasing patient satisfaction and contributing to fulfillment of its community benefit obligations as a nonprofit organization.

ORGANIZATIONAL RE-EDUCATION

LBMMC has a longstanding tradition of listening to its customers, and of reaching out to the diverse communities the organization serves. In 1999 and 2000, LBMMC convened Hispanic and Cambodian Task Forces comprised of members of the community, physicians and medical center/hospital administrators, to develop and implement action plans to address the needs of LEP patients in the Latino and Cambodian communities. Through focus groups, expert interviews and community forums, LBMMC identified barriers to accessing care for LEP patients in the two largest ethnic minority community groups and established priorities for reducing those barriers. Both the Latino and Cambodian Task Forces identified communication problems as one of the biggest barriers, and members of both groups recommended that dedicated bilingual/bicultural interpreters be more readily available. Input from the community task forces also generated initiatives to translate hospital signs and to identify bilingual employees through bilingual "I Speak (language)" badges, and placement of flyers and posters throughout the medical center and medical staff offices.

A key element in this overall effort is educating providers, as well as medical center and office staff. The informational brochure developed for providers emphasizes the importance of interpreter services as consonant with the organization's commitment to principles of access and equity. Presentations to providers also note that providing qualified interpreter services reduces the risk of medical liability due to miscommunication.

The provider brochure also contains information on how to work with an interpreter, recommending that the provider: (1) Brief the interpreter on the nature of the visit or encounter. (2) Speak to the patient directly, not to the interpreter; the interpreter will then relay the information to the patient in the patient's language; (3) Pause or stop after two or three sentences, as the interpreter will use the consecutive rather than simultaneous mode.

A web site template currently under development is designed to facilitate provider access to interpreter services. It includes links to the email address to the assistant to the Executive Director of

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Information Services, a downloadable request form, a policies and procedures document, and Title VI of the Civil Rights Act of 1964.

Other initiatives that LBMMC plans to implement in the future include:

- Organizational self-assessment on language capabilities.
- Bilingual medical campus mapping.
- Translation of hospital signage into additional languages.
- Translation of patient education materials for LEP and low-literacy patients, including use of alternative vehicles such as "fotonovelas" (similar to comic books but using photographs instead of drawings) and audiotapes.
- Staff cultural awareness workshops (with particular attention to health beliefs, cultural issues affecting health care delivery and patient behavior), and
- Staff Spanish classes.

POLICY ISSUES FOR ORGANIZATIONS SERVING LEP POPULATIONS

Long Beach Memorial Medical Center, as a participating Medicaid, Medicare and State Child Health Insurance Program (SCHIP) provider, has an obligation as a recipient of federal funds under Title VI of the Civil Rights Act and Executive Order 13166 to provide effective access to LEP populations. In California, the Office of the Patient Advocate (OPA) is a state agency charged with assisting HMO enrollees to access services from their health plan. As an outgrowth of its first statutorily mandated HMO report card, OPA expanded its second report card survey of California health plans to include information on cultural and linguistic access. The recently released Year 2 Report Card, for 2002, found that all plans reported providing linguistic access services for their members but there was great variability (both within and between plans) in how members obtain information about available services and how to access them. As federal and state contractors for publicly funded Medicaid, Medicare or SCHIP programs, health plans are subject to Title VI and Executive Order 13166 requirements to provide linguistic access to LEP members, but these requirements do not apply to their commercially insured members. Plans also showed substantial variability and often a lack of clarity about responsibility for providing linguistic services; some were considered the responsibility of the health plan, while

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others were shared or delegated to a provider contractor (medical group, Independent Practice Association [IPA] or individual provider).[7]

The California Legislature is considering a bill that would require the state Department of Managed Health Care to establish linguistic access standards that would apply to all health plan members.[8] However, this legislation contains no provisions regarding payment for providing language assistance services. The provision of interpreter services thus remains an unfunded mandate for healthcare providers participating in federally funded programs and may also become such for managed care contracting providers.

CONCLUSION

As a nonprofit hospital with a longstanding tradition of service to a highly diverse community, Long Beach Memorial Medical Center recognized both business and regulatory imperatives for effectively serving LEP patients, and proactively upgraded its interpreter services function as part of its continuing quality improvement program for customer service. However, not all providers are willing or able to make this kind of effort, and there are few incentives, positive or negative, for them to do so. Including interpreter services as an optional Medicaid and SCHIP covered benefit would probably encourage more hospitals to enhance their capacities to serve LEP patients. However, few states are likely to expand covered benefits in the current economic climate. In the private health insurance market, the provision of interpreter services is driven more by customer service needs. State mandates for provision of language assistance and culturally competent services to commercially insured patients would necessitate new contractual terms with provider organizations likely to press for rate increases to cover an expanded scope of services.

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