Follow-up Review of Language Access Services

Report to the University of New Mexico Health Sciences Center

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- everyone who participated in creating and maintaining the Interpreter Language Services activity binder, which was very useful in tracking the efforts made to comply with the recommendations of the 2005 report.
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And as always, I would like to thank the Staff Interpreters and Bilingual Employees who work every day to facilitate understanding between limited-English-proficient patients and the UNMHSC staff who serve them.
Executive Summary

In fall of 2005, the University of New Mexico Health Sciences Center (UNMHSC) contracted for an external review of the institution’s language access services. The resulting report was used as a template for quality improvement activities in language access over the following 2½ years. In spring of 2008, the organization contracted for a second review in order to measure the advances that had been made and to identify areas of continued opportunity for improvement. The following report contains the results of that second assessment. It describes the state of language access at UNMHSC in April of 2008, compares that to the level of services being offered in 2005 and recommends steps to improve the services further.

A summary of the recommendations for further action follows.

Recommendation #1: Advisory Committee
- I recommend that the Committee continue to meet regularly at whatever interval is suitable to the participants to work toward mutually agreed-upon goals, which could include:
  - Creation and periodic oversight of a second two-year plan.
  - Serving as a conduit to the Interpreter Language Services (ILS) Department for reports from the community of incidents in which patients did not receive timely and appropriate language services.
  - Making recommendations to UNMHSC for further improvements in language access programs, based on community concerns and identified service delivery gaps.

Recommendation #2: Institutional support
- Continue periodic reminders from the administration to staff regarding language access services.
- Review policies and procedures at the beginning of every two-year plan.
- Consider changing the policy regarding child interpreters to prohibit the use of minors under the age of 16 to interpret for interactions in which clinical information is discussed, except in cases of emergency.
- Evaluate flow of PSN variance reports and encourage their filing.
- Evaluate the level of response from LEP patients to the Press-Ganey surveys. If response is low, conduct satisfaction surveys with patients orally.
- Conduct staff satisfaction surveys electronically on an annual basis.
- Link language access services to other Quality Improvement Initiatives structures in the healthcare system.
- Review contracts for out-sourced patient services to assure that patients are receiving language assistance when they are referred outside the system.
- Network with other public hospitals across the country to share best practices, compare strategies, reveal resources and benchmark usage data if possible.
Recommendation #3: Upgrade data systems

- Give top priority to the design of a routine reporting system that allows for the efficient identification of preferred language, of interpreter need and of provision of language access services.
- Catalogue all points of patient contact across all UNMHSC services to assure language access at all of them.
- Continue trainings with frontline staff on the importance of tracking language code in IDX and Cerner.
- Investigate and resolve why language codes might not match in IDX and Cerner.
- Follow up with patients who show no language code.
- Provide staff with a pull-down list on the internet of languages, with an “I speak ______” statement to assist with language identification.
- Improve tracking of language services provided by Employee Interpreters.

Recommendation #4: Language resources

- Continue to upgrade the linguistic and interpreting skills of Employee Interpreters or implement skills testing and limit the use of those who do not pass to non-clinical interactions.
- Provide encouragement and/or incentives to Employee Interpreters to continue serving above and beyond their 52 interpretations/year.
- Consider having interpreters round on LEP in-patients.
- Consider a tiered interpreting system.
- Evaluate the cost-effectiveness of having a Vietnamese interpreter on-call off hours.
- Investigate the implications of allowing staff interpreters who travel to use the administrators’ parking area.
- Assure the quality of the speakerphones.
- Make instructions for accessing telephonic interpreting services more accessible.
- Review the multilingual phone tree protocols to make sure they are clear, easy to use, and working, for all services including pharmacy.
- Look into new ways to develop interpreter resources in languages of lesser diffusion, such as Swahili and Arabic.
- Continue with plans to pilot a video-interpreting system.

Recommendation #5: Quality assurance

- Test and track bilingual providers.
- Assure best value in the interpreter candidate language screening program.
- Continue to assure the availability of interpreter training.
- Continue to upgrade the skills of Employee Interpreters.

Recommendation #6: Outpatient pharmacy

- On-going staff training on language access.
- Provide opportunities for the pharmacy bilingual staff to take Bridging the Gap and become Senior Bilingual Employees if they are interpreting for other pharmacy staff.
- Evaluate the advisability of installing dual handset phones at the pharmacy windows.
Recommendation #7: Staff training
- Continue trainings on language access for all staff and providers.
- Confirm that all staff members with patient contact have received training on working with interpreters through the methods listed above; for those who have not (including MDs, PAs, ARNPs and RNS) schedule training.

Recommendation #8: Signage
- Assure that signage regarding the availability of interpreters is permanently and conspicuously posted in a central area (such as a waiting room) of each clinic.
- Continue and expand the use of “I Speak” cards currently being distributed by Admitting.
- Complete the revision of the Navajo patient-rights video
- Consider the installation of symbol-based signage

Recommendation #9: Funding
- Suspend efforts to access a Federal Medicaid Match at this time, but stay abreast of Federal Medicaid Match, it might be worth reconsidering this option.

Recommendation #10: Services to speakers of Navajo
- Form a special Sub-committee on Native American Language Access issues.
- Coordinate the work of the Committee with the newly-formed Bernalillo County Off Reservation Native American Health Commission and UNMHSC Native American Affairs Office.

Recommendation #11: Translation Services
- Develop a system to assure that any document sent for translation is written at a 6th grade level.
- Consult with clinics and with the Community Advisory Committee to prioritize the types of documents that most need translation; not every document needs to be translated.
- Continue to advertise the department’s capacity for translations. Consider how best to encourage staff to actually download and use the translated documents posted on the intranet.
- Assure that all printers are capable of printing in a Vietnamese font, or make Vietnamese documents available in a pdf format that could be printed on any printer.

Recommendation #12: Five-year plan
- In consultation with the Community Advisory Committee, develop a second two-year plan to be completed by June 2010.

Additional Recommendations
- Add a very clear language flag in the patient’s electronic record
- Ask nursing staff to post “I Speak” signs over in-patient beds.
- Pilot the use of patient initiator cards
- Investigate the usefulness of Prolingua
- Publish
Introduction

The following assessment of language access services at the University of New Mexico Health Sciences Centers (UNMHSC) constitutes a follow-up to a similar assessment conducted in late fall of 2005 as the result of a civil suit filed by the New Mexico Center for Law and Poverty (see Roat, Cynthia E. Review of Language Access Services, Report to the University of New Mexico Hospital. January 2006).

Following the assessment cited above, the UNMHSC agreed to implement the recommendations of the report. In late fall of 2007, a change in senior leadership on these initiatives led to a re-evaluation of progress made. Community advocates continued to hear frequent reports of lack of language assistance at the UNMHSC facilities. At the suggestion of these advocates, the UNMHSC leadership now responsible for interpreter services decided to invite the external consultant who wrote the 2005 report to conduct a follow-up assessment to document what advancements had been made and what still remained to be done to provide authentic language access at UNMHSC facilities. This is the report of that assessment.

Methodology

Like the first assessment in 2005, this report is based on four major sources of information. First, I reviewed all the available usage data relevant to language access at UNMSCH. Second, I conducted two telephone interviews with leaders among the community advocates. Third, I made a three-day site visit to UNMHSC, during which I spent one day interviewing administrators, service providers and interpreters at the hospital. Following is a list of the titles of those interviewed:

- CEO
- Administrator, Ambulatory Services
- Chief Nursing Officer
- Director of Specialty Clinics
- Director of Inpatient Pediatrics and Hospital Service
- Director of General Pediatrics
- Director of Medical Services at UNM School of Medicine
- Director, Ambulatory Business Operations
- Manager, Interpreter Language Services
- Manager, Centralized Scheduling
- Staff interpreters (4)
- Nurse Practitioner, North Valley Maternal Health and Family Planning
- RN and Surgical Coordinator, Northeast Heights ENT Clinic
- Manager, Southeast Heights Clinic
- Registered Pharmacist, Outpatient Pharmacy
- Case Manager, Department of Social Work
- Manager, Admitting
- MRI Technologist
- Charge nurse, Emergency Department
- RN, Emergency Department
- Charge nurse, Neurology Intensive Care, night shift.

Finally, I spent the second day of the visit at a retreat for key UNMHSC staff and community advocates to discuss the findings of the assessment and to plan for next steps. On the third day, I was able to interview the Director of Ambulatory Medicine. Upon returning home, I conducted a telephonic interview with the Executive Medical Director of Inpatient Services.
A draft of the report was reviewed by key UNMH staff and the advocate group in late May and early June. Input was incorporated as appropriate, and this final report was completed in late June 2008.

**Definitions**

In order to assure clarity in communication, some definition of terms employed in this report may be useful.

**Limited English proficient (LEP)**

An adjective used to describe individuals who do not speak English well enough to communicate effectively with English-speaking staff about their health concerns. An LEP patient might speak English well enough to make an appointment but not well enough to describe his chest pain or to understand how to control his diabetes.

**Language Access Services / Language Assistance**

All services in an institution that assist staff in communicating with limited English proficient patients. Language Access Services can include the use of bilingual providers, interpreters, translated materials, multilingual signage, etc.

**Interpreting Services**

Specifically, the provision of interpreters for interactions in which staff and patients speak different languages.

**Interpreting**

The conversion of a *spoken or signed* message from one language to another.

**Translation**

The conversion of a *written* message from language to another.

**Bilingual staff or provider**

Any employee who is capable of providing his or her service to patients in any of two or more languages.

**Employee Interpreters, Bilingual Employees (elsewhere in the U.S. called a “dual-role interpreter” to differentiate from Staff Interpreters who are also employees)**

A bilingual employee who is also asked to provide interpreting services for other employees.

**Dedicated or Staff Interpreter**

An employee whose sole purpose in the institution is to provide interpreting services.

**Agency interpreter**

An interpreter who is not an employee of the hospital, but who provides interpreting services at the hospital under contract to a language agency, which is in turn contracted, by the hospital.
Remote interpreting
The provision of interpreting services by an interpreter who is not in the room with the patient and provider. Usually conducted over the telephone or through a video link.

Telephone interpreting (OPI)
Interpreting services provided over the telephone, often through a speakerphone or with dual headsets.

Video medical interpreting (VMI)
Interpreting services provided through a video link.

Assessment
Evaluation of an individual’s skills in a particular area of interest.

Certification
A guarantee by a certifying body that a particular individual is capable of demonstrating a particular set of pre-defined skills up to a pre-defined standard. To be credible, a certification process must be shown to be scientifically valid and reliable.
Description of Current Language Access Services as of April 2008

Background information on University of New Mexico Hospital
A description of the University of New Mexico Health Sciences Centers historical role in the providing health services in Albuquerque can be found in the initial report on language access services. Since 2005, on-going construction has provided new, state of the art facilities for a number of departments. Of import to the language access program has been the addition of:

- The state’s only dedicated pediatric emergency room.
- The Barbara and Bill Richardson Pavilion for inpatient care.

The core mission of the health system has not changed, nor has its financial situation, its commitment to the provision of uncompensated care, or the overall composition of its patient population.

Has UNMHSC’s limited-English-proficient (LEP) population grown or become more diverse since the first assessment? The institution has not yet completed the data system interfaces necessary to effectively track the prevalence of limited-English-proficiency among the general patient population, so at this time, it is not possible to ascertain exactly the number or the linguistic diversity of LEP patients in the system. However, anecdotal reports from those involved in patient care suggest that both the number of LEP patients and the number of languages they speak has increased since 2005. A look at the U.S. Census Data Extrapolation\(^1\) calculated for 2006 supports this possibility. While statewide, the LEP population seems to have declined a bit, in Bernalillo County and Albuquerque, it has increased.

<table>
<thead>
<tr>
<th>Geographic area</th>
<th>% of population LEP in 2000</th>
<th>% of population LEP in 2006</th>
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<td>New Mexico</td>
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<td>10.9</td>
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<tr>
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<td>10.4</td>
</tr>
<tr>
<td>Albuquerque</td>
<td>8.7</td>
<td>9.5</td>
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</tbody>
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And, as always, these numbers most probably undercount the Spanish-speaking population due to the number of undocumented residents who do not appear in the census data at all.

As in 2005, the principle language in which language assistance is needed is Spanish, followed distantly by Navajo and Vietnamese. The secondary migration of 10,000 Vietnamese into Albuquerque has significantly increased the demand for interpreters in this language. Also of note is the recent introduction into the system of new refugee patients speaking languages for which interpreters are extremely scarce, for example, Swahili and Combo. Despite these challenges, the staff with which I spoke felt that UNMHSC was doing a good job overall in providing language access and that services had improved significantly since 2005. At the same time, they all had recommendations for how the system could be further enhanced.

The community advocates with whom I spoke and with whom we met during the Language Access Retreat continue to be concerned about language assistance at UNMHSC. They still

express concern about the limited availability of interpreter services as well as the quality of the services provided by Employee Interpreters, the use of family members and even children as interpreters, and the lack of translated discharge instructions and medication labels. While recognizing that advances have been made, they also express disappointment at a perceived lack of authentic transparency and defensiveness demonstrated until recently by the system’s representatives to the Community Advisory Committee.

**General information on UNMHSC language access program**

Programs to provide language assistance at UNMHSC have advanced significantly over the past 2½ years. Following is a comparison of the system’s services in late 2005 with those found in early 2008. It should be noted that these generalizations are being based on limited interviews and observations.

**Policy**

In 2005, UNMHSC had clear and comprehensive policies regarding language access, but staff did not seem to be aware of them. Language access was not addressed in new employee orientation, and staff did not know where to find the policies. By 2008, orientation on language access had been added to the new employee orientation at both the system level and in some departments, and the staff who were interviewed showed themselves to be both more aware of the policies regarding the provision of interpreters and more consistent in their understanding of how to get an interpreter.

**Demand**

The best way to calculate demand for interpreter services is to track the other services provided to patients who have a non-English code in their patient record. If that coding system is being applied consistently, such a report will indicate how many patient encounters took place that would require interpretation.

In 2005, UNMHSC was not able to accurately calculate the demand for interpreter services, for two reasons. First, the language coding system was unreliable, most probably under-representing the number of patients who needed language assistance. Even if the coding had been reliable, no computer program allowed the creation of a report of services provided to non-English coded patients.

By January 2008, progress had been made in correctly coding patient’s preferred language, however UNMHSC was still lacking a system to easily retrieve information about services provided. Data about the number of interpretations provided was also improving, however, this does not tell us how many patient encounters needed interpretation since those encounters where no language assistance was provided would not be counted.

In the months just prior to this review, the UNHSC administration asked the Information Solutions Department to help solve the problem of data retrieval. The Director of Information Solutions worked to configure methods through which the language flags on patient records in Cerner and IDX could be used to count how many LEP patients were being seen for outpatient and inpatient services. As of the time of this review, this complex task was close to being completed, however the finalized data was still unavailable.
Overall strategy
The goal of the UNMH’s language access program is to provide language access at all points of patient contact. In 2005, no attempt had been made however, to actually catalog all of the points of patient contact and assure that language support is being provided. This remains true in 2008.

In 2005, UNMH’s strategy for providing language assistance focused largely on maximizing the use of its current staff’s language skills and mobilizing outside resources to fill the gaps. In 2008, UNMHSC still relies on the same six basic resources to provide language access to patients, however it has added a few more to its strategy (bolded below):

1. Bilingual providers
2. Employee interpreters (dual-role interpreters)
3. Staff Interpreters
4. Agency telephonic interpreters
5. Agency interpreters for American Sign Language
6. Translations
7. Multilingual signage
8. Multilingual medication information and labeling

The following section will describe the current functioning of each resource.

Language Resources
1. Bilingual providers
   As in 2005, some providers at UNMSHC are seeing LEP patients using their own bilingual skills, thereby eliminating the need for an interpreter. And, as in 2005, there are still no systems to systematically identify which providers are bilingual or how often they use their skills in clinical encounters. As a result, data on service to LEP patients still do not include the number of LEP patients who were served by a bilingual provider.

   Nor has any system been put in place to evaluate the level of any given provider’s language skills. Providers who self-assess as being competent in a language other than English are allowed to see patients in that language without further testing. Senior clinical administrators are open to such a testing program and do not feel that providers would object.

   Command of a second language is being required by certain clinics now: for example, at the North Valley Women’s Health and Family Planning Clinic. Bilingualism is a preferred qualification for all clinical staff but not generally required, nor is it specially remunerated anywhere. No targeted effort is being made to hire more bilingual staff.

2. Employee Interpreters (often called “dual-role” interpreters elsewhere)
   Employee Interpreters, or Bilingual Employees, are those bilingual employees who fulfill another function at UNMH to which interpreting is secondary. They are most often clerks or Medical Assistants and appear to be largely heritage speakers of their non-English language.2

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2 Heritage speakers of a language are those who learned the language at home while living in a country in which a different language was spoken in society at large and for educational purposes.
In 2005, Employee Interpreters interpreted in their own departments if they were not busy with other tasks, or, with permission from their supervisors, in other departments as requested. These interpreters received a bonus of $25 per week in addition to their regular salary if they provided at least 7 interpretations per year. Employee Interpreters were supposed to document their work, but this requirement was not enforced and therefore did not render any useable data. A list of Employee Interpreters and their shifts was available to UNMH staff on an internal website.

To earn the designation of “Employee Interpreter” at UNMH in 2005, a bilingual employee had to volunteer for the position and pass a language assessment test (see below under Quality Assurance in Interpreting). As of November 15, 2005 there were 312 bilingual employees at the hospital who were functioning as Employee Interpreters. Of these, 95.6% speak Spanish. The rest spoke Navajo (3), Vietnamese (3), Farsi (2), Swahili (2), Romanian (2) and German, Urdu, Pashto, Hindi and Mandarin (1 each). Eighty-four percent worked days, 5.4% worked evenings, and 8% worked nights.

By 2008, some significant changes have been introduced to this system. First of all, the administration has strengthened its expectation that all Employee Interpreters document their work. While this is an area where there is still opportunity for improvement, documentation of Employee Interpreters’ services has increased significantly.

Secondly and most notably, after negotiations with the union, new prerequisites were put in place as of February 2008 for any new bilingual staff wishing to interpret. These individuals will be called Senior Bilingual Employees, receive $30/week, and must satisfy the following requirements.

a. SBEs must pass a language skills test at the ACTFL Advanced High or Superior level instead of at the Advanced Low level. Forty hours of basic training is required instead of simply suggested.

b. SBEs must shadow a staff interpreter and be shadowed by that interpreter before being allowed to interpret alone.

c. SBEs must provide 52 interpretations per year to maintain their status.

The Employee Interpreters who joined the program prior to this new agreement will be allowed to continue to interpret under the old system.

As of April 2008, there were 318 Employee Interpreters, of which 94% are Spanish-speakers. The rest speak Navajo (4), Farsi (2), Swahili (2), Romanian (2), and one each speak Pashto, Tagalog, German, Urdu, Portuguese, Vietnamese, Hindi and Mandarin.

In support of both Staff Interpreters and Employee Interpreters, a full FTE Educator position has been opened for FY 2009. The Educator will assist with continuing education and skills practice for staff interpreters, teach courses designed to improve the skills of Employee Interpreters, coordinate testing and perform periodic quality and competency assessments for providers and staff.
3. Staff Interpreters
In 2005, UNMHSC had 10 FTE Staff Interpreters: 6½ FTE for Spanish, available only during the day shift; one FTE and two casual pool for Vietnamese, and ½ FTE for Navajo.

By 2008, the staff had expanded. At the time of the site visit, 12 FTE staff interpreters were covering two shifts at UNMH (day shift and evening shift); in mid-May, one of the FTEs was transferred to the graveyard shift, and .7 FTE remained vacant. Once filled, this FTE will cover a 10 hour weekend day/evening shift. Four more interpreter FTEs will be added in FY 2009.

4. Agency telephonic interpreters
UNMHSC continues to use Pacific Interpreters as its telephonic interpreting provider. In 2005, the system was paying $1.35/minute; by 2008 competition in the field had dropped the price to $1.09/minute.

In 2008, telephonic interpreting was still not well accepted by hospital provider staff, which prefers to use on-site interpreters. Providers still complain about the logistic difficulty of having to find the phone and plug it in, and some feel that interpreting over the phone is too slow, less accurate and less supportive of the patient. In some services, the use of diagrams to teach or the presence of many people in the room make use of telephonic interpreting awkward. Despite these problems, use of the service has increased; $240,000 is budgeted for telephonic interpreting services in FY2009 compared to $147,310 in FY2005.

5. Agency interpreters for American Sign Language
UNMHSC continues to contract with Community Outreach Program for the Deaf for the provision of interpreters of American Sign Language. Fees have risen from $45/hour with a two-hour minimum to $55/hour for regular appointments, and from $65/hour to $75/hour for appointments scheduled with less than 24-hours of notice.

6. Translations
In 2005, translations were principally done in-house by interpreters in their down time. No data was being collected on how many translations were being done, nor were there written procedures on how translations would be accomplished.

By 2008, most translation work has been outsourced to Pacific Interpreters at a rate of 21¢ per word for a two-week turn around. Staff interpreters do only very simple, short translations. The volume of translations has increased significantly to about 15 per day. There seems to be some question, however, as to how much the translated documents are actually being used by clinic staff.

Vietnamese staff interpreters are concerned about the quality of the outsourced Vietnamese translations, feeling that the verbatim translations being done are virtually incomprehensible to the Vietnamese community in Albuquerque. They would like to proofread translations done by external translators. There is also some frustration around being able to print Vietnamese documents on printers that do not have Vietnamese fonts. This is especially true for the Southeast Heights clinic where a large number of Vietnamese patients are seen.
7. Multilingual signage
In 2005, multilingual signage in the hospital and most clinics was exceedingly scarce. By 2008, the prevalence of some type of multilingual signage had increased significantly. Documents such as patients’ rights, the availability of interpreters, and how to access financial assistance were frequently posted in Spanish and Vietnamese as well as English.

The efficacy of this signage was impacted, however, by where the signs were posted. In a number of clinics, the sign regarding the availability of interpreters was tacked to a bulletin board and covered up by other announcements. In others, it was posted in areas where patients would be unlikely to see it.

Finally, while UNMHSC overall still lacks multilingual signage for wayfinding purposes, the new Pavilion has incorporated a symbol-based system to assist in wayfinding. While is not clear how effective this system will be, instructions on how to use it are available throughout UNMH in English, Spanish and Vietnamese.

8. Multilingual medication information, counseling and labeling
In 2005 I was unable to collect information regarding language access in the UNMH pharmacy. As of 2008, however, UNMHSC had systems in place to provide language access.

In order to identify the need for language access, the pharmacy has incorporated a language code into its own patient database, which is not connected to IDX. When providers send prescriptions with the language noted, or when patients present who do not speak English, the language code is updated. There is also a multilingual phone line to order refills, although community advocates hear from patients that this is not always working.

Seven Bilingual Employees (all Spanish speaking) are available to interpret at the outpatient pharmacy, which also has access to the telephonic interpreting system and the capacity to provide medication information and labeling in both Spanish and Vietnamese. Spanish warning labels were easily accessible for staff in the outpatient pharmacy. Staff members are even aware of the best practice regarding dual-language labeling so that both patient and providers can read the label. Reports from community advocates, however, suggest that bilingual labeling is rarely used and that even the provision of non-English labeling is inconsistent. Pharmacy staff admits that the telephonic interpreting system is disliked and that family members may be used to interpret in lieu of the phone. Some pharmacists, however, report using the teach-back method to assure understanding. Bilingual Employees in Pharmacy also express frustration at a lack of access to the interpreter training program.

9. Use of family and friends to interpret
Family and friends are still being used to interpret. Some providers indicate that they feel comfortable using family and friends if the conversation seems to flow well. Others resort to family and friends when staff interpreters are late or have to leave before the appointment is complete. In-patient providers report using family and friends frequently for non-clinical communications and occasionally for clinical communication when staff interpreters are not available. The ED reports using family to interpret, but not children, whom they feel shouldn’t be in the ED anyway.
**Administration**
At the time of the site visit in 2005, Interpreter Language Services had just become a separate department under the supervision of the Administrator of Ambulatory Care. The language-screening program was being implemented by Human Resources.

By 2007, responsibility for the language-screening program had been transferred to Interpreter Language Services. In the last months of that year, the Administrator of Ambulatory Care retired. Her successor, concerned by the continuing adversarial relationship with community advocates and the inability of the current system to provide reliable data on which to base decisions, mobilized personnel from various departments to resolve a number of long-standing issues. At this time, there is an active interest in and commitment to language access services at the highest level of UNMHSC administration.

**Interpreter dispatch**
In 2005, clinic staff had to fax or call in a request for an interpreter for any appointment, scheduled or not. A central scheduler then either assigned or dispatched an interpreter, depending on need and availability.

By 2008, the system has changed. Spanish staff interpreters have been assigned a “territory.” Each is responsible for downloading all relevant outpatient appointments in his or her territory each day and either providing interpretation for that appointment or negotiating with the clinic to have an Employee Interpreter available. This allows the interpreters greater flexibility to serve more patients and to assure a best match between the skill of the interpreter and the probable complexity of the appointment. Vietnamese and Navajo staff interpreters cover or arrange for all appointments in their language groups.

Walk-ins, unscheduled services in diagnostic imaging, and inpatient services still require staff to call ILS to request an interpreter. Despite the increase in the number and flexibility of staff interpreters, providers still complain that there are not enough of them. Providers in in-patient settings note that typically there are 12-20 staff members who interact with patients on a daily basis, usually using patients’ family, friends and children to interpret. Pediatric providers in particular estimate that 30% of their patients are LEP and they feel that they need an interpreter dedicated to each in-patient pediatric floor. On the clinic side, specialty providers complain that interpreters often arrive late and have to leave before these typically longer appointments are complete, slowing down the clinic and leaving providers to turn to lower quality interpreting resources. The availability of Vietnamese interpreters in off-site clinics seems to be a particular issue. Staff at the pediatric ENT clinic reported being asked to schedule Vietnamese patients in the early morning or late in the day in order to get an interpreter, however there are no providers working at those times.

It is important to note that there is a significant difference between the language assistance provided by Spanish interpreters and that provided by the Vietnamese and Navajo interpreters. Because some degree of Spanish is so widely spoken among the staff at UNMHSC, Spanish interpreters have more flexibility to interpret only for the clinical portion of each patient visit, then to move on to another patient. Bilingual staff or Employee Interpreters can cover the less complex conversations around making follow-up appointments, wayfinding, etc. However, the
Vietnamese and Navajo interpreters must essentially provide escort interpreting services, staying with patients from the time they enter to the time they leave the health center. This makes scheduling much more difficult and less flexible as well as raising questions about the usefulness of remote interpreting (telephonic and video) for these patient groups.

Because of a concern about the delay in getting an interpreter, the providers and staff with walk-in or ED patients seem to be accessing language resources in pretty much the same order in 2008 as they did in 2005:

1. Get by with their own limited language skills, or hand signs
2. Use family or friends to interpret, depending on the nature of the content to be discussed. Many providers I interviewed reported using family and friends to interpret when the content to be discussed was not excessively technical.
3. Find an Employee Interpreter in their own department, if there is one available in the right language.
4. Find the Staff Interpreter, if there is one assigned to their department and it is between 8:00 and 4:30 Monday to Friday.
5. Try to find an Employee Interpreters from another department, based on the list of such interpreters posted to the intranet.
6. Call Interpreter Language Services if it is between 8:00 – 4:30 Monday to Friday.
7. Use the telephonic interpreter line.

As a step toward streamlining interpreter dispatch, the UNMHSC administration conducted in early 2008 a two-week time-in-motion study with the staff interpreters, designed to determine how much time they were spending traveling and waiting as opposed to actually interpreting. The study showed that staff interpreters are averaging 22 minutes per encounter, with travel and wait time accounting for fully one third of that. Half of the wait time is being spent waiting for the provider, 16% is being spent waiting for the patient, and in 15% of the cases, the patient no-shows. These findings suggest that a significant increase in efficiency could be attained through switching to a remote interpreting system. Since telephonic interpreting is so poorly accepted by providers, the answer may be found in video interpreting.

**Interpreter quality assurance**

Quality assurance in interpreting is based on six steps: appropriate recruiting, language screening, training, assessment, monitoring and continuing education. I will first discuss these steps as they apply to Employee Interpreters and then discuss how they apply to Staff Interpreters.

As in 2005, Employee Interpreters at UNMH are currently self-recruited volunteers. However, the level of language skill required to interpret has been significantly increased since 2005. At that time, language skills were being screened by Language Testing International, the testing arm of the American Council on the Teaching of Foreign Languages (ACTFL). Employee Interpreters were required to rate Advanced Low or higher on the ACTFL scale. About 75% of candidates passed the test, but experience showed candidates at the Advanced Low level did poorly in training and made interpreters of questionable accuracy.

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3 This language scale, developed by the American Council for the Teaching of Foreign Languages, runs from Superior to Advanced, Intermediate and Novice. The latter three are sub-divided into High, Mid, and Low.
Since February of 2008, bilingual staff interested in interpreting must pass a language-screening test at a level equivalent to the ACTFL Advanced High or Superior rating. The test is offered by Pacific Interpreters (PI) and costs $120/candidate, the same cost as LTI’s test. Of significant concern, however, is the uncertainty as to whether the test being applied by PI is really a test of language skills alone or also a test of interpreting skills. If the latter is true, this may be one reason that none of UMNHSC’s candidates have passed the test to date; even bilinguals with strong language skills need training to pass a test of interpreting skills. That fact that they could not should also raises a question as to whether bilingual staff that have not been trained should be interpreting at all.

In 2005, training was not required for Employee Interpreters at UNMH, however about 140 of the 312 Bilingual Employees had taken the 40-hour course, *Bridging the Gap*, taught by the manager of Interpreter Language Services. As of February 2008, new Employee Interpreters will be required to take the course.

In 2005, Employee Interpreters underwent no skills assessment or monitoring. As of 2008, there is still no skills assessment. However, a program for continuing education has been implemented. A one-hour workshop is offered once a month over lunch by ILS staff. Attendance is voluntary. Generally, the same 30 Employee Interpreters (about 10% of total) choose to attend every month.

There are mixed opinions among UNMH staff members and community advocates about the quality of the language skills and interpreting being provided by the Employee Interpreters. Some providers feel that the quality of interpreting has been adequate, others feel the quality is poor, suggesting that skill levels among Bilingual Employees may differ significantly and that the quality assurance measures currently in place are not guaranteeing consistent competence among Bilingual Employees. Given that most of these interpreters 1) have been screened at what turned out to be a sub-standard level and 2) have received neither training, monitoring nor continuing education, this concern is justified. The recent changes in program requirements are certainly a positive step. However, the fact remains that the majority of Employee Interpreters have been grandfathered in at the previously required skill level. Concerns about quality remain.

Staff interpreters also complain that some Employee Interpreters do only the minimum, refusing to serve after they have completed their minimum of seven interpretations and declining to give their names for charting purposes.

Staff Interpreters at UNMH have been principally recruited from the more skilled of the Employee Interpreters, and more recently, from outside the health system. Candidates must have a high school diploma or GED, have completed at least 40 hours of basic training, and have at least one year of experience as a medical interpreter. Staff Interpreters also have their language skills screened and must score at the Advanced High or Superior level. There is no assessment done of their interpreting skills, no monitoring provided. Staff interpreters are welcome to participate in the continuing education classes, however, and are occasionally sent to interpreter conferences in other parts of the country.

UNMHC staff raves about the staff interpreters, noting a clear difference in the quality of interpreting provided by Bilingual Employees and Staff Interpreters. Some providers go so far as
to say that the presence of a staff interpreter not only changes the quality of the care provided but the very direction of the care itself. Some comment that working with these interpreters on-site had “ruined” them for using either the Employee Interpreters or the telephone, neither of which could compare to the quality of the interpretation provided by the Staff Interpreters. Overall, the only complaint about Staff Interpreters is that there are not more of them.

A final note about quality assurance of translations deserves to be included. Those interpreters at UHMHSC who also do short translations are now required to pass the LTI writing test at an Advanced High level and to perform an accurate sight translation during an oral interview.

**Staff training on use of interpreters**

In 2005, there appeared to be a lack of training for providers on language access issues in general and how to work effectively with interpreters in particular. From the clinical leadership down to the residents, I got the distinct impression that providers at UNMH were not giving quality interpreting the importance it deserved. LEP patients were seen as too time-consuming and priority was given to pressing any supposed bilingual available into service as an interpreter.

During the site visit in 2008, I noted three significant changes in the area of staff training. The first was the addition of information on language access to the new employee orientation. Although this training does not reach doctors or residents, it does reach all new staff and is an important step forward. Secondly, a module on language access has been added to the annual “competencies” that staff is required to complete on-line. It is not clear, however, whether providers, or only nursing and support staff, are required to complete this module. The third major shift, due to personnel changes, is a significant alteration in the attitude toward language access among top clinical leadership. While many providers still report a rather cavalier attitude among their colleagues regarding interpreter services, the overall mind-set seems to be changing.

**Data collection**

The area in which UNMHSC was most desperately lacking in 2005 was data collection. Without reliable data on the demand for interpreter services and the usage of the various forms of language assistance available, it is impossible to ascertain to what degree UNMHSC is meeting the language needs of its patients or to design a coherent program that meets that need in a cost-effective way.

As mentioned earlier, UNMHSC administration finally brought the expertise of Information Solutions to bear on this problem in early 2008. As a result, some preliminary data was made available at the time of the site visit, however it was not enough to paint a coherent picture of demand for and provision of language assistance.

Information Solutions can only work with data that has been collected, however. In 2008, significant doubt remains about how consistently demand and usage data are being collected.

When patients first register, their language preference can be noted in IDX. This information can also be noted in the Cerner database, although this must be done separately. In 2005, it was clear that correctly noting a patient’s language access code was not being done consistently. In 2008, this was still a problem, although progress had been made. As a result, many patients’ language
needs are being discovered only when they come for their appointments, leading to a large number of same-day requests to ILS.

When patients access care through the ED, there is still no easily visible code to inform all ED staff members who have contact with this patient what language he or she speaks. Informing inpatient services about the language needs of admitted patients has improved however; language is included on both the triage note which accompanies a patient from the ED to the floor and in the verbal report that the ED nurse does with a nurse on the floor whenever a patient is admitted.

Data about service provision must also be collected. While tracking of staff and telephonic interpreter services is excellent, services provided by a bilingual provider are not noted. Employee Interpreters have improved in logging their interpretations, but there is still much room for improvement. Finally, it is not clear whether nursing and medical assistant staff are reflecting services to LEP patients in their ambulatory payment codes, which impacts level of payment.

Another sort of data that most health systems often collect is patient satisfaction data. In 2005, this was done in two ways. A variance report could be filed anonymously by staff when any situation occurred that was outside normal operating procedure. There was, however, no way to track how many of these were related to language, and at least two providers who filed these variances reported that they never heard back on them.

By 2008, the variance report form has been altered to include “language” as a root cause for the situation being reported. There still seem to be some glitches in the flow of reports, however the ambulatory care administration is in the process of tracking down the problem.

In 2005, patient satisfaction surveys were being sent out by mail by Press-Ganey Associates. While they claimed to be sending Spanish translations to any patients identified in IDX with a Spanish language, the flagging system was so haphazard that many LEP patients were receiving English surveys. By 2008, the system seems to have improved. Surveys are sent more regularly in both Spanish and Vietnamese. Four questions regarding the provision of language assistance were added, and free text responses written in Spanish or Vietnamese were being scanned and mailed to ILS for translation and review.

### Expenditure

The following shows the growth of the Interpreter Language Services budget.

<table>
<thead>
<tr>
<th>FY</th>
<th>Total</th>
<th>Percent Increase</th>
<th>FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$576,528</td>
<td>n/a</td>
<td>9.0</td>
</tr>
<tr>
<td>2006</td>
<td>$625,534</td>
<td>+8.5%</td>
<td>9.0</td>
</tr>
<tr>
<td>2007</td>
<td>$756,498</td>
<td>+20.9%</td>
<td>10.0</td>
</tr>
<tr>
<td>2008</td>
<td>$952,724</td>
<td>+25.9%</td>
<td>14.0</td>
</tr>
<tr>
<td>2009</td>
<td>$1,427,691</td>
<td>+49.9%</td>
<td>19.0</td>
</tr>
</tbody>
</table>

4 Budgeted
5 Does not include FTEs for upper Administrative Mgmt or system-wide staff hours external to ILS cost center
6 Does not include $348,970 in funds approved through allocations for video monitor interpreting software and hardware.
The cost of UNMH’s language access program still comes entirely from the hospital’s operating budget. Expense and salary support for this program increased 148% (almost tripled) between FY2005 and FY2009. No reimbursement is being provided either through private insurance, managed care contracts, the State Medicaid office, or a Federal Medicaid match.

Summary
UNMH has made significant progress in improving its language access services over the past 2½ years, with especially promising changes occurring in the first months of 2008. Of particular note are the more stringent requirements for Senior Bilingual Employees and the improved data tracking that is currently being implemented. On-going challenges include the quality of interpreting among Employee Interpreters (pre-2008), staff training and interpreter availability.
Analysis and Recommendations

Per the request of both Community Advocates and UNMHSC staff, I will structure this section by evaluating the progress made on each specific recommendation from the 2005 report and, where appropriate, suggest some additional recommendations.

Recommendation #1: Advisory Committee

Original recommendation
Form a Community Advisory Committee to:

- Provide input on the development of a five-year plan for the improvement of language access services throughout the UNM health systems.
- Serve as a conduit to the Interpreter Language Services (ILS) Department for reports from the community of incidents in which patients did not receive timely and appropriate language services.
- Serve as a sounding board for new ideas from staff about the improvement of language access services.
- Serve as cultural informants about the needs and concerns of the LEP communities served by the hospital.
- Monitor adherence to the five-year plan.

Progress made
UNMHSC’s Community Advisory Committee, comprised of representatives from UNMHSC, the New Mexico Center for Law and Poverty as well as other community organizations, has met regularly since it was officially established in February of 2006. By July, the group had helped develop a two-year plan for language access services. However, until early 2008, relations on the Committee remained antagonistic. Community advocates feel that institutional representatives often came to the table in a defensive posture and that the Committee was used primarily as a means of communicating UNMHSC’s language access initiatives, not as the bi-directional consultative body that was originally envisioned. On the other hand, UNMHSC staff expresses frustration their efforts were not being appreciated and that complaints about lack of interpreter services most often did not include the details (such as day, time, clinic, provider) that would allow them to follow up. Despite this tension, the formation of the Committee is itself a step toward better communication, one that will bear more fruit as trust increases.

Next steps
I believe that with the new relationship of trust that is growing under the Committee’s new UNMHSC leadership, the group could fulfill its potential of becoming a true forum for sharing ideas, resources, feedback and recommendations between health system and community. I recommend that the Committee continue to meet at regular intervals to work toward mutually agreed-upon goals, which could include:

- Creation and periodic oversight of a second two-year plan for the improvement of language access services throughout UNMHSC, based on this report and scheduled to begin when the current two-year plan is completed. I suggest that Interpreter Language Services (ILS) Department regularly provide usage data to the Committee to document advances toward plan goals.
• Serving as a conduit to the Interpreter Language Services (ILS) Department for reports from the community of incidents in which patients did not receive timely and appropriate language services. The incident reports must include enough information to allow the institution to provide effective remedial action, and ILS must update the Committee on action taken.

• Making recommendations to UNMHSC for further improvements in language access programs, based on community concerns and identified service delivery gaps.

**Recommendation #2: Institutional support**

**Original recommendation**
Demonstrate clear support from upper management for the language access policies already in place and for new ones.

- Distribute a memo from the CEO, expressing clear support for and educating staff as to the current policies regarding language access.
- Review policies every two years.
- Instruct and encourage staff to use the anonymous online variance reporting system on the UNMH intranet to report incidences when language access was not afforded according to policy.
- Use telephone exit surveys, applied annually over the course of two weeks, to capture satisfaction among LEP patients and to identify gaps in service.
- Name a group of Language Access Coordinators, one at each medical facility within the UNMHSC, to provide input to ILS as to how language access is being implemented within each facility.
- Centralize responsibility and control for language access services in the hands of Interpreter Language Services.
- Move the responsibility and budget for language screening to ILS.
- Empower ILS to convene and facilitate the Community Advisory Committee.
- Plan for the addition of a full-time scheduler to ILS if the data collection systems are upgraded.

**Progress made**

- A number of efforts were made to communicate clearly to all staff the administration’s support for language access services.
  - A memo was attached to paychecks in May 2006; a presentation was made to the Medical Executive Committee in July 2006; an email was sent to clinical faculty by the Vice President of Clinical Affairs in July 2006; and an article sent out by the Executive Vice President for UNMHSC in October 2007.
  - A PowerPoint presentation on language access was added to the New Employee Orientation.
  - A module on language access policies was added to the annual online competency trainings required of all staff and providers.

- Policies were reviewed in March 2007.
• The Patient Safety Net (PSN) online variance report system was updated in April 2007 and a presentation on using the system to report concerns about language access was offered to management that same month. At least 12 variances were reported between March and August of 2007 (the only period for which data was available). More recently, the PSN has been amended to allow the report to be flagged as language-related. This will help assure that language-related variance reports reach ILS in a timely fashion.

• A Patient Satisfaction Survey was conducted by ILS in May 2007. The patient satisfaction survey was conducted with 69 Spanish-speaking patients, apparently by telephone. It inquired about the availability and type of interpreting services, the quality of the interpretation, the availability and quality of translated materials, and overall satisfaction with the service. Of respondents, 88% said they were offered an interpreter. Satisfaction with the quality of the interpreting was very high. A lower number (72%) said they received translated materials, but of those that did, a high percentage felt the materials were understandable.

• A second satisfaction survey was conducted by ILS with UNMHSC staff and providers in June 2007. The survey, which generated 126 responses, asked about timeliness, quality of service, interpreter competence, courtesy and comprehensibility. Unlike previous surveys, this one allowed respondents to differentiate between staff, bilingual employee and telephonic interpreters. Satisfaction with staff interpreters was relatively high in all categories except timeliness, but satisfaction had increased in every category since a similar survey in a previous year. Satisfaction with Bilingual Employees was lower in every category except timeliness, in which they were judged to be somewhat better. Satisfaction with telephonic interpreters was generally lowest, with timeliness judged to be about the same as the Bilingual Employees.

Notably, over half the respondents offered comments. The comments about staff interpreters generally fell into two categories: those praising the interpreters’ excellent work and those complaining about timeliness and availability. Comments about Bilingual Employees were divided between praise for the interpreters’ work, concern for the quality of their interpreting, and frustration with their unavailability when they were busy with their non-interpreting work. Comments regarding the telephonic interpreting service revealed a high level of dissatisfaction. Respondents commented on the inconsistent quality of the interpreting, the difficulty in finding and setting up the phones, the impact on the quality of the care experience, difficulty in hearing. A surprisingly high number reported never having used the service at all.

It is not clear what was done with the results of this survey.

• Language Access Coordinators were named at each medical facility in May 2007 and have met quarterly since. Though enthusiastic at first, participants felt that the group lacked a clear sense of purpose. In addition, facilities are often too big for one individual to act as a communicative bridge between the ILS and the entire staff of that facility.
• By July 2006, control of the language access program was centralized in ILS, including responsibility for the language-testing program.

• Contracting a full-time scheduler was not necessary, partly because of the shift to assigning each Spanish staff interpreter responsibility for covering Spanish appointments in certain clinical areas.

Next steps
• Continue periodic reminders from the administration to staff regarding language access services. I believe that the ongoing communication from upper management to UNMHSC staff about the importance of interpreter services may be responsible for some of the changes in staff attitude noted in the most recent assessment. These communications will need to continue, however. The incorporation of this information into new employee orientations is a best practice that should continue. And the online module on language access services should be required of all staff; both administrative and clinical, including health care providers.

    In the communications to staff cited above, I did not find any reference to discouraging the use of family and friends, and prohibiting the use of minors to interpret. This message still needs to be disseminated.

• Review policies and procedures at the beginning of every two-year plan.

• Consider changing the policy regarding child interpreters to prohibit the use of minors under the age of 16 to interpret for interactions in which clinical information is discussed, except in cases of emergency.

• Evaluate flow of PSN variance reports and encourage their filing. While the PSN system has been improved, there remains some question as to whether all the variance reports regarding language are arriving at ILS and generating a timely response. This issue should be studied and resolved. Filing of variance reports should be encouraged as a means of pinpointing glitches in language access systems.

• Evaluate the level of response from LEP patients to the Press-Ganey surveys. If response is low, conduct satisfaction surveys with patients orally. While it is appropriate that Press-Ganey include questions regarding interpreter services on their written satisfaction survey, there is ample research data to suggest that LEP patients will be unlike to return those written surveys in significant numbers. Oral surveys conducted face-to-face with exiting patients, or by phone with patients who have had recent contact with UNMHSC, or through focus groups are more likely to generate results. Since these sorts of surveys are labor-intensive, it may be feasible to conduct them only biannually. Whenever conducted, however, effort should be made to sample patients from a variety of facilities and a variety of services. In addition to Spanish speakers, Vietnamese and Navajo patients should be surveyed as well.
• Conduct staff satisfaction surveys electronically on an annual basis. Assuming that all the contractors and employees with patient contact at UNMHSC were sent the 2007 staff satisfaction survey, the response rate was low. Anything that will boost participation in future surveys would be a positive addition.

• Reconsider the need for or role of the Language Access Coordinators. The formation of this group was suggested in 2005 as means of extending the reach of the limited ILS staff into all UNMHSC facilities; the LACs were to be ILS’ eyes, ears, and sometimes hands throughout the institution. Indeed, a recent project funded by the Robert Wood Johnson Foundation in ten healthcare facilities around the country showed significant such results in working through “Unit Champions.” However, the approach did not seem to yield results at UNMHSC. With the addition of an educator to the ILS staff, it may be that outreach can be accomplished more effectively through this individual. Or, it might be useful to have LACs continue to act as liaisons with relatively small facilities such as the Outpatient Pharmacy and the off-site clinics. The question of the role of the LACs can best be decided with input from ILS, the Community Advisory Committee and the LACs themselves.

• Link language access services to other Quality Improvement Initiatives structures in the healthcare system. A staff member knowledgeable about language access programs should participate in any Quality Improvement committees or activities carried out in the health system. In this way, language access will become even more integrated into how UNMHSC does business.

• Review contracts for out-sourced patient services to assure that patients are receiving language assistance when they are referred outside the system. If no language assistance clause is included in these contacts, language should be added when the contracts are next renegotiated.

• Network with other public hospitals across the country to share best practices, compare strategies, reveal resources and benchmark usage data if possible.

**Recommendation #3: Upgrade data systems**

**Original recommendation**

• Retrain front line staff to assure accurate completion of the language access field in both IDX and Cerner.
• Register bilingual providers.
• Reprogram IDX to send a report to ILS whenever a patient with a non-English language flag makes or cancels an appointment, so that ILS can schedule an interpreter.
• For any patient seen without a prior appointment, institute a retrospective tracking system so that a record can be maintained of who provided language access services.

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5 “Building a High-Quality Language Services Program Toolkit”, available online as of June 6, 2008 at www.speakingtogether.org.
Progress made
- Trainings for front-line staff regarding the entry of the language access code were conducted in November 2005, April 2007, and May 2007. Yearly online competency training was implemented as of July 2007.
- A partial list of bilingual providers at UNMH was compiled in June 2007.
- IDX now provides scheduling reports that includes new appointments but not cancelled appointments.
- As of March 2007, clinical staff is expected to document in every LEP patient’s chart who provided language assistance to that patient.

Next steps
- Give top priority to the design of a routine reporting system that allows for the efficient identification of:
  - Which patients needed language assistance, e.g. had a non-English language code and received services at UNMHSC?
  - During any given clinical encounter, whether in-patient or out-patient, who provided language assistance: a bilingual provider, a bilingual employee interpreter or a staff interpreter? And who provided language assistance at each stage of the appointment (registration, triage, medical encounter, hearing test, etc.)?
    This data must be collected in such a way that it can be mined both individually, in case of follow-up on a particular patient, and in aggregate, in order to assess the level of service provision. Optimally, both outpatient and inpatient encounters should be tracked. How to effectively and efficiently track the need for and provision of language assistance to inpatients, however, is an on-going debate in the language access field.
- Catalogue all points of patient contact across all UNMHSC services to assure language access at all of them
- Continue trainings with frontline staff on the importance of tracking language code in IDX and Cerner.
  This information is needed both to assess the level/type of language needs of LEP patients in the UNMHSC system and to appropriately schedule interpreters.
- Investigate and resolve why language codes might not match in IDX and Cerner.
  Although these programs are used differently, one for patient records and one for scheduling, the correct language code in each is important, albeit for different purposes. How to assure that the language codes for each patient match in both systems is a question for Information Solutions and frontline managers familiar with the workflow around these two programs.
- Follow up with patients who show no language code
  While time consuming, this one-time task could help create a more complete database of language needs among UNMHSC patients.
• Provide staff with a pull-down list on the internet of languages, with an “I speak ______” statement to assist with language identification.

• Improve tracking of language services provided by Employee Interpreters
  - Continue reminding Employee Interpreters to track their interpreting.
  - Consider using AMION as an option for tracking this service.

Recommendation #4: Language resources

Original recommendation
Reconsider mix of language resources.
• Either upgrade the linguistic and interpreting skills of Employee Interpreters or limit their use to non-clinical interactions and use more Staff Interpreters.
• Either add Staff Interpreters as unmet demand warrants, based on hard data, or shift to remote interpreting (telephonic or video).

Progress made
• As of February 2008, Senior Bilingual Employees will be required to demonstrate a higher degree of fluency in their non-English language, take 40-hours of basic training and undergo shadowing by a staff interpreter before being allowed to interpret.

• Four additional Staff Interpreter FTEs were added in FY 2007 and 4 more are budgeted for FY 2008. In addition, an educator position has been added to ILS.

• Video-interpreting will be piloted on a small scale in 2008, using in-house interpreter resources housed in a call-center.

Next steps
• Continue to upgrade the linguistic and interpreting skills of Employee Interpreters or implement skills testing and limit the use of those who do not pass to non-clinical interactions.

• Provide encouragement and/or incentives to Employee Interpreters to continue serving above and beyond their 52 interpretations/year.

• Consider having interpreters round on LEP in-patients
  One way to assure that LEP in-patients can speak at least once a day directly with the care staff is to ask staff interpreters to round on LEP in-patients. If patients have any questions or concerns, the interpreter can get a nurse and interpret for the interaction. While not optimal, this approach represents an improvement to the current system.

• Consider a tiered interpreting system
  While not formalized, staff Spanish interpreters are essentially already implementing a tiered interpreting system, in which less acute cases are handled by Employee Interpreters and more difficult cases are handled by staff interpreters. If a way could be found to
institutionalize this approach for other languages as well, it could help assure that the highest quality interpreting is available for the most difficulty clinical conversations.

- Evaluate the cost-effectiveness of having a Vietnamese interpreter on-call off hours.

- Investigate the implications of allowing staff interpreters who travel to use the administrators’ parking area. The staff interpreters who must travel to external clinics feel that having access to the closer parking area would cut their travel time and make them more efficient.

- Assure the quality of the speakerphones. I heard multiple complaints on this site visit about poor quality in the signal on the speakerphones. If this is an issue, switching to full-duplex phones may help.

- Make instructions for accessing telephonic interpreting services more accessible. Some institutions have the telephone and access number printed on a sticker and put on the back of staff name badges. Staff also needs to be reminded to have the patient’s MRN ready when calling for a telephonic interpreter.

- Review the multilingual phone tree protocols to make sure they are clear, easy to use, and working, for all services including pharmacy.

- Look into new ways to develop interpreter resources in languages of limited diffusion, such as Swahili and Arabic. As the refugee population in Albuquerque grows, UNMHSC will find itself challenged to provide interpreters in a growing number of languages for which there are few interpreters. It may be useful to network nationally with other public hospitals to identify potential interpreters or to identify and train promising candidates from the refugee community itself. Building a relationship with local and national refugee resettlement organizations can help UNMHSC be aware of both new groups that are in the pipeline and new resources to help meet their needs.

- Continue with plans to pilot a video-interpreting system. Based on the results of the time-in-motion study, it is clear that staff interpreters could serve more patients using a remote interpreting system, and it appears that video will be much more acceptable to both providers and interpreters than the telephonic interpreting system currently in place. UNMHSC has already moved ahead in finding equipment to roll out a video interpreting system. However, implementing video interpreting is much more than simply making the equipment available. Building buy-in among staff is equally important for a successful outcome.

In addition, both providers and interpreters have some doubts about the new approach. Interpreters wonder whether the video will allow them to see enough of the patient’s body language, whether dual-role interpreters used in the system will have the necessary interpreting skills, and whether any remote interpreting system is appropriate for high acuity cases. Providers are wary of seeing technology as a panacea for communication.
problems. Both groups wonder how going remote will impact the patient-interpret relationships that help build trust, and who will pick up the tasks that interpreters currently do for patients such as wayfinding, filling out paperwork and explaining how the health system works. In addition, any new system will need adjustment as ILS learns how to most efficiently implement video interpreting and how to address the pushback or passive disinterest of provider staff.

I therefore recommend the following:
- Arrange for UNMHSC staff responsible for this system to visit San Francisco General Hospital and/or University of California at Davis Medical Center to learn about the process of successfully implementing video interpreting in a large urban medical center. I can provide contact information is that is needed.
- Arrange for all interpreters who will be doing video to join on a conference call with experienced video interpreters at SFGH or UC Davis so that they can ask questions specific to video interpreting.
- Pilot video interpreting in a clinic with high volumes of LEP, clinics with complex patients, and/or possibly the ED.
- Consider the possibility of turning this into a documented research pilot, with the goal of potentially publishing results in a peer-reviewed journal.

- After the VMI pilot, analyze the use of on-site, telephonic and video interpreters to identify gaps in service delivery and determine which mode of language service delivery needs to be adjusted.

**Recommendation #5: Quality Assurance**

**Original recommendation**
Upgrade quality assurance.
- Test the language skills of self-reported bilingual providers,
- Return the acceptable grade on the LTI language screening to Advanced High for Employee Interpreters,
- Require Employee Interpreters to pass basic interpreter training,
- Ask each Employee Interpreter to shadow a Staff Interpreter for at least four hours, and to be shadowed for at least four hours.
- Clarify that UNMH interpreters are not “certified.”
- Require both Employee Interpreters and Staff Interpreters to take periodic continuing education

**Progress made**
- The language skills of self-reported bilingual providers are not yet being tested, although the clinical leadership is open to this possibility.
- As of 2008, all new Senior Bilingual Employees will be required to achieve the equivalent of ACTFL’s Advanced High or Superior on a language-screening test. Bilingual Employees who entered the program before 2008 will not be retested to the new standard.
- As of 2008, all new Senior Bilingual Employees will be required to:
  - take 40 hours of basic interpreter training.
- shadow a staff interpreter for at a minimum of four hours and be shadowed by a staff interpreter for four hours.

- Voluntary continuing education workshops are being offered monthly on an on-going basis to both Staff Interpreters and Bilingual Employees.

- Various documents regarding interpreter services at UNMHSC have clearly stated that the interpreters at the institution are not certified.

**Next steps**

- Test and track bilingual providers
  Testing bilingual providers’ language skills will allow UNMHSC to assure that providers seeing LEP patients without an interpreter are actually competent to do so. A good test of a provider’s language skills should include an oral test and require use in conversation of at least basic medical terminology, for example, that used in eliciting a medical history. Testing for listening comprehension should also be included. Language tests are commercially available from:
  - Language Testing International
  - Language Line Services
  - Pacific Interpreters
  - ALTA
    I recently learned of a new language screening service being used by some healthcare institutions on the Eastern Seaboard called ALTA. I have not yet had a chance to learn more about this service, but I was told that the screening has been shown to be valid and reliable, and that it costs only $50 per candidate. If this is true, it is worth looking into. The website is [www.altalang.com](http://www.altalang.com).

- Assure best value in the interpreter candidate language screening program
  - Make sure PI is testing language not interpreting skills; retest any candidates failed by a test that required interpreting.
  - Make sure that PI can relate their scores to the ACTFL scale, since that is the contractual basis of your cut-off for candidates.
    I don’t believe PI can actually use the ACTFL scale in reporting scores, as I believe it remains the intellectual property of ACTFL. However, they could tell you how their scoring corresponds to the ACTFL scale.
  - Look into the other language screening tests listed above.

- Continue to assure the availability of interpreter training
  At this time, UNMHSC offers *Bridging the Gap* internally only to employees of UNMH; I believe there are two trainers who are licensed to teach it. UNMHSC should make training available to all employees of the health system who are used to interpret. In the long term, UNMHSC may consider either offering these trainings for a fee to non-UMNHSC staff or supporting the development of a training program at a local community college. Either of these measures would help build a cadre of skilled interpreters available to the community at large, include, of course, to UNMHSC when it needs to hire or contract with interpreters.
Review of Language Access Services at UNMHSC

- Continue to upgrade the skills of Employee Interpreters. The increased requirements for Senior Bilingual Employees are inarguably an important step forward. However, the vast majority of employee interpreters will continue under the old requirements. Observations during the 2005 assessment, staff comments during this assessment, and responses to the staff satisfaction survey all suggest that the interpreting skills of many in this group are still in question. While the requirements for bilingual employees already in the system cannot be raised, it is possible to provide more targeted supervision and support. Following are a few suggestions as to how this could be done.
  - Have the ILS Educator shadow randomly-chosen Employee Interpreters who started prior to 2008 to identifying poor interpreting and correcting poor practice.
  - Provide additional encouragement and incentives to bilingual employees to attend basic interpreter training and the monthly interpreter forums. Such encouragement could take the form of lunch, certificates of attendance, raffling a door prize (such as a bilingual medical glossary or other training material), public recognition of anyone who attends a certain number of forums per year, or other motivators.
  - Assure that the continuing education sessions are fun and practical, with lots of interpreting practice.

Recommendation #6: Outpatient pharmacy

Original recommendation
Assure language access at the outpatient pharmacy through:
- improved communication of language needs
- availability of language support for counseling
- the use of Spanish and Vietnamese labeling.

Progress made
- Language codes are being entered into the Patient Profile used by pharmacy staff.
- The Outpatient Pharmacy has 14 Bilingual Spanish staff and access to telephonic interpreting.
- A Vietnamese-speaking pharmacist was hired in May 2008.
- Capacity exists in the Pharmacy to label medications in Spanish and Vietnamese.
- Some medication information is available in Spanish.
- Warning labels are available in Spanish.

Next steps
- On-going staff training on language access
  It appears that the pharmacy has all the tools it needs to provide language access; the staff simply needs to use them. On-going training, including emphasis on the institutions’ expectations around language access, is in order.

- Provide opportunities for the pharmacy bilingual staff to take Bridging the Gap and become Senior Bilingual Employees if they are interpreting for other pharmacy staff.

- Evaluate the advisability of installing dual handset phones at the pharmacy windows
  Due to the background noise and issues of confidentiality in the outpatient pharmacy, a
dual-handset phone would facilitate telephonic interpreting. If the phones currently used there are speakerphones, a change to dual-handset phones might increase the use of this resource by pharmacy staff.

**Recommendation #7: Staff training**

**Original recommendation**
Build support for language access through staff training.

- Prioritize meeting with and listening to the concerns of the nursing staff.
- Work with the School of Medicine to introduce training on working with interpreters into the second year classes on medical interviewing.
- Add a session on working with interpreters to the residency programs being hosted at UNMH.
- Make available an on-line training on working with interpreters that can be accessed at any time and carries CME credits.

**Progress made**

- ILS staff attended meetings with nurses in March 2006
- In February, June, October 2006 and June 2007 the Academic Affairs Faculty Quick Start orientation incorporated information on interpreters. First year medical students now receive a session on interpreter issues as one of the Perspectives in Medicine mandatory sessions.
- A competency on working with interpreters is required of UNMH residents as of July 2007.
- An online competence on working with interpreters was implemented in November 2006 and updated in April 2007.
- A full-time Educator position has been added to Interpreter Language Services.

**Next steps**

- Continue trainings on language access for all staff and providers.
  The orientation for new employees, the annual staff competencies, the class for medical students and the on-line training for residents should be continued.

  In addition, please note that in the PowerPoint presentation for new employees on language access, there were many slides whose text has been pulled verbatim from other sources (some of which I wrote). These sources need to be cited on the slides.

- Confirm that all staff members with patient contact have received training on working with interpreters through the methods listed above; for those who have not (including MDs, PAs, ARNPs and RNS) schedule training.
Recommendation #8: Signage

Original recommendation
Improve signage and way-finding

• Post permanent notices at least in Spanish and Vietnamese stating a patient’s right to an interpreter at every point of first contact with patients, including all reception areas, the ED and Financial Services.
• Implement an audiovisual method of informing Navajo LEP patients, as well as pre-literate Spanish and Vietnamese speakers, of their right to an interpreter.
• Consider possible means to improve wayfinding, including international symbols and “I speak” cards.

Progress made

• Laminated paper notices in Spanish and Vietnamese stating a patient’s right to an interpreter were posted at key points of patient contact in January 2006.
• A Navajo video informing patients of their rights, including the right to an interpreter, was completed and made available on every computer in patient care areas of UNMHSC. The video is currently unavailable as it is being revised. It is not clear how patients were to know to ask to see the video or how many staff offered Navajo patients the option to see the video.
• “I speak” cards in Spanish and Vietnamese are being distributed by staff in Admitting so that patients can inform caregivers that they need an interpreter.
• A symbol-based wayfinding system has been incorporated into the new Hospital Pavilion at UNMH. Information on this system is available in English, Spanish, and Vietnamese.

Next steps

• Assure that signage regarding the availability of interpreters is permanently and conspicuously posted in a central area (such as a waiting room) of each clinic.

• Expand the use of “I Speak” cards currently being distributed by Admitting.

• Complete the revision of the Navajo patient-rights video
  In addition to revising and re-issuing the video, front line staff must be trained to ask about patient’s tribal background and offer the video to Navajo speakers.

• Consider the installation of symbol-based signage
  While such a project would be ambitious, symbol-based signage could help even English speakers better navigate the large central UNMHSC facilities. (See a report by the Hablamos Juntos project called “The Universal Symbols in Health Care Workbook” at www.hablamosjuntos.org).

Recommendation #9: Funding

Original recommendation
Evaluate the advisability of seeking a Federal Medicaid Match.
Progress made
The possibility that the state might apply for a waiver to use a Federal Medicaid Match to pay for interpreter services for Medicaid patients was researched in early 2007. State budget shortfalls led HSD staff to state that they would not be willing to pursue this possibility at this time.

Next steps
- Suspend efforts to access a Federal Medicaid Match at this time, but stay abreast of Federal legislation over the coming years.
  It does not appear that the State of New Mexico Department of Health is willing to apply for the federal Medicaid match at this time, largely due to the current state shortfalls in the Medicaid budget. This is understandable. If the state economy improves or if Congress legislates a higher reimbursement rate for interpreter services through the Federal Medicaid Match, it might be worth reconsidering this option.

Recommendation #10: Services to speakers of Navajo
Original recommendation
Expand the role of the Navajo interpreter to include rounding on Navajo in-patients and advising the institution on how to improve communication with Native American communities.

Progress made
The position for a staff Navajo interpreter has been upgraded from .5 FTE to 1.0 FTE. Currently, an Employee Interpreter in Health Information Management is dedicating more than 50% of her time to interpreting until the dedicated interpreter position is filled.

Next steps
- Fill the full-time Staff Interpreter position as soon as possible.
- Coordinate the work of the Committee with the newly-formed Bernalillo County Off Reservation Native American Health Commission and UNMHSC Native American Affairs Office.

Recommendation #11: Translation Services
Original recommendation
Improve translation services
- Consult with clinics and with the Community Advisory Committee to prioritize the types of documents that must need translation.
- Advertise the department’s capacity for translations, and post clear instructions for requesting a translation.
- Use interpreters as translators only for relatively simple, transitory documents such as announcements, flyers, and simple brochures.
- Send complex documents, especially any document with legal ramifications, to a professional translator. Interpreting and translating are related but different skills.
- Before starting a translation, check bilingual health-related websites for pre-translated documents.
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- Post all translated documents on the UNMH intranet website in a pdf format so that they can be downloaded, but not edited, by clinical staff.
- Consult with the Navajo members of the Community Advisory Committee about the advisability of translating documents into Navajo.

Progress made
- As far as I could tell, there is no system for proactively choosing documents to translate; all translation requests are honored and outsourced for translation in the order they were received. There is a system to fast-track translation requests when some urgency (usually a patient safety issue) is identified.
- Information on ILS’s translation services has been included in the 2007 online mandatory training on language access.
- As of 2006, most translation work has been outsourced to Pacific Interpreters. UNMHSC interpreters now translate only relatively simple documents such as announcements and flyers.
- Translated documents are posted to the UNMH intranet website in a pdf format.
- Feedback on the need for translation into Navajo was requested of the Community Advisory Committee.

Next steps
- Create a system to assure that documents sent for translation are written in plain English.
- Consult with clinics and with the Community Advisory Committee to prioritize the types of documents that most need translation; not every document needs to be translated.
- Continue to advertise the department’s capacity for translations.
- Consider how best to encourage staff to actually download and use the translated documents posted on the intranet.
- Assure that all printers are capable of printing in a Vietnamese font, or make Vietnamese documents available in a pdf format that could be printed on any printer.

Recommendation #12: Five-year plan

Original recommendation
Develop a five-year plan, with clear annual goals, to improve language access services.

Progress made
- A two-year plan was completed and approved by the Community Advisory Committee in July of 2006, implementation was scheduled to be completed by June 2008.

Next steps
- In consultation with the Community Advisory Committee, develop a second two-year plan to be completed by June 2010. Have the Committee provide oversight of the implementation of the plan.
Additional Recommendations

- Add a very clear language flag in the patient’s electronic record
  Providers still complaining that they typically don’t know that a patient is LEP till they
  walk into the exam room. Providers say that this information needs to be included in the
  electronic record with other critical non-clinical information in such a way that it jumps
  out at providers when they review the record before entering the exam room.

- Ask nursing staff to post “I Speak” signs over in-patient beds.
  As a help to the numerous hospital staff who interact with in-patients, some hospitals are
  experimenting successfully with posting the patient’s language on the wall over the bed
  on a sign that reads, “I speak ______________.”

- Pilot the use of patient initiator cards
  Polyglot Inc. has recently developed a “Patient Initiator” card. Laminated and about the
  size of a business card, these have eight pictures that allow patients to communicate their
  basic needs: I’m hungry, I’m thirsty, I need to go to the bathroom, I’m in pain, I need my
  medications, I need the nurse, I need a telephone, I need an interpreter. The cards are
  designed to be given to patients when they are admitted for their use throughout their
  hospital stay and disposed of when they are discharged. They currently cost 10¢ each. Of
  course, any pilot would require buy-in from the nursing staff.

- Investigate the usefulness of Prolingua
  Polyglot Inc has also developed a computer-based communication aid that allows staff to
  provide selected information or ask selected yes/no questions to patients in their own
  language. With this software, the staff member chooses the question, indicates the
  language, and the computer speaks the question to the patient. It may be worthwhile to
  ask for a demonstration of this product to judge whether it might be useful at UNMHSC.
  More information can be found at www.pgsi.com.

- Publish
  My final recommendation is that UNMHSC encourage staff and providers to publish
  articles about their work in language access, perhaps in concert with community
  advocates. The story of UNMHSC’s integration of language assistance into the way it
  does business is an important one, and many of the initiatives taken here are best
  practices. Whether from a clinical, and administrative, or an advocacy point of view,
  there is much of value to share from the UNMHSC experience that could benefit both the
  field and the health system’s reputation.

Conclusion

Over the past 2½ years, UNMHSC has made significant progress toward integrating language
access into its provision of care. The systems necessary to make language access work are
largely in place; they simply need to have the bugs worked out and to be used more consistently
by UNMHSC staff. Both UNMHSC staff and the community advocates who have served on the
Community Advisory Committee are to be commended for their ongoing efforts to assure clear
communication between the LEP patients at UNMHSC.