Review of Language Access Services

Report to the University of New Mexico Hospital

Cynthia E. Roat, MPH

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Finally, I would like to thank the interpreters of UNMH, both Staff Interpreters and Employee Interpreters, as well as the staff of the Interpreter Language Services Department, who have made it their personal mission to assure that language will never be a barrier to the provision of quality care at this institution.
Executive Summary

In fall of 2005, the University of New Mexico Hospital contracted for an external review of the institution’s language access services. This report is the result of that review. The report both describes the state of language access at UNMH in November of 2005 and recommends steps to improve the services.

The principle recommendations of this report are:

1. Form a Community Advisory Committee to:
   - Provide input on the development of a 5-year plan for the improvement of language access services at all the UNM health systems.
   - Serve as a conduit to the Interpreter Language Services 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.

2. Demonstrate clear support from upper management for the language access policies already in place and for new ones
   - Educate staff as to the current policies regarding language access.
   - Review policies every two years.
   - Encourage staff to use the anonymous system on the UMNH intranet to report incidences when language access was not afforded according to policy.
   - Use exit surveys applied by Spanish speakers to capture patient satisfaction among LEP patients over the course of one month at the beginning of this process and once a year afterward.
   - 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.

3. Centralize responsibility and control for language access services in the hands of Interpreter Language Services
   - Move the responsibility for language testing to Interpreter Language Services.
   - Empower ILS to convene and facilitate the Language Access Advisory Committee.
   - Plan for the addition of a full-time scheduler to ILS if the data collection systems are upgraded.

4. Upgrade data collection systems
   - 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.
• For any patient seen without a prior appointment, the tracking will have to be done retrospectively.

5. Reconsider mix of language resources
   • Focus on Employee Interpreters, or
   • Focus on Staff Interpreters, or
   • Shift to Telephonic Interpreting, or
   • Shift to Video Interpreting

6. 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

7. Build support for language access through staff training on language access issues
   • 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.

8. 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.
   • Consider possible means to improve wayfinding.

9. Seek a Federal Medicaid Match.

10. Expand the role of the Navajo interpreter.

11. Improve translation services
   • Consult with clinics and with the Language Access Advisory Committee to prioritize the types of documents that most 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.
• 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 Language Access Advisory Committee about the advisability of translating documents into Navajo.

12. Develop a five-year plan for the improvement of language access services
Introduction

The University of New Mexico Hospital (UNMH) have been actively concerned with language access at its multiple facilities since at least the early 1990s. Informal efforts to maximize use of bilingual employees as interpreters, however, led to community concerns about the timeliness, availability and quality of interpreting services, culminating in a complaint filed with the Office for Civil Rights in 2001, which is still technically pending. Since then, UNMH has made significant improvements in its language access program, revising official policies regarding language access, establishing a formal Interpreter Language Service, hiring a number of dedicated interpreters, adding a telephonic interpreting service, implementing formal language screening for both staff and employee interpreters, and starting a 40-hour interpreter training program for many of the employees who are functioning as interpreters.

Nevertheless, by 2004, community advocates continued to feel that interpreting services were not being provided consistently and with quality at UNMH. Under the auspices of the New Mexico Center for Law and Poverty, the advocates filed in spring of 2005 a civil suit against the University of New Mexico, the organization with oversight responsibility for the hospital. This action, together with ongoing internal concern about the same issues, led the hospital leadership to agree to a number of corrective steps, including a comprehensive review of the language access program at UNMH. The review was to provide both a clear description of the current state of language access at the hospital and suggestions for improving the services if necessary.

There were several specific questions to which the leadership was seeking answers.

- Is the system as cost-efficient as it could be?
- If the hospital had a “good” program, how many more on-site staff would be needed?
- Are the requirements to be an interpreter strict enough?
- What are accepted standards of practice in this field?
- What are the accepted standards of provision of service?
- How can we do better?

This report will attempt to answer these questions.

Methodology

This report is based on four major sources of information. First, I reviewed all the available data relevant to language access over the past several years. Second, I made a three-day site visit during which I interviewed administrators, service providers and interpreters at the hospital. Following is a list of the titles of those interviewed:

- CEO
- Hospital legal counsel
- Director of Risk Management
- Human Resources staff
- Chief of Staff
- Interim Chief Nursing Officer
- Physicians Assistant at Southeast Heights Clinic
- Director of Care Management Services
- Director of Interpreter Language Services
- Director of Patient Financial Services
- Director of the National Union of Hospital and Health Care Employees, Local 1199
- Interpreter Scheduler

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Third, I met for about three hours with the community advocates at the New Mexico Center for Law and Poverty. Finally, I had the opportunity to observe five interpreted patient-provider interviews, three with Staff Interpreters and two with Employee Interpreters. I also observed about an hour of interpreter training offered by the Director of Interpreter Language Services.

I made a conscious decision not to interview patients at this time, as I felt that this would intrude on their care and their privacy.

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 and providers 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
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 and translated materials.

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 (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 when the interpreter 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 November 2005

Background information on University of New Mexico Hospital
The University of New Mexico Hospital (UNMH) is part of the University of New Mexico Health Sciences Center (UNMHSC), an academic institution and full service health care system providing primary to quaternary care, based in Albuquerque, NM and serving populations from throughout the state. Originally a public hospital established by the Indian Health Service and Bernalillo County to provide care for native peoples and the uninsured in Bernalillo County, the University of New Mexico Hospital was administered from 1956 – 68 by the county. In 1964, the University of New Mexico established its medical school, and when the first class graduated in 1968, the school required a clinical setting for a residency program. The hospital was leased to UNM for $1/year and a residency program established, but the original mission of the institution remained the same. In accordance with legal statute, a board was formed to oversee the hospital, which is also governed by the UNM Board of Regents.

UNMHS comprises a number of discrete but linked institutions that provide clinical care, all but three of which are physically close to the main hospital complex:

- UNM Cancer Research and Treatment Center
- UNM Carrie Tingley Hospital
- UNM Children’s Hospital
- UNM Children’s Psychiatric Hospital
- UNM Hospital
- UNM Psychiatric Center
- 20 off-site primary care clinics

The system has 500 beds (380 in the main hospital, 100 psychiatric beds and 20 beds for pediatric rehabilitation) and experiences 25,000 admissions annually, as well as 3,600 deliveries, 500,000 outpatient visits, and 84,000 emergency visits.

UNMH is a teaching hospital; the physicians providing service at the hospital are employees of the UNM School of Medicine, and over half the care is provided by residents from the UNM residency programs.

UNMHC’s mission focuses on education and research, the provision of clinical services, and the development of partnerships with public and private health-related enterprises. The core values of the organization clearly demonstrate a commitment to delivering excellence in health care, to diversity of thinking and people, and to compassion and respect for a highly diverse patient population. With this comes a commitment to serving patients without regard for their ability to pay. It is notable that this hospital system, although operating on a very slim margin, has managed to keep in the black, a state relatively unusual among public hospitals nationwide.

However, this commitment has created a clear challenge for the hospital. The past years have seen a significant increase in the number of patients requiring uncompensated care, from an average of 22-24% in past years to 27% in 2005. This trend is due to reductions in employer-
provided insurance, increases in insurance premiums, and the shift by other local hospitals of their uninsured patients to UNMH.

In addition, UNMH serves a patient population with multiple complex medical and psychosocial problems. Staff report feeling often overwhelmed and discouraged by the difficulty of meeting all their patients’ needs with the resources available to them. Although important, language barriers represent only one of the many challenges faced by staff trying to provide services to this group.

While there is insufficient data to track whether and how much the prevalence of limited-English-proficient (LEP) patients has grown among the UNMH patient population, language barriers are clearly growing among the general population in UNMH’s catchment area. In Albuquerque, almost 30% of the population speaks a language other than English at home, and 8.7% of population speaks English “less than very well,”1 a common measure of limited English proficiency. In Bernalillo County, 9.3% of the population is LEP, while in New Mexico as a whole, the total is 11.9%. Clearly, Albuquerque, Bernalillo County and New Mexico are all above the national average of 8.1% LEP. In fact, New Mexico has the fifth highest percentage of limited English speakers in the country, after California, Texas, New York and Hawaii. Even these elevated numbers almost certainly understate the problem, since the large undocumented Spanish-speaking population in the state is most likely not reflected in the census data.

The hospital staff I interviewed all agreed, however, that language barriers do represent a significant barrier to care at UNMH. The languages most commonly spoken are Spanish, Navajo and Vietnamese. While there is no reliable data, some staff estimate the language breakdown among LEP patients at UNMH to be 90% Spanish, 5% Navajo, 4% Vietnamese and 1% other. Some felt that that there has been an increase in the number of patients who do not speak English in the past few years, but there is insufficient data to either support or refute this view. Other staff felt that there has simply been an increase in awareness of this challenge. Either way, all the staff I spoke with expressed satisfaction in the steps UNMH has taken to meet this challenge as well as a sense that the system could still be improved.

General information on UNMH language access program
UNMH has made significant improvements over the past four years in the provision of language access services. The following is a description of how the system works as of November of 2005. It should be noted that any generalizations are being based on limited interviews and observations.

Policy
While language access is not addressed in the hospital’s strategic planning, UNMH does have clear and comprehensive policies regarding language access that reflect current thinking in the field. Unfortunately, it is not clear if staff is aware of the policies. Staff with whom I spoke did not know of any written policy or where to find it. New employees do not get any information on language access or interpreter use in their orientations. As a result, it appears that the policies are not being implemented in a consistent way.

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1 All data in this paragraph is taken from the 2000 U.S. Census
Demand
Unfortunately, the data currently collected by the hospital on the level of demand for interpreter services is not reliable. In 2004, (the year for which data was available) Interpreter Language Services received 7,020 requests for service. In contrast, multiplying the total reported service data for the health system by the percent of the population of Bernalillo County that the 2000 census identifies as LEP, we can estimate a very different level of demand for services:

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\begin{align*}
25,000 \text{ admissions} \times 9.3\% \text{ LEP} &= 2,325 \\
3600 \text{ deliveries} \times 9.3\% \text{ LEP} &= 3348 \\
500,000 \text{ outpatient visits} \times 9.3\% \text{ LEP} &= 46,500 \\
84,000 \text{ emergency visits} \times 9.3\% \text{ LEP} &= 7,712 \\
\text{Total LEP encounters} &= 59,885
\end{align*}
\]

This estimate almost certainly underestimates the level of demand, for several reasons:
1. UNMH serves patients from outside Bernalillo County;
2. LEP patients are more likely than the general population to have no insurance and therefore will most certainly be over-represented among the population served by a public hospital;
3. each “visit” listed above may actually include several encounters with language access services at different stages of the provision of service.

Still, in the absence of reliable data, this number may serve as an approximation of annual LEP encounters at UNMH.

Unfortunately, it is not possible to determine why there is such a large gap between projected demand and the number of requests being received by ILS. It may be that these patients are being served by Employee Interpreters and bilingual providers, or it may be that patients are not receiving language services. Most likely it is a combination of both; what the balance is will require a change in data collection.

Overall strategy
The goal of the UNMH’s language access program is to provide language access at all points of patient contact. No attempt has been done however, to actually catalog all of the points of patient contact and assure that language support is being provided.

While not clearly elucidated as such, UNMH’s current strategy for achieving this goal focuses largely on maximizing the use of its current staff’s language skills and mobilizing outside resources to fill the gaps. This strategy is based on six discrete resources for language support:

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 (minimal to date)

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

1. Bilingual providers
   While it is clear that some providers are seeing LEP patients using their own bilingual skills, thereby eliminating the need for an interpreter, there is no system that tracks either how many providers are bilingual or how often they use their skills in a clinical encounter. As a result, data on service to LEP patients do not reflect the number of LEP patients who were served by a bilingual provider.

   There is also no system in place to evaluate the degree 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.

   Finally, command of a second language is a preferred qualification for clinical staff but never required, nor is it remunerated. No particular effort is being made to hire more bilingual staff.

2. Employee Interpreters (often called “dual-role” interpreters elsewhere)
   Employee Interpreters 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. Employee Interpreters interpret in their own departments if they are not busy with other tasks, or, with permission from their supervisors, in other departments as requested. These interpreters receive a bonus of $50/pay period in addition to their regular salary, if they provide at least 7 interpretations per year. A list of Employee Interpreters and the hours they work is available to UNMH staff on an internal website.

   To earn the designation of “Employee Interpreter” at UNMH, a bilingual employee must volunteer for the position and pass a language assessment test (see below under Quality Assurance in Interpreting). As of November 15, there were 312 bilingual employees at the hospital who were functioning as Employee Interpreters. Of these, 95.6% speak Spanish. The rest speak Navajo (3), Vietnamese (3), Farsi, (2), Swahili (2), Romanian (2) and German, Urdu, Pashto, Hindi and Mandar in (1 each). Eighty-four percent work days, 5.4% work evenings, and 8% work nights. Broken down by clinic, it is notable that there are 13 Employee Interpreters in the ED, 12 in the Business Department, and 11 at the Southeast Heights Clinic. Most other clinic areas have 1-2 Employee Interpreters only.

3. Staff Interpreters
   UNMH currently has 10 FTE Staff Interpreters.
   Spanish: six full-time and one half-time interpreters, available 8:00 – 4:30 Monday-Friday. One is permanently deployed in the ED, one to Medical Specialties, one to OB Diabetes (on Monday and Wednesday) and one to Surgical specialties. In addition, one has been placed on-call over the weekends as an experiment. This interpreter carries a pager, is paid at a lower rate for being on-call, and is paid double-time if called in to interpret. To date, the usage on the weekend has been high.

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2 Heritage speakers of a language are those who learned the language at home while living in a society in which a different language was spoken in society at large and for educational purposes.
Vietnamese: one full-time and 2 casual pool (employees with no set hours, no benefits) interpreters.
Navajo: one half-time interpreter.

4. Agency telephonic interpreters
UNMH currently has a contract with Pacific Interpreters, the third largest provider of telephonic interpreting services in the country. PI provides telephonic interpreting in most languages to UNMH at a cost of $1.35/minute.

In support of the telephonic interpreting system, four dual-headset telephones have been installed in the ED that connect directly to Pacific Interpreters. These phones are located at check-in, at triage, at discharge and in the waiting area. A cordless phone is available at the nursing station in the ED that can be brought to any bedside. In all other areas of the hospital, a telephonic interpreter can be accessed with a unique code through speakerphones that are brought to the patient’s room (in-patient) or available in exam rooms (out-patient). Radiology is the only exception, where telephones cannot be used in the procedure rooms.

Telephonic interpreting does not appear to be well-accepted by hospital provider staff, who prefer to use on-site interpreters. Of those I spoke with, some complained about the wait time; upon further questioning, all of these were trying to connect with an interpreter of Navajo. Others complained of the logistic difficulty of going to find the phone and plug it in, while others felt that interpreting over the phone was less accurate and less supportive of the patient. Nonetheless, expenditures on telephonic interpreters accounted for 19% of the 2005 Interpreter Language Services budget, so somebody must be using the service.

5. Agency interpreters for American Sign Language
UNMH holds a contract with the Community Outreach Program for the Deaf for the provision of interpreters of American Sign Language. This service costs UNMH $45/hour with a two-hour minimum for appointments scheduled more than 24-hours in advance, and $65/hour for appointments scheduled with less notice.

6. Translations (minimal to date)
Translations are done largely in-house by interpreters in their down time. No data is available on how many translations have been done over the past year, nor are there written procedures on how translations will be accomplished.

Administration
Until very recently, language access at UNMH was coordinated through Care Management, a department of Professional Support and Services. In addition to the 10 FTE Staff Interpreters, the program employs a supervisor and a scheduler/administrative assistant. In fall of 2005, Interpreter Language Services became a separate department. The language testing program is being implemented under the direction of Human Resources.

Interpreter dispatch
The first step to effectively dispatching interpreters is tracking need. When patients first register, their language preference can be noted in IDX, but it appears that this is not being done.
consistently. 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, it appears that there is no system for “tagging” the patient’s chart so that all staff members who have contact with this patient know what language he or she speaks. In the same way, providers who attend patients referred from the ED normally discover a patient’s language needs only upon trying to speak to the patient.

In these cases, then, providers or staff who cannot communicate with the patient seem to be accessing language resources in this order:

1. Get by with their own limited language skills, or hand signs
2. Use family or friends to interpret, if the content to be discussed is not clinical in nature. For clinical interviews, many of the staff members I interviewed were clear about their reluctance to use family members, and their refusal to use children as interpreters. On the other hand, it does appear that some providers are using family to interpret, based on various reports I heard.
3. Find an Employee Interpreter in their own department, if there is one available in the right language. Some bilingual doctors are also being asked to interpret for other physicians.
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. Check out the list of employee interpreters on the intranet.
6. Call Interpreter Language Services if it is between 8:00 – 4:30 Monday to Friday.
7. Use the telephonic interpreter line.

Sometimes when the patient’s appointment is pre-scheduled, staff will call interpreter services to book an interpreter ahead of time. Cancellations are often not called in, however, leading to the interpreter’s time being booked but not used.

Financial Services has taken pro-active steps to recruit a heavily bilingual staff. Twelve out of 20 financial assistants are bilingual (8 have been formally screened), as are eight of 11 bilingual billing assistants. Telephone interpreters or family members are used as a back-up only, or in cases of languages other than Spanish. Bills are sent only in English, as the billing is done by an external company that does not have the capacity to produce foreign language bills. Some forms, form letters and brochures have been translated into Spanish, and fewer into Vietnamese.

I could find no information on how language services are being provided for telephone triage or consulting nurse lines.

**Interpreter quality assurance**

Quality assurance in interpreting is based on six steps: appropriate recruiting, language screening, training, assessment, monitoring and continuing education.

Employee interpreters at UNMH are self-recruited, that is, they volunteer to serve as interpreters, needing only the permission of their supervisors. Their language skills are screened by an outside contractor, Language Testing International, at a cost of $120 per test. LTI is the testing arm of
the American Council for the Teaching of Foreign Languages (ACTFL) and, as such, uses the ACTFL scale when assessing language skills. The ACTFL scale runs from Superior to Advanced (High, Mid, Low), Intermediate (High, Mid, Low) and Novice (High, Mid, Low). To be designated an “Employee Interpreter” a candidate at UNMH must receive an assessment of Advanced Low or higher. This standard was lowered from Advanced High several years ago. The test is offered monthly, over the course of the week. About 75% of UNMH candidates pass it; those who fail must wait for six months before attempting the test again. Training is not currently required for employee interpreters at UNMH, although many do take the 40-hour course, Bridging the Gap, which is taught by Guadalupe Reyes of Interpreter Language Services. As of November 2005, about 140 had taken the course; Interpreter Language Services staff would like to see all Employee Interpreters screened and trained by the end of 2006.

Employee interpreters undergo no skills assessment or monitoring. There are no continuing education requirements.

A number of UNMH staff and many of the advocates expressed concern about the quality of the language skills and interpreting being provided by the Employee Interpreters. Based on the minimal observation I made of two dual-role Spanish interpreters and some 20 students in the Bridging the Gap class, I have to agree that quality should be a concern. I heard a great many Anglicisms in the Spanish, as well as grammatical errors, mixing of English and Spanish and a lack of adequate vocabulary. While I did not witness any interpreting that I thought was dangerously inaccurate, the interpreters were overfocused on interpreting words rather than meaning, rendering the source speech into awkward and confusing constructions in the target language. The interpreters routinely omitted parts of the patient’s speech and initiated diagnostic questions not asked by the provider. In addition, the interpreters used poor interpreting technique: they were invasive, used summarization and switched between first and third person throughout the interpretation. It would be inappropriate to generalize to the entire group of Employee Interpreters from the few I observed, however, this experience confirms the need to investigate further the skills of the Employee Interpreters.

Staff Interpreters at UNMH have been principally recruited from the more skilled of the Employee Interpreters. To be considered for an interpreter position, they 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 by LTI, but they must score at the Advanced High or Superior level. There is no assessment done of their interpreting skills, and no monitoring. A previous peer shadowing program was suspended as Staff Interpreters were loath to criticize their colleagues, and the Interpreter Supervisor did not have the time to monitor the Staff Interpreters. As with the Employee Interpreters, there are no continuing education requirements.

I had the opportunity to observe two of the Staff Interpreters. Both had excellent Spanish and English language skills. While one’s interpreting skills were superior to the other’s, the faults of the latter were more those of style, not of accuracy or completeness, and could be easily remedied with minimum coaching.

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1 For an explanation of the ACTFL scale, please see Appendix A.
Without exception, the UNMH clinical staff I interviewed spoke very highly of the Staff Interpreters. They were described as “very professional,” “nice to work with”, “polite,” “patient” and “really helpful.” The general complaint was that there were not more of them.

As a final comment, I would like to add that all the interpreters I spoke with demonstrated a high degree of commitment to their work. The Staff Interpreters in particular were passionate about providing clear communication to patients and providers and about building the language access program at UNMH. They, and the Employee Interpreters as well, all expressed a deep-seated concern for the well-being of the patient and desire to help them access the care they need at UNMH.

Translation services
Translation has been a secondary focus of the Interpreter Language Services over the past several years. Requests for translations come in over the phone, but documents must be submitted in electronic format. The translations themselves are generally done by Staff Interpreters on their down time. In the case of Vietnamese, an outside translator has been contracted, as the Vietnamese Staff Interpreter does not have time to translate. After an initial translation, a second interpreter edits the text and a third reviews it. None of the interpreters has been screened for her writing skills in either language, none have received training or assessment as translators, and there is no monitoring or continuing education offered them in this area. No inventory of translated documents exists.

Staff training on use of interpreters
At present, there appears to be a lack of training for providers on how to work effectively with interpreters. While some in-services have been offered in a few clinics, these appear to be insufficient. In my observations in the clinics, I saw one provider who worked exceptionally well with the interpreter, using the interpreter as a language resource to connect directly with the patient, and others who instead used the interpreter as a buffer between themselves and the patient.

While my contact with providers was too limited to generalize, I came away from the site visit concerned that providers at UNMH may not be giving quality interpreting the importance it deserves. Clinical leadership seemed ignorant of the hospital’s legal responsibility to provide language access and expressed a sense that patients should bring their own interpreters. There was a general sense that seeing LEP patients takes a lot longer than seeing English-speaking patients, which caused concern to providers in clinic settings where productivity is an issue. In the ED, I observed a provider using an Employee Interpreter for a clinical interview when the Staff Interpreter assigned to the ED was free and available; when this was pointed out to him, he replied that “it wasn’t important” as he needed “somebody fast.” In addition, I heard several stories from staff of near misdiagnoses stemming from the use of family as interpreters when Staff Interpreters, Employee Interpreters and telephonic interpreters were all available.

Signage and way-finding
There is very little multilingual signage in the hospital at all, making way-finding potentially difficult for LEP patients and families. There are paper posters taped on external doors
announcing the availability of interpreters, but I observed no official notices inside the hospital proper. Language Interpreter Service staff reported that other similar notices posted in clinic areas had been removed.

Data collection
The foundation of a language access program is the tracking of patients’ language preference. Reliable language preference data allows the Interpreter Language Services to calculate demand, to identify trends, and to predict when interpreters will be needed and where, as well as to track how many patients got the interpreters they needed. It also allows providers to be prepared to deal with an LEP patient before entering the exam room.

When patients register at UNMH, their information is entered into IDX. On the positive side, there is a field in the registration program to note language preference, which does not default to English. It appears, however, that front line staff fills out the field only sporadically and inconsistently. In addition, patient demographics and charting are done in Cerner, not IDX, so the front line staff must duplicate the registration in Cerner, where language preference is often not noted. Nor does it appear that language preference is routinely noted on the chart. As a result, the providers with whom I spoke told me that they most commonly do not know they will be dealing with a non-English-speaking patient until they actually start speaking to the patient.

Interpreter Language Services tracks Staff Interpreter usage on an Access database, by department and language. The system is accurate if a bit unwieldy, but tracks only the interpretations that come through ILS scheduling. Employee Interpreters are required to provide documentation of providing at least seven interpretations a month in order to maintain their stipend, but it appears that this system is not being tracked or enforced. The true scope, then, of the services being provided by Employee Interpreters is unknown. The scope of services provided by bilingual providers is also unknown.

Other important data that is not being collected at this time, which would help in planning, include:

- Staff Interpreter productivity (percent of total paid time being spent actually interpreting)
- Staff Interpreter wait times (the amount of time an interpreter spends waiting for the doctor to see the patient)
- Average length of interpreted encounter

Systems are in place to monitor patient satisfaction and patient/staff complaints. A "variance report" is filed by staff when any situation develops that is outside normal operating procedure. While there is no specific tracking on how many of these are related to language, a review of variance reports might give a sense as to how often language is involved in clinical problems. In addition, data on complaints related to language access can be collected through the Spanish-speaking Patient Advocate, or the on-line system for anonymous employee complaints. To date very few of these have related to language issues.

Patient satisfaction surveys are reported to be sent out in Spanish to Spanish-speaking patients, but it is not clear to me how these patients are identified. It does not appear that this system has produced much usable information.
Expenditure
The 2005 budget for Interpreter Language Services was $576,339, of which 19% ($111,00) was budgeted for telephonic interpreting and 19% for ASL interpreting. I could not determine if Employee Interpreter stipends were included in this department’s budget. Language testing was not included in this department’s budget.

The 2006 budget of $672,863 represents a 16.7% increase over the previous year. Telephonic interpreting costs have been projected to increase to 26% of the budget.

The cost of UNMH’s language access program comes entirely from the hospital’s operating budget. 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 major improvements in its language access services over the past four years. All the staff members to whom I talked were well aware of the diversity of their patients and understood that language barriers represented a problem, and all had a clear idea of how they would respond when faced with that barrier. However, the various facets of the language access program are not integrated well and some aspects are not functioning as they should. A more coherent and long-term plan, based on reliable data and with the clear support of upper management, is needed to forge a single effective language access program. In the section that follows, I will recommend a series of steps aimed at meeting that goal.
Analysis and Recommendations

1. **Form a Community Advisory Committee**
   As a public hospital, UNMH has a vested interest in seeking timely and accurate input from the local community about possible gaps in its services, upcoming shifts in community demographics, and community resources that could assist the hospital in carrying out its mission. The historical conflict and the current adversarial relationship between a significant group of community advocates and UNMH over the issue of language access are not conducive to effectively building this program. UNMH must be open to and embrace community input. At the same time, community representatives must understand the realities of a large, underfunded public health care system in which a primary shift in policy toward linguistic diversity is being undertaken.

   I recommend, therefore, that UNMH form a Language Access Advisory Committee, comprised of hospital staff and community members. The committee should include, at least in the short term, Guadalupe Reyes and Patrick Lyford. Community representatives need to be firmly grounded in the communities being served by the hospital and should include representatives both from among the advocates related to the New Mexico Center for Law and Poverty and from other non-affiliated groups.

   Following are some of the tasks that could be undertaken by this Advisory Committee:

   - Provide input on the development of a 5-year plan for the improvement of language access services at all the UNM health systems (see recommendation 12).

   - Serve as a conduit to the Interpreter Language Services Department for reports from the community of incidents in which patients did not receive timely and appropriate language services. These reports must include enough specific information (name of patient, date and location of incident) to allow the ILS staff to effectively follow-up.

   - 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.

2. **Demonstrate clear support from upper management for language access policies, both those already in place and new policies that may emerge.**
   All the language access programs in the country that provide consistent and high quality interpretation share at least one quality: the strong support of upper management. A compelling message must be sent by senior administrators that UNMH is serious about guaranteeing clear communication between its providers and patients, irregardless of the languages they speak. Interpreters must come to be seen as an integral part of the health care team, with their own skills and expertise, without which the providers cannot give effective care. To this end, I recommend the following:
Review of Language Access Services at UNMH

- Educate staff as to the current policies regarding language access. Posting the policies on the intranet is not enough. Attention must be brought to this issue in a visible way. I believe that UNMH management will be able to best ascertain what will be the best vehicle for that message.

- Send a clear message that family and friends are not to interpret in clinical encounters except in cases of emergency.

- Review policies every two years. A useful resource for this work is *Straight Talk: Model Hospital Policies and Procedures on Language Access*, developed with the support of the California Association of Public Hospitals and Health Systems and downloadable at http://parasandassociates.net/index.html.

- Encourage staff to use the anonymous system on the UNNH intranet to report incidences when language access was not afforded according to policy.

- Use exit surveys applied by Spanish speakers to capture patient satisfaction among LEP patients over the course of one month at the beginning of this process and once a year afterward.

- 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 and to help ILS keep it’s finger on the pulse of this large and diverse system.

3. **Centralize responsibility and control for language access services in the hands of Interpreter Language Services**

   Right now ILS is overseeing only the staff and telephonic interpreting portions of UNMH’s language access strategy. Language testing is under the supervision of Human Resources, and the employee interpreters do not appear to be responsible (in their interpreting capacity) to anyone. Therefore, I recommend the following:

   - Move the responsibility and the budget for language testing to Interpreter Language Services.

   - Empower ILS to convene and facilitate the Language Access Advisory Committee and the group of Language Access Coordinators.

   - Plan for the addition of a full-time scheduler to ILS if the data collection systems are upgraded.

4. **Upgrade data collection systems**

   Most of the decisions on staffing and efficient dispatch of interpreters require concrete and reliable data that does not now exist. Systems need to be put in place to track WHEN an interpreter is needed and WHO provided the interpreting. This includes tracking when an
LEP patient is attended by a bilingual provider who does not need an interpreter, by an Employee Interpreter, by a Staff Interpreter, or by a telephonic interpreter.

Those who know clinical procedure and the capacity of the staff and information systems at UNMH will do better than I at recommending what form this tracking should take. However, here are some suggestions:

- Retrain front line staff to assure accurate completion of the language access field in both IDX and Cerner.

- Register with Interpreter Language Services the providers who are capable of seeing patients in a language other than English. In clinic settings, patients could be matched with providers who speak their language.

- Reprogram IDX so that whenever a patient with a non-English language flag makes or cancels an appointment, a report is sent to Interpreter Language Services. ILS then will enter this appointment into the database. If the provider assigned is language concordant with the patient, no interpreter will be sent. If the provider assigned is not language concordant, an interpreter will be assigned, either from among the Staff Interpreters or from among the Employee Interpreters. These assignments will be registered in the database.

- For any patient seen without a prior appointment, tracking will have to be done retrospectively. Could this be done through Cerner, when the provider is charting? I do not know enough about Cerner to know if such a programming change is possible.

Once this data is being collected routinely, Interpreter Language Services will be able to better analyze the level of demand for language services by department, time of day, and language and how the hospital has been able (or not) to meet the demand. This will allow rational decisions to be made about posting an interpreter full-time in a particular department, or whether more interpreters need to be hired. This data will also allow ILS to identify departments that have unusually high demand or unusually low demand for interpreters, both of which may be red flags.

Another type of data that would be useful to the hospital is the amount of time that Staff Interpreters spend interpreting and the amount they spend in transit or waiting for providers. This data can be used to determine the advisability of shifting to remote interpreting. In addition, tracking average length of interpreted encounter will help the interpreter scheduler know how much time to block from an interpreter’s schedule for any given appointment, making more efficient use of the interpreter’s time. All of this data could be gathered through an annual one-week time-motion study in which Staff Interpreters track their movements at 15-minute intervals throughout the day.

5. Reconsider mix of language resources

Based on the discrepancy between the projected demand for interpreter services and the number of interpreter requests being received by ILS, it appears that most interpreting at
UNMH is being done by Employee Interpreters, followed by Staff Interpreters, followed by outsourced telephonic interpreters. There are strengths and drawbacks to this model. While UNMH is lucky to have so many bilinguals to train as interpreters, many staff members reported being frustrated at having to call all over the hospital for an interpreter, while others expressed concern about the quality of the interpreting. Some medical centers that use this model have also discovered that dual-role interpreters burn out more quickly due to the stress of being constantly pulled from their other jobs. I asked about this at UNMH, and I did not find any evidence of this phenomenon, but it is something to be watched. Certainly if UNMH decides to continue to build on this model, it will be necessary to increase the skill level of the Employee Interpreters and to find a way to track their services.

There are other models for the provision of language access services that are open to UNMH. The institution could freeze the Employee Interpreter program, provide no additional training to these interpreters, and restrict their use to non-clinical interactions. More highly trained Staff Interpreters could then be used for clinical interpreting. This model is called a tiered interpreter system, and it works well if staff will buy in to calling the Staff Interpreters instead of grabbing the closest Employee Interpreter for clinical interactions. This model has the benefit of making use of the institution’s bilingual staff’s language skills without having to invest a great deal of effort into upgrading their interpreting skills, while still providing first class interpreting for the more difficult encounters.

Without hard usage data, it is difficult to make an estimate of how many Staff Interpreters UNMH would need to make such a model work. However, for comparison sake, I would like to include some benchmarking data from other hospitals that may be useful.4

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>UNMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient load</td>
<td>300 beds</td>
<td>500 beds</td>
<td>500 beds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>460,000 outpatient visits</td>
<td>500,000 outpatient visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1 Trauma Center</td>
<td>Level 1 Trauma Center</td>
</tr>
<tr>
<td>Patient demographics</td>
<td>38 languages</td>
<td>35 languages</td>
<td>3 languages</td>
</tr>
<tr>
<td>40% patients are LEP</td>
<td></td>
<td></td>
<td>9.3% patients are LEP</td>
</tr>
<tr>
<td>Interpreting Services</td>
<td>128,000 interpreted encounters</td>
<td>55,000 interpreted encounters</td>
<td>59,885 interpreted encounters</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(est)</td>
</tr>
<tr>
<td>Resources</td>
<td>40+ FTE interpreters</td>
<td>15 FTE interpreters</td>
<td>10 FTE interpreters</td>
</tr>
<tr>
<td></td>
<td>100 per diem interpreters</td>
<td>100 on-call interpreters</td>
<td>2 administrative</td>
</tr>
<tr>
<td></td>
<td>6 FTE administrative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language Access Strategy</td>
<td>● Hiring/training bilingual staff</td>
<td>● Interpreter services (including volunteer interpreters)</td>
<td>● Dual-role interpreters</td>
</tr>
<tr>
<td></td>
<td>● Bilingual/bicultural outreach workers in 4 language groups.</td>
<td>● Share interpreter resources with other local health institutions through videoconferencing</td>
<td>● Staff Interpreters</td>
</tr>
<tr>
<td></td>
<td>● Interpreter Services</td>
<td>● Provider training</td>
<td>● Telephonic interpreting as a back-up</td>
</tr>
<tr>
<td></td>
<td>● Translation</td>
<td>● Outcome tracking and reporting</td>
<td></td>
</tr>
</tbody>
</table>

4 Because this data was sent to me confidentially, I am not at liberty to identify the institutions in question.
This data suggests that an additional 5 interpreters might meet the need, however, there are many other issues to be considered. Still, building up the Staff Interpreters is a reasonable option.

Another possible model for UNMH is the call-center model. In this model, Staff Interpreters are pulled back into a central call-center and most interpreting is done over the phone. Interpreters do not waste time traveling between clinics or waiting for the doctor. If interpreting over the phone is just not working, the Staff Interpreter can still go down to the clinic. This model has the benefit of being easily scaleable so as to be able to provide telephonic interpreting to other local or regional health care institutions, converting Interpreter Language Services into a profit center.

To be successful with this model, UNMH will need to first build greater acceptance of telephonic interpreting among providers. At this time, all the staff whom I interviewed disliked it, many vehemently so. There was a sense that the connection with the patient was diminished, that the interpreting was less accurate and that the logistics were inconvenient. If UNMH wishes to work with this model, several steps might help:

- Invest in full-duplex dual-headset/speakerphones that connect directly to ILS.
- Rewire the jacks for plugging in the phones to waist height so that nurses don’t have to crawl under the furniture to plug them in.
- Work with providers to establish guidelines for when an on-site interpreter will be used and when the calls will go to telephonic interpreters.
- Invest in rapid call-switching software for interpreter services so that calls to interpreters can be switched and queued automatically.

Steps one and three above would be positive steps for the program even if a call-center model is not implemented.

A final option that has been discussed at UNMH is video-interpreting, a model in which an interpreter is brought into the exam room via a computer and a web cam. The benefit of this method, as all remote methods, is the more efficient use of the interpreter’s time. I did not have time while at UNMH to investigate the feasibility of this model, which would require enormous band-width and a computer in every room, but I do note that UNMH is one of the most “wired” hospitals in the country, so this approach might be no more difficult to implement than the telephonic model. It should be noted that this technology is in its infancy, with only a handful of institutions in the country having experience with it. If UNMH is interested in this model, I suggest staff visit San Francisco General, UC Davis Medical Center, Cambridge Health Alliance in Boston or Holy Cross Medical Center in Teaneck, NJ.

In summary, there are a number of different models for the provision of interpreter services that UNMH can adopt. Of course, any model will include all the resources at hand; the difference is in the mix and the emphasis. Without the data regarding demand and service
provision, I cannot recommend any particular model over another. For the sake of making recommendations in this report, I will assume that UNMH is going to continue with the model currently being implemented.

6. Upgrade quality assurance
UNMH has made a good start toward quality assurance but instituting a language screening program for interpreters. However, over time, additional steps need to be implemented.

- Test the language skills of self-reported bilingual providers, both doctors and nurses. While UNMH could use the same test to screen providers’ language skills as it does for interpreters, LTI’s test is not specific to medical settings. Language Line Services might be willing to adapt its interpreter language screening test for providers. In addition, both Kaiser Permanente in California and the National Center for Interpretation Testing, Research and Policy in Tucson are working on language screening tests specifically designed for health care providers. If screening is implemented, it will be important to reward those who submit to testing with some sort of bonus, gift card or other recognition.

- Return the acceptable grade on the LTI language screening to Advanced High. I recently did an admittedly informal and unscientific survey of interpreter programs around the country that use LTI to screen language skills. Seven of 10 respondents replied that they accepted either Superior or Advanced High as a prerequisite for training. The GA State Administrative Office of the Courts requires Advanced Mid for interpreters to be “registered”, their lowest form of documentation. And two groups accepted Advanced Low, although one of these respondents mentioned that the Advanced Low candidates either were poor test-takers or tended to struggle with the interpreting during training. Based on this, on the experiences of the interpreter trainer at UNMH, and on my observations while on the site visit, I recommend that future Employee Interpreters be held to the higher standard.

Recognizing that this may be a difficult move politically, another possibility is to change screening programs. Language Line Services, NetworkOMNI, and Pacific Interpreters all have language screening programs. LLS and Network OMNI’s programs may be more scientifically based, while PI’s is cheaper. If another program is chosen, it is important to make sure that the passing level is equivalent to the ACTFL Advanced High.

- Require Employee Interpreters to successfully complete basic interpreter training. Being bilingual is only the start of becoming an interpreter. Interpreting requires particular skills, knowledge and sensitivities that must be learned. If Employee Interpreters are going to be providing services for clinical interactions, they must receive training as interpreters.

- Ask each Employee Interpreter to shadow a Staff Interpreter for at least four hours, and to be shadowed for at least four hours.
Since there is no skills assessment being done at UNMH, mentored observation is the next best way to assure that Employee Interpreters understand and are capable of carrying out their role as an interpreter.

- Clarify that UNMH interpreters are not “certified.” None of the interpreters at UNMH have gone through a valid and reliable skills assessment, and so none can say they are certified. At this time there is no national certification for medical interpreters in the United States. There are certification processes for medical interpreters that are conducted over the telephone by Language Line Services and by NetworkOMNI. It might be wise to have the Staff Interpreters go through one of these certifications, which are quite challenging, however I would not recommend requiring Employee Interpreters to be certified, as it is likely that a large number would not pass the test.

- Require both Employee Interpreters and Staff Interpreters to take periodic continuing education
  Continuing education for Staff Interpreters should include participation in regional conferences (for example, those of the Massachusetts Medical Interpreter Association, the California Healthcare Interpreting Association, and the Arizona Interpreter Association) and on-line vocabulary study. This training could be designed by the Interpreter Supervisor and conducted in a self-study format.

Continuing education for Employee Interpreters should be focused on supervised practice of interpreting skills and vocabulary development. These trainings could be organized and facilitated by the Staff Interpreters.

7. **Build support for language access through staff training on language access issues**
   Building support for language access among providers who are exceptionally busy and who are already dealing with complex clinical issues will not be easy, if only because any change is not easy under those circumstances. The fact that the physicians at UNMH are supervised through the UNM School of Medicine makes it even more difficult. Nonetheless, UNMH will benefit from having its nursing and medical staff more completely on-board with language access. In addition, there are techniques to working effectively with an interpreter that need to be learned. To that end, I recommend the following:

- **Prioritize meeting with and listening to the concerns of the nursing staff. Include instruction on how to work effectively with an interpreter. Make the meetings brief, direct and to the point, and provide food.**

- **Work with the School of Medicine to introduce training on working with interpreters into the second year classes on medical interviewing. Such training is being routinely included in medical school curricula at many medical schools.** I believe the UNM program for Physicians Assistants may already have such a program, being taught by

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5 Harvard, University of Washington, UCLA, Northwestern University, University of Chicago, University of Nebraska, University of Rochester, Oregon Health and Sciences to name a few.
Debbie Weissman, a PA at the Southeast Heights Clinic.

- Add a session on working with interpreters to the residency programs being hosted at UNMH. Again, other residency programs are doing this, for example the Family Practice Residency at Swedish Medical Center in Seattle. This session could be taught by the Interpreter Supervisor.

- Another option for Residents and for Attending Physicians is an on-line training on working with interpreters that can be accessed at any time. This program carries two credits of continuing medical education from Rush Medical College in Chicago. It costs $30 for the two credits. If the hospital wished to purchase bulk access to the program, the cost is reduced even further. The program, called Communicating through Health Care Interpreters, can be found at the website of Medical Directions at http://www.vlh.com/myvlh/courses/1705/index.cfm.6

8. Improve signage and way-finding

UNMH has virtually no bilingual signage, some of which is required by the Office for Civil Rights and much of which would help LEP patients navigate the system. Therefore I recommend the following:

- Post permanent notices at least in Spanish and Vietnamese regarding a patient’s right to an interpreter. These notices should be posted at every point of first contact with patients, including all reception areas, the ED and Financial Services. They should be posted in a permanent and formal format. A sample text reads:

  "Attention. If you do not speak English, or if you are deaf, hard of hearing, or sight impaired, you can have interpretive and translation services provided at no charge. Please ask for assistance."

  A poster with this text translated into 21 different languages can be downloaded for free at http://www.floridajobs.org/PDG/PostersforEmployers/IS%20Poster%2011x17.pdf

- Over time, consider possible means to improve wayfinding:
  Translation of signage into Spanish, at least
  Installation of symbol-based signage, which would help even English speakers navigate better. (see a report by the Hablamos Juntos project called “The Universal Symbols in Health Care Workbook” at www.hablamosjuntos.org).
  Installation at each entry point of a “Patient Passport” display. I saw this implemented at Children’s Hospital of Philadelphia, where it has been a great success. The display holds colored cards, or “passports,” each in a different color and different language. On one side the passport has this message in the non-English language: “Please present this card to any hospital employee and they will help you get to where you need to go.” On the other side is printed, in English, “The holder of this card speaks (whatever the language is). Please help this patient find his way. Do not leave this patient alone until he or she

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6 In the spirit of full disclosure, I would like to state that I have a fiscal interest in this program, but I know of no other on-line program like it to recommend.
has either reached the destination or is in the care of an interpreter.” The card then has a space to write the patient’s name, medical identification number and destination, so that staff can use the card to help patients who are moving between departments.

9. Seek a Federal Medicaid Match
There is a mechanism by which federal Medicaid funds can be accessed to help pay for interpreter services for Medicaid patients. The mechanism is complex and the funds must be passed through the State Medicaid Office with matching funds from the state. To date, fourteen states have programs in place to access this money, each in a different way.

I do not know whether the New Mexico State Medicaid office would be willing to seek this Federal Administrative Match, or if UNMH would be eligible for it. However, this is one of the few sources of reimbursement for interpreter services, so it might be worth looking into. A useful overview of this program can be found in Language Services Action Kit, pages 15-30, published by the National Health Law Program (NHeLP) and available free of charge from their website at www.healthlaw.org. Another valuable resource on the Federal Medicaid Match is Mara Youdelman, Staff Attorney at NHeLP (youdelman@healthlaw.org, 202-289-7661).

10. The special case of the Navajo
While it is clear that Spanish is the principle interpreted language at UNMH, I was concerned to hear that the Indian Health Service facility in Albuquerque closed in August of 2005, and that the 25,000 patients previously served by that facility would be shifting to UNMH. Under the circumstances, it seems prudent to inquire of IHS if it has any language data on that patient population, so that ILS can prepare for a possible increase in the need for interpretation in Navajo.

I would also like to suggest that UNMH consider widening the scope of service of its half-time Navajo interpreter to include special support for in-patient monolingual Navajo-speaking patients. This is a model of the interpreter’s role pioneered at the University of Manitoba Health Sciences Center in Winnipeg. In this model, hospital interpreters made rounds each day to visit with monolingual Ojibway- and Cree-speaking patients who had been med-evaced to the hospital from Northern Manitoba. These patients were often traditional in their beliefs and most often alone until their families could arrange transportation to Winnipeg. The interpreter facilitated communication with nursing staff, helped identify and resolve patient concerns and sometimes just provided an opportunity for the patient to talk. This program significantly improved the hospital’s relations with the First Nations communities and built trust with patients and their families. UNMH may want to evaluate the usefulness of such a program at its in-patient facilities.

11. Translation services
The development of translation capacity is secondary to the development of quality interpreter services, because English documents can be sight translated for patients if necessary. However, as interpreter services improve, the hospital may want to turn its attention to the translation of internal documents. When that time comes:
Review of Language Access Services at UNMH

- Consult with clinics and with the Language Access Advisory Committee to prioritize the types of documents that most 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. Translators are first and foremost writers and must have excellent writing skills in the target language. Translators, therefore, should have their writing skills screened and receive training in the discipline. UNMH may do better to contract out this work.

- Before starting a translation, check bilingual health-related websites for pre-translated documents. An example of such a website is www.languagemed.com. Pre-translated documents can also be found on many pharmaceutical sites, on the websites dedicated to particular diseases, or on the website of the National Institutes of Health at http://www.nlm.nih.gov/medlineplus/spanish/medlineplus.html.

- 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 Language Access Advisory Committee about the advisability of translating documents into Navajo. My sense from working with the Navajo interpreters at the Northern Navajo Medical Center in Shiprock, AZ, is that few monolingual Navajo speakers read the language and so translation may not be the best way to communicate information.

12. Develop a five-year plan for the improvement of language access services

The recommendations made in this section cannot be implemented all at once, for both logistical and budgetary reasons. I suggest that Interpreter Language Services, with input from the Language Access Coordinators and the Language Access Advisory Committee, develop a five-year plan with clear annual goals and benchmarks so that this work can proceed at a reasonable pace with reasonable expectations.

Conclusion

The many recommendations made in this report are not in any way to be construed as a harsh judgment of UNMH’s current language access program. It is my hope, however, that they will lead to vigorous and animated discussions of the direction in which the program should go and of the best way to mobilize UNMH’s human and material resources for the benefit of the hospital’s staff and limited-English-proficient patients.
Review of Language Access Services at UNMH
Appendix B
ACTFL PROFICIENCY GUIDELINES -- SPEAKING
Revised 1999
Published by the American Council on the Teaching of Foreign Languages

SUPERIOR
Speakers at the Superior level are able to communicate in the language with accuracy and fluency in order to participate fully and effectively in conversations on a variety of topics in formal and informal settings from both concrete and abstract perspectives. They discuss their interests and special fields of competence, explain complex matters in detail, and provide lengthy and coherent narrations, all with ease, fluency, and accuracy. They explain their opinions on a number of topics of importance to them, such as social and political issues, and provide structured argument to support their opinions. They are able to construct and develop hypotheses to explore alternative possibilities. When appropriate, they use extended discourse without unnaturally lengthy hesitation to make their point, even when engaged in abstract elaborations. Such discourse, while coherent, may still be influenced by the Superior speaker's own language patterns, rather than those of the target language.

Superior speakers command a variety of interactive and discourse strategies, such as turn-taking and separating main ideas from supporting information through the use of syntactic and lexical devices, as well as intonational features such as pitch, stress and tone. They demonstrate virtually no pattern of error in the use of basic structures. However, they may make sporadic errors, particularly in low-frequency structures and in some complex high-frequency structures more common to formal speech and writing. Such errors, if they do occur, do not distract the native interlocutor or interfere with communication.

ADVANCED HIGH
Speakers at the Advanced-High level perform all Advanced-level tasks with linguistic ease, confidence and competence. They are able to consistently explain in detail and narrate fully and accurately in all time frames. In addition, Advanced-High speakers handle the tasks pertaining to the Superior level but cannot sustain performance at that level across a variety of topics. They can provide a structured argument to support their opinions, and they may construct hypotheses, but patterns of error appear. They can discuss some topics abstractly, especially those relating to their particular interests and special fields of expertise, but in general, they are more comfortable discussing a variety of topics concretely.

Advanced-High speakers may demonstrate a well-developed ability to compensate for an imperfect grasp of some forms or for limitations in vocabulary by the confident use of communicative strategies, such as paraphrasing, circumlocution, and illustration. They use precise vocabulary and intonation to express meaning and often show great fluency and ease of speech. However, when called on to perform the complex tasks associated with the Superior level over a variety of topics, their language will at times break down or prove inadequate, or they may avoid the task altogether, for example, by resorting to simplification through the use of description or narration in place of argument or hypothesis.

Cynthia E. Roat, MPH, 2005
ADVANCED MID
Speakers at the Advanced-Mid level are able to handle with ease and confidence a large number of communicative tasks. They participate actively in most informal and some formal exchanges on a variety of concrete topics relating to work, school, home, and leisure activities, as well as to events of current, public, and personal interest or individual relevance.

Advanced-Mid speakers demonstrate the ability to narrate and describe in all major time frames (past, present, and future) by providing a full account, with good control of aspect, as they adapt flexibly to the demands of the conversation. Narration and description tend to be combined and interwoven to relate relevant and supporting facts in connected, paragraph-length discourse.

Advanced-Mid speakers can handle successfully and with relative ease the linguistic challenges presented by a complication or unexpected turn of events that occurs within the context of a routine situation or communicative task with which they are otherwise familiar. Communicative strategies such as circumlocution or rephrasing are often employed for this purpose. The speech of Advanced-Mid speakers performing Advanced-level tasks is marked by substantial flow. Their vocabulary is fairly extensive although primarily generic in nature, except in the case of a particular area of specialization or interest. Dominant language discourse structures tend to recede, although discourse may still reflect the oral paragraph structure of their own language rather than that of the target language.

Advanced-Mid speakers contribute to conversations on a variety of familiar topics, dealt with concretely, with much accuracy, clarity and precision, and they convey their intended message without misrepresentation or confusion. They are readily understood by native speakers unaccustomed to dealing with non-natives. When called on to perform functions or handle topics associated with the Superior level, the quality and/or quantity of their speech will generally decline. Advanced-Mid speakers are often able to state an opinion or cite conditions; however, they lack the ability to consistently provide a structured argument in extended discourse. Advanced-Mid speakers may use a number of delaying strategies, resort to narration, description, explanation or anecdote, or simply attempt to avoid the linguistic demands of Superior-level tasks.

ADVANCED LOW
Speakers at the Advanced-Low level are able to handle a variety of communicative tasks, although somewhat haltingly at times. They participate actively in most informal and a limited number of formal conversations on activities related to school, home, and leisure activities and, to a lesser degree, those related to events of work, current, public, and personal interest or individual relevance.

Advanced-Low speakers demonstrate the ability to narrate and describe in all major time frames (past, present and future) in paragraph length discourse, but control of aspect may be lacking at times. They can handle appropriately the linguistic challenges presented by a complication or unexpected turn of events that occurs within the context of a routine situation or communicative task with which they are otherwise familiar, though at times their discourse may be minimal for the level and strained. Communicative strategies such as rephrasing and circumlocution may be employed in such instances. In their narrations and descriptions, they combine and link sentences...
into connected discourse of paragraph length. When pressed for a fuller account, they tend to
grope and rely on minimal discourse. Their utterances are typically not longer than a single
paragraph. Structure of the dominant language is still evident in the use of false cognates, literal
translations, or the oral paragraph structure of the speaker's own language rather than that of the
target language.

While the language of Advanced-Low speakers may be marked by substantial, albeit irregular
flow, it is typically somewhat strained and tentative, with noticeable self-correction and a certain
grammatical roughness. The vocabulary of Advanced-Low speakers is primarily generic in
nature.

Advanced-Low speakers contribute to the conversation with sufficient accuracy, clarity, and
precision to convey their intended message without misrepresentation or confusion, and it can be
understood by native speakers unacquainted to dealing with non-natives, even though this may
be achieved through repetition and restatement. When attempting to perform functions or handle
topics associated with the Superior level, the linguistic quality and quantity of their speech will
deteriorate significantly.

INTERMEDIATE HIGH
Intermediate-High speakers are able to converse with ease and confidence when dealing with
most routine tasks and social situations of the Intermediate level. They are able to handle
successfully many uncomplicated tasks and social situations requiring an exchange of basic
information related to work, school, recreation, particular interests and areas of competence,
though hesitation and errors may be evident.

Intermediate-High speakers handle the tasks pertaining to the Advanced level, but they are
unable to sustain performance at that level over a variety of topics. With some consistency,
speakers at the Intermediate High level narrate and describe in major time frames using
connected discourse of paragraph length. However, their performance of these Advanced-level
tasks will exhibit one or more features of breakdown, such as the failure to maintain the narration
or description semantically or syntactically in the appropriate major time frame, the
disintegration of connected discourse, the misuse of cohesive devises, a reduction in breadth and
appropriateness of vocabulary, the failure to successfully circumlocute, or a significant amount
of hesitation.

Intermediate-High speakers can generally be understood by native speakers unaccustomed to
dealing with non-natives, although the dominant language is still evident (e.g. use of code-
switching, false cognates, literal translations, etc.), and gaps in communication may occur.

INTERMEDIATE MID
Speakers at the Intermediate-Mid level are able to handle successfully a variety of uncomplicated
communicative tasks in straightforward social situations. Conversation is generally limited to
those predictable and concrete exchanges necessary for survival in the target culture; these
include personal information covering self, family, home, daily activities, interests and personal
preferences, as well as physical and social needs, such as food, shopping, travel and lodging.
Intermediate-Mid speakers tend to function reactively, for example, by responding to direct questions or requests for information. However, they are capable of asking a variety of questions when necessary to obtain simple information to satisfy basic needs, such as directions, prices and services. When called on to perform functions or handle topics at the Advanced level, they provide some information but have difficulty linking ideas, manipulating time and aspect, and using communicative strategies, such as circumlocution.

Intermediate-Mid speakers are able to express personal meaning by creating with the language, in part by combining and recombining known elements and conversational input to make utterances of sentence length and some strings of sentences. Their speech may contain pauses, reformulations and self-corrections as they search for adequate vocabulary and appropriate language forms to express themselves. Because of inaccuracies in their vocabulary and/or pronunciation and/or grammar and/or syntax, misunderstandings can occur, but Intermediate-Mid speakers are generally understood by sympathetic interlocutors accustomed to dealing with non-natives.

**INTERMEDIATE LOW**
Speakers at the Intermediate-Low level are able to handle successfully a limited number of uncomplicated communicative tasks by creating with the language in straightforward social situations. Conversation is restricted to some of the concrete exchanges and predictable topics necessary for survival in the target language culture. These topics relate to basic personal information covering, for example, self and family, some daily activities and personal preferences, as well as some immediate needs, such as ordering food and making simple purchases. At the Intermediate-Low level, speakers are primarily reactive and struggle to answer direct questions or requests for information, but they are also able to ask a few appropriate questions.

Intermediate-Low speakers express personal meaning by combining and recombining into short statements what they know and what they hear from their interlocutors. Their utterances are often filled with hesitancy and inaccuracies as they search for appropriate linguistic forms and vocabulary while attempting to give form to the message. Their speech is characterized by frequent pauses, ineffective reformulations and self-corrections. Their pronunciation, vocabulary and syntax are strongly influenced by their first language but, in spite of frequent misunderstandings that require repetition or rephrasing, Intermediate-Low speakers can generally be understood by sympathetic interlocutors, particularly by those accustomed to dealing with non-natives.

**NOVICE HIGH**
Speakers at the Novice-High level are able to handle a variety of tasks pertaining to the Intermediate level, but are unable to sustain performance at that level. They are able to manage successfully a number of uncomplicated communicative tasks in straightforward social situations. Conversation is restricted to a few of the predictable topics necessary for survival in the target language culture, such as basic personal information, basic objects and a limited number of activities, preferences and immediate needs. Novice-High speakers respond to simple, direct questions or requests for information; they are able to ask only a very few formulaic questions when asked to do so.
Novice-High speakers are able to express personal meaning by relying heavily on learned phrases or recombinations of these and what they hear from their interlocutor. Their utterances, which consist mostly of short and sometimes incomplete sentences in the present, may be hesitant or inaccurate. On the other hand, since these utterances are frequently only expansions of learned material and stock phrases, they may sometimes appear surprisingly fluent and accurate. These speakers' first language may strongly influence their pronunciation, as well as their vocabulary and syntax when they attempt to personalize their utterances. Frequent misunderstandings may arise but, with repetition or rephrasing, Novice-High speakers can generally be understood by sympathetic interlocutors used to non-natives. When called on to handle simply a variety of topics and perform functions pertaining to the Intermediate level, a Novice-High speaker can sometimes respond in intelligible sentences, but will not be able to sustain sentence level discourse.

NOVICE MID
Speakers at the Novice-Mid level communicate minimally and with difficulty by using a number of isolated words and memorized phrases limited by the particular context in which the language has been learned. When responding to direct questions, they may utter only two or three words at a time or an occasional stock answer. They pause frequently as they search for simple vocabulary or attempt to recycle their own and their interlocutor's words. Because of hesitations, lack of vocabulary, inaccuracy, or failure to respond appropriately, Novice-Mid speakers may be understood with great difficulty even by sympathetic interlocutors accustomed to dealing with non-natives. When called on to handle topics by performing functions associated with the Intermediate level, they frequently resort to repetition, words from their native language, or silence.

NOVICE LOW
Speakers at the Novice-Low level have no real functional ability and, because of their pronunciation, they may be unintelligible. Given adequate time and familiar cues, they may be able to exchange greetings, give their identity, and name a number of familiar objects from their immediate environment. They are unable to perform functions or handle topics pertaining to the Intermediate level, and cannot therefore participate in a true conversational exchange.