



Hablamos Juntos: Improving Patient-Provider Communication for Latinos

An RWJF national program

SUMMARY

Hablamos Juntos: Improving Patient-Provider Communication for Latinos, a national program of the Robert Wood Johnson Foundation (RWJF), the first national effort to help health care organizations meet the challenge of providing language services and signage. It ran from October 2001 through June 2006.

The program was targeted toward communities or service areas with new and fast-growing Latino populations. It focused on developing:

- Affordable models of innovative language services (including both interpretation, which refers to spoken encounters, and translation, which applies to written documents).
- Interpreter services, informational materials in Spanish and easy-to-understand signage to post within health facilities.

Key Results

- The *Hablamos Juntos* national program office—originally located at Tomas Rivera Policy Institute at the University of Southern California in Los Angeles and then moved to the Fresno Center for Medical Education and Research, part of the University of California, San Francisco—created building blocks for language services programs, including:
 - A prototype health care interpreter training program.
 - A computer-based program to assess interpreters' proficiency in Spanish and their readiness to interpret.
- RWJF also funded 10 demonstration projects. The projects were located in rural and urban communities with high numbers of Latinos in 10 different states.
- Health care systems, health plans, including one for-profit plan, community-based organizations and educational institutions developed and ran the projects.

- See [Appendix 1](#) for contact information. See [Site Profile List](#) for links to profiles of four projects and [Project List](#) for Program Results on two others.
- Five demonstration sites established interpreter training programs with local education partners. See [Key Site Results](#) for examples of training programs developed by the sites.
- Three demonstration sites—all health care systems—adopted language services systemwide and paid for them as part of ongoing operations after the program ended. See [Temple Program Results Report](#), [Memphis Program Results](#) and [Inova Sidebar](#) for more details.
- Most sites used new approaches to expand language services throughout their facilities, including hiring more interpreters and using special software and equipment.
- The national program office began an initiative to develop symbols and signs to guide patients to various locations within health care facilities. The work was eventually completed under a separate RWJF grant (ID# 049836) and resulted in a [best practice workbook](#) and a [set of signage symbols](#). RWJF also funded the further development of best practice standards for health care symbols (ID# 056777) by staff at the national program office.
- The demonstration sites did not significantly change Latino patients' experiences, according to the evaluators. The researchers speculated that their measurements may not have been sensitive enough to detect changes during the evaluation period.

Administration and Evaluation

The national program office managed the projects and provided technical assistance to their staffs. A [national advisory committee](#) assisted in project selection.

A team from the [RAND Corporation](#) in Santa Monica, Calif., a nonprofit institution that conducts research and analysis in order to improve policy and decision-making, evaluated the program.

Funding

The RWJF Board of Trustees authorized *Hablamos Juntos* in April 2001 for up to \$18.5 million. In October 2005, they authorized up to \$5.4 million for a three-year renewal. The second phase was to increase the use of effective language services by health care systems.

THE PROBLEM

According to the [U.S. Census Bureau's 2000 census](#), more than 28 million Latinos in the United States over the age of 5 spoke Spanish at home. Among those, almost 9 million said they spoke English "not well" or "not at all," according to the census.

Those numbers have climbed through the decade, with Latinos becoming the largest and fastest-growing minority group in the United States. The Latino population increased by 3.3 percent from 2004 to 2005 alone, and numbered some 42.7 million in 2005.

Language Barriers and Health Care

The [2005 National Healthcare Disparities Report](#) published by the federal [Agency for Healthcare Research and Quality](#) states that language is a barrier to high-quality health care for many racial and ethnic minorities. According to the report, language barriers can:

- Reduce patients' compliance with medication regimens and limit their participation in medical decision-making.
- Impair the development of respect, trust and understanding between patient and provider.

The *Hablamos Juntos* website cites [additional research](#) suggesting that language barriers can lead to lower quality of care and poorer outcomes. The research shows that many patients who speak little or no English:

- Are not fully aware of existing services or how to use them.
- Have difficulty making medical appointments.
- Are less likely to receive preventive care.
- Receive less detailed information about rehabilitation therapy.
- Understand less about using their medications.
- Are unable to communicate adequately with health care providers and ancillary staff at all points within the health care delivery system.
- Are less satisfied with their health care experiences, making them less likely to keep subsequent appointments and more likely to visit the emergency room.

The research also shows that providers who do not speak the same language as their patients may be less able to:

- Make an accurate diagnosis.
- Meet informed consent requirements.

- Explain care option to patients, which may lead them to offer fewer options.
- Convey health care information and education.
- Convince patients to comply with a treatment regimen.

Despite these consequences, most health care providers lacked formal language services for patients speaking little or no English when *Hablamos Juntos* began in 2001, and most felt they could not afford them. (The term language services is used here to mean interpretation, which refers to spoken encounters, and translation, which applies to written documents.)

Instead, providers tended to turn to anyone readily available, or to family members, including children, for interpretation. Rarely did they consider the language proficiency of the interpreters or their knowledge of medical terminology.

The following composite anecdote captures a common approach to interpretation. It appeared in *Confessions of a Linguistically Challenged Health System*, a history of the *Hablamos Juntos* project at Temple University Health System.

The ER doctor leans in and smiles. "Hi, I'm Dr. Johnson and I'll be taking care of you today. What seems to be the problem?"

"Que?" replies the patient hesitantly.

"Oh," says Johnson, her smile turning to a frown. She raises her voice and talks slowly, as if she was speaking with a hearing-impaired person. "DOO YOUUU SPEEEAK ENGLISH? HABLA INGLES?"

"No, no hablo ingles," replies the frightened patient. She has come to the ER, six-year-old son in tow, because of dizziness and frequent headaches. She is 21-weeks pregnant, alone and afraid.

Johnson turns her head and yells over her shoulder, "Hey, John, I have a pregnant patient over here who doesn't speak English. Can you go find Maria from Housekeeping to interpret? I think she's cleaning room 10."

"Maria is on her break," John replies.

Policies to Promote Access to Language Services

In 1964, Congress enacted Title VI of the Civil Rights Act to prevent discrimination on the basis of national origin. According to Title VI, health providers that receive federal funds, including Medicare and Medicaid, must provide language assistance to people who speak little or no English.

New vigor was given to those provisions in August 2000, when President Bill Clinton signed Executive Order 13166 directing federal agencies to help recipients of federal

funding comply with Title VI. The Department of Justice and the Health Care Financing Administration (now the Center for Medicare & Medicaid Services) took further steps to achieve compliance, including informing state Medicaid directors that federal funds were available to help.

At the same time, providers began to face additional pressures to address language barriers from accrediting bodies, such as the Joint Commission for the Accreditation of Health Organizations (JCAHO).

In both formal and informal conversations with RWJF staff, a number of health care organization leaders communicated concerns about their ability to respond.

- They felt uncertain about how to provide language assistance and fearful of the cost, even with federal funds available.
- They also pointed out the absence of operational guidance—for example, federal standards required the use of "trained" interpreters but did not define that term.

CONTEXT

Access to quality health care for all Americans has long been a goal of RWJF. Foundation staff developed *Hablamos Juntos* to address concerns about non-financial barriers to health care access, including language and culture, according to Pamela S. Dickson, the senior program officer for the program at RWJF.

That was also the focus of *Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care*, an RWJF initiative launched jointly with the Henry J. Kaiser Family Foundation in 1992. See [Program Results Report](#) on the program.

Opening Doors was built around the recognition that even when health care is available and affordable, language, culture, race and ethnicity can impede access and lead to poorer health outcomes.

Opening Doors allocated \$5.5 million for 23 projects in rural and urban areas in 11 states to identify and reduce sociocultural barriers. Three of those projects involved trained language interpreters who facilitated communication between patients and providers.

Other RWJF-supported projects in the 1990s and early 2000s for people facing language and cultural barriers included:

- A project at the University of Maryland at College Park to improve access to care among Latino children. Researchers analyzed and compiled data from the 10 states with the largest populations of Latino children and convened an expert panel that developed policy recommendations designed to improve their health. (See [Program Results Report](#) on ID# 037533.)

- A survey by the People-to-People Health Foundation about the use of and barriers to health care services among undocumented Latino immigrants in El Paso and Houston, Texas. (See [Program Results Report](#) on ID# 026618.)
- A series of studies conducted by the University of California, Los Angeles, School of Public Health, on the effects of immigrant and citizenship status on health insurance coverage and access to health care services. (See [Program Results Report](#) on ID# 026855.)

Hablamos Juntos was the first national effort to help health care organizations meet the challenge of providing language services.

PROGRAM DESIGN

Laying the Groundwork for an RWJF Response to the Problem

In the fall of 2001, RWJF awarded the [Partida Group](#) a two-month grant (ID# 043087) to gain more insight about language barriers.

Yolanda Partida, the Partida Group's executive director, and her associates interviewed leaders of Latino community organizations and experts in interpretation and translation. They also searched academic and business publications for potentially replicable models for addressing language barriers to health care.

Through these efforts, they discovered the field lacked:

- An operational definition of what made a competent health care interpreter.
- Agreed-on standards or assessment tools to measure an interpreter's qualifications.
- An agreed-on approach to training health care interpreters.
- Standards to guide curriculum development.
- Replicable models or best practices.

National program office staff continued to build on these preliminary findings with further research on the availability and quality of interpreter training programs. The accumulated knowledge helped staff to shape the program, plan technical assistance for participating health care sites, and develop assessment and training tools (see [The Program](#)).

Consumer Research

To help inform the development of *Hablamos Juntos*, RWJF staff commissioned Wirthlin Worldwide (now part of Harris Interactive), a New York-based research firm, to conduct

research on the perspectives of Latino patients with limited English and health care providers who cared for such patients (Grant ID# 044021).

In October and November 2001, Wirthlin conducted a telephone survey of approximately 1,000 physicians, nurses, health care executives and pharmacists who cared for Latino patients and 500 adults whose primary language was Spanish.

As detailed in the [Wirthlin report](#), researchers found that:

- 94 percent of provider respondents regarded patient-provider communications as very important to quality care.
- 68 percent of provider respondents regarded helping Spanish-speaking patients better use and benefit from the health care system as a top priority.
- 68 percent of Spanish-speaking respondents said that positive outcomes were more difficult to attain when providers neither spoke Spanish nor offered interpreters.
- 65 percent of Spanish-speaking respondents were concerned about using an interpreter because they believed the interpreters would not explain things to them clearly, omit information or disregard their privacy, among other reasons.
- 19 percent or 1 in 5 Spanish-speaking respondents reported being sick, but decided not to visit a doctor because the doctor didn't speak Spanish or have an interpreter.

Program Goals

The goals of the program were to implement and test strategies to improve the availability and quality of language services for Latinos who speak little English, and to show that it made good business sense for institutions to support these services.

In order to create an organizational environment supportive of language services, RWJF wanted the sites in the program to address:

- Improving interpretation services.
- Developing informational materials in Spanish.
- Designing easy-to-use symbols and signage.

Grantmaking Strategy

RWJF program staff decided to award one-year planning grants, for up to \$150,000 to 10 sites, followed by two-year implementation grants of up to \$850,000 to those sites that met the objectives of their planning grants.

Participating providers were expected to match 25 percent of the grant funds to increase the likelihood that they could sustain program activities after RWJF funding ended.

By the end of the grant period, RWJF expected participating organizations to fully integrate translated text and interpretation services into their systems and to develop the financial mechanisms to sustain them.

THE PROGRAM

Start-Up Phase

The *Hablamos Juntos* national program office was established in October 2001 at [Tomas Rivera Policy Institute](#), a nonprofit research organization at the University of Southern California in Los Angeles. (The national program office moved with the national program director to the Fresno Center for Medical Education and Research at the University of California, San Francisco, in October 2005.)

Throughout the program, Yolanda Partida served as national program director. Rebecca Romo served as program assistant and the program's Web master, Elsa Maldonado/Gutierrez, remained with the program throughout the launch and completion of the demonstrations.

Emma Tsui, originally with the Partida Group helped launch the NPO and later returned in the last year of the demonstrations. Dania Wasongarz, M.P.H., was hired as the first deputy director, followed by Rosa Ramirez, M.P.A., M.S.W. After their departures, that position remained unfilled. Carlos Torres-Sanchez, initially program manager in the Birmingham Alabama demonstration joined the national program officer as program manager.

A [national advisory committee](#), including leaders of health care organizations and experts in Latino culture and health, was formed to participate in the grantee selection process, recommend the final grantees and provide ongoing guidance to the program.

During the start-up period, staff began to establish a national presence and credibility on the issue of language barriers to health care, and launched the 10 demonstration sites. Staff also conducted extensive research, through Web-based searches and expert interviews, to learn more about programs available to train interpreters.

Scholars Network

The national program office established a Scholars Network to guide program development. Program staff met twice, in January and March 2002, with 13 experts on the impact of language on health care. The scholars:

- Concluded that the field lacked evidence-based models, standards and definitions, but that it was important for the national program office to set standards for the grantees in their use of interpreter training and translation of material.

- Emphasized that despite common practice, children should never be used as health care interpreters.
- Helped to establish criteria for selecting demonstration sites.
- Undertook and completed a review of current literature, *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature* as well as a critique *The Need for More Research on Language Barriers in Health Care: A Proposed Research Agenda*.
- Wrote papers on interpreters and language barriers:
 - "Translation as a Strategy for Effective Communication," and "Effective Patient-Provider Communication Across Language Barriers."
 - "Models For The Provision Of Language Access in Health Care Settings"
 - "Limited English Proficiency and Breast and Cervical Cancer Screening in a Multiethnic Population"
 - "Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers are Measured Matters"
 - "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters"
 - "The Language Divide, The Importance of Training in the Use of Interpreters for Outpatient Practice"
 - "Effects of Limited English Proficiency and Physician Language on Health Care Comprehension"
 - "Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services"
 - "Medical Interpreting and Cross-cultural Communication"
 - "Revisiting the Interpreter's Role, A Study of Conference, Court and Medical Interpreters in Canada, Mexico, and the United States"
 - "Patients Who Don't Speak English: Improving Language Minorities' Health Care with Professional Interpreters"
- Wrote two background papers on translation, *Translation as a Strategy for Effective Communication* and *Effective Patient-Provider Communication Across Language Barriers*, which the national program used to develop program activities and posted on their website.

Funding the Projects

Staff at RWJF and the national program office and advisory committee members began the site selection process in December 2001. The national program office received 178 letters of intent to apply for funding from health care organizations in 40 states and, after review by office staff and RWJF program staff, invited 23 to submit full grant proposals.

After review of the 23 proposals, a team comprised of national program and RWJF staff, members of the advisory committee and other consultants then visited 15 applicants at their sites and selected 10 of them—a diverse group of health care providers in communities with new and fast-growing Latino population—for planning grants.

RWJF awarded up to \$1 million to each provider (in two phases over 36 months). The 10 grantees, learning of their selection in September 2002, were located in rural and urban communities in 10 states. They included health care systems; health care plans, including one for-profit plan; community-based organizations; and educational institutions in varying degrees of fiscal health.

For a list of sites with contact information, see [Appendix 1](#).

Evaluation

RWJF selected a team from the [RAND Corporation](#)—a nonprofit institution in Santa Monica, Calif. that conducts research and analysis in order to improve policy and decision-making—to evaluate the program. See [Evaluation Planning and Implementation](#) and [Evaluation Findings](#) for more information on the evaluation and its findings.

The Planning Phase

National program office staff worked with the demonstration sites during the sites' planning year, from October 2002 through September 2003, to define the following requirements for their projects:

- Increase the availability and quality of interpreter services for Latinos who speak little or no English.
 - Pilot test four assessment tools to measure interpreters' language proficiency and interpreting skills.
 - Develop partnerships with local educational institutions to develop college-level health interpreter training programs.
 - Develop organization-level understanding and support to foster an environment committed to serving patients who speak little or no English.
 - Develop or adopt creative solutions using technology to increase language support available to Spanish-speaking patients.

- Develop useful Spanish-language materials.
 - Develop policies and procedures leading to the production of useful health-related materials in Spanish, making sure that important health information is not lost in translation.
 - Develop Spanish-language material and contribute to recommendations for the development of national Spanish-language products.
- Develop easy-to understand signs to navigate health care facilities.
 - Support the development and testing of symbol-based signage to help patients who speak little English find their way around the health care facility.

Staff from the national program office, RWJF and the sites agreed to broaden the original program concept by emphasizing:

- The concept of increasing language capacity, rather than solely developing interpreter and translation services during medical encounters and adding signage. This was designed to encourage health care organizations to address language access wherever they interfaced with patients, including registration and medical records, in addition to clinical areas.
- The need to engage top leadership of the health care organizations to help promote broad cultural changes within their facilities.

During the planning year, the national program office expected all 10 sites to develop:

- A resource and needs assessment that contained:
 - A profile of the Latino population with limited English in the organization's region.
 - An assessment of the language capacity of local health care providers.
 - Opportunities to partner with local organizations to improve language services in the region.
 - Future trends and expected demands for language services.
 - An inventory of interpreters within their organizations.
- A project design document that included the interventions the organization planned to test; the scope of work for the implementation phase; and the possible long-term impact of the project.
- A five-year business plan laying out an analysis of expected costs, cost savings and potential funding sources to sustain the project after RWJF funding ended.

Site staff presented their resource and needs assessments at meetings with national program office staff throughout the planning year. At these meetings, national program office staff also reviewed available research about reducing language barriers and building language capacity in health care organizations and discussed planned evaluation activities.

National program office staff created a compendium, *Interpreter Training Programs* (see the [Bibliography](#)), to provide sites with examples of academic, community and employee training programs.

Workgroups

To develop program standards and guidelines for the implementation phase, the national program office convened two 30-member work groups that each met twice during the planning year:

- A language capacity work group developed standards for the interpreters used at the demonstration sites.
- A translation/Spanish-language written materials work group made recommendations to the sites about how to approach translation of written materials.

Each 30-member work group included at least one participant from each site, as well as staff from the national program office and other experts in interpreter training and translation.

Engaging Physicians

National program staff took several steps to understand how providers perceived language and cultural barriers and to motivate them to improve services for Latino patients:

- Alan Nelson, M.D., a member of the *Hablamos Juntos* national advisory committee, and an advisor to the American College of Physicians, helped arrange meetings between national program staff and leaders of national physician organizations. Their conversations focused on how language barriers affected providers and how they could work most effectively with the *Hablamos Juntos* program.
- With a grant from RWJF (ID# 048717), Lake, Snell, Perry and Associates (now [Lake Research Partners](#)), a research firm in Washington, conducted focus groups with a range of physician specialists treating patients who speak little or no English. From May through July 2003, the firm conducted six focus groups at four sites: Falls Church, Va.; Atlanta; Columbus, Ohio; and Olympia, Wash.

During these focus groups, physicians said:

- The communication techniques they already use—typically communicating through bilingual friends and family members—are adequate to overcome language barriers. Very few had experience with professional medical interpreters or language telephone lines.
- Good communication is important, but communicating with patients who speak little English is not necessarily more challenging than communicating with other groups, such as the elderly or those with little education.
- Time and costs are the biggest barriers to improving communication with patients who speak little English. Many physicians were not motivated to take action since they perceived they were already meeting the needs of their patients.
- The idea that models and ideas already existed to improve communications with patients with limited English was an incentive to consider changing their approaches.

The consulting firm prepared a report, *Physician Perspectives on Communication Barriers* and an *Executive Summary* on its findings.

The Implementation Phase

All 10 sites received funds for the implementation phase of *Hablamos Juntos*, which began in October 2003. Project sites focused on the three planned areas:

- Improving interpretation services.
- Developing informational materials in Spanish.
- Designing easy-to-use symbols and signage.

Engaging top leadership was a priority for national program staff, who brought the chief executives of the participating grantee organizations together twice during the implementation phase. The intent was to encourage executives to view language services as part of high-quality care and to incorporate them into routine health system procedures. See [Key Site Results](#).

Improving Interpretation Services

National program office staff helped project sites measure interpreter competence and build local capacity to train interpreters by:

- Developing a computer-based interpreter assessment program.
- Offering workshops on assessing interpreter skills and creating interpreter training programs (grant ID# 049387).

- Demonstrating videoconferencing and speakerphone interpretation technologies, and giving project staff a chance to test the equipment.

See [National Program Office Results](#) for more details.

Developing Informational Materials in Spanish

To meet one of the program's core goals of identifying useful Spanish materials, national program office staff asked sites to evaluate their Spanish materials (such as marketing brochures, legal/consent forms and patient care instructions). Sites also evaluated their internal policies and procedures for developing such materials.

The sites reported that:

- Existing materials varied in quality and many had extensive errors.
- Most documents had been translated to meet legal and statutory requirements of government or professional review organizations.
- In general, organizations had established quality review procedures for the development of English materials but not for those in other languages.
- Procedures for obtaining translated documents were generally ad hoc.

To compile a repository of good translated documents, site staff forwarded samples of materials deemed of good quality to the national program office for further review.

See [National Program Office Results](#).

Developing Symbols and Signage

To help visitors find their way in a health care setting, the national program office staff began to develop a set of symbols that would be understandable to anyone, regardless of their language or literacy level. Staff:

- Engaged [JRC Design](#), a firm in Scottsdale, Ariz., to develop a feasibility report to evaluate whether symbols were a viable option for health care signage. The report, *Symbol Usage in Health Care Settings for People with Limited English Proficiency*, provides a history of symbols use in multilingual communities around the world as well as [evaluate](#) existing use of symbols in a healthcare setting and provides [recommendations](#) for developing and testing a set of health care symbols.
- Worked with JRC Designs and the 10 demonstration sites to test symbol images designed for essential terms commonly found in health environment signage, such as "Admissions," "Emergency," "Outpatient Services" and "Pharmacy."
- Three hundred participants, in the demonstrations, from four language groups: English, Spanish, Indo-European and Asian languages provided input on the

comprehension value of candidate symbols. Seventeen of the 28 symbols could be understood by at least 87 percent of the multilingual participants.

RWJF program staff ultimately decided this promising initiative warranted separate funding. In May 2004, RWJF provided a \$375,000 grant (ID# 049836) to the [Society for Environmental and Graphic Design](#) (a nonprofit group of professional designers) to work with JRC Design and a team of independent graphic designers to continue developing and testing the [set of symbols](#). Together, they:

- Compared symbols reaching 87 percent, the threshold set for comprehension, to existing signage four volunteer hospitals: Somerville Hospital, Somerville, Mass.; Saint Francis Medical Center, Grand Island, Neb.; Grady Memorial Hospital, Atlanta; and Kaiser Permanente, San Francisco Medical Center, San Francisco.
- Created the [Universal Symbols in Health Care Workbook](#), providing examples of best practices for sign systems found primarily in transportation and parks.

The *Hablamos Juntos* national program office published *Development of Universal Symbols for Healthcare Environments*, a technical report describing the work undertaken to develop and test the set of symbols. See the [Bibliography](#).

RWJF will report further on this project in a separate Program Results report on ID# 049836 when the project is completed.

Evaluation Planning and Implementation

The evaluation was conducted by Leo Morales, M.D., Ph.D., the principal investigator, assisted by M. Susan Ridgley, J.D., a senior policy analyst at the RAND Corporation, who was co-principal investigator. The evaluators:

- Interviewed project directors, principal investigators and administrators at each *Hablamos Juntos* site, as well as representatives of provider organizations in each area. This enabled them to develop case studies describing the intervention in each site and documenting barriers and facilitators to implementing language services.
- Conducted five Latino patient focus groups at five sites, with about eight patients apiece, to explore their experiences and satisfaction with health care interpreters.
- Conducted and analyzed results from two waves of telephone surveys completed in June 2004 and March 2006.
 - During the first wave, the researchers conducted a total of 1,291 patient interviews—1,044 in Spanish and 239 in English—across 10 sites.
 - During the second wave, they conducted 1,033 interviews—948 in Spanish and 84 in English—across nine sites. The tenth site, CHOICE, in Olympia, Wash.,

ultimately focused on policy activities, not patient care, and so did not participate in the second round.

- Estimated the annual costs of implementing *Hablamos Juntos* projects at eight sites.

The researchers decided that outpatient and inpatient experiences needed to be measured separately in the telephone surveys. (For specific measures, see [Appendix 3](#).)

In November 2003, RWJF provided the evaluators a small additional grant to develop inpatient measures, which they used to assess patient experiences at Inova Health System in Virginia and the Regional Medical Center at Memphis.

Additional Grants to Address Special Opportunities

During the implementation phase, RWJF made \$600,000 in additional grants to other organizations to test or evaluate new technologies, financing approaches and communication strategies to reduce language barriers in health care. Grants were awarded to:

- The [Indiana University School of Medicine](#) to develop a computer-based touch screen system to gather health information from Spanish-speaking patients. (Grant ID# 041999)
- [Third Sector New England's Access Project](#), a Boston-based initiative that focuses on health and health care access, to work with the [National Health Law Program](#), a public interest law firm. (RWJF funded the development and implementation of the Access Project; see the [Program Results Report](#).) The grant enabled the organizations to develop an action kit for providers that highlighted legislative requirements and financing opportunities for language services. (Grant ID# 046674)
- [Grantmakers In Health](#), a nonprofit association of philanthropies in Washington, for a meeting to explore additional grantmaking opportunities to ensure patient access to language services in health care. (Grant ID# 046933)
- The Center for Public Service Communications, a consulting firm in Alexandria, Va., to convene state refugee health coordinators and others to discuss ways to make linguistically and culturally appropriate materials about health services available to refugees and immigrants. Participants recommended creating a Web-based repository for such information. (Grant ID# 048380)

For details about the first three grants, see [Appendix 2](#). RWJF will report on its grant to the Center for Public Service Communications (ID# 048340) in a separate Program Results report when the project is completed.

CHALLENGES

The program dealt with a number of challenges:

- **RWJF, the national program office and the project sites may have been unrealistic about what could be accomplished in two years.**
 - The national program office had to invest time and resources to develop technical assistance and tools in each of the three focus areas—interpretation, translation and signage—before sites could fully launch their projects.
 - Once they had the tools, demonstration sites struggled to develop training programs and to assess, train and deploy interpreters. Even more challenging was promoting culture change: incorporating interpreters into the culture of the organization and teaching staff to work with them proved to very time-consuming.
 - Staff at several demonstration sites saw participation in national program office activities as a distraction. They felt frustrated at not being able to focus more on developing language services according to their own organizational priorities.
- **The program was unable to establish a clear business case for language services.** Of the three sites that conducted cost studies of their language services programs:
 - Temple University in Philadelphia and Neighborhood Health Plan of Rhode Island were unable to demonstrate a cost savings or return on investment during the short time they collected data on their interpreter services.
 - Molina Healthcare of California, the only for-profit demonstration site, was able to identify cost savings from TeleSalud, its Spanish-language nurse advice telephone service. See the [Molina Sidebar](#) for more information.
- **Technologies such as videoconferencing and telephone interpretation that could extend language services without the high ongoing costs of personnel had high start-up expenses.** Administrators in many sites balked at the start-up expenses. And some interpreters and providers resisted using equipment, preferring in-person encounters.
- **Physicians may not be willing to take responsibility for ensuring access to language services.** Although program staff originally intended to focus on physicians, focus groups and position papers of physician organizations suggested language services are not a high priority for them. Moreover, none of the demonstration sites were based in physician practices, making it difficult to know whether the lessons learned applied to them.

OVERALL PROGRAM RESULTS

National Program Office Results

According to staff reports and interviews with RWJF, the national program office:

- **Became recognized as a source of information on language barriers to health care and on developing language services for patients speaking little or no English.** For example:
 - JC Resources, which provides technical assistance to hospitals being surveyed by the [Joint Commission on the Accreditation of Healthcare Organizations](#), invited program staff to conduct workshops for health care providers on language barriers. JC Resources then produced and sold audiovisual materials based on the workshops.
 - The program director served on a technical expert panel convened by the [Office of Minority Health](#) within the U.S. Department of Health and Human Services to inform its publication, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*.
 - She also participated in two panels convened by the Joint Commission for Accreditation of Health Care Organizations (JCAHO):
 - The *Hospital, Language and Culture, A Snapshot of the Nation* project designed to learn how hospitals are addressing accreditation standards related to cultural and language needs of patients.
 - *Understanding Adverse Medical Events for Minority Patients* a study to examine current practice of incident reporting related to limited English proficient patients (2004–2005).
 - The [National Health Law Program](#) used materials produced by the national program office about symbols in health care settings in its *Language Services Resource Guide for Health Care Providers*.
 - The *Hablamos Juntos* [website](#) received from 130,000 to 260,000 hits per month during the program.
- **Sponsored a workshop designed to help demonstration projects create creating interpreter training programs.** Some 22 people attended, including staff from all 10 sites and from the local education institutions with whom they planned to partner. The workshop, held in Oakland, Calif., was supported by RWJF through a grant (ID# 049387) to [Kaiser Permanente](#).
 - By September 2005, five demonstration sites established training programs with local education partners and produced locally trained interpreters. (See [Key Site Results](#).)

- The California State Assembly awarded *Hablamos Juntos* and the demonstration sites a certificate of recognition for supporting the spread of interpreter training programs.
- **Developed a computer-based program to assess interpreters' proficiency in Spanish and their readiness to interpret.**
 - The program developed computer based administration of tests to assess language proficiency and interpreting skills. The program used videotaped vignettes to simulate a health care encounter and included four tools, two to test language skills and two to test interpreter readiness. [The California Endowment](#) permitted the national program office to use three assessment tools and provided funding for the server supporting the assessment program.
 - The national program office developed instruction manuals and protocols for establishing local testing centers and sponsored a workshop for 17 representatives of nine sites to learn how to administer and score the assessment tools. Site staff established 37 local testing centers and a total of 882 tests were administered in the 10 demonstrations.
 - Pilot tests in the demonstration sites confirmed the need to assess and train health care interpreters (see [Key Site Results](#)). Test takers were given an individual improvement plan based on their results. At the end of the testing program, test takers received a report which compared their individual score with the average score from the national sample.
- **Generated interest in interpreter assessment tools from other organizations.** For example:
 - The California Endowment retained test design experts to evaluate and improve the assessment tools.
 - Pending the development of empirically validated assessment tools, two national companies specializing in language services developed their own tests and offered them commercially.
- **Reviewed Spanish documents submitted by the sites and developed a system for classifying translation errors.** Doctorate-level Spanish-language specialists studied error patterns in 87 documents to learn how more useful Spanish materials could be developed. Common types of errors included:
 - Translated texts did not convey the function or intended outcome of the original document.
 - Translations were "word-for-word" rather than "meaning-for-meaning." For example, the term "chicken pox" cannot be understood by translating "chicken" and "pox" separately.

- Translators did not use correct words or were unable to translate terms unique to the American health care system. For example, "advance directives" was translated in 10 different ways in the reviewed documents.
- The original text was of poor quality, providing a poor starting point for a translation.
- **Was unable to create a repository of model Spanish materials.** The Spanish language specialists concluded that none of the documents from the sites was worth using on a widespread scale.
- **Created *Mundo Hispano*[®], a Web-based search tool that helps translators find idioms specific to audiences from different Spanish-speaking regions.** The program reports the frequency with which Spanish words and phrases appear on websites in 21 countries with Spanish-speaking populations, including the United States. The Google-based program was short lived because search engine improvements made by Google were not compatible with *Mundo Hispano* searches.

Communications Results

- **The national program office created and disseminated information resources to help demonstrations develop programs in the absence of nationally adopted standards of practice and best practice models.** These included:
 - Eight background papers on:
 - Language proficiency testing: *Language Testing Options*
 - Interpreter training models: *Interpreter Training Programs*
 - Potential funding source for training programs: *Workforce Investment Act*
 - Developing written materials:
 - *Bridging the Communication Gap: A Focus on Methods of Translation*
 - *Translation as a Strategy for Effective Communication with Patients and Clients: A How-To Guide*
 - *Provider to Patient Written Communication Across Language and Cultural Barriers*
 - *Development of an Instrument to Test the Cultural Adequacy of Health-Related Written Materials for Latinos in the USA*
 - Interpreter models: *Models For The Provision Of Language Access In Health Care Settings*
 - The *Universal Symbols in Health Care Workbook*, targeting hospital executives and environmental designers.

- Four [Fact Sheets](#) on diversity among Latinos and health care disparities for Latinos.
- Three briefs on lessons learned about key program issues:
 - *Affordable Language Services: Implications for Health Care Organizations* highlights the effects of language barriers on patient safety and quality of health.
 - *It's More than Words* describes the program goal of providing useful written materials.
 - *Developing Better Non-English Materials: Understanding the Limits of Translation* describes the challenges of producing translated texts and evaluating them for quality.
- A [collection of stories](#) about patients facing language barriers and how interpreters at several *Hablamos Juntos* demonstration sites helped them.
- A [resource library](#) for hospitals and health plans to disseminate tools and resources developed by the demonstration sites and the national program office. The library, still being expanded in spring 2007, covers:
 - Health care signage and symbols.
 - Interpreter services.
 - Non-English materials.
- Periodic electronic [newsletters](#) via an e-mail listserv.
- A joint effort with the *Journal of General Internal Medicine* to produce a supplemental issue dedicated to language barriers in health care. The journal is scheduled to be released in October 2007.

Most of these resources are posted on the [website](#), as are copies of reports, papers and bibliographies collected from outside sources, and links to related websites and organizations. See the [Bibliography](#) for further details.

- **RWJF produced a Webcast on *Hablamos Juntos* in October 2003 that highlighted the problems of language barriers at a hospital in South Carolina.**

KEY SITE RESULTS

Most demonstration sites worked within their own facilities to reach patients and providers dealing with language barriers. Some sites set up community-level projects, and two addressed state-level policies on language services.

Partida and staff at the demonstration sites described results in their reports to RWJF:

- **Staff in the grantee organizations piloted the national program office's interpreter assessment program.** By September 2005, they had administered 462 language proficiency tests and 420 interpreter readiness tests. People taking the tests included interpreters employed by the grantee organizations and by other health care organizations in the project communities.
 - 44 percent were "heritage" speakers who were born in the United States and grew up speaking Spanish but had no formal education in their native language.
 - 17 percent had never been educated in the United States.
 - More than half reported they had never had interpreter training.
 - Scores were generally low. For example, on the intermediate-level language proficiency test, participants earned an average score of 70 percent; they averaged 53 percent on the advanced-level test. On the interpreter readiness test, the average score for "attention to details and sequences" was 62 percent; it was 57 percent for "cultural/social appropriateness. Participants earned their highest scores on reading comprehension, averaging 80 percent.
- **Five sites developed Spanish interpreter training programs that reflected local needs.** For example:
 - [Central Nebraska Area Health Education Center](#) worked with a local community college to offer interpreter training courses in far-flung rural counties through the college's interactive videoconferencing system. See the [Nebraska Sidebar](#) for more information.
 - *En Español*, a nonprofit created to improve access to health care for Latinos in the Birmingham, Ala. area, and Samford University in Birmingham created a certificate interpreter training program that offered courses in the evenings and weekends to accommodate working adults. Some health care organizations subsidized tuition for their employees. *En Español* also hosted monthly professional development sessions for local interpreters. See the *Hablamos Juntos Educational Partners website* for more information.
 - The [University of North Texas Health Science Center at Fort Worth School of Public Health](#) developed a health interpreting and health applied linguistics graduate-level program. Three students received master's degrees in public health from the program in 2006.

Other [training programs and links](#) created during the program and afterwards are listed on the *Hablamos Juntos website*.

- **Sites tried new approaches to extend language access services and encourage providers and other staff to use services appropriately.** For example:
 - [Inova Health System](#) in Falls Church, Va., developed the new position of patient navigators. Their primary role was to serve as medical interpreters, but they also acted as troubleshooters and advocates, helping to identify gaps in Inova's language services. See the [Site Profile](#) for more information.
 - [Molina Healthcare of California](#) piloted an in-house, 24-hour nurse call center in two California counties, using Spanish-speaking nurses. Molina eventually expanded the call center throughout California and to six other states. See the [Site Profile](#) for more information.
 - All sites tried to increase awareness among employees about the effects of language barriers on patient safety and quality of care. Among other activities, site staff made presentations, conducted workshops and "lunch and learn" series and hosted expert presentations about communication barriers and the need for language services.
 - Project staff at [En Español](#) in Birmingham, Ala., surveyed providers in partner health care organizations about their knowledge, attitudes and practices related to Latino patients and used the results for provider orientation and training.
 - The [Neighborhood Health Plan of Rhode Island](#) offered training sponsored by the University of Massachusetts Medical School to help health plan employees work with interpreters.
 - The [Regional Medical Center at Memphis](#) used their Quality Council, a senior leadership group reporting to the governing board, as the oversight body for implementing *Hablamos Juntos* and developed policies to encourage the hiring of bilingual staff. Staff also developed practice guidelines for providers about when to use trained interpreters and when the use of other resources, such as bilingual staff, is appropriate. See [Program Results Report](#) for more information.
 - Inova Health System offered tuition reimbursement to staff interested in learning Spanish and to interpreters seeking to upgrade their skills. See the [Site Profile](#) for more information.
- **Sites used technology and a variety of other tools to extend language access to all points where patients, providers and staff might meet.** For example:
 - [En Español](#) staff developed two software programs to help people speaking little or no English apply for Medicaid. Clients could use a self-guided program at a computer kiosk to fill out preliminary applications, and Medicaid specialists could use a phrase communication tool to assist their clients.
 - The [Regional Medical Center at Memphis](#) provided maps and directions in Spanish at the electronic information kiosks located at its main entrance.

- Memphis also installed Spanish-language patient education software and dual handset telephones that made it easy to access interpretation assistance quickly throughout the facilities. See [Program Results Report](#) for more information.
- [Inova Health System](#) provided pocket-sized, laminated "memory joggers" to remind providers when and how to access language services and "point-to" cards for patients in the labor and delivery suites to indicate their pain levels. See the [Site Profile](#) for more information.
- [Temple University Health System](#) posted symbols-based and multilingual signage throughout its facilities. See [Program Results Report](#) for more information.
- **Two sites developed a single source of qualified medical interpreters for local health care institutions:**
 - The [Greenville Hospital System](#), a *Hablamos Juntos* project site, and three other health care systems in upstate South Carolina, created a nonprofit corporation, MedVerse[®]. MedVerse provided contract interpreter and translation services for themselves and other area health care providers through the end of the grant. See the [Site Profile](#) for more information. See [Greenville Sidebar](#) for more information.
 - [Central Nebraska Area Health Education Center](#) developed a medical interpreter videoconferencing system to provide Spanish interpretation in hospitals and health centers located in six rural Nebraska counties. See the [Nebraska Sidebar](#) for more information.
- **Two sites worked at the state level to improve language services.**
 - The Rhode Island Department of Health asked staff at the [Neighborhood Health Plan of Rhode Island](#) to participate in developing standards for translated materials. Those standards were incorporated into contracts between the state and Rhode Island's three Medicaid managed care organizations in 2005.
 - [CHOICE Regional Health Network](#), a nonprofit provider consortium in Olympia, Wash., sponsored four community forums to develop public support for language services and to improve the design of the state-funded interpreter program for Medicaid patients. One hundred stakeholders—including representatives of state agencies, contract interpreter and translation agencies, public schools, social service agencies and the state legislature and judicial system—attended at least one meeting.
- **In order to offer better Spanish materials, whether translated or created from scratch:**
 - All sites inventoried their translated materials and began keeping records of how translations were developed and adopted.

- Sites took many poor quality materials out of circulation after their document review.
- Temple University Health System, Inova Health System, the Neighborhood Health Plan of Rhode Island and others developed policies outlining who was responsible for making decisions about Spanish materials.
- Temple created a centralized repository on its intranet to provide organizationwide access to translated texts. See Program Results for more information.
- **Three health systems incorporated language services systemwide and by the end of the program had absorbed their costs into ongoing operations.** The three sites—Temple University Health System in Philadelphia, Inova Health System in Virginia and the Regional Medical Center in Memphis—used trained interpreters as the backbone of their programs and reported that:
 - Organizational leadership became committed to providing language services as part of providing high-quality care.
 - They redesigned their policies and procedures to facilitate access to language services. For example, Memphis incorporated information about the languages their patients spoke into medical records.
 - Providers and other staff increased their use of language services and became more aware of language barriers and their consequences for care.
- **Two sites closed their *Hablamos Juntos* projects when the grant ended:**
 - *En Español* in Birmingham, Ala., ceased to exist.
 - The four South Carolina hospitals that had created MedVerse[®] agreed to dissolve the nonprofit corporation. However, the four hospitals ultimately established their own language services programs, adding a total of 20 interpreters to their rosters.

For examples of projects where languages services were institutionalized, see Program Results on [Temple University Health System](#) and the [Regional Medical Center at Memphis](#).

Four Sidebars highlight specific project innovations:

- [Testing a New Model of Health Care Interpreter \(Inova\)](#)
- [Developing a Telephone Contact Center for Spanish-Speaking Health Plan Members \(Molina\)](#)
- [Creating a Video-Medical Spanish Interpreting System in Six Rural Nebraska Counties](#)

- [Creating a Nonprofit Corporation to Provide Contract Interpreter and Translation Services to Health Care Organizations in Upstate South Carolina \(Greenville\)](#)

EVALUATION FINDINGS

The evaluators reported key findings in a report to RWJF. The case studies they developed for each site suggested that:

- **Physicians and nurses did not always appreciate the difference between trained and ad-hoc interpreters (such as family or bilingual staff with other roles).** Interpreters routinely described an uphill struggle to integrate themselves into the health care team.
- **Once physicians and nurses did accept in-person, trained interpreters, they preferred them to less costly alternatives, such as telephone interpreter services or videoconferencing.**
- **Few sites focused on integrating physicians into the planning process or developing physician champions, strategies the research literature suggests are effective.** Instead, they often used in-service training at busy meetings to orient staff to the new language services, which was not enough to overcome resistance to change.
- **Tools for judging the competency of interpreters and guidelines for determining how much and what kind of training is appropriate had not yet been rigorously evaluated.**
- **Despite efforts to professionalize the role of the interpreter, it remains a low-wage job with little in the way of a career ladder, and high turnover is a risk.** Moreover, local markets may not be able to provide enough jobs to sustain demand for interpreter education programs.
- **Sites were unable to produce data—about, for example, patient outcomes and patient satisfaction—necessary to determine whether the benefits of interpretation offset its costs.**
- **Focus group respondents were generally satisfied with the interpreter services they received from either professional interpreters or other bilingual staff.** (They did not generally distinguish *Hablamos Juntos*-sponsored language services from other services.)
 - Respondents agreed that interpreters allowed them to communicate more effectively with their health care providers, even if there were delays in accessing them.
 - Most respondents said they would prefer to speak with a fully bilingual health care provider or a professional medical interpreter. However, some expressed a

firm preference for family members as interpreters, for reasons of convenience, availability and privacy.

- **Patient reports did not change significantly between the first and second wave of surveys, but some measures of outpatient and inpatient experience declined unexpectedly.**

- Researchers used nine outpatient measures at seven sites. (See Appendix 3.) One measure improved at one site (availability of interpreters) while six other measures (including quality of interpreter services and satisfaction with care) declined at three sites. (Scores on the other measures remained unchanged at each site.)
- Researchers used nine inpatient measures at two sites. (See Appendix 3.) One measure improved (rating of hospital stay). Two declined (problems getting medical care due to language barriers with doctors and rating of doctors' care). The other measures at each site remained unchanged.
- The researchers speculated that their measurements may not have been sensitive enough to detect changes during the evaluation period.

- **The cost analysis offered a rough guideline for providers planning language services.**

- Annual costs of operating the *Hablamos Juntos* projects averaged \$666,000 per site (ranging from about \$324,000 to \$1.2 million).
- Predictably, costs rose with the number of clinical units that received interpreter and other language services, the number of personnel and the number of full-time interpreters.
- Temple, Memphis Regional and Inova focused especially on providing interpreters in key high-volume units (obstetrics and emergency services) and had fewer personnel and lower costs compared to other sites.
- The researchers were unable to calculate a cost-per-patient encounter. Some sites only collected data about encounters involving a professional interpreter, while others included any kind of interpreter encounter. This made it impossible to compare the cost-efficiency of the demonstration site interventions.

Evaluation Challenges

According to the evaluators:

- Many sites did not initially understand that RWJF required them to participate in the evaluation, and they found evaluation activities burdensome.

- Difficulties negotiating institutional review board requirements with each participating health care organization, coupled with new federal regulations on patient privacy, resulted in costly delays.
- The evaluators intended to interview English-speaking Latinos, but were unable to identify them in sufficient numbers, and so abandoned the use of a comparison group.

The scope of *Hablamos Juntos* broadened during the planning phase and the sites progressed at different rates, but the evaluation was not structured to capture that evolution.

LESSONS LEARNED

1. **Do not assume that any Spanish-speaking individual can interpret in a health care encounter.** Test for proficiency before hiring interpreters or using bilingual employees to interpret. Many people who speak Spanish are "heritage speakers" who learned Spanish at home and may not be fully proficient, particularly in medical Spanish. (Program Director/Partida)
2. **Training interpreters is critical to improving language services.** If training is not a part of a health care organization's mission, it should partner with an experienced training entity. (Program Evaluator/Ridgley)
3. **Providing interpreter services may not be enough to improve patient outcomes.** Patients speaking little or no English may still suffer a lack of continuity of care, redundant services and miscommunication as they move from one provider setting to another. (Program Director/Partida)
4. **Clearly define procedures within a health care organization for developing written materials in other languages.** Centralize requests and ensure that translators understand the purpose of the texts they are translating and can use language appropriate to the audience. For example, patient education materials for low-literacy patients may require different language than legal documents. (Program Director/Partida)
5. **Focus initially on introducing languages service into one or two units within a hospital, rather than an entire multihospital system.** National program office staff worked with grantees to scale down their reach as they began to develop their initiatives. (Program Director/Partida)
6. **Adapt information systems that enable patients' language preferences to be collected routinely.** This will allow information to be widely shared as health care providers move to electronic records. (Program Director/Partida)
7. **Use conference calls as a cost-effective way to communicate among grantee organizations.** The national program office found scheduled conference calls to be an

excellent way for sites to get technical assistance, share information and learn from each other. (Program Director/Partida)

8. **Be sensitive to the range of skills among project directors, and to the differing environments of their sites.** Identifying these differences early enabled national program office staff to provide additional support to grantees that needed it, and to address issues such as unique reporting requirements at a given site. (Program Director/Partida)
9. **Engage executive-level leaders early so that new language services become an organizational priority and part of mainstream operations.** Executives were generally most supportive of interventions that could be embedded into existing practices, such as customer relations, safety monitoring and quality improvement. (Program Director/Partida and Program Evaluator/Ridgley)
10. **Bring physicians into the planning process.** Many physicians did not see language services as their responsibility. Recruiting "opinion leaders" among physician staff may create champions of the new services who model their use. (Program Evaluator/Ridgley)
11. **Link language services to quality improvement and patient safety.** The demonstration sites best able to adopt and sustain language services were those able to make a case to the rest of the organization that they were essential to high-quality care. (RWJF Program Officer)
12. **Create durable structures in order to embed language services within the health care system.** It is not enough just to hire an interpreter; the real goal is to make changes in organizational culture and to develop an interpreter infrastructure across communities. (Program Director/Partida)
13. **Consider alternative evaluation strategies for projects that are likely to evolve.** An evaluation designed to follow the development of a variety of models might have yielded more useful information than an outcomes-oriented survey. (Program Evaluator/Ridgley)

A SECOND PHASE

In October 2005, the RWJF Board of Trustees authorized up to \$5.4 million for a three-year renewal of *Hablamos Juntos* to increase the use of effective language services. The program has two components:

- Policy development.
- Improving practice.

In May 2006, RWJF awarded the *Hablamos Juntos* national program office a one-year, \$662,138 grant (ID# 055860) to continue to oversee development of language services

policies. This grant was renewed in August 2007 with a one-year \$655,693 grant (ID# 061332).

To capture lessons learned and promote wider use of products developed by the 10 demonstration sites, national program staff has been working to:

- Expand the Web-based resource library.
- Publish articles in industry trade magazines.
- Work with regulatory agencies, such as the Joint Commission on the Accreditation of Healthcare Organizations, to direct hospitals to the approaches and tools developed by grantees.

Staff also has been working with specialists in communication, translation and sociology, among others, to develop Spanish-language materials.

This report will be updated with the results of this work in the fall of 2008.

AFTERWARD

To further advance improvements in practice, RWJF funded a new national program, *Speaking Together: National Language Services Network*, to undertake a new approach towards improving language services.

Speaking Together explores the integration of language services with other clinical processes for purposes of quality improvement in clinical care. Part of this work entails the development and testing of language services performance measures. The network includes 10 acute-care hospitals serving large numbers of patients speaking little or no English.

The national program office is located at the department of health policy at [George Washington University School of Public Health and Health Services](#). RWJF's Board of Trustees authorized up to \$3.1 million for the program. The core component of *Speaking Together* is a 16-month collaborative process that enables the 10 hospitals to pilot interventions to:

- Improve the quality and accessibility of language services for patients speaking little or no English.
- Use quality performance measures to monitor improvements in the delivery of language services to patients.
- Demonstrate how quality of care can be affected by improving language services and communication, focusing on diabetes, heart disease and depression.

Sidebars

TESTING A NEW MODEL OF HEALTH CARE INTERPRETER

Inova Health System Sidebar

In the early 2000s, some 20,000 Latino patients were being admitted every year to Inova Fairfax Hospital and Inova Alexandria Hospital, two hospitals within the [Inova Health System](#). Many of them were young, spoke little or no English and needed emergency care or obstetrics services.

Inova, a not-for-profit health care system based in northern Virginia that includes hospitals, emergency and urgent care centers and other health-related organizations, established the role of the patient navigator to meet their needs.

Key Responsibilities

Inova's patient navigators were stationed in the emergency room and obstetrics units of the two hospitals, and their primary role was to serve as medical interpreters. As observers, trouble-shooters and advocates, they also helped to make the system work for Spanish-speaking patients by:

- Guiding them through admissions, triage and discharge processes, and during financial discussions.
- Pointing out that Spanish-speaking patients did not always understand their discharge instructions and were sometimes unable to make follow-up appointments in their own language. Project staff responded by making sure patients had a follow-up appointment and a reminder card in Spanish before leaving the emergency room.
- Pointing out that Inova providers and other staff needed encouragement to access language services. Project staff responded by distributing pocket-sized, laminated "memory jogger" cards with instructions for accessing language services.

Recruitment and Training

Patient navigators were required to have a high school diploma, 40 hours of interpreter training and two years previous experience as a health care interpreter. Staff also looked for patient navigators who could:

- Withstand the high-pressure environment of a hospital.
- Think and work independently.

- Interact with a very wide range of patients and providers.
- Tolerate the "invisible" role that a professional interpreter must play.

It was not easy to find "just the right person," said Martine Charles, director of Inova's department of cultural competence and its *Hablamos Juntos* project site.

Project staff emphasized professional development by:

- Contracting with staff of [Northern Virginia Area Health Education Center](#), who had expertise in interpreter training, to observe and critique each patient navigator.
- Offering a tuition reimbursement benefit to encourage patient navigators to upgrade their training.
- Holding monthly meetings where navigators presented and discussed unusual or difficult encounters.

An Art and a Science

Project staff described medical interpretation as both an art and a science. A hospital newsletter article, "Un Dia Tipico" ("A Typical Day"), quotes a staff member as follows:

"These professionals are well-versed in medical terminology in both languages, sensitive to cultural differences and aware of the nuances of dialects.... A good interpreter is present but invisible, standing back so the patient and the providers can make eye contact."

Interpreters emphasize that they will repeat everything the patients and providers say, without editing, additions or deletions. They always speak in the first person, saying, for example "I have a pain in my stomach," and not "she has a pain in her stomach."

After the demonstration project ended, Inova Health System incorporated the costs of the patient navigators into ongoing operations. By April 2007, seven patient navigators were providing interpretation for some 2,500 encounters each month and the project director was recruiting two more patient navigators.

DEVELOPING A TELEPHONE CONTACT CENTER FOR SPANISH-SPEAKING HEALTH PLAN MEMBERS

Molina Healthcare of California Sidebar

Some 65 percent of [Molina Healthcare of California](#)'s members identified themselves as Latino, and 45 percent said they preferred to speak Spanish. But only about 2 percent of

calls to the health plan's nurse-advice call line, staffed by an outside vendor, were from Spanish-speaking members.

Through *Hablamos Juntos*, Molina saw an opportunity to pilot "TeleSalud," an in-house telephone contact center where Spanish-speaking members could access health care advice 24 hours a day. The health plan tested the service in the California counties of Riverside and San Bernardino, home to a large and growing Latino population. Molina was a not-for-profit plan when the program began, but changed its status mid-grant to become the national program's only for-profit demonstration site.

TeleSalud Services

When TeleSalud was launched in April 2004, Spanish-speaking operators referred patients to either Spanish-speaking nurses or physicians. By October 2004, trained, bilingual registered nurses answered all calls, using protocols reviewed and updated by Molina physicians every six months. Molina distributed ID cards with the toll-free TeleSalud phone number to all Spanish-speaking members.

TeleSalud nurses made follow-up calls the next day to any member who sought their advice. They could also make referrals, offer health education and help schedule appointments. In June 2005, the nurse advice line received 325 calls, up from 128 in January 2005.

TeleSalud and Cost Savings

From December 2004 through February 2005, project staff compared the type of care members chose after calling in to the nurse advice line to what members said they would have chosen without advice.

Staff reported that members guided by the advice line often avoided going to costly emergency rooms or urgent care centers. Based on that three-month analysis, project staff estimated that patient choices saved the health plan approximately \$2,500 per month.

Expanding TeleSalud

By the end of the project, Molina no longer used an outside vendor for any of its nurse-advice calls. Instead, the in-house unit handled all calls, with one telephone number for Spanish speakers and another for English speakers. By January 2005, Molina was offering TeleSalud to members throughout California. By the end of 2005, members in Indiana, Michigan, New Mexico, Ohio, Texas and Utah also had access to TeleSalud services.

Martha Bernadett, M. D., the project director, reported that approximately 15 percent of the 50,000 calls to the TeleSalud line in California were from Spanish-speaking patients.

She also noted that TeleSalud nurses were a major source of referrals to care for patients with chronic or complex health conditions, which are often hard to manage.

CREATING A VIDEO-MEDICAL SPANISH INTERPRETING SYSTEM IN SIX RURAL NEBRASKA COUNTIES

Central Nebraska Area Health Education Center Sidebar

The far-flung population of rural Nebraska needed more translation services in its hospitals, but in the early 2000s demand was not sufficient for each hospital to hire its own translators. To fill the gap, the [Central Nebraska Area Health Education Center](#), located in Grand Island, Neb., partnered with six not-for-profit hospitals around the state to introduce a videoconferencing system.

The six hospitals—located in the counties of Adams, Buffalo, Colfax, Dawson, Hall and Platte—had all worked together previously to improve health care for Latinos living in their communities.

Video Links Across Locations

The participating hospitals were connected to a videoconferencing system through a new statewide communications network known as the Nebraska Statewide Telehealth Network. Operated through a collaboration of hospitals and public health departments and subsidized by the Nebraska Public Services Commission, the network is designed to:

- Connect rural patients to clinicians.
- Provide increased access for Nebraskans to educational opportunities in health care.
- Allow health care professionals across Nebraska to collaborate.

The videoconferencing system is easy for connected hospitals to use. Once they are together, a patient and provider can turn on a monitor with an attached camera and microphone. They then dial into the medical interpreter so that all the parties can see, hear and speak with one another. The health education center supplied six equipment carts to participating hospitals so videoconferencing equipment could be wheeled to rooms as needed.

Four hospitals began using the system in 2005, and two more were hooked up the following year. Other hospitals that were not hooked up to the videoconferencing system could access the center's medical interpreters by telephone.

By September 2005, the health education center employed four full-time and four part-time medical interpreters, who were based in the central office and two of the partner hospitals. Interpreters were available 24 hours a day, seven days a week.

"I like to get the visual of the patients' faces," says Jessica Calderon, one of the health education center's medical interpreters, who prefers the video system to the telephone. "You can tell whether they really understand. And when they say, 'It hurts here,' I know where they are pointing. The patients seem more at ease and are willing to ask more questions when they can see me."

At least one patient confirmed that advantage. She said that "an angel" was looking over her shoulder, helping her to understand her provider.

Training Health Care Interpreters

The health education center worked with [Central Community College](#), a two-year public institution, to develop a training program for medical interpreters.

Central Community College has three main campuses—in Columbus, Grand Island and Hastings—and three Learning Centers—in Holdredge, Kearney and Lexington. All these towns are located in central Nebraska.

Much of the instruction occurred through distance learning. Students received online instruction and participated in biweekly group sessions through the college's interactive videoconferencing system. Students also created in-person support networks and sometimes met for lunch.

Sixteen students completed the Central Community College medical interpreter certificate program by September 2005. Most of the interpreters employed by the health education center were certified through the program.

The Videoconferencing Service Proves Difficult to Grow

In general, health care providers were slow to adopt videoconferencing. Most nurses found it easier to use the telephone service, especially at night, and the training that helped hospital staff feel more comfortable using the system proved difficult to schedule.

"A constant challenge remains convincing medical staff that video medical interpreting is the next best method of interpretation, after face-to-face contact, for the patient and the provider," said project director Sara Cunningham.

Some of the partner hospitals eventually hired in-house interpreters and some providers continued to use their own hospitals' contract telephone interpretation services. Although the center expanded videoconferencing to a sixth site, in Hamilton County, continued low

use of the service led to cutbacks. As of April 2007, the center employed only two full-time and three part-time interpreters.

CREATING A NONPROFIT CORPORATION TO PROVIDE CONTRACT INTERPRETER AND TRANSLATION SERVICES TO HEALTH CARE ORGANIZATIONS IN UPSTATE SOUTH CAROLINA

Greenville Hospital System Sidebar

Four competing nonprofit hospitals in upstate South Carolina realized they were facing common challenges:

- A rapidly growing Spanish-speaking patient population in need of language services.
- Little knowledge about how to provide such services in a way that complied with federal guidelines.
- Rising fees for contract interpreter services (which had jumped from approximately \$15/hour to \$45–\$60/hour from 1995 to 2002).

The four competitors banded together in 2002 to form MedVerse[®], an independent, nonprofit corporation, to provide themselves with reliable and affordable contract interpreter and translation services. Greenville Hospital System, one of the four founding hospitals, received the *Hablamos Juntos* grant on behalf of the project.

To sustain its business, MedVerse also sold services to other health care providers.

Building an Interpretation Business

Each sponsoring hospital designated two employees to serve on a board of directors charged with planning the business. The board used grant funds to hire an executive director. MedVerse offered these services:

- Medical interpretation for patients and providers.
- Interpreter training for health and human service organizations.
- Document translation.
- Training in Latino cultural competency for health care providers.

MedVerse began its operations with nine medical interpreters under contract, all of whom were assessed and trained through protocols created by MedVerse's executive director.

At its peak in the fall of 2004, MedVerse had 35 interpreters and averaged about 2,260 interpretation encounters per month. Interpreters served 11 hospitals, including the four sponsors, as well as clinics and private practices.

MedVerse charged \$25–35 per hour for on-site interpreter services, a below-market rate it was able to afford by using RWJF funds as a subsidy.

MedVerse also had five document translators who served eight health care providers in South Carolina, including the four sponsors, and seven providers in six other states. Together, they translated a total of 200 documents during the first year of operation.

Challenges and the Demise of MedVerse

Initially, MedVerse provided an essential service, especially to client hospitals that had not developed extensive language services. But as demand rose, along with increases in Latino patients and provider awareness of the need for language services, contract interpreting expense became excessive. One sponsoring hospital established its own interpretation program by the end of the first project year, depriving MedVerse of one of its most consistent sources of revenue.

A further complication was an almost total turnover in MedVerse's staff and board membership during the start-up period.

Ultimately, MedVerse was unable to make the transition from a grant-funded project to a self-sustaining small business. All four hospitals that sponsored MedVerse concluded they needed their own in-house services, and in October 2005, the board voted to dissolve the corporation.

The Collaborative Work Leaves Results

Juana Slade, the project director, believes MedVerse's efforts improved language services in the region. All four sponsoring hospitals ultimately established their own language-services programs, adding a total of 20 interpreters to their rosters. Each program developed:

- A strategy for documenting interpreter competency.
- Standardized protocols for providing access to language services.
- Formal quality control procedures.
- Ongoing education for interpreters.

"MedVerse raised the bar on the quality of language services—not only for the four sponsors and their internal programs but also for independent contractors," said Slade. "The contractors out there now are capable and competent."

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APPENDIX 1

Projects and Contact Information

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APPENDIX 2

Grants to Address Special Opportunities

RWJF set aside funds for four small grants to test or evaluate new technologies, financing approaches and communication strategies to reduce language barriers in health care. Three grants are described below. RWJF will report separately on its grant to the Center for Public Service Communications (ID# 048340).

Grantee

Indiana School of Medicine (Indianapolis, IN)

- Development and Evaluation of Patient Education and Health Care Professional Training Programs for Spanish-Speaking Diabetics

Amount: \$466,011

Dates: January 2002 to December 2004

ID#: 041999

Contact

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This RWJF grant to the Indiana School of Medicine supported researchers developing a computer-based system to collect health care information from Spanish-speaking patients with diabetes.

Through the program, named "HealthXpress," Spanish-speaking patients were able to read questions in Spanish on a computer. The program accommodated low-literacy users by using audio tracks, color-coded symbols and road sign symbols. The program converted their answers into one-page summary charts for non-Spanish-speaking health care providers.

By March 2005, the researchers had tested the program on 458 Spanish-speaking patients with diabetes.

- 297 used the system without assistance.
- 397 reported no problems understanding how to use the system.
- 409 reported that all of the questions were easy to understand.
- 356 thought that their doctors were better able to help them using their answers from the program.

The researchers also began developing touch-screen patient education modules focusing on diabetes management during the grant period.

Grantee

Third Sector New England, Inc. (Boston, MA)

- Developing an Action Kit for Providers, Advocates and Policymakers on Language Services Reimbursement

Amount: \$100,000

Dates: September 2002 to July 2003

ID#: 046674

Contact

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RWJF awarded this grant to [Third Sector New England](#), which guides other nonprofit organizations to build skills, to support the [Access Project](#), a Third Sector initiative that helps local communities improve health and health care access. RWJF supported the development of the Access Project. See [Program Results Report](#). The Access Project developed an [action kit](#) for health care providers that included:

- Legislative requirements for health care providers to ensure access to language services.
- Information on how states can get funding to help pay for language services (for example, through Medicaid and the State Children's Health Insurance Program).
- Examples of successful language service models.

The Access Project updated the action kit in February 2004.

Grantee

Grantmakers In Health (Washington, DC)

- Grantmaker Meeting and Reports on Medical Interpretation

Amount: \$35,000

Dates: November 2002 to August 2003

ID#: 046933

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RWJF provided partial support to [Grantmakers In Health](#), a nonprofit association of philanthropies, for a one-day meeting in San Francisco in April, 2003. The California Endowment awarded Grantmakers In Health an additional \$45,000 for this project.

At the meeting, 30 grantmakers identified grantmaking opportunities to ensure patient access to language services in health care, including:

- Promoting awareness among providers about the importance of language services and their obligation to provide them.
- Equipping providers with resources and learning opportunities to foster their capacity to provide services.
- Facilitating agreements among health plans to create an industry standard for covering the costs of professional interpretation.
- Supporting research to identify and evaluate the most effective modes of delivering language services, including technological advancements.

Grantmakers In Health summarized the meeting results in a report, *In the Right Words: Addressing Language and Culture in Providing Health Care* (see the [Bibliography](#)).

APPENDIX 3

Evaluation Measures of Spanish-Speaking Patients' Experiences with Care

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The program evaluators developed these measures to assess patients' experiences with care in the demonstration sites.

Outpatient measures of experiences with care:

- Problems getting telephone advice because office staff did not speak Spanish.
- Problems getting necessary care or treatment.
- Provider communication.
- Problems getting care because the doctor did not speak Spanish.
- Availability of interpreters.
- Quality of interpreter services.
- Helpfulness of office staff.
- Problems setting up appointments because the office staff did not speak Spanish.
- Satisfaction with care.

Inpatient measures of experiences with care:

- Communicating with nurses.
- Problems getting nurse care due to language barriers.
- Communicating with doctors.
- Problems getting medical care due to language barriers with doctors.
- Availability of interpreters.
- Quality of interpreter services.
- Rating of nursing care.
- Rating of doctor care.
- Rating of hospital stay.

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PROJECT LIST

Reports on the projects managed under this National Program are listed below. Click on a project's title to see the complete report, which typically includes a summary, description

of the project's objectives, its results or findings, post grant activities and a list of key products.

- [Memphis Medical Center \(the MED\) Improves Language Services for Spanish-Speaking Patients Through RWJF's *Hablamos Juntos* Program \(Grant ID# 48231, etc., October 2007\)](#)
- [Temple University Health System in Philadelphia Improves Language Services for Spanish-Speaking Patients Through RWJF's *Hablamos Juntos* Program \(Grant ID# 46830, etc., October 2007\)](#)