

Overcoming Language Barriers to Care: Hablamos Juntos

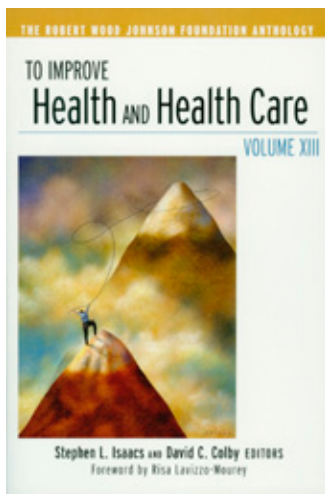


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Editors' Introduction

Title VI of the Civil Rights Act of 1964 declared that “No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” With the passage of Medicare and Medicaid legislation in 1965 (as well the provision for community health centers in the anti-poverty program), Title VI’s requirements for nondiscrimination in medical care became applicable to just about every hospital, health center, clinic and physician in the United States. Yet for many years health care professionals did not see providing services to patients in their own language as a legal requirement, even though the immigrant population in the United States was rising rapidly. It was only in 2000 that President Clinton signed an executive order making it clear that Title VI applied to persons with limited English-language proficiency.¹

Although the law might have been slow to recognize something as obvious as the importance of patients and health providers being able to communicate in a language they both understood, foundations, advocacy groups and some policy-makers grasped its significance much earlier. In 1991 the Robert Wood Johnson Foundation determined that reducing the social and cultural barriers to health care would be one of its objectives. To reach this objective, it developed several programs to decrease language barriers to medical services. The most significant of these was *Hablamos Juntos* (We Speak Together, in English translation). In this chapter, Irene Wielawski, a free-lance journalist and former investigative reporter for the *Los Angeles Times* and *Providence Journal-Bulletin*, looks at *Hablamos Juntos*, examining its conceptual bases, observing the program in action at two sites, and offering some thoughts—based in part on the evaluation of the program—on the challenges to language-access programs and possible ways of overcoming them.

As this chapter illustrates, even an apparently simple idea such as providing Spanish-English interpretation can run into practical implementation problems. Reducing social and cultural barriers to care—including language barriers—requires thoughtful, sophisticated and multifaceted approaches. Perhaps the best illustration of the importance of understanding and working within the appropriate cultural context is found in Anne Fadiman’s book *The Spirit Catches You and You Fall Down*, the real-life story of how the great cultural gap between caring, well-meaning physicians and the parents of an epileptic Hmong girl led to a tragic series of misunderstandings.² As Wielawski observes, the Foundation has learned from *Hablamos Juntos* and has adopted approaches to ensuring better communication between providers and patients in the context of its efforts to improve the quality of health care and reduce the inequalities in accessing it.

1. Jellinek, P. S., and Isaacs, S. L. *Overcoming Language Barriers to Health Care*. Public policy case study. Los Angeles: The California Endowment, July 2007.

2. Fadiman, A. *The Spirit Catches You and You Fall Down*. New York: Noonday Press, 1997.

Imagine lying in a hospital room—nervous, uncomfortable, hoping for good news, fearing the worst. Now imagine all the people you have to deal with during your hospital stay. They include the doctors and nurses who stop in to take your vital signs, feel your skin, listen to your heartbeat, probe the sore places, move your limbs, and otherwise work over your body. Add to the crowd therapists, phlebotomists, x-ray technicians, pharmacists, transport and food service workers, and perhaps an aide to help you with bathing and other personal needs. Now imagine that the hospital you've landed in is in Ecuador, Cambodia or Tajikistan and that most of the people caring for you don't know enough English to explain what they're doing or grasp what you're trying to tell them. Are you allergic to penicillin? Taking blood thinners? Prone to anesthesia reactions? Immunosuppressed?

For the majority of English-speaking Americans, this would be a rare experience—the result of an accident or a sudden illness while abroad. But for a growing number of immigrants residing in the United States this is the norm. Our hospitals don't routinely provide interpreters at the bedside, though law and regulation say they should. And when interpreters are on hand, their level of skill can vary greatly, and their use by clinicians is often erratic, even at the most progressive medical centers.

Considering what a challenge it can be for many Americans fluent in English to find their way in a busy hospital, provide a cogent medical history, or work through an insurance issue, it's not hard to grasp the impact on patients unable to communicate adequately in English and possibly raised in a different medical culture. There are no definitive data, but advocates say people with limited English proficiency often act similarly to uninsured people who delay care and fail to follow up on medication and other recommended treatments.

The situation has consequences for health care quality and cost in the United States health care system. Studies show that language and cultural misunderstandings can lead to misdiagnosis and flawed treatment. Patients who can't understand English well enough to follow self-care instructions are more likely to suffer harmful and costly complications. Even when individual patients aren't significantly harmed, experts say, the cumulative lapses, delays, and confusion resulting from missed or misunderstood messages undermine national efforts to improve health system performance and population health.¹

The diversity of languages and cultures threaded through the American tapestry is vast indeed. In New York City's borough of Queens, for example, it is estimated that 138 languages are spoken. In California, 43 percent of the population speaks languages other than English at home.² Nationally, 18 percent of the population, or 47 million people, speak a different language at home, and of this group 20 million, or about 7 percent of United States residents, cannot function in English.³ Logically, language services that facilitate communication between health care providers and non-English-speaking patients ought to be a win-win-win for patients, providers and the system. Practically, though, how can hospitals, clinics, doctors' offices, nursing homes, home care agencies, pharmacies, testing labs, and all the other entities that make up our health care system accomplish this?

This question attracted the attention of the Robert Wood Johnson Foundation, which responded with what it thought was a tightly focused demonstration program to make the business case for investments by health care organizations in linguistic services. Called *Hablamos Juntos*, Spanish for

We Speak Together, the undertaking was authorized to run from 2001 to 2005 with \$18.5 million in funding, and was then reauthorized for three years with an additional \$5.4 million (this was reduced by \$3 million to fund a new program called Speaking Together). Focused on the linguistic needs of Spanish speakers, the nation's fastest-growing minority group, *Hablamos Juntos* had two main goals: to show that investments in interpreters, multilingual signage, and other aids to patients with language barriers were cost effective; and that they improved health care access and quality.

Grantees carried out many useful activities, but the program as a whole was unable to demonstrate either cost effectiveness or improvements in health care access and quality for patients with limited English proficiency, according to the program's evaluators. Instead, the program demonstrated that effective communication has more layers than an onion and transcends words. It found communication deficits that go far beyond language incompatibility and have implications for high-quality medical practice across the full spectrum of patients. And it identified weakness in some of the assumptions driving policy and national debate in this area, highlighting the need for more research and better data. These may not have been the lessons that the Robert Wood Johnson Foundation set out to extract from its experiment, but they are nonetheless valuable for being unexpected.

Anything New Here?

Language diversity among patients is hardly a twenty-first-century phenomenon in this nation of immigrants. Health care workers can recite stories about the strategies they've used to elicit information from non-English-speaking patients. And every immigrant, even those now acculturated and fully bilingual, can recall early experiences when their inability to communicate with medical personnel was a source of anxiety and misunderstanding.

Health care professionals and institutions have coped in various ways over the years, frequently relying on family members, including children, to translate for non-English-speaking patients. Other ad-hoc translators have included community volunteers and bilingual employees of the hospital or the doctor's office. Health care organizations routinely kept lists of employees' foreign language skills so they could be called upon by clinical staff in a pinch. Some clinicians have relied upon their school Spanish or Russian or Chinese to patch together dialogues with patients. Still others, referred to by linguistic experts as "heritage speakers," have used the language of their childhood to reach patients with whom they shared ethnic backgrounds.

None of these communication methods is considered ideal. John Prescott, an emergency room physician who is now chief academic officer for the Association of American Medical Colleges, recalls working in a West Virginia hospital that lacked interpreters and having to press a traumatized five-year-old into service in order to obtain critically important information about the boy's injured parents. Prescott's memory of doing so is a painful one, although assuaged by the greater urgency of saving the child's parents. In this way, catch-as-catch-can communication with patients of limited English proficiency became engrained in American medical culture, and seemed to suffice, especially over the many years when acute illness and injury largely defined the clinical encounter. If a patient was bleeding profusely or writhing from the pain of bone fractures, conversation necessarily took a back seat to action.

As for follow up care, there simply wasn't that much to talk about. Until fairly recently, patients stayed in the hospital until they were well enough to resume their lives and livelihood. There were few effective medicines to correct the faults in metabolism or biochemistry that undermine health over time. And most patients didn't need a detailed discharge order to tell them what they already knew from their mothers and grandmothers: stay warm, eat nourishing food and take it easy.

It's a different world today. Take, for example, the modern hospitalization experience. People today tend to be admitted only for serious illness or injury, and discharged as quickly as medically possible, shifting the recuperative burden onto patients and their families. Patients typically go home from a hospital or surgical center with many pages of instructions for self-care that can include complicated drug therapies, special diet and exercise regimens, and the use of sophisticated assistive devices—underscoring the need for effective and ongoing communication with patients as they cope with chronic illness.

The mortality picture also is very different from a century ago. Most people alive now will die from complications of one or more chronic conditions, such as cardiovascular disease. A breakdown of current national health care spending illustrates this trend. Of the \$2.2 trillion in 2007 expenditures, an estimated three-quarters was spent on chronic illness. This staggering proportion has given impetus to the movement for so-called patient-centered care, in which everyone works together to help patients achieve optimum self-care, thereby, it is hoped, improving overall population health and reducing costs from exacerbations of illness. If a child hospitalized for asthma needs follow-up monitoring by the school nurse, the hospital, school, and family collaborate to make that happen. If a diabetic's blood sugars remain high, nurse educators and dieticians step in to help the patient achieve control and avoid debilitating and costly kidney, eye and circulatory complications.

“When you look at where our health care costs are going, you have to also consider that we have an aging population with an accumulation of behaviors that have health and financial consequences,” says Yolanda Partida, a health policy researcher at the University of California, San Francisco, and a management consultant in Fresno, California, who served as the national program director for *Hablamos Juntos*. “Almost every chronic condition—diabetes, asthma, heart disease—is about what the patient does or doesn't do behaviorally. They have to understand the connection.” In this twenty-first-century context, rudimentary provider-patient dialogues based on half-forgotten language studies, child translators, or a handy bilingual colleague have come under scrutiny. The *Hablamos Juntos* experiment sought to raise the communication to a professional level with specially trained bedside and telephone interpreters as well as better print materials that went beyond literal translation to incorporate nuances of Latino culture.

Legal Mandates

A body of laws, policies and standards developed by professional organizations define the obligations of health care organizations to ensure that patients with limited English proficiency have access to health care equal to that of English-speaking patients. This regulatory history is not without controversy. The push to address linguistic barriers for immigrant patients as well as issues of cultural sensitivity in health care delivery competes for priority with many other deficits in the American

health care system. Mandates have seesawed somewhat over the years, compliance has lagged, and enforcement is generally lax, observers say.

The main platform for language access regulation and policy is the Civil Rights Act of 1964, specifically Title VI, which prohibits discrimination on the basis of “race, color or national origin.” Title VI is binding on entities that receive federal funding, which includes virtually all health care organizations through their participation in Medicare and Medicaid and receipt of government grants for research and public health services.⁶

Title VI’s applicability to patients with limited English proficiency has emerged through presidential decrees and agency memoranda. The Department of Health and Human Services (HHS) made the link to language explicit in 1980 with an advisory stating, “No person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English.”⁷ In 2000 President Bill Clinton signed Executive Order 13166, directing federal agencies to review all programs to ensure that people with limited English proficiency had equal access. The HHS Office of Civil Rights followed up with guidelines for health care organizations, including obligations to assess language needs in their communities, develop written policies governing language access, train staff to implement these policies, and create systems of monitoring compliance. The guidelines were softened during the administration of President George W. Bush through the addition of four mitigating factors to reduce compliance obligations and costs for small health care enterprises.⁸ State law also comes into play, but there’s little uniformity. Alice Chen and colleagues, reporting in the *Journal of General Internal Medicine*, describe a “haphazard patchwork of legal obligations” that varies “from state to state, from language to language, from condition to condition, and from institution to institution.”⁹

Complicating the landscape even further is the fact that health insurers don’t reimburse for language services in most states, putting the cost of compliance—estimated in 2002 at \$268 million annually¹⁰—on the backs of providers and, indirectly through higher fees, on patients and taxpayers. Complaints from provider organizations, such as the American Medical Association, resulted in federal authorization for reimbursement for interpreters provided to patients covered by Medicaid and the State Children’s Health Insurance Program (CHIP). But states must match the money to activate this option, and only a dozen states and the District of Columbia have opted to do so. Significantly, populous states with the largest proportion of limited English speakers—California, New York and Texas—have not.¹¹

Hablamos Juntos Takes Shape

Staff members at the Robert Wood Johnson Foundation had been concerned for some time about disparities in health care for certain racial and ethnic groups compared with Whites. Initially, the Foundation, like other philanthropies, sought to address these disparities by targeting broader-based barriers to health care such as lack of health insurance and a paucity of local health services. Many of the Foundation’s investments in the 1980s and 1990s—for example, school-based health centers, programs to expand health care services through free clinics, and outreach efforts to enroll eligible people in publicly financed health care programs—benefited ethnic and racial minority groups

primarily, but the criteria for inclusion were mostly financial. The thinking in philanthropic circles was influenced by public concern over gaps in the nation's health insurance system and the inability of many people to pay for medical services. This also drove the political agenda; a campaign promise of universal health coverage helped Bill Clinton gain the White House in 1992.

But could insurance—or the lack of it—entirely account for statistics showing that babies in certain minority groups were at unusually high risk of dying in the first year of life and, if they survived, were likely to have a shorter life span than White babies? Could it explain differences in the rate of medical diagnostic tests and preventive care provided to minority versus White patients? Could it justify higher than average rates of amputations among minority patients for complications of diabetes?

In 1991 the Robert Wood Johnson Foundation made reducing social and cultural barriers to care one of its priorities, and launched several programs to address this directly. Among the most noteworthy were Projecto HEAL and Opening Doors.¹² Projecto HEAL (Health Empowerment, Access, and Leadership), or, more formally, the Program to Address Sociocultural Barriers to Health Care in Hispanic Communities, was a \$3 million program funded in 1992 that enabled eight communities to address health issues that they themselves determined as priorities. That same year, the Robert Wood Johnson Foundation joined forces with the Henry J. Kaiser Family Foundation in mounting a \$5.5 million program (\$1.5 million from Kaiser, \$4 million from Robert Wood Johnson), called Opening Doors: Reducing Sociocultural Barriers to Health Care. According to a report on the program, between 1994, when implementation began, and 1998, Opening Doors identified a perception among minority patients across all twenty-three sites that health care personnel do not respect them, as evidenced by the absence of “active listening” (nodding, smiling, note taking, and other responsive behavior when patients described symptoms or medical history), poor eye contact, and deficiencies in basic courtesy such as addressing patients as Mr. or Mrs.¹³ The grantees were able to improve conditions for specific groups of ethnic and minority patients in their communities, but the program offered little direction for system-wide improvements in language access and cultural sensitivity.

Hablamos Juntos took shape in 2001 amid ferment over emerging research showing that even when insurance coverage is comparable, patients from racial and ethnic minority groups receive lower quality care than Whites. The Hablamos Juntos design team at the Foundation decided to focus on language barriers and the effectiveness of remedies such as interpreters, universally understood signage and multilingual printed materials. Discussion at the Foundation centered on the needs of Latinos, whose numbers had risen more than 50 percent between 1990 and 2000 to 35.3 million people, or 12.5 percent of the U.S. population. This became the genesis of Hablamos Juntos' singular focus on Spanish-speaking patients as a group from which solutions could be extrapolated to other ethnic and language groups, according to Pam Dickson, assistant vice president of the Foundation's health care group.

“There was clearly a correlation between language discordance and poor quality of care,” Dickson says. “At the time, we at the Foundation were operating on the theory that a good role for us to play was as a supporter of demonstration projects. We felt the ideas would be adopted by health care organizations as a result of demonstrated competency.” To achieve that result, the Hablamos Juntos call for proposals stressed the importance of designing cost-effective solutions to encourage

investment by providers in language services. Hablamos Juntos grantees were charged with developing and testing systems of medical interpretation, signage and print materials in a variety of health care settings, and gathering data on cost and patients' experience in order to answer questions about affordability and Latinos' access to quality health care.¹⁴

Eligibility was restricted to health care organizations that served a Latino population of at least 10,000 and that had grown by at least 50 percent between 1990 and 2000. The sites selected for the experiment were: Birmingham, Ala.; Los Angeles; Grand Island, Neb.; Philadelphia; Providence; Greenville, S.C.; Memphis; Fort Worth; Falls Church, Va.; and Olympia, Wash. Each site initially received \$150,000 to fund a year's worth of planning and organizational work, including finding community partners, cataloguing existing resources, and identifying signage and print material needs.

A two-year implementation phase, with \$850,000 per site, began in 2003. That's when things got complicated, in part because of the specific questions Hablamos Juntos was created to answer, but also because of questions about health care communication in general. The first year of implementation, 2003, came on the heels of the release of a report by the Institute of Medicine (IOM) titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.¹⁵ Based on a review of more than 100 studies of quality variations in health and health care for ethnic and racial minorities, the IOM report concluded that these disparities had many causes.

Some were intrinsic to the patients themselves; for example, the report cited evidence of variations in drug efficacy in some racial and ethnic populations, and a tendency to avoid seeking care or reject doctors' advice. But stronger evidence indicted wide-ranging and deeply engrained deficiencies in the American health care system, including fragmentation of services and the linguistic barriers that Hablamos Juntos grantees were trying to overcome. Human factors also contributed to disparities, the IOM found, including prejudicial attitudes among some medical personnel or uncertainty about how to evaluate symptoms in patients who couldn't speak English. This tangle of factors and the difficulty of teasing out any one of them for meaningful experimentation challenged Hablamos Juntos grantees.

Collectively, the sites tackled many language-related issues, including training and certification of medical interpreters, deploying them effectively in health care settings, and using universal symbols to improve signage. The sites, however, had almost nothing in common. Some projects took place in large hospitals, others in small community organizations with limited resources. Two grantees were Medicaid health plans that provided no direct patient care services. Some sites focused exclusively on technical aspects of language access, such as how to bring video and telephone-assisted interpretation to geographically scattered health care organizations. Others probed psychosocial, organizational, economic, and legal dimensions of linguistic access.

There was also great variability in the population served—Latinos—resulting from the many nationalities in that demographic group. “What we learned from Hablamos Juntos is we had ten different projects addressing different populations in different locations,” says Debra Perez, a senior program officer in the Foundation's research and evaluation department. “There wasn't a uniform way of assessing the interpreter services from one site to another.”

While individual sites made progress toward goals within their own institutions, *Hablamos Juntos* as a program did not prove the business case for interpreter services. Costs were significant, with insufficient evidence of improved clinical efficiency, health outcomes, and patient satisfaction to offset them, according to an evaluation completed by the RAND Corporation in March 2007. The evaluation team, led by Leo Morales of the University of California, Los Angeles, found “only a few positive effects on patients,” which the evaluators attributed partly to the experiment’s short duration.¹⁶ The evaluators also faulted leadership for allowing sites to pursue agendas that were “too ambitious for the time and resources available.” In successor programs, such as *Speaking Together*, the Foundation addressed the conceptual flaws that the evaluation revealed. But if cross-site comparisons had to be jettisoned because of site-to-site variability, this was also the experiment’s most interesting aspect. The experiences of two *Hablamos Juntos* grantees help illustrate this diversity of perspective among grantees united primarily by their commitment to improve the health and health care of Spanish-speaking patients.

**Temple University
Health System
Philadelphia, Pa.**

There’s nothing gentrified about North Philadelphia, the area that surrounds the Temple University Health System. Here, the city’s distinctive orange-tinged brick row houses feature iron bars on the lower windows; parking lots are surrounded by twelve-foot-high chain link fence and razor wire; and the most ubiquitous businesses are check-cashing and pawn shops. Gritty and dangerous after dark, it is home to predominantly working-class and unemployed Philadelphians, many of them immigrants.

A generation ago, they were Polish and Irish, living alongside the African-Americans whose presence in the area predates the Civil War. Now they’re mostly Puerto Rican, though there are clusters of Cubans and Dominicans, and community leaders say the Mexicans are starting to move in. Temple’s hospitals—Temple University Hospital, the system’s flagship academic medical center, and two affiliated community hospitals—began noticing an increase in Spanish-speaking patients in the mid-1990s. Used to a patient mix of about half White and half Black, most of them English-speaking, the newcomers unsettled business as usual at the Temple hospitals. “Our doctors and nurses began complaining about communication problems and expressing a need for language services,” recalls Charles Soltoff, an associate vice president for marketing and principal investigator on the *Hablamos Juntos* grant.

The Temple system supports teaching and research for the Temple University School of Medicine while serving as Philadelphia’s primary safety net provider, continuing a mission established by its founders in 1892 to provide care regardless of patients’ race, nationality or creed. But in today’s climate, with growing numbers of uninsured patients, the mission has left Temple chronically short on capital.

“We’re always challenged financially and there’s a lot of internal competition for resources,” says Soltoff, who nevertheless began discussions with Latino community leaders about ways to improve communication between Spanish-speaking patients and Temple clinicians. The discussions led Soltoff to develop a marketing plan with the twofold purpose of improving the Temple system’s interactions with Spanish-speaking patients and cementing the loyalty of Philadelphia’s growing Latino market.

As part of the plan, he asked Temple's administrative leaders to consider investing in interpreters. "It was clear," Soltoff says, "that the Latino population was going to be served exclusively through our emergency room if we didn't do something."

In researching how other hospitals had responded to patients with limited English proficiency, Soltoff came upon the Hablamos Juntos call for proposals. "I read it and thought, 'Wow, this is just like my plan!'" He got the go-ahead to apply for a grant from his CEO, Joseph W. "Chip" Marshall III (who retired in 2008). "Chip's okay told me we were making a permanent commitment to interpreters, because he was opposed to grants unless they could be made a part of the core mission of the hospital." Marshall recalls being impressed with the Hablamos Juntos concept but not its focus on the linguistic needs of a single minority group. He instructed staff to think bigger.

"I told them it can't just be for Spanish speakers, it has to be for all languages and communication issues," Marshall says. "The idea was to get people at Temple focused on fundamentally changing the way we deliver care and clear away the excuses for not doing so. The Hablamos Juntos grant enabled us to kick-start that process, but it was not going to end just because the grant ended."

Lucky thing, because the Hablamos Juntos part of Temple's experience turned out to be three steps forward and two back and marked by disagreement and tension over the best use of interpreters that linger to this day. The Temple team chronicled some of this in a gently humorous pamphlet called *Confessions of a Linguistically Challenged Health System*.¹⁷

On the positive side, the Hablamos Juntos grant helped Temple hire in-house interpreters, promote better use of existing telephone-based interpretation services, improve the quality of translation of written materials, and adapt institutional policy to promote language access. Temple also developed its own training curriculum and proficiency standards for interpreters, after deciding that available academic and commercial programs were not suitable. Credentialing as a medical interpreter at Temple today requires forty-five hours of classroom training plus ongoing in-service sessions, observation and practice.

The training includes lectures on physiology and medical terminology as well as on cultural diversity among Latinos, who may use different words or home remedies depending upon what country they're from. These variations based on nationality can be significant in a health care setting. For example, the word *constipación* when used by Puerto Ricans, Dominicans and Cubans means what it sounds like in English: constipation. But this is a false cognate, used widely by Latinos from the Caribbean region possibly because of their historically close interactions with English speakers. The actual Spanish word for constipation is *estreñimiento*. And when Mexicans say *constipación*, notes Raquel Diaz, Temple's manager of interpreter training, they're describing nasal congestion.

Temple's interpreters pass extensive written and oral exams to demonstrate comprehensive knowledge of these nuances of usage. All the more bitter, then, their initial Hablamos Juntos experience: almost no one called on their expertise. In all the work to prepare Temple for interpreters, including garnering support from the system's top executives and administrators as well as Latino community leaders, no one thought to bring front-line clinical staff into the discussions. "We took away some

real lessons from *Hablamos Juntos*,” says Deborah Rosen, director of health care outreach for Temple, which oversees the current interpreter program. “We thought interpreters would be embraced with open arms—like ‘Where have you been all my life?’ It really didn’t happen that way.”

Instead, the four interpreters hired under the grant and assigned to the emergency rooms and maternity units—locations where *Hablamos Juntos* leaders thought they would be most needed—were initially ignored by the medical staff, who continued to rely on family members or their own language skills to communicate with Spanish-speaking patients. Even when the interpreters were called upon, protocols limited their effectiveness. They were not allowed to respond on a need basis throughout the hospital, but had to remain in their assigned locations—ER or maternity—even if there was no work to do. Also, they were not allowed to break away from an ongoing interpretation to answer a new page. This differed from standard clinical protocol, where pages must be answered promptly, and irritated medical staff, who thought the interpreters should have to operate like others on the clinical staff. (One reason that Temple restricted interpreters to fixed locations was to satisfy data collection requirements under the *Hablamos Juntos* grant. If the interpreters had been on a hospital-wide dispatch and triage system—as they are today—collecting data on patients’ health status, length of hospitalization, satisfaction and so on would have been impossible.)

The untested assumption of *Hablamos Juntos*—that medical staff would welcome the interpreters—led to tensions at Temple and a difficult work environment for the four interpreters hired under the grant. “They were asked to do things that were out of the scope of practice for an interpreter, like hold the leg of a woman in labor or push a gurney,” Rosen recalls. “We had to tell the providers that this was not an appropriate role for the interpreter, but it was not uncommon for them to respond disdainfully, saying things like ‘Why can’t they do something more useful? Why can’t they answer the phone or do callbacks to non-English speaking patients?’”

Tension resulting from these early misunderstandings about purpose and function persisted after the *Hablamos Juntos* grant ended in 2005. Temple revamped its interpreter program, and today use of interpreters is mandated under risk-management and quality protocols. All staff must use in-house interpreters, agency interpreters who conform to quality standards, or telephone interpretation services if patients can’t speak English or simply prefer to speak in their native language. The protocols prohibit a physician or clinician who speaks the patient’s language from interpreting unless he or she has passed a test for language proficiency and is credentialed as a dual-role medical interpreter, according to Rosen. The Temple system has thirty-five dual-role employees augmenting a staff of ten full-time interpreters.

Annemarie Martin-Boyan, an attorney for the hospital, puts the rationale bluntly: “People die if you can’t communicate with them. From my point of view, I don’t want to deal with the complaints and litigation that can come out of a failure in this.” Robert Pezzoli, former executive vice president of the Temple system, makes the same point, but anchors his thinking in the medical school precept “First do no harm.” Pezzoli says, “I look at our interpreter services as an investment rather than a cost, because if we can’t communicate effectively with our patients and their families, it becomes a risk.”

But practical questions continue to be raised, related to resources and efficiency both in Temple's hospitals and among community-based practitioners located in forty-eight offices belonging to Temple Physicians, Inc., a subsidiary of Temple Health Systems. The ninety-five physicians receive compensation tied to productivity, making the use of interpreters a potential financial liability. "Working with a translator or a telephone language line slows things considerably," says Eric Mankin, CEO of Temple Physicians. "It takes time to find an interpreter and get him or her in the room, or alternatively to get the language line on the phone."

Mankin doesn't recall any physician in the group expressing reluctance to follow translation guidelines because of personal income concerns, but adds that productivity pressures are only one complicating factor. Not all patients welcome interpreters—a finding of the *Hablamos Juntos* evaluation across all sites. Some refuse their services, Mankin says, preferring family members. Mindful of the policies of their parent company, as well as federal and state mandates pertaining to language access, the Temple Physicians group now asks these patients to sign a waiver, acknowledging the offer—and their refusal—of an interpreter.

Mankin worries about the cumulative effect of such awkward and legalistic procedures on subtler aspects of patient-provider communication. "Ninety percent of diagnosis comes from the patient's story, which you get by talking and asking questions, but also through nuance and body language," Mankin says. "You lose a lot of nuance with interpreters. And it's hard to convey empathy, which is very important. Really, how can you empathize through a translator?"

Overall, however, the positives of providing interpreter services outweigh the negatives, Temple clinicians say. "The interpreters are able to provide clear answers and interpret cultural differences," Ernie Bertha, director of pediatric emergency services, said in an interview for a Foundation Grant Results Report in 2007. "Our care becomes much warmer, more personal, more personable."¹⁸

The manager of Temple's interpreters, Angel Pagan, sees their role in health care settings as still evolving. Now, their value is measured mostly in terms of improved clinical communication and better relations with Philadelphia's Latinos and other patients with limited English proficiency. In time, Pagan believes interpreters will also prove cost-effective, as public and private insurers penalize providers for inefficiency and errors. "Right now you have to look at this as the right thing to do for patients and for medical care quality, because you can't prove a direct return on investment," Pagan says. "But I come from a managed care background and I can tell you if you have a post-surgical patient and care or testing is delayed due to communication failure, you're not going to get paid for that extra day in the hospital."

**Molina Healthcare
Long Beach, Calif.**

Molina Healthcare is exactly the kind of managed care health plan that Angel Pagan had in mind when he predicted that interpreters would eventually be seen by health care organizations as a worthwhile investment. According to Molina's calculations, its version of interpreter services saved the for-profit company more than \$1 million in 2008 simply by guiding patients to timely and appropriate health care services.

Unlike the Temple health system, Molina provides little direct care. Rather, it contracts with hospitals, physicians and other health care professionals to provide care to its members, all of whom are covered by Medicaid, CHIP, or a combination of Medicaid and Medicare. So from the outset Molina's approach to the *Hablamos Juntos* challenge to improve language access was different from Temple's. This was partly due to the health plan's location in Southern California and partly to the mission established by its founder, the late C. David Molina. Molina was a public hospital emergency room doctor who wanted to improve primary and preventive care for poor residents of his community, many of them Latino. Molina's children now run the health plan; his daughter, Martha Bernadett, a physician and Molina Healthcare's executive vice president for research and innovation, was principal investigator on the *Hablamos Juntos* grant.

"Serving the economically disadvantaged is our main niche, but we also have members who need help to overcome language or cultural barriers," says Bernadett, noting that 60 percent of the membership is Latino. "Initially, we were planning to train interpreters and translate patient education literature. But we were saved from that by the grant's very valuable requirement that we first do a needs assessment."

The assessment revealed surprisingly negative feedback about interpreters. Bernadett says the Latinos surveyed overwhelmingly did not trust lay people to represent them or get their doctor's message right. "The responses we got were comments like 'Interpreters make mistakes. That's why I like to bring my cousin or my aunt or my brother-in-law.' And they told us about actual experiences with mistakes that interpreters had made," Bernadett recalls. "When you questioned them closer about it, you'd discover it wasn't really a big mistake, but the patient thought it was."

Molina's *Hablamos Juntos* team analyzed the responses in the context of Latino cultural values, which accord high esteem to doctors and nurses. It led them to abandon the translation idea and substitute a twenty-four-hour advice telephone line staffed by bilingual nurses. Called *TeleSalud/Nurse Advice*, the service was launched in 2004. Unlike Temple's interpreters, who serve as communication intermediaries between patients and providers, *TeleSalud's* Spanish-speaking nurses operate as clinicians, advising callers on self-care for minor illnesses and injuries, while directing callers with more serious symptoms to their physician's offices or the nearest emergency room.

In launching *TeleSalud*, Molina drew lessons from a previous, unsatisfactory experience with a commercial nurse hotline. This outsourced advice line initially seemed to be an instant success with Molina Healthcare members; data from the vendor showed a steady increase in use, according to Bernadett. But a closer look at the data revealed a startling anomaly. Only 2 percent of callers to the toll-free advice line were being connected to Spanish-speaking nurses. This made no sense in light of Molina's overwhelmingly Latino membership. "There was clearly an access issue going on," Bernadett says. "After asking our vendor some very pointed questions, we found out they had very few Spanish-speaking nurses and also that our members had to go through several steps on the phone with English speakers before they could get to the Spanish-speaking nurse."

TeleSalud, therefore, was developed in-house to insure control over the quality of the service. The health plan recruited widely for nurses, establishing both clinical and cultural hiring criteria as well as a salary scale attractive to experienced nurses. The current *TeleSalud* nurses are all registered nurses

with backgrounds in critical care and emergency nursing. Most are in their forties or older and have at least twenty years of nursing experience, according to Kathy Williams, clinical manager of the advice line.

The extensive training that Temple interpreters receive to differentiate word usage by nationality occurs more casually at Molina, mostly at staff meetings or over lunch. TeleSalud nurses are predominantly Latinas, but their heritage is as diverse as that of Molina's members: Mexico, Guatemala, Peru and El Salvador. Because the nurses work side by side in a call center, they're able to help each other out and share knowledge, for example, of medicinal teas that certain patients might use or about practices such as swaddling feverish infants.

"Our approach is one of support to the member, but we're doing medical triage at the same time, so it's important to inquire about any home remedies the patient is already employing," Williams says. "There's a wide range of calls. You have people who should have called 911 twenty minutes ago and you have people who just have a cold. With the second group, our aim is to discourage them from going to an ER and exposing themselves to more serious infection. But you have to use your clinical judgment. If that judgment is that the patient may come to harm, then the advice changes to 'I think it might be a good idea for you to go to the emergency room now.'"

TeleSalud was piloted in Southern California's San Bernardino and Riverside Counties, where many Latino members live, including new immigrants who have little experience with preventive care and tend to use emergency rooms in crisis. As TeleSalud began to get repeat callers, nurses took the opportunity to discuss things like immunizations and well-baby checkups, as well as follow-up care. The system has expanded since *Hablamos Juntos* to include a bilingual appointment-scheduling line to which nurses can transfer a caller if they judge that a physician visit is needed.

Other new services include after-hours prescription refills, case management for members with chronic conditions, and calls to patients who have been treated in ERs to make sure they follow up with their doctors. While each service is intended to help patients, each is also designed to reduce costs by preventing unnecessary ER use or exacerbation of illness, leading to expensive hospitalization. Molina calculates savings based upon analysis of the number of callers triaged by TeleSalud to alternate sources of care, whether it's a next-day doctor's appointment, a visit to an urgent care center, a consultation with a specialist in chronic disease management, or simply reassuring instruction on home care measures.

Aftermath

Hablamos Juntos spurred the Robert Wood Johnson Foundation to once again re-evaluate its approach to racial and ethnic disparities in health care. Program leaders realized that it wasn't practical or sufficient to "ask some poor hospital to just offer translation services" or to expect the federal government to pay extra for cultural competence, according to Anne Weiss, senior program officer and leader of the Foundation's Quality/Equality team. Instead, the Foundation's strategy has become one of folding the special needs of ethnic and minority patients into overall efforts to improve health care quality, whether that means giving medicine to patients who can't afford their prescriptions,

arranging home nurse visits, or using an interpreter to help, say, a Chinese-speaking diabetic understand the dietary regimen.

In 2005 the Foundation authorized \$3 million to support certain *Hablamos Juntos* activities through mid-2009. The same year, it launched a new program, *Speaking Together: National Language Services Network*, that was, in the words of Foundation assistant vice president Dickson, “more consistent with our philosophy of looking at better communications between non-English speakers and providers as one way of improving quality of care.” Under the *Speaking Together* program, ten hospitals nationwide are working to identify, test and assess strategies for effective language services in the context of overall medical care quality. Among early findings is the need for greater use of interpreters at key moments of information exchange—for example, at assessment and discharge—not just during the acute phase of treatment.¹⁹

Hablamos Juntos helped define this broader mission of language services as a contributor to health care quality through insights about communication deficits that extended beyond the program’s targeted Spanish-speaking population. For example, in translating consent documents for surgery and other treatments, grantees discovered that the English versions were cluttered with legalistic jargon that obscured important information about risks and benefits.

Other successor programs that opted for a more comprehensive approach include *Expecting Success: Excellence in Cardiac Care*, an \$11 million program that ran between 2005 and 2009. Instead of trying to improve health outcomes via a limited focus on language assistance, as in *Hablamos Juntos*, *Expecting Success* worked from evidence that African-American and Latino cardiac patients fared poorly due to a wide array of factors, including communication deficits, and it tailored remedies accordingly.²⁰

Through *Expecting Success*, the Foundation also encouraged data collection on patients’ ethnicity, race, language and cultural characteristics in order to build an information base capable of pinpointing disparities and informing evidence-based solutions. “It’s not enough to know that 80 percent of patients are getting good care across the board,” Dickson says. “You want to know, is that 90 percent of White patients but only 40 percent of African Americans?” She adds, “You have to think strategically about where this fits in a hospital’s or other organization’s gestalt, their operational game plan.”

Conclusion

The last twenty years has seen considerable effort by government, philanthropy and the private sector to improve cultural competence in the American health care system. Although knowledge of the influence of culture on health and health care has been around a lot longer than that, the activity of recent years has been prodded by a wave of new immigrants and mounting evidence of disparities in the health of people outside the American mainstream.

A landmark 1985 study by the Department of Health and Human Services documented persistent deficits in Black and minority health.²¹ This led in 1988 to the creation of an assistant directorship within the Centers for Disease Control (now called the Centers for Disease Control and Prevention) dedicated to minority health. The unit became the Office of Minority Health in 2002, and, three years later, the Office of Minority Health & Health Disparities (OMHD).

This evolution of OMHD parallels developments in the research field. What was once viewed as primarily racially based inequality in health care access and quality now is seen as multifactorial. The proof is OMHD's expanded mission, which today includes not only populations defined by race and ethnicity but also groups whose poor health correlates with socioeconomic status, geography, gender, age, disability, and particular risks related to sex and gender.²²

Experiments like *Hablamos Juntos* have contributed to this broader view of population characteristics contributing to disparities in health and health care. The answers are complicated, intertwined, and not always amenable to precise measurement. As the Institute of Medicine found in its 2002 study, *Unequal Treatment*, it's difficult to isolate a single factor—race, poverty, illiteracy, isolation, cultural beliefs—that if squarely addressed can be convincingly shown to improve the health of a population group.

Hablamos Juntos sought to tease out one factor—language barriers—for remedy with a variety of measures that health care organizations might be persuaded to invest in, especially if they resulted in cost savings from things like improved efficiency, reduced risk of complications from misunderstanding, and more appropriate use of health care services by patients with limited English proficiency. However logical this seemed at the outset, measuring impact proved difficult, partly because of the short duration of the *Hablamos Juntos* experiment—only two years to implement language improvements and conduct follow-up with patients—and partly because of the great variability of approaches tested by *Hablamos Juntos* grantees. Also complicating the analysis were significant differences in the characteristics of the Latino population each site set out to help. The two projects highlighted in this chapter—Temple University Health System's interpreter program and Molina Healthcare's *TeleSalud Advice* clinical service—amply illustrate the difficulties of cross-site comparisons in assessing health impact and bang for the buck.

Perhaps because it was evaluated after only two years, *Hablamos Juntos* did not make the case for the cost-effectiveness of interpretation. Most private health insurers and government payers do not reimburse providers for these expenses. Tellingly, states with the largest immigrant populations and the most to gain from service improvement to patients with limited English proficiency have not taken advantage of federal options to reimburse the cost of interpreters through their Medicaid and CHIP programs. Absent solid evidence of savings elsewhere—Molina Healthcare stands out as an exception—cost remains a pressing concern for health care providers faced with growing numbers of uninsured patients and strained budgets. The situation is not likely to change soon, given the battered state of the American economy.

Results from *Hablamos Juntos* also raise questions about whether professional interpreters are the best option for non-English-speaking patients. Surveys of Latinos served by the project found that the majority preferred providers who spoke their language and, lacking that, some still opted for family members over interpreters. These are important findings that deserve further study.

Perhaps some of the health system's traditional ways of communicating with patients who have limited English skills deserve a second look. Old ways of doing things tend to get harshly judged in the excitement over a new approach. But is it really so bad for a bilingual physician to talk to patients in their native language, or for a bilingual nurse or clerk or family member to help out? Indeed,

medical and nursing schools have invested heavily in promoting diversity in their student bodies to build capacity in the health care workforce to respond to patients' needs and preferences.

The needs of providers cannot be overlooked if the goal is to make language and cultural competence part of the standard of care in the United States. At Temple University Health System, erroneous assumptions about the medical staff's receptivity to interpreters led to several rough years for Temple's interpreters, and lingering tensions. Temple's *Hablamos Juntos* leaders, candid about their missteps in the spirit of helping others avoid them, say unequivocally that the medical staff should have been part of their planning process.

Hablamos Juntos demonstrated that effective communication is no less complicated and nuanced than many other factors underlying health and health care quality. Even people who are able to say exactly what they mean regardless of what pressures they are under can't be sure their messages are being received as they intend. Tone of voice, arms akimbo, wrong facial expression can send well-chosen words skidding into a bog of between-the-lines inference. Even when people speak the same language, emotion can sabotage comprehension. Patients have been shown to retain very little of the information that follows a serious diagnosis like "You have cancer." Personality traits lead some patients to exaggerate symptoms while others minimize them. Time pressures that define the modern health care encounter favor the terse over the long-winded, the distraught, the confused, and the silent. Still, patients with these idiosyncrasies—and many more—present daily in ERs, clinics and doctors' offices.

None of this is to discount the importance of speech—or the contributions of *Hablamos Juntos* grantees in devising improved signage and educational literature in patients' native languages. There's no question that the health care system must address language barriers if it is to achieve overall quality goals. But context can't be overlooked. The Foundation's decision, post *Hablamos Juntos*, to incorporate language and cultural access into broader quality initiatives acknowledges this symbiosis and offers an opportunity to broaden the dialogue about communication in health care—a conversation enriched by the trials, errors, insights and accomplishments of *Hablamos Juntos* grantees.

"We were a kind of Petri dish," says Yolanda Partida, *Hablamos Juntos*' national program director. "We were able to take a close look at language issues in a specific population of patients and, from that, learn a great deal about how to improve communication with all patients, not just those with limited English proficiency."

Notes

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- 10 Jellinek, P. S., and Isaacs, S. L. *Overcoming Language Barriers to Health Care*. Public policy case study. Los Angeles: The California Endowment, July 2007, p. 17.
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- 12 The foundation also funded Project Hope, to study economic and cultural barriers in access to care for Latinos; the University of Washington, to conduct a survey on cancer screening among Hispanic women; and the Emory University School of Medicine, to conduct an assessment of health literacy.
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