

Language Assistance Plan For Spoken and Sign Language Services

Call to Best Practice: Goals and Rationale

Goal

Our goal is to provide high quality spoken and sign language assistance services to support the Six Aims and decrease health care disparities. This includes:

- To provide language assistance services;
- To use trained interpreters consistently and appropriately; and,
- To create a HealthPartners culture of knowledge and expectation about the use of trained interpreters.

The Six Aims

The HealthPartners family of organizations is committed to providing services to persons with limited English proficiency (LEP) or who are deaf or hard-of-hearing that support the six aims of safety, timeliness, equity, efficiency, effectiveness, and patient/member-centeredness.

Language barriers negatively affect access, quality of care, patient and member satisfaction, and provider satisfaction, while increasing costs of care and legal liability. Providing language services promotes high quality of care and service and makes good business sense, given the changing demographics of the communities we serve. There also are legal and regulatory requirements and guidance supporting these practices.

Health Care Disparities

Language assistance services are a key strategy to address health care disparities. Reducing health care disparities is a top national and Minnesota public health priority.

The Institute of Medicine released a report in 2002 entitled, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” It states that we need to: *Increase awareness of racial and ethnic disparities in health care among the general public and key stakeholders and to increase health care providers’ awareness of disparities.* The Chair of the IOM Committee, Alan Nelson, MD, stated: *“The real challenge lies not in debating whether disparities exist, the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them.”* One of the IOM recommendations is to: *Promote the use of interpretation services where community need exists.*

It has been documented that even though most health care providers want to offer them the same attention and concern as to any other patient, limited English proficient (LEP) and deaf and hard-of-hearing patients often encounter obstacles.

- They may delay making an appointment because of the difficulty communicating over the telephone. Meanwhile, the health problem may become more severe or advanced requiring more expensive or invasive treatment.
- Misunderstandings about the time, date, and location of appointments are more likely to occur if the patient does not understand English.
- Even when patients arrive at the facility on time, they may be late for appointments because of difficulty communicating with registration staff.
- There may be confusion and misunderstanding about the medical interview and examination affecting the documentation of a complete and accurate medical history and possibly the accuracy of the diagnosis.
- In addition, miscommunication can result in unnecessary or inaccurate tests. Even when tests are necessary, if patients are not given instructions in a language they can understand, they may not be adequately prepared physically or psychologically to undergo the procedures.
- Likewise, if patients are to comply with a treatment plan, they must have a clear understanding of what is required of them.

The provision of language assistance services increases the efficiency and effectiveness of the delivery of health care to persons who need these services. The cost of an interpreter is less than the cost of a blood test. There is a return on investment in interpreter services seen through the decreased number of unnecessary tests, procedures, and repeat visits, and increased medical and prescription drug compliance.

Who is Accountable?

The entire HealthPartners enterprise is accountable for the provision of language assistance services. All segments— medical, dental, and health plan — have responsibility to implement the Language Assistance Plan.

In addition, interpreter services are a covered benefit under the HealthPartners contract with the Minnesota Department of Human Services for state public programs products. Most health plan coverage, for example commercial plans, does not include interpreter services. In these situations the federal Health and Human Services (HHS) agency requires physicians or other providers or health care entities who receive federal financial assistance from HHS where the patient receives care to provide interpreter services at no charge to the patient.

The HHS Office for Civil Rights states that any recipient of HHS federal financial assistance must provide meaningful access to persons with limited English proficiency. This extends to the entity's **entire operation**, not just the part receiving federal financial assistance. Recipients of HHS federal financial assistance include:

- Hospitals, nursing homes, home health agencies, and managed care organizations.
- Universities and other entities with health or social service research programs.
- State, county, and local health agencies.

- State Medicaid agencies.
- State, county and local welfare agencies.
- Programs for families, youth, and children.
- Head Start programs.
- Public and private contractors, subcontractors and vendors.
- Physicians and other providers who receive Federal financial assistance from HHS.

How Success Will be Measured

Satisfaction data are a key indicator of our success. Various measurement tools will be used; for example, patient, member and provider satisfaction surveys.

Definitions

See Attachment A for a definition of terms used in this plan.

Demographics of our Population

HealthPartners is accountable for monitoring our community demographics and ensuring that our language assistance services match the community need. Our data collection efforts enable our ability to monitor and match the need.

See Attachment B for information on the demographics of our area and organization.

Best Practice for Providing Spoken and Sign Language Assistance

Our plan to achieve best practice includes the following:

- Establish a Language Assistance Plan for the enterprise
- Create tools to make it easy for staff to implement the plan
- Develop clinic models of effective and efficient delivery of interpreter services
- Establish service and quality expectations for interpreter vendors
- Establish oversight of interpreter services
- Monitor and evaluate how well we are doing
- Establish procedures for appropriate, third-party payor reimbursement of state public program interpreter services
- Pilot train-the-trainer model under the Regions Hospital Fellows in Cross Cultural Care program

Best Practice Services

HealthPartners works to ensure access to care and high quality services. HealthPartners shall assess the need and communicate options for spoken and sign language assistance services using professional, trained interpreters whenever possible. HealthPartners shall take reasonable steps to provide these services.

The following options represent best practice for language assistance services:

- Communication services for deaf and hard-of-hearing persons include but are not limited to: sign language and spoken interpreters; written communication; adaptive equipment such as, TDDs (Telecommunication Devices for the Deaf); closed caption television; and visual aids.
- Bilingual providers and staff who can communicate directly with patients and members in their preferred language. Bilingual providers and staff must stay within the scope of their job description when providing bilingual care and services. (See the Quality section regarding criteria for bilingual providers and staff.)
- Face-to-face spoken language interpretation provided by trained interpreters (employees or contracted vendors).
- Telephonic spoken language interpreter services, especially when an interpreter is needed instantly or when services are needed for an unusual or infrequently encountered language.

Use of any kind of interpreter should be documented in the record at each encounter.

Use of Nonprofessional Interpreters

Some individuals with limited English proficiency may request that a family member or friend act as an interpreter. Use of family members or friends raises quality concerns such as:

- the possibility of medical errors
- mistaken naming of body parts
- mental health diagnoses being missed due to family shame
- inadequate testing due to inadequate histories, etc.

The use of family members or friends as interpreters could result in a breach of confidentiality or reluctance on the part of our patients and members to disclose information critical to their situation.

In particular, the use of minors to interpret does not represent best practice.

When receiving a request for family members and friends as interpreters, it is appropriate to suggest that the family consider a professional interpreter. We must make the individual aware that he or she has the option of having the provider or physician provide an interpreter without charge. We cannot require an person with limited English proficiency to use a family member or friend as an interpreter. If the patient or member declines the use of professional interpreters, that is their right.

See *Your Guide to Interpreter Services* on ERIC for suggestions about how to discuss this with patients and members.

Documentation

Use of any kind of interpreter, including a family member or friend, should be documented in the record at each encounter.

If the patient or member declines the use of professional interpreters, this should be documented in the record.

When Do We Provide Language Assistance Services?

We provide these services when a patient, member, family member, guardian, assigned caseworker, provider or staff person identifies a barrier to communication.

At a minimum, an interpreter should be present for:

- Encounters with the doctor or provider
- Teaching
- Scheduled tests or procedures
- Ancillary services
- Patient discharges
- When the patient or family requests it

Methods of Providing Interpreter Services

- Face-to face trained interpreters — employees or vendors — trained in third party (triadic) interpretation
- Bilingual providers/employees
 - May be used for direct communication with a patient or member.
 - Should not routinely act as third-party interpreters since they have not been trained in third-party interpretation.
 - May interpret if they are competent in the skills of interpreting. However, they must be aware of potential conflicts of interest.
- The Language Line telephone spoken interpretation service

How to Arrange These Services

See *Your Guide to Interpreter Services* on ERIC to learn how to schedule interpreters and use the Language Line.

How to Respond to Telephone Callers with Limited English Proficiency

- Use the Language Line (See *Your Guide to Interpreter Services* on ERIC to learn how to use the Language Line)
- Use a bilingual employee working in the scope of their job description

Quality of Language Assistance Services

Interpreters must have training, meet requirements for providing high quality interpreter services, and demonstrate their competency.

Professional Interpreters

- Demonstrated competency via certification, e.g., Registry of Interpreters for the Deaf (RID) professional interpretation; spoken language certification
- Trained in medical terminology
- Trained in HealthPartners-specific expectations
- Otherwise qualified if certification not available
 - Understanding of and sensitivity to cultural issues
 - Demonstrated proficiency in both English and the other language, including demonstrated ability to convey accurate information in both languages
 - Orientation and training that includes the skills and ethics of interpreting and the standards of practice (e.g., confidentiality)
 - Fundamental knowledge in both languages of medical terminology and our programs
- Upholds professional code of conduct

Bilingual Providers and Staff

- Competency requires more than just self-identification as bilingual. It is highly recommended that competency is demonstrated in some manner.
- Bilingual providers and staff may be able to provide **direct** communication services within the scope of their job description, but should not perform as third-party interpreters unless they have been trained to do so. Training for performing triadic interpretation represents best practice. For example, a bilingual medical office assistant should not be used to interpret for a medical encounter. A bilingual physician or nurse, however, could directly communicate with their patient during a patient encounter.

Education and Communication

Employees are informed of our language assistance services and policies in several ways.

- New employee orientation
- Internal communications
- Website
- Staff, management and committee meetings
- Clinic-specific training via the care delivery supervisor, business systems supervisor or equivalent
- Staff training within departments

Patient and Member Communication

Patients and members are informed about language assistance services by:

- Member materials
- Posted materials in care delivery settings
- Appointment scheduling process
- Providers and employees
- Member Services staff

Patients and members learn about our language assistance services at various points of contact:

- Patients entering the health care delivery system
- Members contacting health plan
- Sales communicating with potential members
- Brokers and employer groups communicating with potential members
- Appointment Center/medical office assistant staff

Oversight and Monitoring

The Cross-Cultural Care and Services Committee, leads the strategic development and review of initiatives related to language assistance across the enterprise. The Committee reviews implementation of the Language Assistance Plan semi-annually.

The Interpreter Services Workgroup provides enterprise-wide leadership regarding the provision of spoken and American Sign language services for limited English proficient, deaf and hard-of-hearing patients and members. The Workgroup promotes required and best practices in interpretive services system-wide, based on the principles of providing care and service to limited English proficient, deaf and hard-of-hearing patients and members which is safe, timely, efficient, equitable, and patient- and member-centered. (See Attachment C for membership of these committees)

Monitoring may be accomplished through data collection, surveys, complaint investigations, regular review, including annual executive updates, and community feedback.

We identify the languages needed by our populations throughout our enterprise in several ways.

Data Collection

- Health care delivery system data collection includes data on race, language and country of origin.
- Health plan member website data collection
- Disease- and case management data collection
- Member Services data collection
- CareLine data collection

Patient/Member Satisfaction Measures

- Patient and member satisfaction surveys

Complaints and Appeals Data and Monitoring

- Health plan data and monitoring system
- Delivery system data and monitoring system

Physician/Provider Satisfaction Measures

- Provider satisfaction surveys about interpreter services provided by vendors and employees

Community Feedback

- Annual meetings with key community organizations

Effectiveness Evaluation

- Organizational assessment indicate decline in use of family members
- Patient satisfaction increases
- Health care disparities monitoring

Senior Management Review

- Annual presentation to Strategy and Planning Committee

Regular Update Process

- Semi-annual review by the Cross Cultural Care and Services Task Force and the Interpreter Services Work Group

Attachment A: Definitions

Bilingual: a term describing a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter, but by itself, does not ensure the ability to interpret.¹

Bilingualism: ability to use two languages. Fluency in a second language requires skills in listening comprehension, speaking, reading, and writing, although in practice some of those skills are often considerably less developed than others. Few bilinguals are equally proficient in both languages. However, even when one language is dominant, performance in the other language may be superior in certain situations; e.g., someone generally stronger in Russian than in English may find it easier to talk about baseball in English.²

Interpreting: The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.¹

Interpretation: The act of receiving a message in one language and sending exactly the same message in another language through a verbal or signed exchange. Interpretation also includes body language messages.³

Encounter: (for purposes of this document) A communication event in which the services of an interpreter are required.

Limited English Proficiency (LEP) or Persons with LEP: Individuals who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. (Note: This may not be easy to identify. Some people may know enough English to manage basic life skills, but may not speak, read or comprehend English well enough to understand in a meaningful way some of the more complicated concepts they may encounter in the health and human services systems.)⁴

Sign(ed) language: Language of hand gestures and symbols used for communication with deaf and hearing-impaired people.¹

Translation: The conversion of written text into a corresponding written text in a different language.¹

¹The *Terminology of Health Care Interpreting: A Glossary of Terms*, published by The National Council on Interpreting in Health Care, 2001.

² *The Columbia Electronic Encyclopedia, Sixth Edition*, 2003, Columbia University Press.

³Durham et al, *Interpreting Services Manual*, Worcester: University of Massachusetts Medical Center, 1997.

⁴Minnesota Department of Health Glossary on www.dhs.state.mn.us

Attachment B: Demographic Description

We continually track the number and proportion of individuals with limited English proficiency in our area and organization.

Minnesota Demographics

- Minnesota's immigrant population continues to increase, according to the Minnesota Demographic Center. Here are the estimated numbers of immigrants in the state in 2004:
 - Hispanic 175,000
 - Hmong 60,000
 - Somali 25,000
 - Vietnamese 25,000
 - Russian 12,500
 - Laotian 13,000
 - Cambodian 7,500
 - Ethiopian 7,500

- In 2004, more than 9,800 immigrants came to the Minneapolis-St. Paul area, with the majority coming from Africa (3,693) and Asia (3,175).

- Minnesota's Hispanic population grew 166% during the 1990s, from 53,884 to 143,382. The number of Latinos in Minnesota is projected to grow 98 percent between 2000 and 2015. By 2030 this population will grow by 143,000 over 2000.

- Since the 2000 census, the percentage increase for Asians in Minnesota has been 18%.

- Minnesota has the largest Hmong and Somali populations in the U.S.

- Minnesota has the highest percentage of refugees of any state (30% of Minnesota immigrants are refugees vs. 10% nationally).

- In 2000, 8.5 percent of the Minnesota population spoke a language other than English at home.

- Language spoken at home for the population 5 years and over in the metro counties: Spanish or Spanish Creole 140,565; Hmong 41,878; German 37,298; African Languages 25,799; Vietnamese 18,249. (Census 2002)

HealthPartners Demographics and Data

The HealthPartners Organizational Assessment survey (2003-4) found that our top three languages are:

- Health plan - Spanish, Hmong, Somali/Russian
- Hospital - Spanish, Hmong, Russian/Vietnamese
- Clinic/providers - Spanish, Hmong, Somali

The top three languages after English in the HealthPartners Medical Group clinics are: Somali (2%), Spanish (2%) and Hmong (1%) (*November 2005*).

The hospital and clinics are collecting language, race, and country of origin data. In future, this will provide additional language information about the patients we serve.

Attachment C: Program Development & Oversight Structure

Cross Cultural Care and Service Task Force Members

Scott Aebischer, SVP, Customer Service, Product Innovation
Calvin Allen, SVP, HR & Corporate Strategic Planning
Steve Bunde, Senior Director, Corporate Integrity & Internal Audit
Jennifer Clelland, Director, Government Programs
Joe Dangor, Manager, Corporate Communications
Karen Dobbins, Senior Director, Diversity and Inclusion
Joe Hessburg, IS&T Consulting Analyst (First Trust)
Judy Jerde, Senior Nursing Project Coordinator
Pat Lund, Senior Specialist, Corporate Communications
Nancy McClure, SVP, HPMG & Clinics
Judy Moseley, VP, Patient Care Services (Regions)
Sandra Rainey, Executive Assistant, Executive Offices
Katie Sayre, SVP, Health Plan Operations & Government Programs
Jeanette TaylorJones, Manager Site Specialty Care (Riverside)
Krista Van Vorst, Strategic Health Informatics, Consultant
Deanna Varner, Community Relations Program Manager
Pat Walker, MD, Medical Director, Center for International Health, **Co-Chair**
Donna Zimmerman, VP, Government & Community Relations, **Co-Chair**

Interpreter Services Work Group

Chris Boyer, Senior Interpreter, Hearing Impaired
Steve Bunde, Senior Director, Corporate Integrity Internal Audit
Jennifer Clelland, Director, Government Programs, **Co-Chair**
Denise Edgett, Manager, Clinical Services, Integrated Homecare
Richard Flatz, Manager, Urgent Care Services
Sarah Horst, Appointment Center Trainer, Call Center
Kathy Jenkins, Spanish Interpreter, Regions Hospital
Jane Johnson, Outpatient Case Manager, Riverside Internal Medicine
Diane McGuire, Manager, Patient & Health Education
Carrie McWell, Senior Manager, Member Services, Riverview Service Center
Nancy Niggley, Sign Language Interpreter Lead
Tracy Pederson, Senior Coordinator Public Programs, Government Programs
Pat Showers, Senior Director, Dental Clinic Operations
LouAnn Thornberg, Business Systems Administrator, HealthPartners Eye Care
Michaela Timmers, Senior Manager, Member Services
Sidney Van Dyke, Manager, Interpreter Services, Regions Hospital, **Co-Chair**
Lori Wenborg, Business Systems Administrator, Surgical Specialties
Jennifer Wiltse, Manager, Provider Relations and Contracting
Donna Zimmerman, Vice President, Community & Government Relations

Attachment D: Resources

- HealthPartners Cross Cultural Care and Services Website (<http://eric>)
- www.lep.gov: Pathway to the federal government's activities on language access and includes a link to Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance
- National Standards for Culturally and Linguistically Appropriate Services in Health Care, US Department of Health and Human Services (www.omhrc.gov/CLAS)
- The National Council on Interpreting in Health Care (www.ncihc.org)
- Bridging the Language Gap: How to Meet the Need for Interpreters in Minnesota, Report from the Working Group of the Minnesota Interpreter Standards Advisory Committee
- Health and Human Services Office for Civil Rights (OCR) Limited English Proficiency (LEP) guidance (www.hhs.gov/ocr/lep)
- Diversity Rx website sponsored by the National Conference of State Legislatures, Resources for Cross Cultural Health Care, and Henry J. Kaiser Family Foundation (www.diversityrx.org)
- National Association of the Deaf (www.nad.org)
- Registry of Interpreters for the Deaf (www.rid.org)
- Midwest Center on the Law and the Deaf (www.mclld.org)