



# Language Access

Understanding the Barriers and  
Challenges in Primary Care Settings  
**PERSPECTIVES FROM THE FIELD**

Sharon E. Barrett, MS • Carley Dyer • Kathie Westpheling, MPH



## About ACU

The Association of Clinicians for the Underserved (ACU) is a nonprofit, transdisciplinary organization of clinicians, advocates, and health care organizations united in a common mission to improve the health of America's underserved populations and to enhance the development and support of the health care clinicians serving these populations. To learn more about ACU, visit [www.clinicians.org](http://www.clinicians.org).

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# Table of Contents

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<b>Executive Summary</b>	iv
<b>Language Access Barriers and Challenges in Primary Care Settings</b>	1
<b>Background</b>	1
<b>Introduction</b>	3
<b>Common Language Barriers and Challenges in Providing Care</b>	4
Organizational and Practice Issues	4
<i>Interpreter Services</i>	4
<i>Problems in Referring Patients to Specialists and Other Services</i>	6
<i>Competing Language Needs</i>	6
<i>Cost, Reimbursement and Staffing</i>	7
The Clinic Visit	8
<i>Patient Intake and Triage</i>	8
<i>Clinician-Patient Communication</i>	8
Written Forms and Patient Education Materials	9
<b>Recommendations</b>	10
<b>Conclusion</b>	13
<b>Bibliography</b>	15
<b>Appendix 1—Study Methodology and Limitations</b>	16
<b>Appendix 2—Contact Information for Sites Visited</b>	18

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## Executive Summary

**L**inguistic and cultural barriers create real threats to receipt of quality care by individuals with limited English proficiency (LEP). They also pose major challenges to safety net providers who deliver health care services to them in primary care settings.

The term LEP is used to refer to individuals who do not speak English as their primary language and who have a limited (or no) ability to read, speak, write, or understand English. Almost 20 percent of the U.S. population, or approximately 54.9 million people, speak a language other than English at home. An estimated 24.2 million people or 8.7 percent of the U.S. population are considered LEP. Although over 300 different languages are spoken in the United States, Spanish is the primary language spoken by the majority of non-English speakers.

Safety net providers—those health care clinicians that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients—deliver primary care services to a disproportionately high number of LEP patients. With growing numbers of these patients, it is important to examine language access issues within the broader context of issues that affect access to care, such as culture, literacy, and health literacy. It is equally important to identify effective strategies to address language access in primary care settings, and to consider the fiscal and social implications of not addressing this issue.

Limited information is available in the health literature on the language service issues that primary care clinicians, nonclinical staff, clinic managers, and administrators confront every day in providing services to LEP patients. This report summarizes what the Association of Clinicians for the Underserved (ACU) learned when, in 2007, it surveyed its member clinicians, health care clinics, and clinical networks about the problem. ACU visited seven clinical sites to learn in more detail about language services in safety net primary care settings. Together, the survey and site visits enabled ACU to gain a better understanding of language access barriers and challenges and the strategies used to address these problems, and to develop recommendations to improve the provision of language services.

### MAJOR BARRIERS AND CHALLENGES

ACU found that major language access issues fall into three broad categories: organizational policies and practice issues, including use of interpreters, competing language needs, patient referrals to specialists and other services, cost, reimbursement, and staffing; communication during the clinical visit; and availability and use of language-appropriate patient

forms and patient education resources. Participants identified cultural competency, literacy, and health literacy as related issues that need to be considered when examining language access barriers and strategies for improving patient-clinician communication.

## **RECOMMENDATIONS**

ACU's recommendations for reducing current language access issues in primary care settings address four broad areas and include steps to:

- Improve the quality of care by examining operating procedures and human resource policies and by endorsing national practice standards.
- Provide members of the care team and administrators with ongoing professional training to enhance language, cultural awareness, and communication skills.
- Advocate for additional fiscal support including reimbursement for the added costs of providing care to LEP patients.
- Advocate for the development and inclusion in all federal clearinghouses patient educational materials and clinical forms, written in different languages and at low literacy levels.

## **CONCLUSIONS**

This report offers a glimpse into the language challenges identified by safety net providers in primary health care clinics and the strategies they employ to meet the care needs of LEP patients. It provides constructive insights for interim measures that can be undertaken until the larger issue of limited resources available to safety net providers can be addressed. In addition, the report provides a foundation for the development of organizational policies and procedures to ensure access to care, further evaluation of language access strategies, and application of these tools in similar practice settings. The findings also promote the development of language appropriate educational materials and videos, and the use of telephone language lines and training for interpreters and clinic staff to facilitate meaningful communication between all members of the care team and LEP patients. Lastly, this report supports the need to develop reimbursement strategies and additional funding to support the cost of providing care to LEP patients.





# Language Access Barriers and Challenges in Primary Care Settings

## BACKGROUND

*A quiet gentle man approaches the clinic front desk and says nothing. The front desk personnel can see that the man is sick and in pain. When he begins to speak, the front desk staff member knows that he is using a language other than English or Spanish. She smiles, says hello and reaches for an “I Speak” poster, a sheet that lists a number of different languages. Slightly, confused, the man examines the sheet and points to Russian. Luckily, one of the clinicians knows some Russian and is paged to the front desk. At the same time, another staff member reaches for the phone to contact a telephone interpretation service to get an interpreter on the phone.*

*While use of an “I Speak” poster assisted this gentleman because he was literate in his own language, it may not help individuals who are illiterate in their native languages. In this case, the clinic would have to use other methods, such as asking for help from the clinic’s bilingual staff or using a telephone language line to help identify the patient’s language, a feature many language lines offer.*



Linguistic and cultural barriers create real threats to receipt of quality health care by individuals with limited English proficiency (LEP). They also pose major challenges to safety net providers who deliver health care services to them in primary care settings.



Siloam Family Health Center,  
Nashville, TN

Almost 20 percent of the U.S. population, or approximately 54.9 million people, speak a language other than English at home. In addition, an estimated 24.2 million people or 8.7 percent of the U.S. population have limited English proficiency. Although over 300 different languages are spoken in the United States, Spanish is the number one language spoken by the majority of non-English speakers. Traditionally, LEP individuals settled in urban areas, but increasingly they are moving to suburban, rural, and frontier areas. The fastest growth of LEP populations has been in the Southeast, the West, and in the Midwest.

Safety net providers—those health care clinicians that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients—deliver primary care services to a disproportionately high number of LEP



patients. In recent national surveys, 63 percent of hospitals and 54 percent of general internal medicine physicians reported treating LEP patients at least weekly, while 84 percent of federally qualified health centers reported treating LEP patients daily. With growing numbers of LEP patients, it is increasingly important to examine language access issues within the broader context of issues that affect access to care, such as culture, literacy, and health literacy. It is equally important to identify effective strategies to address language access in primary care settings, and to consider the fiscal and social implications of not addressing this issue.

In health care, language access services are defined as any service that helps a LEP patient obtain the same access to and understanding of health care as a native English speaker. This includes oral interpretation, written translations, signage, and the provision of services in non-English languages by bilingual clinicians. Oral interpretation can be provided by bilingual clinical staff, bilingual non-clinical staff, and professional on-site interpreters or through telephone interpretation and video-conferencing.

Under Title VI of the Civil Rights Act, any organization that receives either direct or indirect federal funding must ensure that LEP individuals have meaningful access to their programs and services. In August 2000, President Clinton issued Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*. Subsequently, the Department of Health and Human Services (DHHS) Office for Civil Rights and its Office of Minority Health issued *Standards for Culturally and Linguistically Appropriate Services* (CLAS), providing renewed emphasis on addressing language access in health care. However, the lack of direct funding for language services has made it difficult for federally funded health care systems to respond to the language needs of their patient populations. Most systems, already financially strapped, are not fully equipped to respond efficiently to the language needs of LEP populations seeking care.

It is widely accepted that use of language services benefits LEP patients in obtaining health care and assists members of the care team in providing quality health services. The accurate exchange of information between health care providers and their patients assists patients in making more informed decisions, ensures informed consent for treatment, and avoids breaches of patient-provider confidentiality. Accurate communication can prevent unnecessary tests and procedures, hospitalizations, medical errors and injuries, and expensive lawsuits. Despite the benefits of language access services, not all clinics have fully employed use of such services. As the number and distribution of LEP patients continues to grow, effective and efficient provision of viable language services in primary care facilities will remain critical to ensure health access and patient safety.



**Some facilities are able to adapt rapidly to diverse language and cultural needs; others are grappling with the issues as they arise. All are seeking strategies and tools to address these issues.**

## INTRODUCTION

Limited information is available in the health literature on language service issues with which primary care clinicians, non-clinic staff, clinic managers, and administrators grapple daily in communicating with LEP patients who require primary or acute medical care. Although some studies have examined clinician practices in hospital-based and small private-practice settings, little qualitative research has specifically focused on frontline providers in community health centers (CHCs), federally qualified health centers (FQHCs), free clinics, full-service health departments, or faith-based primary care centers. The perspectives of such safety net providers are critical. These providers often serve as a patient's first introduction to the health care system and can influence the patient's attitudes, treatment compliance, and any future engagement with the system. In addition to not speaking English well, these patients may not be fully literate in their native language. Care team members need communication skills and tools to engage LEP patients to diagnose their health conditions and jointly develop appropriate treatment plans. Information from these safety net providers can be used to shape care practices and influence policy recommendations for language access services, patient safety, and care quality.

In 2007, the ACU conducted a national survey of its member clinicians, health care clinics and clinical networks. From among the survey respondents, ACU selected six primary care clinics for more extensive interviews during site visits to obtain more in-depth information about language services in safety net primary care settings. The purpose of the survey and site visits was to gain a better understanding of language access barriers and challenges, the strategies the participants use to address these problems, and to develop recommendations to improve the provision of language services. Additional information on the study methodology is provided in Appendix 1; a list of the clinics that participated in site visits is provided in Appendix 2.

Other than English, the primary language spoken by patients at the participating clinics is Spanish. Other languages such as Urdu, Russian, Hmong, Tagalog, Chinese, Japanese, Vietnamese, and African and Arabic languages are encountered periodically, depending upon the location of the facility. As different populations migrate into communities in response to social, economic, or other opportunities, the predominant language spoken within the community may change and community-based clinics need to adjust to meet the needs of these emerging populations. Primary care facilities that may have customized their services for a specific population are faced with providing services to multiple racial and ethnic populations with distinct cultural beliefs and language requirements. Some facilities are able to rapidly adapt to the diverse language and cultural needs; others



are grappling with the issues as they arise. All are seeking strategies and tools to address these issues.

## **COMMON LANGUAGE BARRIERS AND CHALLENGES IN PROVIDING CARE**

Language barriers influence how care is planned and delivered. As expected, clinic managers and facility administrators are concerned with having adequate organizational policies and operating procedures in place, qualified staff, and adequate financial support. The care team is more focused on communication challenges, including the literacy and health literacy levels of the patients, demonstrating cultural sensitivity during and after the clinic visit, and identifying appropriate clinical forms and patient education resources in various languages.

### **Organizational and Practice Issues**

#### ***Interpreter Services***

The availability, scheduling, and quality of interpreters are major issues for many of the primary care clinics, especially in those sites without staff interpreters. The biggest concern is having competent interpreters on-site or available in a timely manner, especially for acute or emergency care.

Some LEP patients, unaware of interpreter services in the clinics, ask an English-speaking friend, neighbor or a community member to serve as their interpreter. Problems arise if these individuals assume an advocate role or suggest treatment options to the clinician instead of serving in the interpreter capacity, which requires the interpreter to only interpret what is said by the patient and provider. These individuals may also provide personal opinions or summarize what is being said by the clinician rather than accurately interpreting. To avoid awkward situations and ensure competent interpretation, front desk personnel should advise patients of the availability of telephone interpreter services and schedule interpreters to be on-site when LEP patients have appointments.

When a trained interpreter is not available, some clinics turn to trained and non-trained volunteer interpreters who are familiar with the different dialects spoken in the community. These individuals may be used when a patient speaks an uncommon dialect not readily available through the telephone language lines. These individuals may not be as proficient in medical terminology as desired, or understand the process for successful interpreting, but they provide assistance until the language service can locate an appropriate interpreter.

Some sites employ individuals and health professionals from the community. At the Estancia Public Health Office (Estancia, N.M.), the receptionist

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**Currently, there are no national standards for assessing interpreters' literacy or health literacy levels in either their native language or in English.**

and triage staff member is bilingual, knows many of the patients, and has established trusting relationships with them. This individual also serves as an interpreter for the non-bilingual clinicians who perform service rotations at the clinic.

Use of telephone interpreter services varies from facility to facility. Some report limited use of telephonic language services even where the phone numbers are posted, and phones and outlets are available in the exam room; others depend upon this tool regularly. One clinician reported, "I feel awkward talking on the phone in a three-way conversation to discuss a patient's health condition or treatment plan and would prefer the interpreter being present in the exam room."

The assurance of quality and accuracy in interpretation is another challenge for non-bilingual clinicians when the interpreter is available only through the telephone. Another clinician reported, "It is sometimes difficult to determine if the patient understands when the interpreter is present and even more difficult when the services are being provided through telephone language lines...I must, however, trust the interpreter's skill sets and rely on my gut feelings...and the vocal inflections and facial expressions of the patient to determine if communication is effective."

A number of facilities are not equipped with phone lines, outlets, or speakerphone capabilities in each exam room. Administrators refer to cost as a barrier for supplying each exam room with the necessary equipment. Facilities that use telephone language services on a regular basis generally have an 800 access number visibly posted in each exam room. The amount of staff training on how to work with telephone interpreters may influence the use of these services. In facilities where training has occurred, use of such services is more frequent.

Facilities would like access to more on-site interpreters competent in the languages needed by clinic. Identifying and retaining these professionals is a recurring problem. Some facilities report that once trained, interpreters frequently seek out higher salaries in other types of health care settings, rather than staying in the safety net settings. Some facilities will pay or contribute a portion of the cost of interpreter training for a specified period of time. During the training, participants also discuss topics such as the role of the interpreter, ethical issues, confidentiality, etc. They may then be tested to determine language comprehension and verbal skills in the specified language. Currently, there are no national standards for assessing interpreters' literacy or health literacy levels in either their native language or in English. A few states (Indiana, Massachusetts, North Carolina and Oregon) are exploring these issues but these vary considerably.



### ***Problems in Referring Patients to Specialists and Other Services***

Clinics often encounter problems when referring patients to specialists and other services outside of the clinic. There are a limited number of specialists who conduct pro bono work or accept uninsured patients, and even fewer who offer interpreter services. Patients with some form of insurance may have better access to specialists, but they experience similar challenges if language is an issue. Specialists in solo or small-practice settings do not routinely maintain interpreter services. Depending on their size, X-ray and imaging centers may or may not have adequate interpreter resources available. Therefore, clinics generally try to make arrangements for interpreter services for non-English speaking patients whom they refer to specialists, regardless of their insurance status.

Scheduling interpreters to assist patients when referrals are made to outside specialists or hospitals can be challenging and costly. Interpreters are generally compensated on an hourly basis, including travel time and the time spent waiting with the patient to see the clinician. If the interpreter misses the appointment, the patient must either reschedule or forgo the service. In some cases, a bilingual staff member, because of a personal interest in the patient's condition, will accompany the patient to the outside specialist. These individuals do this on their own time without compensation or reimbursement. In other cases, patients ask a family member or friend who speaks English to accompany them to any visits outside of the clinic.

Through a contract with the District of Columbia, La Clinica del Pueblo (Washington, D.C.), the study's pilot test site, has assumed citywide responsibility for coordinating LEP patients and interpreters at health sites where there are no on-site interpreters. The clinic utilizes special online software to receive and manage requests for interpreters for their clinic and other health care systems in the D.C. metropolitan area. The clinic has a database of qualified interpreters and is able to efficiently schedule interpreters with LEP patients who are referred to specialists in private practices, to labs, imaging centers, and hospitals where interpreter services are not available in-house. Siloam Health Care Center (Nashville, Tenn.) has assumed similar responsibilities in the Nashville area. Funding from a state contract for mainstreaming and assisting immigrants and refugees entering the United States assists in region-wide coordination of interpreter services.

### ***Competing Language Needs***

Primary care clinics may experience additional challenges when a patient's language is different from the ones most commonly encountered. Through needs assessments and outreach into the community, clinics try to stay

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attuned to any changes in demographics. Yet, one clinician stated, “We realize that we may not always be prepared for every patient that may walk through the door. We have addressed, however, the language issues related to Spanish...by virtue of its prevalence in the community.”

Sometimes clinics are limited in their ability to access interpreter services quickly enough when confronted with less common languages, dialects or slang. When faced with these kinds of language needs, clinics initially rely on creative approaches, especially in acute care situations.

In one clinic, a patient only spoke Mandarin, a language not often heard in this particular clinic. Although the clinic called the telephone language line, an interpreter familiar with Mandarin was not readily available. Luckily, the patient had a friend who spoke English and Mandarin and was able to reach the friend on his cell phone. Although the process was slow, the clinic staff was able to triage and preliminarily diagnose the patient’s health condition. In another clinic, a similar language situation occurred. The triage personnel contacted a neighboring primary care facility where a staff member spoke the language of the patient. A three-way dialogue took place and the patient received treatment.

**Clinics find that recording the preferred language, either manually or electronically, in the patient’s record or chart assists all members of the care team.**

In another clinic, a patient spoke Mixteco, an indigenous dialect from Central America. Staff was unfamiliar with the dialect and the telephone language line had to locate an interpreter who spoke Mixteco. Fortunately, another patient in the clinic waiting room could speak Spanish as well Mixteco. The patient who only spoke Mixteco welcomed the help of the other patient, enabling the clinicians to get a general understanding of the first patient’s health issue. Although this raised concerns about the accuracy of the interpretation and confidentiality issues, it allowed time for the telephone language services to locate an interpreter familiar with the dialect. Staff agrees that use of this approach is only acceptable for time-limited necessary interactions and should not be relied on for most interactions.

### ***Cost, Reimbursement and Staffing***

Clinics generally receive no reimbursement for the additional time that may be required to counsel or educate LEP patients concerning their health condition, treatment plan, or medication management. Other costs absorbed by the clinics may include on-site interpreter fees, subscription costs for use of language line services, employee training, and for patient education materials or videos in appropriate languages. Most clinics do not have sufficient funding to support either on-site language classes or those at local community colleges or other training sites. Some employees pay out of pocket for these courses and participate in cultural sensitivity and health literacy seminars at professional conferences they may attend.



Adequate and appropriate staffing is an ongoing challenge. Salary levels at community-based primary care facilities may be lower than in other practice settings. Clinicians and administrators encounter difficulties in attracting, hiring, and retaining bilingual staff. Although some clinics are able to support a small financial incentive to attract bilingual applicants, most care team members usually do not receive additional bonuses or salary differentials for their language skills. One administrator reported, “Given the populations we serve, salary levels are calculated taking into consideration that most positions require bilingual professionals.”

Clinicians also express concern about limited access to after-hours bilingual services. One clinician stated, “The possible lag time in treating or providing follow-up to LEP patients after clinic hours adds additional stress to the entire clinic care team.” Non-bilingual providers on call might receive critical lab results for a LEP patient in the evening or after clinic hours. Clinicians may not be able to communicate with these patients unless they can reach a bilingual clinician or can return to the clinic to access telephone interpreter services. In some cases, the clinician on call may have to wait until the following day to communicate through an interpreter or staff member, possibly affecting the quality of care the patient is receiving.

## **The Clinic Visit**

### ***Patient Intake and Triage***

During intake, patients are often asked in which language they converse when at home. Clinics find that recording the preferred language, either manually or electronically, in the patient’s record or chart assists all members of the care team. It alerts front desk staff that an interpreter or bilingual staff member may be necessary to secure informed consent and complete patient intake forms. It also guides them in scheduling future appointments, in how to leave messages, how to communicate referral information and in deciding whether an interpreter may be needed to conduct follow-up calls. It alerts triage staff that an interpreter or bilingual staff member may be needed for communicating with clinicians during the clinical encounter. In clinics that do not routinely record the patient’s language preference, staff will not have the necessary information to allow appropriate advance scheduling of interpreters.

### ***Clinician-Patient Communication***

Clinician-patient communication during the clinical visit may be time consuming when language is an issue. Working with interpreters can be cumbersome, especially if a non-bilingual clinician has limited experience or training on how to use interpreters effectively. Often, there are no equivalent words for medical terms in a patient’s native language; for example, there is no exact Spanish translation for terms such as gallstones or blood thinners. This may make it difficult for the clinician to convey

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**Costs and other liabilities associated with translating forms from English to other languages make in-house development difficult.**

**Availability and access to a central repository of forms and educational resources would provide health facilities the capability to download accurate and timely information as needed.**

a diagnosis and equally confusing for LEP patients to understand their health condition(s). One clinician reported, “LEP patients are less likely to ask questions when I cannot speak their language.” Another clinician added, “It is difficult to provide general health education information to LEP patients unless I have a good grasp of the language or they speak English.”

Some clinicians supplement the dialogue with LEP patients by using hand and facial gestures, diagrams, and picture boards. Other clinicians may seek the help of their community outreach workers and *promotoras*. Although there are possible quality control and accuracy issues with materials that are downloaded from the Internet, staff turn to the Internet for printed materials that are written in the patient’s language or videos produced in the patient’s language.

A particular concern is medication management and patients’ ability to understand medication instructions. Some clinicians are able to write the script in Spanish. Most rely on the pharmacist to translate the directions into the appropriate language. Pictures and symbols are placed on the prescription label to help patients understand the purpose of the medication and when to take it. Patients are also asked to bring all of their medications to each clinic visit for review and clarification on their use.

Clinicians cite concern about the use of family members, children, or friends as interpreters. On occasion, LEP patients request that an English-speaking family member serve as the interpreter. Most clinics try to limit use of this approach to emergency situations because of patient confidentiality and the need to have the patient fully disclose all symptoms and give a complete medical history. One clinician stated, “I discourage use of a family member serving as an interpreter even when a patient requests that a family member interpret. I don’t think patients fully appreciate their own need for confidentiality or the types of questions I may need to ask. Sometimes questions asked may place patients in an awkward position and they may not always reveal all of the medically necessary information. This is especially true if that family member serving as an interpreter is a young adult. The only time I will use a family member is in an emergency.”

### **Written Forms and Patient Education Materials**

The lack of availability of intake, consent, and patient confidentiality forms in a patient’s native language can be a major access barrier for LEP patients. Costs and other liabilities associated with translating forms from English to other languages make in-house development difficult. Although some clinicians have found language resources and patient education materials in appropriate languages on the Internet, knowledge about these materials is limited. In addition, unless materials are reviewed or come



from a reliable source, materials from a Web site may provide inaccurate, inadequate, or inappropriate information. Often, there is very little quality control on information secured from a Web site. Dissemination of such materials can be more problematic than useful, especially for patients not familiar with their health condition(s) or medications.

Clinicians consistently ask if there is a central repository on the Internet for securing sample forms and patient education materials in various languages, written at low literacy levels. Availability and access to this kind of resource would provide health facilities the capability to download accurate and timely information as needed, minimizing the need to stockpile educational resources that might become outdated and unused.

## RECOMMENDATIONS

It is generally acknowledged that the structure, mission, and operating philosophy of a health care organization create the environment for how care is provided. As health care teams implement principles of patient-centered care, organizations must have in place the supports, practices, resources, and opportunities for its staff to learn and enhance core competencies to meet the needs of its users. Positive health outcomes require that patients also have the skills to manage their care in the home environment. Adequate communication between the care team and patients is essential for any level of success. Given the additional challenge when communication may be in a language other than English, clinics must take certain actions to assure the same level of quality care is being provided. Recommendations include:



### **1. Develop written operating procedures and human resource policies to support language access.**

In clinics serving LEP patients, written policies and practice procedures supporting language access should be evident at all levels within the organization to ensure that all individuals have equal access to the same care. Organizations should be familiar with the intent of Title VI and the CLAS standards, regardless of whether the clinic is receiving federal funding.

All organizations should determine if they have written operating policies and procedures governing the following activities:

- Operating policies for hiring or engaging appropriate interpreters, translators, and bilingual clinical and non-clinical staff. Hiring announcements might state that preference will be given to individuals who are bi/multi-lingual, especially for positions

requiring the individual to work with patients who may have limited English or no English skills.

- Organizational policies for providing care to LEP patients should include a complaint process specifically for patients who feel that they have been discriminated against or received inadequate care due to language barriers.
- Board development policies should support and reflect the patient population.

**2. Appointment scheduling for LEP patients should take into account the availability of language services and facilitate tracking the language service needs of the community.**

Coordinating LEP patient appointments with interpreters can be time consuming and demanding. Clinics should explore the feasibility of using available software to plan for and track LEP appointments and language service needs. Increased attention to appointment scheduling of LEP patients may improve care management by ensuring that appropriate interpreters are present at the time of the appointment, whether in the facility, the hospital or for visits to specialists without on-site interpreters. This would also allow facilities to better understand their own needs, better coordinate care management, and project language access service needs of their communities.

**3. Install telephone language service lines in exam rooms.**

Facilities should strongly consider installing telephonic or video capabilities in all exam rooms or, at a minimum, in designated exam rooms to facilitate access to telephonic or video interpretation. With proper training, care team members would then be able to communicate with patients using telephone interpreter services more efficiently. These capabilities would allow the clinician and patient to focus on the patient's health care concerns and goals.

**4. Provide employees periodic mandatory training to enhance their language, culture competency and communications skills.**

In primary care facilities where languages other than English are spoken, staff should participate in periodic mandatory training to enhance their language, culture, and communication skills. Each new hire should receive an employee manual containing the organization's LEP policies and practices, Title VI requirements and CLAS Standards, available language resources used by the clinic, and any tools that facilitate communication to LEP patients.



Staff orientations might include:

- a review of the organization's philosophy, practices and procedures for providing care to LEP patients;
- specific training on improving skills in communicating with LEP patients;
- the value of understanding the literacy levels of patients and the implications for care; and
- an understanding of cultural differences and the implications for patients' care-seeking behaviors.

In addition, resources should be made available to support staff who would like to develop speaking proficiencies in Spanish and other relevant languages. A clinic, however, should ensure that only those with sufficient skills, both in the target languages as well as other necessary skill sets, are used as interpreters or translators.

**5. Require interpreters and bilingual staff providing services in languages other than English to adhere to the National Center on Interpreting for Health Care (NCIHC) Code of Ethics and Standards of Practice.**

Currently, there are no national standards in place for interpreters or bilingual staff providing services directly in non-English languages. A handful of states have developed some form of standards. NCIHC is a multidisciplinary organization that has as its mission the promotion of culturally competent professional health care interpreting as a means to support equal access to health care for individuals with limited English proficiency. Until federal or state policy makers require certification of language skills and promote a set of competencies for interpreters, NCIHC's Code of Ethics and Standards of Practice should be promoted as a mechanism to govern the roles, responsibilities and actions of interpreters. Bilingual staff that provide services directly in non-English languages would be held accountable to the same Standards of Practice and Code of Ethics.

**6. Advocate for additional fiscal support and reimbursement for the costs of providing care to LEP patients.**

Additional reimbursement or higher compensation for providing services to LEP patients is suggested as a method of subsidizing or underwriting clinics that routinely provide a large amount of healthcare services to LEP patients. Reimbursement would be calculated at a level that would allow clinicians the flexibility of partnering with interpreters to explain and answer questions concerning the patient's health condition(s) and treatment options. Case managers, social workers, *promotoras* and community outreach workers would be compensated for any consultation

**Given the rapid pace with which communities are changing, safety net providers may not be able to keep up with the various language needs of their LEP patients unless provided the necessary resources.**

and education of LEP patients. Funding could occur through existing payment mechanisms (such as Medicaid, SCHIP, or FQHC prospective payment systems) or be based on new approaches.

**7. Advocate for the development of patient education materials and clinical forms in languages other than English and at low literacy levels and their inclusion in all federal clearinghouses.**

Primary care facilities are seeking clinician-friendly tools, sample clinical forms and patient education materials and videos that are targeted to their LEP populations. Some materials can be found on the Internet, but no guidelines exist that require products to be developed in multiple languages or categorized by literacy level. Federally-funded clearinghouses should be required to develop and identify patient education materials and videos in languages other than English and Spanish that are written for low literacy populations. Any materials should be easily identified by accessing the Internet and searching for LEP resources. Resources might include:

- written patient education materials and audio-visual materials ranging from general prevention messages to disease specific information;
- sample universal patient intake and consent forms, HIPAA templates; and
- prewritten language sheets, perhaps containing symbols or illustrations, for communicating with patients for activities such as drawing blood, collecting urine samples, and other specific procedures; and
- a database of language access services available by geographical locations that could guide facilities to the services provided by each.

## **CONCLUSION**

A commitment to care management, health care quality and patient safety drives the efforts of frontline providers in meeting the care needs of all patients, including those with LEP. To do this requires a multifaceted approach that affects every level of the health care clinic and includes every member of the care team. This report reflects ACU's synthesis of the findings from the study. Seven recommendations are suggested for enhancing the practices currently used to reduce language barriers and challenges confronted by safety net providers serving LEP patients. These recommendations support the *Language Access in Health Care Statement of Principles*, developed by NHeLP and a broad coalition of national organizations. This coalition seeks to develop a consensus-driven agenda to improve policies and funding for access to quality health care for LEP individuals.



The recommendations also complement the DHHS Office of Minority Health's recently released publication, *A Patient Centered Guide to Implementing Language Access Services in Healthcare Organizations*. The guide provides suggestions for clinicians and clinics wishing to implement language access services for LEP patients in a variety of care settings.

Primary care clinicians continue to be proactive in their efforts to meet the health care needs of LEP patients. Compelled by compassion and a strong commitment to provide quality care to all patients, they are employing creative approaches for communicating with LEP patients. Given the rapid pace with which communities are changing, safety net providers may not be able to keep up with the various language needs of their LEP patients unless provided the necessary resources to hire and retain bilingual staff, access interpreters through telephone language lines, participate in ongoing skills training, and have access to tools and evidence-based strategies for communicating effectively.

This report offers a glimpse into the language challenges identified by safety net providers in primary health care clinics and the strategies employed to meet the care needs of LEP patients. It was written to provide constructive insights given the limited resources available to safety net providers. It provides a foundation for the development of organizational policies and procedures to ensure access to care, further evaluation of language access strategies and application of these tools in similar practice settings. The findings also promote the development of language-appropriate educational materials and videos, use of telephone language lines, and training for interpreters and clinic staff to facilitate meaningful communication between all members of the care team and LEP patients. Lastly, this report supports the need to develop reimbursement strategies and additional funding to support the cost of providing quality health care to LEP patients.

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## Appendix 1—Study Methodology and Limitations

In 2007, ACU conducted a two-phase descriptive study to examine language service issues of safety net providers. The study sought information on how these problems are being addressed and recommendations on how to improve the provision of language services. During the first phase, ACU collected baseline information through an online survey about language service challenges and barriers that primary care clinicians and health care facilities face across the country. In the second phase, demographic data from the survey pool of 222 respondents was stratified by:

- the setting of the health care facility (urban, suburban, rural or frontier);
- the type of facility (Community Health Centers, Federally Qualified Health Centers, free clinics, hospital-based ambulatory care facilities, health department clinics, residency based facilities, faith based clinics and other facilities);
- the barriers and challenges; and
- the diversity of languages spoken at the facility.

Six primary care sites were selected from the sample pool to participate in more detailed analysis. Selection criteria included diversity of the facility type, geographic location, population served, languages spoken and problems identified. The sites that agreed to participate included:

- The Bailey's Health Center, Falls Church, Virginia (full-service county health department, suburban)
- The Estancia Public Health Office, Estancia, New Mexico (full-service local department of health, frontier)
- Telluride Medical Center, Telluride, Colorado (community health center, rural)
- Siloam Health Care Center, Nashville, Tennessee (faith-based primary care center, suburban)
- Cross-Over Health Ministry, Richmond, Virginia (faith-based primary care center, urban)
- Northeast Missouri Health Council, Inc., Kirksville, Missouri (federally qualified health center, rural)

Three interview guides (one for clinicians, one for administrators, and one for front desk personnel) were developed by adapting the interview

guides developed for ACU's health literacy study, *Health Literacy Practices in Primary Care Settings: Examples From the Field* and by incorporating appropriate questions from the survey instrument used in the language access study *Hospitals, Language, and Culture: A Snapshot of the Nation*. These interview guides were pilot tested by interviewing clinicians, administrators, and front desk personnel during a one day site visit at La Clinica del Pueblo in Washington, D.C. Based on responses to the questions in the interview guides, revisions were made and the guides were finalized.

Interviews were conducted on-site with members of the care team including: physicians, nurses, nurse practitioners, medical assistants, social workers, psychologists, promotoras, outreach workers, lay health workers, administrators and managers, and front desk staff to further explore the language access barriers and challenges identified in the online survey, strategies used to address these issues, and recommendations for improving the provision of language services during clinical visits.

## STUDY LIMITATIONS

The barriers and challenges in this report reflect a synthesis of the collective perspectives of safety net providers from the online survey and from the six primary care sites visited. As with any self-reported information, the data reflect the experiences and personal knowledge of respondents and interviewees. Budget limitations precluded additional site visits. Given the reoccurring themes articulated by the study participants, ACU feels that it has captured the current perspectives of safety net providers on barriers and challenges they face in delivering health care services to LEP patients.



Community Health Partners Inc., Livingston, MT



## Appendix 2—Contact Information for Sites Visited

SITE	TYPE	LANGUAGES ENCOUNTERED
<b>La Clinica del Pueblo</b> Isabel Van Isschot Director of Interpreter Services Department 2831 15th Street, N.W. Washington, DC 20009 202-464-0157 • 202-328-3560 fax iisschot@lcdp.org • www.lcdp.org	Urban Federally Qualified Community Health Center—Pilot Site	Spanish, Urdu
<b>Telluride Medical Center</b> Beth Kuperman Director of Bilingual Medical Programs and Patient Relations PO Box 1823 • 500 W. Pacific Avenue Telluride, CO 81435 970-728-3848 • 970-728-3404 fax beth@tellmed.org	Rural Community Health Center	Chinese, Italian, Polish, Russian, Serbo-Croatian, Spanish, Vietnamese
<b>Cross-Over Ministry</b> Sheila Pour, PA-C Physician Assistant 108 Cowardin Avenue Richmond, VA 23224 804-233-5016 ext. 110 <i>front desk phone</i> 804-231-5723 fax personal email pour@netzero.net	Faith-Based Organization Urban Free Primary Care Clinic	Arabic, Chinese, French, Hindi, Hungarian, Korean, Persian, Portuguese, Serbo-Croatian, Spanish, Tagalog, Urdu, Other Various African Languages
<b>Northeast Missouri Health Council, Inc</b> Marca Cenatiempo, MBA, LCSW HDC/Grants Coordinator 314 East McPherson Kirksville, MO 63501 660-627-5757 ext. 30 • 660-627-5802 fax mcenatiempo@nmhcinc.org	Rural Federally Qualified Health Center	Spanish, Russian, Japanese, Swahili
<b>Estancia Public Health Office</b> Audrey M. Rodriguez, RN Nurse Manager 300 S. 8th Street • PO Box 107 Estancia, NM 87016 505-384-2351 • 505-384-2626 fax audrey.rodriguez@state.nm.us	Frontier Full Service Local Health Department	Japanese, Spanish
<b>Bailey's Health Care Center</b> Christina Stevens Program Director, Fairfax County Community Health Care Network 6196 Arlington Boulevard Falls Church, VA 22044 703-531-3859 • 703-246-2962 or 2411 703-246-8766 fax christina.stevens@fairfaxcounty.gov	County Managed Primary Health Care Center	African languages, Arabic, Armenian, Chinese, French, French Creole, German, Greek, Gujarati, Hebrew, Hindi, Hungarian, Italian, Japanese, Korean, Laotian, Miao Hmong, Mon-Khmer Cambodian, Navajo, Persian, Polish, Portuguese, Portuguese Creole, Russian, Scandinavian languages, Serbo-Croatian, Spanish, Tagalog, Thai, Urdu, Vietnamese, Yiddish
<b>Siloam Family Health Center</b> Mark McCaw, MSSW Program Administrator 820 Gale Lane Nashville, TN 37204 615-298-5406 ext. 111 • 615-555-4010 fax Mark.McCaw@siloamhealth.org	Christian Ministry Urban Free Primary Care Clinic	African languages, Arabic, Chinese, Burmese, French, French Creole, German, Hindi, Kirundi, Korean, Laotian, Persian, Russian, Serbo-Croatian, Spanish, Somali Tagalog, Urdu, Vietnamese





Association of Clinicians for the Underserved  
1420 Spring Hill Road, Suite 600  
McLean, VA 22102  
[www.clinicians.org](http://www.clinicians.org)



National Health Law Program  
1444 I St NW, Suite 1105  
Washington, DC 20005  
[www.healthlaw.org](http://www.healthlaw.org)