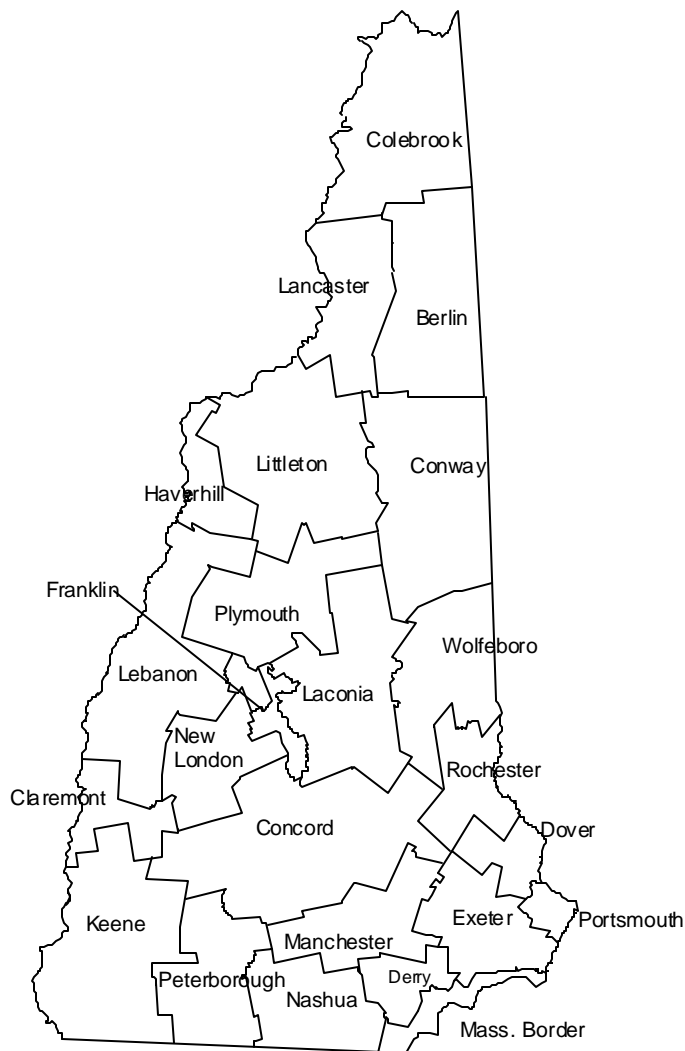


# Assessing Language Interpretation Capacity Among New Hampshire Health Care Providers



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**Funded by the Endowment for Health**

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**The Cultural Imperative** recognizes culture in its diversity and its value in all aspects of our work and life. Our mission is to help individuals and organizations understand and utilize the diverse cultures in their organizations and their marketplaces: strengthening each client's cultural competence. The Imperative offers keynote presentations and workshops, organizational assessments, strategic planning, and executive coaching to clients in health care and a variety of other industries. The Imperative was co-founded by Principals Beau Stubblefield-Tave and Roger Husbands.

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**The Endowment for Health** is a statewide, independent, private, non-profit foundation created in 1999 as a result of the sale of Blue Cross Blue Shield New Hampshire to Anthem Insurance Companies, Inc. The mission of the Endowment for Health is: *To improve the health and reduce the burden of illness of the people of New Hampshire.* The theme of Social-Cultural Barriers to Accessing Health was chosen by the Endowment's Board of Directors, in conjunction with its Advisory Council, as one of four critical health issues affecting New Hampshire residents.

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## TABLE OF CONTENTS

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<b>Executive Summary .....</b>	<b>1</b>
<b>Introduction.....</b>	<b>4</b>
<b>Methods .....</b>	<b>10</b>
<b>New Hampshire Demographics .....</b>	<b>13</b>
<b>Findings From the Key Informant Interviews .....</b>	<b>14</b>
<b>Facility Survey Findings .....</b>	<b>16</b>
<b>Interpreter Survey Findings .....</b>	<b>21</b>
<b>ASL Interpreter Survey Findings.....</b>	<b>24</b>
<b>LEP Focused Discussion Groups .....</b>	<b>27</b>
<b>Key Findings .....</b>	<b>31</b>
<b>Next Steps.....</b>	<b>34</b>
<b>Acknowledgements .....</b>	<b>41</b>
<b>Appendices.....</b>	<b>43</b>

“ *The languages coming through the emergency department here keep changing. It's my experience that refugees come in waves; the last few years it was Bosnian refugees, most recently it was African refugees. We rely pretty heavily on the AT&T language line. It slows everything down but I want to give good care so I take the extra time. All are very grateful and polite. My hospital doesn't use in-house interpreters. I often turn to the security guard to interpret for Spanish speakers who come in without their family members. Even though the rules are clear that we are not supposed to use family members, it would be pretending to say that we don't. We need more resources to meet this growing need.*”

- ER physician from Hillsborough County

## **EXECUTIVE SUMMARY**

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The New Hampshire Medical Interpretation Capacity Assessment (MICA) offers a review of the health care language support needs of New Hampshire residents who have limited English proficiency (LEP) and/or who are deaf or hard of hearing (D/HoH). The need to provide quality care, minimize risk exposure, follow legal mandates, respond to changing demographics, and help eliminate disparities are all powerful forces. They encouraged the Endowment for Health and a diverse coalition of providers and advocates to examine the medical interpretation capacity of health care providers statewide. This report identifies and addresses language service issues and suggests a set of next steps to reduce the gap between the medical interpretation needs of D/HoH and LEP patients in the state and the health care system's capacity to serve those needs.

The process was designed to build on existing data resources while collecting new data from:

- Health care providers at hospitals, community health centers, community mental health centers and oral health clinics;
- Interpreters serving both the LEP and Deaf communities;
- LEP patients and community residents as well as advocates from the D/HoH and LEP communities; and
- Policy makers and content experts at the state, local and national levels.

In addition to these data sources, this report is informed by the strategic planning process of the Medical Interpretation Advisory Board (MIAB).

### **DEMOGRAPHICS**

While a vast majority of New Hampshire residents are native born and speak only English, there is a significant and growing group of foreign-born residents, many of whom do not speak English very well. Since 1990, there has been a 22% growth in this limited English proficient population. The state's approximately 30,000 LEP residents are concentrated in southern New Hampshire. Census 2000 data show that Hillsborough County, which includes Manchester and Nashua and which accounts for 31% of the state's population, is home to 48% of the foreign born population, 59% of the Hispanic or Latino population, 57% of newcomers who had immigrated since 1990, and 53% of residents with limited English proficiency.

### **KEY FINDINGS**

#### ***Healthcare facilities:***

- Provider organizations varied widely in their collection, analysis and use of medical interpretation data. We identified a lack of systematic data collection within healthcare facilities. Few organizations were able to easily report on service area and patient needs, or the volume and cost of services provided.
- The demand for interpreter services is increasing and new languages are being spoken throughout the state; 25 of 42 respondents said that the demand for language services has increased over the past few years.

- Provider organizations varied widely in their communities' medical interpretation needs and their own level of services, commitment and resources.
- For purposes of analysis we compared Hillsborough County, which includes the state's most diverse communities, to responses from the rest of the state. Providers from Manchester and Nashua serve a much greater proportion of LEP patients: about one in seven (14%) patients in those facilities that reported their LEP volume, compared with about 2 percent among the non-Hillsborough providers. Facilities that responded in Nashua reported a third of their encounters (32%) were with LEP patients.
- Eighty-five percent of Hillsborough County providers (11/13) use outside paid interpreters as part of their language service strategy compared with 55% of facilities (16/29) outside of Hillsborough, perhaps reflecting interpreter availability. Providers outside of Hillsborough County are more likely to use staff interpreters and bilingual clinical staff as interpreters in serving LEP patients' needs.
- Spanish, French and American Sign Language are the most frequently reported languages needing interpreters. Twelve of the 42 facility respondents reported encountering less common languages such as Arabic, Chinese, Farsi, Korean, Russian and Swahili, an indication of the diversity of language service needs throughout the state.
- The interpreter resources that facilities reported using with the greatest frequency were, in descending order, externally paid interpreters, bilingual clinical staff, bilingual non-clinical staff, and telephone services. At the other end of the spectrum, a substantial portion of facilities reported never using certain resources, such as video interpretation services, volunteer interpreters, ASL interpreter agencies, and staff interpreters.
- The cost and scheduling of interpreters and extended visit time were identified as key problems by facilities. Securing interpretation services for languages infrequently spoken at a given facility (in particular American Sign Language, Vietnamese and Portuguese) was problematic.
- Facilities were more likely to have signage and written materials translated if they saw many LEP patients. Most low volume facilities reported that they had few materials translated.

### ***Interpreters:***

- Interpreters identified compensation as a challenge. On average, spoken language interpreters earn \$15 an hour compared to an average of \$32 an hour for ASL interpreters. The salaries of freelance spoken language interpreters, however, were comparable to those of ASL interpreters.
- Three others items were identified as a source of dissatisfaction for both types of interpreters: travel time, short notification, and the perception that doctors and nurses do not know how to work with interpreters. Many stated that not enough time is allotted for patient visits.

### ***Limited English proficient individuals:***

- Some LEP respondents were pleased with their experience, especially at community health centers. However, the majority of LEP discussion group participants reported

that they must bring their friends, children or other family members with them to interpret for medical appointments. Nearly half believed it was their responsibility to provide or pay for an interpreter.

- Many participants said that they postpone or delay care because they do not have an interpreter available. This was more common for the people who usually use hospitals than for those at health centers. They reported that they often cancel or change their appointments if they can't find someone to bring along to serve as an interpreter.
- Emergency Departments were a common site of care and an important place to have language services available for patients.

## **RECOMMENDATIONS**

- Collect language, race, ethnicity and other demographic data systematically.
- Become more aware of needs by engaging with the community and by monitoring patient satisfaction.
- Address the availability of interpreter services and inform patients of their right to an interpreter.
- Assess and continually improve the quality of interpreter services.
- Explore innovative methods for pooling resources, especially for individual facilities with a low volume of LEP patients.
- Train employees about a patient's right to an interpreter, as well as how to access and work with interpreters.
- Make translation of written materials an integral component of delivering appropriate practices.
- Continue the exchange of best practices between Deaf and Hard of Hearing community and Limited English Proficient advocates.
- Encourage public-private partnerships and broader state involvement.
- Evaluate language proficiency of staff.
- Create ongoing monitoring and public reporting on the state of medical interpretation and its impact on health status of New Hampshire's D/HoH and LEP residents.
- Conduct conversations with health care leaders.

## INTRODUCTION

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The New Hampshire Medical Interpretation Capacity Assessment (MICA) was conceived and funded by the Endowment for Health as an inclusive review of the health care language support needs of New Hampshire residents who have limited English proficiency (LEP) and/or who are Deaf or Hard of Hearing (D/HoH). Beginning in September of 2003, the effort was directed by The Access Project and the Stubblefield-Tave Group (which recently became part of the Cultural Imperative).

The assessment intended to identify and address language service issues and to suggest a politically and financially feasible set of next steps to reduce the gap between the medical interpretation needs of Deaf or Hard of Hearing and LEP patients in New Hampshire and the health care system's capacity to serve those needs. The process was designed to: build on existing data resources while collecting new data from health care providers at hospitals, community health centers, community mental health and oral health clinics; survey interpreters serving both the LEP and Deaf communities; interview LEP patients and community residents as well as advocates from the D/HoH and LEP communities, and policy makers and content experts at the state, local and national levels. We dovetailed with the strategic planning process of the Medical Interpretation Advisory Board (MIAB) and in the next phase will educate hospitals and other health care providers of their opportunities and responsibilities in serving the LEP and D/HoH communities.

### WHY ADDRESS MEDICAL INTERPRETATION CAPACITY IN NEW HAMPSHIRE?

The future of New Hampshire depends in large part on the health of its people. Medical interpretation is an integral part of providing quality health care to maintain and improve the health of New Hampshire residents who have limited English proficiency (LEP) and/or who are Deaf or Hard of Hearing (D/HoH).

The National Center for Cultural Competence offers rationales for providing culturally competent care.<sup>1</sup> Many apply directly to language issues. Each helps explain why providing appropriate medical interpretation is vital to New Hampshire's future:

#### ***Clinical Quality***

Accurate communication ensures the correct exchange of information, which is vital to the effective practice of medicine. Every patient deserves quality care. A patient's ability to understand his or her diagnosis, treatment options, benefits and risks is essential to effective patient care. Similarly, the clinician must be able to understand the patient's symptoms, complaints and concerns. Medical interpretation provides a communication conduit between patient and clinician. In many cases, interpreters will also act as a "cultural broker" to explain various health beliefs, e.g. why taking hypertension medication daily is important even when you're feeling fine or what the "evil eye" is. How important is effective interpretation? "If you can't understand the patient and vice versa, you're practicing veterinary medicine."<sup>2</sup>

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<sup>1</sup> E. Cohen and T. Goode, Policy Brief 1: *Rationale for cultural competence in primary health care*, Georgetown University Child Development Center, The National Center for Cultural Competence, Washington, D.C., 1999.

<sup>2</sup> Anne Fadiman, *The Spirit Catches You and You Fall Down*, Farrar, Straus, & Giroux, 1998.

Trained interpreters need institutional support including continuing education and quality assurance to perform their work. Doctors, nurses, and other clinicians routinely receive such support because of the clinical impact of their work. Hospitals, health centers and other providers must assure quality interpretation services to assure quality patient care.

### ***Risk Management***

Effective communication reduces the likelihood of medical error and makes patients more satisfied and less likely to sue. A patient points out the scar left over from a successful surgery. Her interpreter asks, “What was the surgery for?” The patient replies: “I’m not sure what they took out.” What would have happened if the surgery had not been so smooth? How would a hospital or surgeon explain the lack of informed consent? Providing qualified interpreters reduces liability exposure by reducing the chance of error and miscommunication.

The potential impact of ineffective communication is substantial: a single case in California resulted in a \$71 million judgment. Hospitals and other providers are at risk of liability from undocumented patients who may be afraid to complain for fear of retribution, including deportation. The federal Office of Civil Rights and the New Hampshire Commission for Human Rights have publicly stated that they are willing to complain on behalf of “Jane Doe” patients and seek appropriate remedies while protecting the patient’s confidentiality.

The attitude that “If we don’t count them, we don’t have to serve them” is not prudent risk management in this circumstance. The next \$71 million dollar case filed by an emergency department patient could happen right here. New Hampshire has the opportunity to upgrade its medical interpretation services without legal action and show the rest of the country real leadership in action.

### ***Legal/Regulatory***

Title VI of the Civil Rights Act legally mandates language access for LEP patients, while the Americans with Disabilities Act (ADA) and Titles II and III do so for Deaf/Hard of Hearing patients. LEP and D/HoH patients have the right to participate actively in their care. This often requires provider organizations to offer a qualified interpreter at no charge to the patient. The application of these laws continues to evolve and varies by specific circumstances. For example, a provider in a community like Manchester with a significant Spanish speaking population might be expected to provide in-person Spanish interpreters where a similar provider in Berlin might provide telephone interpretation on an as needed basis.

### ***Demographics***

New Hampshire racial and ethnic makeup is highly varied across the state. There are significant pockets of linguistic minorities and D/HoH patients in a number of New Hampshire communities. The number of D/HoH and LEP residents will continue to grow as the state ages, immigration continues, and birth rates of linguistic minorities outpace those of the general population.

### ***Disparities/Social Justice***

New Hampshire has strong traditions of individualism and of social justice. Providing culturally and linguistically appropriate services is part of eliminating health disparities.

D/HoH residents similarly argue for appropriate interpretation services for them to have equal access to quality care and good health outcomes.

### ***Business***

Is there a business case for providing health care services for LEP and D/HoH patients in New Hampshire? Is it profitable? New Hampshire health care providers must answer the question for themselves based on their own unique circumstances. The five rationales above mean that serving D/HoH and LEP patients is imperative. Therefore, it is in each provider's best interest to determine how to blend margin and mission in serving these patients, for example, by sharing translation and interpretation costs with other facilities. Providers could also advocate for improving insurance coverage for LEP residents, thereby increasing provider revenue streams.

**The need to provide quality care, minimize risk exposure, follow legal mandates, respond to changing demographics, and help eliminate disparities are all powerful forces.**

## **KEY PARTICIPANTS**

### ***Medical Interpretation Advisory Board***

The Medical Interpretation Advisory Board (MIAB) is the statewide forum for addressing issues of cultural competency and medical interpretation for limited English proficient communities in New Hampshire. It has recently become an opportunity for building cooperation among LEP and Deaf and Hard of Hearing advocates as well. The MIAB is co-chaired by Jazmin Miranda-Smith of the New Hampshire Minority Health Coalition and Paula Smith of the Southern New Hampshire Area Health Education Center (SNH-AHEC). From its founding, this group has included front-line and management staff from a diverse group of organizations. Members have represented hospitals, individual language and ASL interpreters, signed and spoken language service providers, community health centers, the state hospital association and medical society, consumers of mental health services and many other stakeholders. During the course of the MICA project, the visibility and diversity of the MIAB increased as new members joined and others returned to the forum.

One critical intersection between MICA and the MIAB was the MIAB strategic planning effort funded by the Endowment and facilitated by Wendy Frosh of Healthcare Management Strategies. By sharing data with each other, the MICA project and the strategic planning process have been synergistic. Together we are documenting the current status of medical interpreter services and presenting next steps in a continuing effort to improve health care access and health outcomes for LEP and D/HoH New Hampshire residents.

### ***Endowment for Health***

The Endowment is a statewide foundation with a brief history but a deep commitment to health care access for all residents of New Hampshire—particularly racial, ethnic, and linguistic minorities and the Deaf and Hard of Hearing community. The Endowment has funded many of the services provided to these communities and has supported previous evaluation efforts as

well. Lindsay Josephs served as Project Officer for this assessment and as a member of both the MIAB and the steering committee for this project.

### ***New Hampshire Department of Health and Human Services***

Our Medical Interpretation Capacity Assessment process encouraged greater communication and coordination between the public and private sector. The Department of Health and Human Services created “Cultural Competency: A Way of Life” as a strategic plan and public report. This comprehensive Diversity Plan, updated in June of 2002 by the Office of Minority Health, commits the state to providing linguistic access through translated materials and qualified interpreters at all points of contact.<sup>3</sup> It provides an opportunity for the State to lead by example in this area.

## **SUMMARY OF APPROACH**

### ***Building on Existing Resources***

A number of data collection efforts preceded this one, including a New Hampshire Hospital Association survey and a Language Bank survey. The findings from these surveys informed the design of new data collection tools and methods. The project attempted to build on this foundation and to minimize the “research burden” on busy people more committed to serving patients than completing forms or interviews. The result was a series of tailored data collection methods including surveys, in person and phone interviews, and active participation in various meetings, particularly of the MIAB.

### ***Steering Committee Guidance***

A diverse group of New Hampshire colleagues served on the steering committee for this project and were supported by national experts as well. Together they reviewed data collection instruments and commented on this report in draft form.

### ***New Data Collection***

Interviews—MICA staff conducted structured interviews with 19 individuals across New Hampshire. Their insights gave us an overview of the complex tapestry of the state. We found similarities and differences in the challenges facing a refugee from Somalia newly relocated to Manchester, a migrant farm worker from Mexico now living in Berlin, and a lifelong New Hampshire resident who is dealing with hearing loss for the first time at age 62. The interviews set the stage for quantitative research. MICA staff shared the results with the MIAB strategic planning effort.

Provider Survey—The provider survey was sent to hospitals, community health centers, dental clinics, and community mental health centers across the state. The survey asked about medical interpretation demands and capacity, and had a response rate of 74% (42 returned surveys). In addition to getting an overall picture of services offered, several participants identified best practices in their own facilities.

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<sup>3</sup> Available at: <http://www.dhhs.state.nh.us/DHHS/MHO/LIBRARY/Program+Report-Plan/diversity-plan.htm>

Interpreter Survey—Interpreters serving both the LEP and Deaf communities have front-line interactions with a variety of institutions and patients. MICA staff coordinated with the SNH-AHEC and the Language Bank to collect complementary data sets. A total of 54 surveys were returned, accounting for a 41% response rate. In addition, eight American Sign Language interpreters completed a modified survey.

LEP Conversations at ESL Class—In two separate sessions, bilingual MICA staff and consultants led discussions with a total of 18 LEP individuals regarding their experiences with the health care system in New Hampshire. Conversations were held in English and in Spanish.

### ***NHHA Forum: Educating and Learning from Hospitals***

The New Hampshire Hospital Association (NHHA) held a forum on April 2, 2004 that drew over sixty hospital participants from across New Hampshire. The session provided an opportunity to inform hospitals of their opportunities and responsibilities in serving D/HoH and LEP patients and community residents, to promote completion of the provider survey, and to learn from each other as well as external experts. Leslie Melby, NHHA VP and MIAB member, coordinated the event. The well-received workshop included Mara Youdelman of the National Health Law Program, Beau Stubblefield-Tave, and other MIAB participants as planners and speakers. (Agenda in appendix.)

### **MOVING FORWARD: “PLANNING THE WORK AND WORKING THE PLAN”**

This report represents a comprehensive and inclusive review of medical interpretation capacity and needs in New Hampshire. In it we offer recommendations for next steps for acting on what we know and learning more that we need to know. The data have helped inform the MIAB strategic plan and vice versa. There remains significant work to be done both in debating and implementing the recommendations offered and in collecting additional data.

The assessment focused primarily on those individuals who are already using the health care system. It would be valuable to spend more time with residents who face barriers so high that they are discouraged from seeking health care at all, unless and until they are in an emergency situation. A more common occurrence is undoubtedly diminished care seeking. Service needs are underestimated because those with the greatest need may request health care less frequently due to language barriers. Future research will need to answer questions such as how many such individuals are there in New Hampshire and how do we provide the resources and incentives to reach and serve them.

This assessment also focused specifically on language barriers. We recognize that many individuals simultaneously face cultural barriers based on race, ethnicity, national origin, class, education level and other factors. We did not assess the cultural competence of New Hampshire health care providers to serve all residents of the state.

Nor did this assessment attempt to evaluate the quality of interpretation services offered. A recently published study reported that the average pediatric encounter at a major teaching hospital included 31 interpretation errors, 19 of which (63%) had potential clinical consequences. This study was based on extensive evaluation of 13 clinical encounters. Ad hoc interpreters (e.g. family members and bilingual staff) were significantly more likely to make

interpretation errors than qualified interpreters, and these errors were more likely to have potential clinical consequences. (Using ad hoc interpreters also raises issues of confidentiality.) However, without appropriate support, continuing education and quality assurance, even trained interpreters can make a significant number of clinically important errors.<sup>4</sup> Are New Hampshire health care providers offering this type of support? Are there language banks and video ASL services? Again, these are questions for future research.

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<sup>4</sup> Flores et al, *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, Pediatrics, Vol. 111, No. 1, January 2003, pp. 6-14.

## **METHODS**

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### **REVIEW OF EXISTING DATA**

A number of advisory board members had previously conducted surveys, documented focus groups, and collected other essential data on the topic of language services. For example, the New Hampshire Hospital Association shared with us the survey of their members they had conducted in December 2002. The Access Project assisted Southern New Hampshire AHEC and the New Hampshire Minority Health Coalition in conducting a survey of interpreters in the fall of 2002. We also had the benefit of the June 2003 survey on practices and attitudes of medical providers commissioned by the Language Bank. All of these previous data collection efforts helped to shape our research goals and methods.

### **INTERVIEWS WITH ADVISORY BOARD MEMBERS AND OTHER KEY INFORMANTS**

We utilized the expertise of advisory board members to provide us with information on existing language service needs and capacity. This was accomplished through 19 face-to-face and telephone interviews from October through February. We began with recommendations from the Medical Interpretation Advisory Board and the Endowment for Health, but continued to add names as they were recommended by those interviewed. We gathered information from the providers, advocates and policymakers about their experiences and perceptions of the availability and quality of medical language services. The information gathered through these interviews was compiled, and in mid-February we shared a draft summary report with the Endowment and Wendy Frosh. This information was then utilized in the development of the survey to be mailed to the various healthcare institutions.

### **SURVEY OF HOSPITALS AND OTHER SAFETY NET PROVIDERS**

After reviewing existing data (both qualitative and quantitative) and consulting with the advisory group, MICA staff developed the survey instrument for health care institutions. Researchers at the National Association of Public Hospitals and Health Systems reviewed our survey drafts, as did staff members from the Joint Commission on Accreditation of Healthcare Organizations. Both organizations provided valuable feedback. We also received significant editing support and encouragement from the Foundation for Healthy Communities.

We then pilot tested the survey instrument with directors of three community health centers in the Greater Boston area. Their critical feedback led us to eliminate many questions and sharpen others.

The NH Community Mental Health Service Administration provided contact information for the ten community mental health centers in the state. We received names of seven community dental clinics from around the state from the Nashua Dental Connection. We double checked that the surveys were being sent to the appropriate individuals at all 62 healthcare institutions. In the case of the 29 hospitals, we sent an extra copy to the CEO requesting his or her assistance in shepherding the project and getting it to the right person who could answer on behalf of the emergency department.

The Endowment for Health also mailed out a pre-survey letter encouraging participation, and that endorsement, combined with extensive telephone follow-ups, helped to maximize participation. We also attribute a strong response rate to the level of cooperation illustrated in our cover letter. It read:

*“This project has been actively supported by the Endowment for Health, the Medical Interpretation Advisory Board, Bi-State Primary Care Association, NH Minority Health Coalition and the NH Department of Health and Human Services, including its Division of Behavioral Health and Office of Minority Health. The New Hampshire Hospital Association and Foundation for Healthy Communities assisted in the development of the survey instrument.”*

In the end, nearly three-quarters of those institutions surveyed responded.

### **INTERPRETER SERVICE PROVIDERS**

Many providers contract with a specialized interpreter agency or independent freelance interpreters. In close collaboration with the Southern New Hampshire Area Health Education Center, the New Hampshire Minority Health Coalition and Lutheran Family Services (operators of the Language Bank), we created a questionnaire that was mailed to such medical interpreters. SNH-AHEC took responsibility for identifying the universe of interpreters because it also was conducting an evaluation of its interpreter training program. Surveys were mailed out from the SNH-AHEC office on its letterhead because of greater familiarity among interpreters with its name. SNH-AHEC staff entered the data in an Excel file and our research assistant then imported the file into SPSS for statistical analysis.

Simultaneously, we developed a similar survey modified for American Sign Language (ASL) interpreters. A list of ASL interpreters was collected with help from the NH Registry of Interpreters for the Deaf and the NH Department of Education’s list of certified interpreters. Susan Graesser, then president of the NH Registry of Interpreters for the Deaf and MIAB member, sent the survey out to her members and we contacted the DOE-certified individuals by phone to see if they did medical interpreting. If so, we then e-mailed them the survey. The Access Project entered and analyzed the data.

### **FOCUSED DISCUSSIONS WITH INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY**

In evaluating the language service needs and the gaps between that need and capacity, the perspective of the limited English proficient (LEP) patient is obviously important. Discussions with LEP individuals provided us with perceptions on the ease of accessing language services and insight on the issue of service quality. We worked through groups that serve a large number of LEP individuals. The guided discussions were done in conjunction with local organizations. This was essential since these organizations had already built trust with their members or clients.

On June 28<sup>th</sup>, MICA staff conducted a bilingual discussion in Nashua with a multi-service organization serving newcomer populations. We chose to work with Spanish speakers in Nashua, because Census 2000 data reports that they are the largest LEP population in that area. The sample was recruited using the snowball technique and three streams were employed to assure a mixed grouping. Subjects were recruited by a Soup Kitchen advocate, a Head Start

Family worker, and a NAMI (National Alliance for the Mentally Ill) advocate, all three of whom are of Latino descent and contributed to the group.

The group discussion was held at the Nashua Soup Kitchen, as it is a trusted place in the community where LEP residents feel safe and visit freely. The group was read a consent form, which explained both the study purpose as well as the risks, benefits and legal parameters of the study. Participants were offered dinner, and then were read a series of questions and asked to comment.

Manchester is a linguistically as well as ethnically diverse city. In order to get feedback from the maximum number of languages represented in that community, we decided to work with an English as a Second Language (ESL) program, delivering the questions in beginner English. The site visit on July 29<sup>th</sup> was held in a classroom at the First Congregational Church in Manchester and facilitated by Linda Sprague. The participants were described as being advanced ESL students. Participants were read a series of questions and asked to comment.

## **DATA ANALYSIS**

For the quantitative survey data, coding was straightforward. Initial analysis was done using SPSS software to provide descriptive statistics. In the case of the facility surveys, analysis was done to compare the responses of high and low volume facilities. The various components of the work produced complementary kinds of information, which were first analyzed separately and then compared.

## **PROMISING & PRACTICAL LANGUAGE SERVICE MODELS**

We sought out promising practices of diverse NH providers in order to highlight examples from other communities that healthcare institutions might adapt. Unfortunately, only six New Hampshire institutions submitted examples of their practices. They included brief descriptions of training for case managers; multicultural presentations; Spanish classes for staff on a weekly basis; translated health information messages on their hot line; and Cultural Competency trainings in which employees learn to be more culturally sensitive through greater awareness of their own values, beliefs and customs and through acceptance of differences.

Finally, we relied on the representatives from national organizations serving on our advisory committee to assist in identifying relevant models in other states. For example, the National Health Law Program and the National Association of Public Hospitals and Health Systems both recently conducted research on this issue. We also borrowed from the Massachusetts Office of Minority Health's report entitled, Best Practice Recommendations for Hospital-Based Interpreter Services. Many of these national examples are incorporated into the recommendation section of this report. We recognize that programs must take into account the unique cultures, needs, values, politics and history of their communities. We look to the advisory board to help us understand what models would be most relevant to New Hampshire providers.

## NEW HAMPSHIRE DEMOGRAPHICS

The population of New Hampshire was 1.24 million in 2002, an increase of nearly 12 percent over the 1990 Census. While a vast majority of New Hampshire residents are native born and speak only English, there is a significant and growing group of foreign-born residents, many of whom do not speak English very well. In 2002, 56,020 people—4.5 percent of the population—were foreign born, about 15,000 more than in 1990.

Over 30,000 New Hampshire residents in 2002 had limited proficiency speaking English,<sup>5</sup> an increase of 22 percent from the 1990 Census figure of just under 25,000. The fastest growth in the LEP population was among Spanish speakers; those with limited English proficiency nearly tripled from 1990 to 2002, and 9,516 Spanish speakers now make up almost a third of the LEP population of the state. Asian LEP immigrants also grew quickly, from 2,573 in 1990 to 5,901 in 2002.<sup>6</sup>

According to the 2000 Census, New Hampshire residents speak over 40 languages other than English. French and Spanish are the most common by far, but a number of other languages—including Arabic, Chinese, German, Greek, Italian, Korean, Polish, Portuguese, Russian, Serbo-Croatian, Vietnamese, and other European and Asian languages—are claimed by at least 1,000 residents.

**Linguistic diversity is concentrated in southern New Hampshire. Census 2000 data show that Hillsborough County which includes Manchester and Nashua and which accounts for 31 percent of the state's population, is home to 48% of the foreign born population, 59% of the Hispanic or Latino population, 57% of newcomers who had immigrated since 1990, and 53% of residents with limited English proficiency.**

**Table 1. Linguistic Diversity in Southern New Hampshire**

Geography	Total population	Foreign born	Entered since 1990	Age 5 and over Speak English less than very well	Hispanic or Latino
<b>New Hampshire</b>	<b>1,235,786</b>	<b>54,154</b>	<b>20,191</b>	<b>28,073</b>	<b>19,910</b>
Manchester	107,006	10,035	5,336	7,054	4,840
Manchester as % of NH	9%	19%	26%	25%	24%
Nashua	86,605	8,778	4,180	4,985	5,153
Nashua as % of NH	7%	16%	21%	18%	26%
Hillsborough County	380,841	25,793	11,512	14,864	11,744
Hillsborough as % of NH	31%	48%	57%	53%	59%

Source: Census 2000

While the concentration of LEP residents in the southern part of the state presents a challenge to its healthcare institutions in providing adequate language access services, facilities in the rest of the state face a different challenge posed by serving a more widely dispersed group of residents with limited English skills.

<sup>5</sup> Defined as speaking English less than “very well”.

<sup>6</sup> U.S. Census Bureau, American Community Survey 2002.

## **FINDINGS FROM THE KEY INFORMANT INTERVIEWS**

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Prior to designing and fielding the provider and interpreter survey, we conducted structured interviews with 19 key informants about the capacity of and need for language services in health care settings in New Hampshire. The informants represented various health care providers, including dental, mental health, community health centers and hospitals; agencies that supply interpreters; advocates for immigrant and minority groups; and the state government. The interviewers asked questions about how the subsequent pieces of the study should be conducted and reported, and also asked for informants' perceptions of the extent of need for language services, how the need was being met, and what some of the barriers were. A brief synthesis of some of the important themes from the interviews follows. Many of these themes emerged with more clarity in the provider and interpreter surveys and in the informal group conversations with consumers that were conducted later.

### **FINDING #1**

**There is a need for broad, systematic data collection tracking the demand for language services and the capacity across the state to meet that demand.** Informants argued for establishing a standard against which progress can be measured, and encouraging—or, if necessary, compelling—providers to collect information in a consistent manner. This study and previous efforts have supplied some information, but they do not take the place of an ongoing tracking system. There is some resistance to tracking, as a clearly documented need would increase the pressure to provide service in response.

### **FINDING #2**

**Absent systematic data, informants perceived that language services vary across the state and across facility types. Quality, though difficult to assess objectively, varies widely.** Some providers use mainly bilingual clinicians rather than interpreters, while others rely exclusively on remote language lines. Different departments within a single facility may even exhibit a wide range of degree of sensitivity to language needs. Capacity is greatest in the southern part of the state, particularly Manchester. One informant called the area north of Manchester a “wasteland” for LEP residents. Even in the south, though, there are capacity gaps, especially among private practitioners and specialists. Many written materials are also not translated. There is some apprehension that capacity is insufficient for the growing LEP population of the state.

### **FINDING #3**

**There are lessons to be shared and learned between the LEP and Deaf and Hard of Hearing (D/HoH) communities.** Informants characterized D/HoH patients as stronger advocates, with greater resources and experience than LEP patients. While one informant identified a need to empower LEP patients to ask for interpreters, D/HoH patients generally know their legal rights and assert them. To the extent that demand for language services drives the supply and the political will to overcome barriers, a closer alliance between these groups might be beneficial.

**FINDING #4**

**There are significant barriers to providing needed interpreters.** Cost is the major one, especially for small providers with minimal demand for the service. Some providers see language service requirements as an unfunded mandate. The availability of Medicaid reimbursement for interpreters does not alleviate the problem because the Medicaid rate is inadequate and the billing system is difficult.

Other barriers the informants identified are concerns about liability, lack of awareness about legal requirements, difficulty in assessing the qualifications of interpreters, time burdens for training and deploying staff, and a lack of knowledge about why interpreters are important and what resources are available.

## FACILITY SURVEY FINDINGS

Overall, 42 facilities completed the provider survey: 19 hospitals, 12 community health centers (CHC's), seven community mental health centers (CMHC's) and four dental clinics. The facilities combined have about 181,000 patient visits per month. Although we requested that hospitals respond specifically about their emergency room practices, three described the experience of their entire hospital system.

### FINDINGS BY FACILITY TYPE

The facilities reported that on average just over one in ten (10.3%) of their patient encounters are with patients with limited English proficiency (LEP); the median LEP percentage reported by facilities was 3 percent.

**The large difference between the average and median figures is that four facilities (three of them Community Health Centers) reported very high LEP percentages of between 30 and 40 percent.**

One of every 200 patients (0.5%) is Deaf or Hard of Hearing (D/HoH) (median 0.3%). Patients of CHC's are most likely to have limited English proficiency or be D/HoH; about one in five (21.5%) of CHC encounters are with LEP patients, and one in 40 (2.6%) are with D/HoH patients. Of facilities responding to the survey, patients at CMHC's are least likely to be LEP or D/HoH.

**Table 2. Patients' Language Needs by Facility Type**

	Total	Facility Type			
		Hospitals	CHC's	CMHC's	Dental Clinics
Number of Facilities	42	19	12	7	4
Visits per month	180,866	112,766	31,299	34,400	2,401
Median	1,250	1,198	1,825	1,300	390
% LEP visits*	10.3	4.0	21.5	< 1.0	12.0
Median	3.0	2.3	4.0	< 2.0	15.0
% D/HoH visits*	0.5	0.3	2.6	0.2	0.2
Median	0.3	0.3	1.0	0.1	**
* Calculation based on respondents that answered the question					
** Fewer than 3 valid responses					

## FINDINGS BY REGION

Facilities that responded in the Nashua area are most likely to see patients with limited English skills. A third of the encounters (32%) were reported to be with LEP patients. The Manchester area has the next highest prevalence of LEP patients, followed by the Lakes and North regions.

## LOCATION OF RESPONDING FACILITIES BY REGION

Greater Manchester:	Manchester, Raymond
Greater Nashua:	Nashua, Salem
North Region:	Berlin, Conway, Lancaster, Littleton, Woodsville
Capitol Region:	Concord
Sea Coast:	Dover, Portsmouth, Rochester
Upper Valley:	Claremont, Lebanon, New London, Newport
West Region:	Keene, Peterborough
Lakes Region:	Franklin, Laconia, Plymouth

**Table 3. Patients' Language Needs by Geographic Region**

	Total	Region							
		Manchester	Nashua	North	Capitol	Seacoast	Upper Valley	West	Lakes
Number of Facilities	42	9	4	8	4	5	5	3	4
Visits per month	180,866	61,100	18,098	7,670	7,358	7,242	67,416	6,552	5,430
Median	1,250	1,650	2,150	875	1,879	1,321	1,166	1,550	1,322
% LEP visits*	10.3	6.3	32.0	4.2	1.0	2.9	0.2	1.0	5.0
Median	3.0	11.5	35.0	2.0	1.0	3.0	0.1	**	**
% D/HoH visits*	0.5	< 1.0	1.6	2.7	1.0	0.4	< 1.0	0.3	< 1.0
Median	0.3	**	0.5	2.0	**	0.5	0.3	1.0	**
* Calculation based on respondents that answered the question									
** Fewer than 3 valid responses									

## FREQUENCY OF LANGUAGES

The frequency with which languages other than English are spoken can be measured in terms of both “breadth” and “depth.” By breadth we mean the number of facilities that report a language accounting for more than five percent of its LEP patients. Depth refers to the number of facilities reporting a language as the *most common* other than English.

Spanish is the most common language on both measures; nearly half (20) of respondents reported Spanish among its patients' languages, and it was the most common non-English language in 17 facilities. The next most frequent languages reported were American Sign Language (in 13 facilities, most common in 6) and French (11 and 8). Notably, 12 respondents

report “other” languages—including Arabic, Chinese, Farsi, Korean, Russian, Swahili and more—among their non-English speaking patients, an indication of the diversity of language service needs throughout the state. Respondents reported the presence of Bosnian (9 facilities), Vietnamese (7), Portuguese (6) and Greek (1) speakers, but none of these languages was the most common at any respondent’s facility.

In the chart below the percentages reflect the prevalence of a language among non-English speakers in a facility, but they do not reflect the overall size of the LEP or D/HoH population in that facility.

**Table 4. Frequency of Languages by Facility**

	No. of facilities reporting > 5% of total LEP or D/HoH patients	No. of facilities reporting most common non-English language	Average % for facilities reporting this language
<b>ASL</b>	<b>13</b>	<b>6</b>	<b>32</b>
<b>Bosnian</b>	<b>9</b>	<b>0</b>	<b>22</b>
<b>French</b>	<b>11</b>	<b>8</b>	<b>44</b>
<b>Greek</b>	<b>1</b>	<b>0</b>	<b>10</b>
<b>Portuguese</b>	<b>6</b>	<b>0</b>	<b>12</b>
<b>Spanish</b>	<b>20</b>	<b>17</b>	<b>51</b>
<b>Vietnamese</b>	<b>7</b>	<b>0</b>	<b>5</b>
<b>Other *</b>	<b>12</b>	<b>5</b>	<b>28</b>
<b>* Most commonly listed languages under Other:</b> Arabic, Chinese, Farsi, Korean, Russian, Swahili.			
<b>Additional languages listed under Other:</b> Albanian, Cambodian, Danka, German, Hindi, Indonesian, Japanese, Laotian, Liberian, Norwegian, Tagalog, un-named African dialects .			

## HOW FACILITIES MEET LANGUAGE DEMANDS

The resource most commonly employed to ensure effective communication for LEP and D/HoH patients is outside paid interpreters; 27 of the 42 respondents reported using this resource. Conversely, only nine respondents reported using staff interpreters. About half of the respondents call on bilingual staff – both clinical (21 of 42) and non-clinical (20) to interpret; only two facilities (both CHC’s) report offering differential pay to the staff who perform the service. Non-clinical staff members mentioned included security guards, receptionists and custodians.

One notable regional variation is that none of eight responding facilities in the North region report using outside paid interpreters, although statewide it is the most frequently used approach. Compared to the state as a whole, facilities in the Capitol, West and Lakes regions rely much less frequently on bilingual staff.

The interpreter resources that facilities report using with the greatest frequency are external paid interpreters (11 report weekly or more frequent use), bilingual clinical staff (10), bilingual non-clinical staff (9), and telephone services (9). At the other end of the spectrum, a substantial portion of facilities report never using certain resources, such as video interpretation services

(19 reporting never using), volunteer interpreters (13), ASL interpreter agencies (12), staff interpreters (11), and bilingual non-clinical staff (10).

### **WRITTEN MATERIALS**

Twenty-two facilities report posting official signage in languages other than English, and 20 translate patient education materials. The prevalence of non-English versions of other written materials declines from there: 16 report providing financial assistance information, 13 patient consent forms, and 4 patient satisfaction surveys. Seven facilities use “I Speak” cards that allow non-English speaking patients to inform staff of the need for an interpreter.

### **DIFFICULTY MEETING LANGUAGE SERVICE NEEDS**

Survey respondents were asked about the distribution of languages (including ASL) among their non-English speaking patients, and the difficulty they experienced in finding or scheduling qualified interpreters for these languages. It was rare for respondents to report difficulty for languages spoken by 10 percent or more of LEP patients; exceptions were the one facility where Vietnamese speakers comprise more than 10 percent of LEP patients and two of the three where Portuguese speakers predominate. More difficulty arose when trying to secure interpreter services for less common languages. Overall, difficulty finding or scheduling ASL interpreters was most common (9 facilities reporting), followed by Portuguese (6) and Vietnamese (5).

Among the problems facilities face in providing interpreter services, scheduling (reported by 19 as somewhat or very difficult), cost (17) and time of encounter extended (17) were about equally common.

**Looking toward meeting needs into the future, 25 of 42 respondents say that the demand for language services has increased over the past few years.**

This view is expressed across the state and across facility types, with the exception of Community Mental Health Centers. Twelve facilities, mainly in the southern part of the state, report new languages spoken in their area in the past few years.

### **COMPARISON OF FACILITIES IN REGIONS WITH HIGH VERSUS LOW CONCENTRATION OF LEP POPULATION**

Census statistics reported earlier show that more than half of the New Hampshire population with limited English proficiency lives in Hillsborough County, which contains the cities of Manchester and Nashua. Among the survey respondents, 13 of the 42 were located in Manchester or Nashua, and the remaining 29 are in other areas of the state. In the aggregate, the Manchester/Nashua providers serve a much greater proportion of LEP patients: about one in seven (14%) patients in the facilities that reported their LEP volume, compared with about 2 percent among the non-Hillsborough providers.

All but two of the Hillsborough County providers use outside paid interpreters as part of their language service strategy. Sixteen of the 29 facilities outside of Hillsborough do so, perhaps reflecting the availability of interpreters in other parts of the state. Conversely, 14 of the 29 non-Hillsborough respondents report using bilingual clinical staff to interpret, and seven report having staff interpreters. The corresponding numbers for the Manchester/Nashua respondents are seven and two (out of 13). Interestingly, more Manchester/Nashua facilities report using bilingual *non-clinical* staff (9) than clinical staff (7) to interpret.

From the series of questions about what language services providers purchased in 2003, it again appears that the Manchester/Nashua respondents avail themselves more of outside resources. Eleven of the thirteen spent money on contract interpreters to do face-to-face work, and nine on telephone interpretation. Only three, on the other hand, reported expenditures for staff interpreters, and two for differential pay to bilingual staff. Fifteen of the 29 non-Hillsborough providers contracted with interpreters, 13 bought telephone interpretation, and three paid staff interpreters.

Hillsborough County providers use interpreter services more frequently than providers in the rest of the state. Eight of 13 respondents reported using outside paid interpreters at least weekly, seven use bilingual clinical staff at least weekly, and 6 use telephone services. With the exception of outside volunteer interpreters, ASL interpreters and video interpretation, a plurality of Hillsborough providers reported using each type of interpreter resource at the most frequent level frequently (at least weekly). Conversely, no more than four of the 29 non-Hillsborough providers reported using any type of interpreter service any more than monthly.

A majority of Hillsborough facilities provide multi-lingual signage (9 of 13) and patient education materials in languages other than English (8). Six provide non-English patient consent forms, and five provide financial information or use "I Speak" cards. Only three offer a patient satisfaction survey in languages other than English. In the 29 non-Hillsborough facilities, as many as 13 provide translated signage, 11 offer education materials and nine have financial assistance information translated. Six have translated patient consent forms, only one has a patient satisfaction survey in non-English languages and one non-Hillsborough facility uses "I Speak" cards.

Ten of the 13 Manchester/Nashua respondents report increased demand for language services (as well as 15 of the 29 non-Hillsborough respondents). Four Hillsborough and seven non-Hillsborough providers have seen new languages in their area in the past few years.

## **INTERPRETER SURVEY FINDINGS**

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To get a well-rounded perspective on the current state of interpreter services in New Hampshire, we sought to incorporate the experiences of the people who actually do the interpretation for patients as well as the organizations and institutions that provide the services. To that end, we conducted a survey of medical interpreters to understand their personal characteristics, their views on how language services are provided in health care settings in New Hampshire, and some of the challenges they face in the existing system. See the Methods section for further details about the survey itself. Following is a discussion of the key findings.

### **INTERPRETER CHARACTERISTICS AND PLACES OF WORK**

Forty-six interpreters completed the survey, 73% of whom were female. A majority (59%) interpreted in Spanish; the next most common languages were Portuguese (13%), Bosnian (9%) and Arabic (7%). Other languages represented were Chinese, French, Russian and Bahasa (an Indonesian language).

Most of the respondents worked in the southern part of the state, although many reported working in multiple regions. A majority (27, or 59%) worked in the Greater Manchester area, while fourteen (30%) worked in Nashua and four (9%) worked in Concord.

The survey asked about the interpreters' current employment status. Nine are employed specifically as medical interpreters by a healthcare organization. Eleven respondents (17%) work for an interpreting service and six (13%) work as freelance interpreters, doing their own scheduling and billing. The largest number (13) do medical interpreting for the organization at which they work, though they are not employed specifically as an interpreter. Five respondents reported that they are not currently doing medical interpretation.

Twenty-two of the responding interpreters said they did other kinds of work in addition to medical interpreting. The list included many teachers, from the professor level to tutors and ESL teachers. Many work in the health care field, as medical records managers, licensed nursing assistants and psychotherapists. Two work as translators of written text. Respondents were also social workers, real estate agents and community educators.

Over the course of the last year, the most common places the interpreters worked were physicians' offices (18 respondents), community health centers (16), and social service agencies (13). This group of interpreters worked less frequently in hospitals: only 10 of the 46 respondents did interpreting in hospital outpatient clinics, nine in hospital emergency departments and eight in inpatient units. In addition, nine reported working in courts or legal service agencies, seven in dental clinics or offices, and six in businesses.<sup>7</sup> We also asked if the employer in these various settings requested the interpreters' qualifications. The courts and legal services agencies asked for them most often (4 of the 9 respondents who interpreted there), followed by community health settings (7 of 16) and physicians' offices (9 of 18). Hospitals were listed less frequently, with emergency departments requesting qualifications from two of

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<sup>7</sup> These numbers add up to more than the 46 respondents because each was asked to identify the three most common settings where they interpreted.

nine interpreters, hospital inpatient units from one of eight interpreters, and outpatient clinics from one of ten.

### **INTERPRETER CAPACITY**

To get a sense of the capacity available from the interpreters who responded to the survey, we asked them to estimate how many interpreting sessions they conduct per month, and about how many hours per week they spend doing medical interpreting. Of the 30 who responded to the first question, half (15) said they do 10 or more sessions per month. Twenty-nine respondents answered the second question; only four said they work 20 or more hours per week at interpreting, seven spent more than 10 hours and 16 more than five hours.

To gauge whether there might be excess capacity among this group of interpreters, we asked if they would like to spend more, less or the same amount of time as they do now working as medical interpreters. More than half (17 of 31) said they would like to do more interpreting; only one would like to do less.

When asked what changes respondents had seen in the demand for their services as medical interpreters over the past few years, 24 of the 39 respondents who answered the question said the demand had increased, three said the demand had decreased, and 12 said it had stayed the same.

### **COMPENSATION**

Reported salaries ranged from \$10.50 to \$45 an hour. The most common and median response was \$15 but this varied widely depending on place of employment. The average salaries for those who work for interpreter service organizations such as the Language Bank, Words or Rosetta Stone was \$21.50. Freelance interpreters reported a range of \$25 to \$45 and those who work as interpreters for healthcare organizations reported an average salary of \$18/hour. A high proportion of the respondents (8) are employed in a different position in an organization but do medical interpreting for that organization. Their mean hourly rate was \$13.75.

Twenty-two interpreters reported receiving benefits such as vacations or health insurance from their jobs while 11 said they did not. Ten reported that they were covered by liability insurance, while 16 said they were not and eight did not know.

We inquired whether these interpreters are reimbursed for mileage for traveling to interpreter jobs. Of the 28 who answered, six said they were always reimbursed, eight said sometimes and 14, half of the respondents, reported never.

### **CHALLENGES**

Respondents were asked to report how often they face any of the following challenges in their jobs as medical interpreters:

- Long travel time
- Patients who do not keep appointments

- Short notification
- Medical terminology
- Inadequate pay scale
- Doctors and nurses who do not know how to work with interpreters
- Not enough appointments

As might be expected, pay scale was most frequently identified as “always” or “often” a challenge, by 15 of the respondents. However, three other items were identified as a source of dissatisfaction just as frequently: travel time, short notification, and that doctors and nurses do not know how to work with interpreters. This suggests (though further investigation would be needed) that there may be some improvements to be made in the systems for deploying and using medical interpreters around the state that go beyond compensation issues.

The challenges least often cited were medical terminology (8 respondents said “always” or “often”), and patients not keeping appointments (10). Thirteen respondents, nearly as many as the most commonly cited challenges, said that not having enough appointments was always or often a problem.

### **GENERAL PERCEPTIONS**

Interpreters were given a chance to comment on their observations of their LEP clients’ experiences with the health care system. Some of their comments were:

- *Most of them have been interpreted by a friend or relative, they do not know how it should be done.*

**“ They [LEP clients] cannot have open communication with the medical staff, nor call for clarification or make appointments ”**

- *They do not understand the U.S. healthcare system*
- *I often interpret for intake/triage/treatment, but minimally for discharge/follow-up.*
- *They struggle too much and wait too much to see a doctor.*

When asked for additional thoughts that the survey questions did not elicit, respondents offered these comments:

- *It [medical interpreting] is very under-appreciated as a job skill or a real position. I love interpreting, but I could not support my family doing it full time. The Nashua community needs interpretation services so much, it is painful to see how much they struggle.*
- *I do not think that medical providers know about the law requiring them to provide and pay for medical interpreters.*

**“ Patients should be informed of their rights ”**

- *Every hospital and clinic should have full time positions.*

## **ASL INTERPRETER SURVEY FINDINGS**

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American Sign Language (ASL) interpreters offered their unique perspective on addressing healthcare services for Deaf and Hard of Hearing patients in the state. We interviewed and surveyed a small sample of ASL interpreters whose names we received from the NH Registry of Interpreters for the Deaf and the NH Department of Education's list of certified interpreters.

### **INTERPRETER CHARACTERISTICS AND COMPENSATION**

Seven of the eight respondents were female and all but one interpreted in medical settings on a part time basis, most frequently on a freelance basis. Half also worked for an ASL interpreter service. Over the last year, they most often interpreted in physician offices, hospital emergency departments and other hospital outpatient areas. Two of them had also interpreted in hospital inpatient units. Their salaries ranged from \$23 an hour to \$40, with a mean and median salary of \$32 an hour. None received benefits such as vacations or health insurance, but 6 of the 8 were always reimbursed for mileage. Since this was part time work for all but one of our respondents, we inquired about what other kinds of work they did. Answers included support staff at agencies for the Deaf, interpreter coordinator at a college, instructor/teacher, housecleaner (for flexible schedule and steady income to fit in with interpreting) and a grant-writer for statewide projects.

### **CHALLENGES**

A frequent challenge these ASL interpreters faced was lengthy travel times, as they reported working in multiple regions of the state. On average they worked in 5 distinct regions, and one respondent said she worked in every region of the state. The Greater Concord and Manchester areas and the Upper Valley were the most often cited, with the Lakes region and Greater Nashua area coming in a close second. These responses were very different from the spoken language interpreters who mostly worked in one, or at most three, regions of New Hampshire.

Medical terminology was the most commonly cited challenge, although one interpreter indicated that she sees this as part of the nature of her job. All 8 respondents indicated that at times doctors and nurses don't know how to work with ASL interpreters, 3 indicating that this is often the case and 5 saying sometimes. Many also reported receiving short notice for appointments, and all had experienced the problem of patients sometimes not keeping appointments. None expressed a problem with their pay scale. Other challenges respondents reported included negative attitudes about the Deaf, not enough time scheduled for appointments in consideration of interpreting requirements (clarifications, explanations, lag time), and receiving calls to confirm appointments that should have been made to the patient.

### **OBSERVED BARRIERS**

The questionnaire asked, "What are the barriers to care for Deaf and Hard of Hearing patients that you have observed?" The most commonly identified barrier had to do with time constraints. For example:

- *The unwillingness on the part of some physician/providers to take the time necessary to fully explain symptoms, diagnosis, meds, etc. (some are great!)*

- *Not scheduling enough time for appointment so patient sometimes feels that the doctor doesn't care enough for them because appointment and diagnosis/treatment often seems hurried. Instead of having time to sit and talk about their condition/symptoms/pains as well as background and other circumstances that might have indirectly contributed to the condition.*
- *Rushed appointments - Doctor doesn't want to slow down for the interpreting process and questions.*

Another grouping of barriers cited concerned an absence or delay in obtaining qualified interpretation:

- *Delays in securing interpreters at times. Office staff not knowing they need to call for communication access nor how/where to call.*

**“ Hospitals tend to think if they have a staff person with a Deaf relative, that the staff person’s “good enough” to interpret, or they try to get an immediate family member to interpret ”**

- *Not always providing interpreters for every appointment.*
- *Deaf patients accepting "someone who signs" in the facility instead of requesting a certified interpreter.*
- *Deaf citizens not requesting an interpreter when they set up the appointment—assuming staff know they are deaf.*
- *In-patient interpreting seems spotty at the hospitals.*

Other barriers mentioned included:

- *They [Deaf patients] often prefer continuity of ASL interpreters, both for confidentiality and smoother service (the interpreter knows the case) but this does not always happen.*
- *Printed materials that need to be explained or interpreted.*
- *Not enough education regarding their own healthcare options. It takes more than an interpreter a lot of times.*
- *Lack of awareness and understanding of Deaf/HoH needs and rights to access.*
- *Need for more training for interpreters specifically medical terminology.*
- *Medical staff needs annual trainings.*

## **BEST PRACTICES**

The survey asked ASL interpreters to describe the best practices for treating Deaf and Hard of Hearing patients. This question received the most detailed comments:

- *The office staff know the Deaf patients by name. They have a separate line in their computer data for "interpreter needed." The office staff acknowledge the ease of the appointment because an interpreter was present. The staff ask if they want the interpreter present for subsequent testing. Hospitals would have an obvious point person that would be contacted when first discovering a Deaf patient would be arriving. This person would inform the floor, ready a TTY and closed*

captioning in the room, and arrange for interpreter services. Deaf patients would be proactive in their care.

- 1) Office staff are open and willing to work with Deaf patient and interpreter and know how to obtain interpreter services. They ask Deaf person for their preferred interpreter. 2) PA/Physician, etc. willing to take time to fully explain, respond to interpreter's requests for clarification when necessary, show overall respect for Deaf patient and their right to access information about their health. 3) Overall respect for the Deaf/HoH individuals as fully functioning, capable individuals.
- Any doctor or nurse who understands the nature of interpreting is ideal. That is: being patient, realizing there is lag time, having visual examples available, etc.
- When the doctor/staff ask the Deaf patient what works best for them.
- I'm describing ideals - no one system has all of these...yet. 1) IT systems which flag Deaf patients. Alerts all providers and secretaries that interpreters are needed. 2) Systems that allow D/HoH patients to express interpreter preferences. 3) Adaptive equipment for in-patients: TTY's, TV with captioning, etc. 4) Centralized interpreter request system.

**“ Any doctor or nurse who understands the nature of interpreting is ideal ”**

## SUGGESTIONS

Finally, we encouraged these eight interpreters to share any other relevant remarks. The following suggestions were offered:

- *There needs to be a general public awareness campaign including targeting medical providers regarding Deaf/HoH individuals, their needs and rights under the law regarding access.*
- *I would like to see a series of ASL medical term workshops to help my knowledge as well as contribute to a more common base use of standardized signs.*
- *Communication is one part but if a patient is staying any length of time in the hospital, is the staff knowledgeable about how to set up and use a TTY? Do they know where to find it in the hospital? Do they know enough not to stand in front of a window (because of the glare) when communicating with a Deaf or HoH person? If a patient does use lip-reading to augment communication, does the staff know not to exaggerate their mouth movements in an attempt to better clarify? Visual aids like 3-D models or pictures should be used to clarify. There is so much peripheral information about medicine and diseases of which a Deaf patient may not be aware. Printed material is a huge barrier because it's printed in English, which will always be a Deaf person's 2nd language. Staff needs to be aware that these printed materials need to be interpreted as well.*

## **LEP FOCUSED DISCUSSION GROUPS**

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To learn first-hand about the experiences of people with limited English skills seeking medical care in New Hampshire, we convened two discussion groups, one in Nashua and the other in Manchester. Discussion groups were used in order to create an environment that would promote an open exchange of ideas between subjects and as a way to mitigate the power imbalance often experienced by underserved populations.

The Nashua discussion group was held at the Nashua Soup Kitchen on June 28, 2004 to explore the experiences of limited English speakers with respect to the medical system in Nashua. We chose to work with Spanish speakers in Nashua because Census 2000 reports that they are the largest LEP population residing there. See the Methods section for a description of how participants were recruited.

The group consisted of eight members, all females, who ranged in age from 34 to 79. The average age was 58. Spanish was the primary language of six of the participants and the discussion was conducted in Spanish. On average, these women had lived in Nashua for 9 years with a range of 2 to 18 years.

As described in the Methods section, the second group took place in an English as a Second Language (ESL) class at the First Congregational Church in Manchester. It was held in English. There were ten contributors to the discussion, again all female. This was a younger group; the average age was 38, with an age range of 18 to 53. Participants had lived in the Manchester area for a shorter period of time than their counterparts in Nashua, from 2 months to 5 years; the average was just 2½ years. Many had refugee status. Primary languages included Amharic, Arabic, Chinese, Farsi, French Creole, Russian and Spanish.

### **RESULTS**

When asked to identify who interprets for them in medical settings, two indicated that they hire an interpreter themselves. Another said that the hospital provides an interpreter. The others mentioned bringing their children, other family members or friends, or just getting by without an interpreter. One woman said that her doctor speaks Spanish. In the two groups combined, seven participants reported that their usual source of health care was a community health center and ten said they rely on local hospitals, two indicating reliance on the Emergency Rooms. Only one participant saw a private physician for her usual care.

There was no agreement about who they think should pay for interpreters. Responses included the government; a refugee center; or the doctor, hospital, clinic or agency providing the services. Nearly half stated that it was their responsibility to pay since they do not speak English.

#### *Availability of Interpreters*

We asked, “When you arrive at a medical/dental/psychological visit are there usually people available to interpret?” Three participants replied in the affirmative stating that there are interpreters when they arrive at the community health center and at one clinic there are people who speak Arabic, French, Spanish, Bosnian and Russian. An Arabic speaker said that there is

paperwork in Arabic as well. Apart from these three, everyone else indicated that there were no interpreters. These respondents said:

- *Neither hospital has interpreters available when I arrive, nor do the labs when they send me for analysis.*
- *There is no one. I usually have to release my children early from school to interpret for me which cause tension at the school if it is always during the day.*
- *There is not a hospital emergency room with interpreters.*

**“ If you go to the emergency room, they  
ask your children to interpret ”**

- *I have not found a place here with an interpreter available when I arrive. When I lived in Lowell there were always interpreters at the hospital no matter when you went.*
- *They always use my kids to interpret for me.*

We inquired whether or not the interpreters are professional and if they are employed by the facility. Two of the women had positive perceptions of their interpreters stating, they said they had had good experiences at the community health center with the interpreter and that the refugee center sends trained interpreters to appointments. Others' comments were less positive:

- *They are not professionals, they are janitors.*
- *There are no interpreters.*
- *I use my friends, they don't work at the hospital.*
- *The community health center has interpreters but I don't think they are certified. Sometimes they do not know the medical terminology.*
- *I pay their employees a little tip to interpret for me.*

#### *Wait times for interpreters*

Some of the most animated replies came in response to the questions, “Do you normally have to wait for an interpreter? How long?”

- *Wait? If you wait you will be waiting forever because no one is going to come.*
- *There is no one to wait for.*
- *I waited forty-five minutes one day and then I left and went back with my kids.*
- *I do not go unless I have someone to bring with me. You never know if I go to the doctor and he can't understand my pain, he will give me the wrong medicine and that is dangerous.*
- *My 13 year old translated for me after my GYN appointment. He explained that I needed a hysterectomy. Sometimes I wonder if I really needed it and what was really wrong.*
- *I never wait because I always bring someone or I do not go.*
- *If I do not have someone, I do not go to the appointment.*

Two women said that the wait was not long because at the community health center, they always have an interpreter ready.

In response to the question “In your opinion do you think your provider wants you to bring your own interpreter?” there was a mix of answers. One woman said her hospital requires her to bring an interpreter. Another stated that that was not the case at the community health center because it always had an interpreter for her.

Many participants said that they postpone or delay care because they do not have an interpreter available. This was more common for the people who usually use hospitals than for those at health centers.

**They reported that they often cancel or change their appointments if they can't find someone to bring along to serve as an interpreter.**

Some bring their children if they can take them out of school or their adult children if they are available. A few women mentioned that they treat themselves or call someone in their native country. *“When I have a problem with the system here I go to my country. I speak English but I feel that the doctors here in Nashua do not want to understand me; like they think because I am Hispanic I don't know what I need. I had to first get medical advice from a doctor in my country so I could advocate for my son, and he actually ended up needing surgery.”*

A number of women spoke of perceived discrimination they face here. *“They don't always listen or care. I told the doctor about a pain I was having. He asked me how long I had it and when I replied 8 years on and off, he stated that if I had it that long I could live with it longer.”*

There was very little awareness of the language line as an option for interpretation. The few who had heard of it had never been offered it. Those who were aware of it had never seen it but had heard that the communication is not clear. One woman said *“I have not seen it or been offered it either but I have been told that you cannot understand anything.”*

When asked about signage in the hospital or community health center in their languages, those who spoke up stated that there are only signs in English.

One woman told a story about her husband who recently went to the emergency room for an infection in his leg. He went two times and could not understand the instruction he was given. He brought a bilingual friend to interpret. The discussion participant reported that the hospital wanted to admit him but the friend could not leave her children alone much longer so she left. The man left as well, as he was afraid to stay in the hospital without an interpreter. When he returned (for the fourth time) with the bilingual friend, he was admitted for a week and informed that he almost lost his leg.

Group members in Manchester were clear that interpreter availability was often not an issue, as many received services through the refugee program.

The groups' experience demonstrated that having a support system in place such as the refugee program facilitated access to linguistically appropriate care.

We ended both discussion groups by asking what is needed to improve language services.

**There was general consensus that interpreters need to be available 24 hours, well trained and aware of medical terminology.**

Interpreting should be their primary job. The most important place to have these services is in the emergency rooms. One woman stated, “*We need good programs to certify interpreters. I have bilingual friends who would be interested in this type of work. I know people who do it now but are not compensated.*”

## KEY FINDINGS

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Over 30,000 New Hampshire residents in 2002 had limited proficiency speaking English,<sup>8</sup> an increase of 22 percent from the 1990 Census figure of just under 25,000. Despite the large increase, these numbers are a relatively small percent of the statewide population (2.4%). There is currently no mechanism for quantifying the prevalence of hearing loss and deafness in New Hampshire, but a statewide needs assessment estimated that the Deaf population accounts for less than one percent of the statewide population.<sup>9</sup> We found that many health care institutions across the state are attempting to meet diverse language needs, even in facilities where an LEP or D/HoH patient encounter is a rare event.

### INSTITUTIONAL COMMITMENT

In our study of New Hampshire institutions, we found wide variation in the extent to which linguistically appropriate services were integrated into the facility's operations. Provider organizations varied in knowledge of their communities' medical interpretation needs and in their own level of services, commitment and resources. Services for linguistic minorities are concentrated in southern New Hampshire but many New Hampshire provider organizations commit substantial resources to serving LEP and D/HoH patients in other regions of the state.

The commitment to providing language services to D/HoH and LEP patients varies, however. Patients and surveys reported that some institutions routinely expect family members and friends to interpret. Nearly half of LEP patients in our discussion groups reported that they felt obligated to provide or pay for interpreters. Many of these patients reported delaying care when they did not have an interpreter available. This was more often true for the people who usually use hospitals than for those at health centers. They reported that they often cancel or change their appointments if they can't find someone to bring along to serve as an interpreter.

ASL interpreters also reported that providers sometimes try to get family members to interpret or view an ad hoc interpreter as "good enough." We cannot estimate the frequency of this practice.

### FREQUENCY OF LANGUAGES

Spanish, French and American Sign Language are the most frequently reported languages needing interpreters. Twelve of the 42 facility respondents reported encountering less common languages such as Arabic, Chinese, Farsi, Korean, Russian and Swahili, an indication of the diversity of language service needs throughout the state.

### WHO INTERPRETS

Some LEP respondents were pleased with their experience, especially at community health centers. At least one institution, bilingual staff and professional interpreters are available so that family members are never expected to interpret. They reported that there are interpreters present when they arrive at the center, and at one clinic there are people who speak Arabic,

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<sup>8</sup> Defined as speaking English less than "very well."

<sup>9</sup> Northeast Deaf and Hard of Hearing Services' Needs Assessment, 2002.

French, Spanish, Bosnian and Russian. An Arabic speaker said that there is paperwork in Arabic as well.

The interpreter resources that facilities reported using with the greatest frequency were, in descending order, external paid interpreters, bilingual clinical staff, bilingual non-clinical staff, and telephone services. At the other end of the spectrum, a substantial portion of facilities reported never using certain resources, such as video interpretation services, volunteer interpreters, ASL interpreter agencies, and staff interpreters.

Patients reported very different reactions to various methods of interpretation and communication—in person, telephonic, video, TTY, et cetera. One Deaf patient may be very comfortable using DeafTalk while another requires an ASL interpreter onsite to communicate effectively regarding sensitive clinical issues. Interpreters and patients confirm that many institutions and providers are not sensitive to individual patient needs regarding medical interpretation.

### **ASSESSING AND IMPROVING INTERPRETER TRAINING AND QUALITY**

We heard from the LEP discussion groups and the interpreter surveys of the need for assessing and improving interpreter quality. Our research indicates that some providers are assessing the competence of their bi-lingual staff and interpreters. Many organizations use interpreters trained in the state and/or language bank services and use that status as an assurance of competence. There is no generally accepted certification, credentialing, or licensing process in the LEP interpretation community, as there is for ASL interpreters and for many other health professionals.

### **PROVIDER/INTERPRETER COLLABORATION**

ASL and spoken language interpreters are trained in how to work with clinicians and patients. They report that many clinicians have not received similar training. Some clinicians are eager to learn, others are quite resistant. Interpreters report significant frustration when working with clinicians who are not well prepared to work with them as colleagues. When asked to identify challenges, the perception that doctors and nurses do not know how to work with interpreters was cited among the frequent problems.

### **INTERPRETER COMPENSATION SCHEDULING AND LOGISTICS**

Pay scale was most frequently identified as “always” or “often” a challenge, by 15 out of 27 spoken language interpreter respondents. Their compensation ranged from \$10.50 to \$45 per hour. ASL interpreters are generally better compensated (\$23 to \$40 per hour). ASL interpreters reported less dissatisfaction with their compensation.

Three items besides compensation were identified just as frequently as a source of dissatisfaction: travel time, short notification, and, as mentioned above, that doctors and nurses do not know how to work with interpreters. This suggests (though further investigation would be needed) that there may be some improvements to be made in the systems for deploying and using medical interpreters around the state that go beyond compensation issues. The logistic issues appear similar for ASL and spoken language interpreters.

## **DATA COLLECTION**

Provider organizations varied widely in their collection, analysis and use of medical interpretation data. Three of the key informant interviewees mentioned that they witnessed resistance to tracking linguistic demographics, as a clearly documented need would increase the pressure to provide service in response. They described an attitude of denial on the part of some providers: “If we don’t count them, we don’t have to serve them.”

Few organizations were able to easily report on service area and patient needs, or the volume and cost of services provided. Many organizations left data-related questions unanswered on the provider survey.

## **WRITTEN MATERIALS AND SIGNAGE**

About half of the facilities reported posting official signage in languages other than English. Facilities in Hillsborough County were significantly more likely to have signage and materials translated into non-English languages than were those facilities in other regions of the state. Most low volume facilities reported that they had few materials translated. Providers indicated that quality translation work is expensive, and that some patients may have limited literacy in their own written language. Only four responding facilities had translated their patient satisfaction surveys. Patients in the LEP discussion groups reported seeing little or no signage in Spanish or other native languages.

## **INCREASING DEMAND**

The population of New Hampshire was 1.24 million in 2002, an increase of nearly 12 percent over the 1990 Census. While a vast majority of New Hampshire residents are native born and speak only English, there is a significant and growing group of foreign-born residents, many of whom do not speak English very well.

We learned from the provider survey respondents that the demand for interpreter services is increasing and that new languages are being spoken throughout the state; 25 of 42 respondents (59%) said that the demand for language services has increased over the past few years. This view is expressed across the state and across facility types, with the exception of community mental health center respondents. Twelve facilities, mainly in the southern part of the state, report new languages spoken in their area in the past few years. As the demand grows, some providers described additional barriers related to the scheduling of interpreters, extended encounter time, and cost. We address possible next steps in meeting these challenges in the following section.

## NEXT STEPS

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We offer the following recommendations based on the research we conducted. Many of these suggested next steps are also supported by the principles outlined in the Medical Interpretation Advisory Board's draft strategic plan<sup>10</sup> and by the national CLAS (Culturally and Linguistically Appropriate Services) standards<sup>11</sup>. We note the relevant principle and/or standard from those two sources under individual recommendations, as appropriate. As we offer these suggestions, we are mindful of the wide variance in demographics across New Hampshire and acknowledge the necessity to differentiate policies reflecting the inconsistent and changing language needs.

The following recommendations focus on health care provider organizations. We recognize that other groups have a role to play in implementing and financing many of these recommendations. Therefore, we also suggest roles for policy makers, insurers, and others. Our research identified organizations that are already implementing a number of these recommendations.

The first two recommendations are related to information needs.

### **1) Collect language, race, ethnicity and other demographic data systematically.**

Systematic data collection, analysis and reporting are essential for community and statewide planning, as well as for individual organization's quality improvement and planning efforts. All sources confirm that data collection today varies widely across New Hampshire's health institutions. Promoting or, if necessary, mandating a consistent data collection and reporting process is an essential foundation to monitoring ongoing progress in serving limited English proficient (LEP) and Deaf/Hard of Hearing patients.

Quantifying the need for services is a necessary step to meeting that need. A language needs assessment of the patient population and of the geographic service area is critical to designing interpreter services. Various sources of geographic service area information include census data, school system data, community benefits needs assessments or focused outreach activities such as health fairs that target linguistic minorities.

Ongoing data collection by provider staff is essential, and training on how to collect such data, is important.<sup>12</sup> Public education, as well as provider education and support, may also

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<sup>10</sup> The full MIAB Strategic Plan will be available through Wendy Frosh and as an appendix to this report which will be posted on The Access Project website, [www.accessproject.org](http://www.accessproject.org).

<sup>11</sup> These National Standards for Culturally and Linguistically Appropriate Services in Health Care were issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health in December of 2000 to respond to the need to ensure that all people entering the health care system receive equitable and effective treatment. The CLAS standards are available from the Office of Minority Health at [www.omhrc.gov/clas/finalcultural1a.htm](http://www.omhrc.gov/clas/finalcultural1a.htm)

<sup>12</sup> Research has shown that some patients are concerned that their limited ability to speak English may affect the way providers treat them. Minority patients express similar concerns regarding race and ethnicity. The Robert Wood Johnson Foundation recently reported that only 34% of survey respondents were initially willing to volunteer information about their racial or ethnic origins. After patients were told such information was "necessary to address health care inequities and would be used for that purpose, 54% said they favored the idea." *Better Data: The First Step in Reducing Disparities in Health Care*, Lee Green, [Advances: The Robert Wood Johnson Quarterly Newsletter](#), Issue 3, 2004.

be important. Policy makers, philanthropies and state agencies can encourage, and potentially mandate, such data collection.

**MIAB Objective**—“Develop data collection and quality improvement systems to monitor the use and effectiveness of medical interpretation services.”

**CLAS Standard 10**—“Health care organizations should ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated.”

**CLAS Standard 11**—“Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.”

**2) Become more aware of needs by engaging with the community and monitoring patient satisfaction.** Provider survey and LEP discussion group comments diverged widely on how well language needs are being met. We suggest monitoring the satisfaction of patients with limited English proficiency by actively requesting feedback through your board and comments to staff. Translate patient satisfaction forms and customize questions so that you can gauge overall satisfaction with interpreter services. Ask if patients’ cultural and ethnic needs are met. Then translate patients’ comments into English for review. Analyze survey results by language groups and consider conducting patient focus groups.<sup>13</sup>

**MIAB Objectives** — “Survey community residents, health care professionals, community-based agencies.”

**CLAS Standard 12**—“Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/ consumer involvement in designing and implementing CLAS-related activities.”

The following six recommendations relate to provider operations.

**3) Address the availability of interpreter services and inform patients of their right to an interpreter.** We heard from the LEP discussion groups and the interpreter surveys of the need for improved access to qualified interpreters. Patients who are Deaf or Hard of Hearing and those with limited English proficiency need to be informed of their right to an interpreter. Addressing the challenge of scheduling problems should be seen as a priority issue.

A possible next step is to set a goal that every D/HoH and LEP patient is offered an interpreter either face to face, or via phone or videoconferencing and that all languages are available at all hours of operation with quality interpreting and timely access.

<sup>13</sup> Presentation by Loretta Saint-Louis, Director of Multilingual Interpreting at Cambridge Health Alliance, Nov. 21, 2003.

**MIAB Objectives:**

- Assess the effectiveness of providing medical interpretation through such means as telephonic, video conferencing and face-to-face interpretation.
- Develop a “resource to demand ratio” model.
- Establish realistic guidelines for service provision within health care organizations.

**4) Assess and continually improve the quality of interpreter services.** Our research indicates that some providers are assessing the competence of their bi-lingual staff and interpreters. Many organizations use interpreters trained in the state and/or language bank services. There is no generally accepted certification, credentialing, or licensing process in the LEP interpretation community, as there is for ASL interpreters and for many other health professionals. Health care providers have a responsibility to verify the qualifications of physicians, nurses and other clinicians who serve patients in their organizations. We suggest that similar assessment and improvement is essential for those providing medical interpretation.

Language service providers and interpretation educators, for both spoken language and ASL, share a responsibility and opportunity to assess and improve interpretation services. ASL Interpreter services, including Northeast Deaf and Hard of Hearing Services and Granite State Independent Living, use only certified medical interpreters. Providers can use services such as the Southern New Hampshire Area Health Education Center and New Hampshire Minority Health Coalition to train bi-lingual staff to become qualified medical interpreters. The AHEC and Coalition assess their trainees’ competence pre and post training.

**MIAB Objectives:**

- Determine level of competency required for medical interpreters.
- Develop certification/credentialing criteria.
- Develop practice standards for medical interpreters.
- Assess competency of current workforce including trained and untrained interpreters.

**CLAS Standard 6**—“Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/ consumer).”

**5) Explore innovative methods for pooling resources,** especially for facilities with a low volume of LEP patients. Smaller providers and those with low volumes of LEP patients reported cost and availability of interpreters as significant barriers to providing interpreter services. Facilities should be encouraged to think regionally and explore establishment of a statewide interpreter bank as mentioned in the MIAB strategic plan.

Policy makers, philanthropies and state agencies should consider supporting this collaboration among provider organizations. Non-provider entities can offer logistical,

financial and political support for this endeavor. A public vehicle might be required, for example, if attorneys determine a private collaboration could raise anti-trust concerns.

**MIAB Objectives:**

- Establish a statewide recruitment center.
- Develop a statewide system for providing interpreter services with 24 hour/7 days per week capability.
- Negotiate statewide contracts for communications services and devices.

**6) Train employees about a patient’s right to an interpreter, how to access and work with interpreters.** Our research indicated that on-going education is needed for providers in working with interpreters, Limited English Proficient, and Deaf/Hard of Hearing patient populations. Train providers in how to communicate through interpreters and, as appropriate, how to use the interpreter as a cultural resource. Research conducted by Massachusetts General Hospital indicates that such training makes a significant difference in clinician’s confidence in their ability to work with an interpreter.<sup>14</sup>

Training staff on a patient’s right to an interpreter can be part of general staff orientation. The means to access an interpreter may vary by service area (e.g. Emergency Department vs. inpatient unit). Many use departmental in-service or orientation sessions to address this issue.

The Cross-Cultural Healthcare Program in Seattle offers an excellent 30 minute video on working with an interpreter.<sup>15</sup> Provider organizations can use this or similar resources as part of their regular clinician and staff education activities and/or as part of cultural competence training.

**7) Make translation of written materials an integral component of delivering appropriate practices.** The provider survey responses indicated that patient satisfaction forms and other educational materials are not being routinely translated. Properly translated written materials can be critical to ensuring effective communication in the medical setting, such as obtaining informed consent, establishing advanced directives, and issuing discharge instructions and prescriptions.<sup>16</sup>

Translation is often confused with interpretation. Translation is the conversion of written text from one language into another, while interpretation involves the spoken or signed word. Effective translation includes determining the literacy level of the target audience and identifying regional language variations.<sup>17</sup> “I Speak” cards have proven to be a cost

<sup>14</sup> Betancourt et al, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, Commonwealth Fund Field Report, Oct. 2002.

<sup>15</sup> CCHCP has been addressing broad cultural issues that impact the health of individuals and families in ethnic minority communities since 1992. *Communicating Effectively Through an Interpreter* is available at <http://www.xculture.org/> or by calling (206) 860-0329.

<sup>16</sup> *Best Practice Recommendations for Hospital-Based Interpreter Services*, Office of Minority Health, Massachusetts Department of Public Health (MDPH).

<sup>17</sup> *Guidelines for Translation of Written Materials*, pg 19-20 of “Best Practice Recommendations for Hospital-Based Interpreter Services,” Office of Minority Health, MDPH.

effective method allowing non-English speaking patients to inform staff of their need for an interpreter.

**CLAS Standard 7**—“Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.”

**8) Continue the exchange of best practices between Deaf and Hard of Hearing community and Limited English Proficient advocates.** Learn from each other. Informant interviews and our own experience indicate the MIAB already serves as a forum for mutual learning between LEP and D/HoH communities. American Sign Language interpreters have been functioning in health care settings for a long time and have established operational and credentialing practices that can serve as models.

Explore achieving parity in compensation for interpreters – the median pay reported in the two discrete interpreter surveys is \$15/hour for spoken language interpreters and \$32/hour for ASL interpreters. The lower pay reported by spoken language interpreters is a function of the high proportion of respondents who are employed in a different position in an organization but do medical interpreting for that organization. Their average was \$13.75/hour as opposed to freelance interpreters who reported making an average of \$33.00/hour. Differential pay for bilingual staff who are called on to serve as interpreters should be considered.

## RECOMMENDATIONS NOT SPECIFIC TO OUR FINDINGS

In addition to the recommendations based on our research in New Hampshire, we offer these more general recommendations that reflect the thinking of our state and national partners who are committed to improving the quality of health care for linguistically and culturally diverse populations.

**9) Encourage public-private partnerships and broader state involvement.** The burden of meeting linguistic needs does not need to fall solely on the healthcare institutions, but it may take a statewide advocacy program to raise awareness of the critical nature and legal implications of providing appropriate medical interpretation.<sup>18</sup> The Endowment for Health has already made a significant contribution to training interpreters and facilitating strategic planning. We encourage you to use and reference the Diversity Plan, produced at the NH Department of Health and Human Services, as a model.<sup>19</sup>

<sup>18</sup> Strategic plan of Medical Interpretation Advisory Board, July 2004 draft.

<sup>19</sup> Plan available at: <http://www.dhhs.state.nh.us/DHHS/MHO/LIBRARY/Program+Report-Plan/diversity-plan.htm>

**MIAB Goal**—Mount a statewide advocacy program to raise awareness of the critical nature and legal implications of providing appropriate medical interpretation.

**MIAB Objectives:**

- Support provider organizations in efforts to improve capacity to serve LEP & D/HoH populations.
- Encourage accrediting organizations – i.e. JCAHO, NCQA – to address safety and quality issues that arise from language barriers.
- Conduct educational sessions with policy makers and elected officials.
- Support education and skill training within LEP and D/HoH communities.

**10) Evaluate language proficiency of staff.** While the presence of bilingual and bicultural providers increases the likelihood that patients will feel more welcome at a given facility, the healthcare organization must be able to ensure the accuracy of the self-declared language proficiency of bilingual providers.<sup>20</sup>

**MIAB Objectives:**

- Assess the competency of the current workforce, including trained and untrained interpreters
- Develop a standardized process for assessing competency for use by all organizations.
- Determine the appropriateness of a single-source provider for competency assessment.

**11) Create ongoing monitoring and public reporting on the state of medical interpretation and its impact on health status of New Hampshire’s D/HoH and LEP residents.** The medical interpretation needs of New Hampshire residents will continue to grow as the state grows older and more ethnically and linguistically diverse. Ongoing monitoring is essential to ensure that the improvement in the availability and quality of medical interpretation grows as well. Policy makers, insurers, philanthropies, interpreters, advocates and providers have a strong shared interest in an effective statewide reporting system used for quality improvement purposes.

**MIAB Goal**— Create the infrastructure necessary to assure the implementation of Plan goals and objectives.

**MIAB Objectives:**

- Assign responsibility for implementation of Plan goals and objectives
- Monitor the success of implementation of Plan goals and objectives

**CLAS Standard 14**—“Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.”

<sup>20</sup> *In the Right Words: Addressing Language and Culture in Providing Health Care*, Grantmakers in Health, Issue Brief 18, August, 2003.

**12) Conduct conversations with health care leaders** to obtain their support for the report and its findings, address any concerns they may have, and create momentum for the advocacy and awareness campaign and other recommendations cited above.

Research conducted this year by the National Public Health and Hospital Institute states that senior leadership plays a crucial role in establishing the level of commitment to meet the linguistic needs of the patient population served.

*Programs and initiatives may succeed or fail on the basis of support from one or more senior leaders. A key role of the senior leadership is to provide all staff members with the tools they need to effectively communicate and treat their diverse patient populations..., and the infrastructure, financial, and morale-building supports necessary for staff to acquire these tools. <sup>21</sup>*

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<sup>21</sup> *Serving Diverse Communities in Hospitals and Health Systems*, National Public Health and Hospital Institute, June 2004.

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## **APPENDICES**

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We have decided to make all of the appendices available via the Internet rather than printing additional pages that many readers may choose not to review. These will be available to view or download at [www.accessproject.org](http://www.accessproject.org).

**A. Key Informant Discussion Guide**

**B. Summary of Key Informant Findings**

**C. Facility Survey**

**D. Facility Survey Cover Letter**

**E. Interpreter Survey**

**F. ASL Interpreter Survey**

**G. LEP Discussion Guidelines**

**H. Medical Interpretation Advisory Board (MIAB) Strategic Plan – *Draft***

**I. Agenda of New Hampshire Hospital Association’s Forum “*What a Difference an Interpreter Can Make,*” held April 2, 2004**

**J. Bibliography**