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Linguistically Appropriate Access and Services; An Evaluation and Review for Healthcare Organizations

by
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Introduction

If you ask a veteran health care provider what has changed over the past 20 years in the patient population he or she serves, chances are the answer will include an increase in linguistic and cultural diversity. Today, as witnessed by the 2000 Census, over 300 languages are spoken in the United States. Immigrants and refugees to this country bring a valuable mix of work skills and cultural wealth; however, meeting the health needs of groups whose English is limited poses a challenge to even the most competent health care system. While most immigrants arrive in good health, the need for health care services for individuals from these immigrant populations, just like for other populations in the USA, can be immediate and, in many cases, urgent. Many refugees, especially those fleeing violent situations, may arrive with complicated medical and psychological problems, increasing their need for health care services. And, as Maria Paz Avery of the Education Development Center writes, "Their immediate and frequently urgent health care needs do not wait for linguistic adjustment or cultural assimilation."[1]

Many health care organizations across the country are unprepared to provide adequate linguistic access. As the mainstream health care industry treats a more diverse clientele, the need for culturally and linguistically appropriate services has increased.

The Massachusetts Medical Interpreter Association has this to say about the misconceptions prevalent today about interpreter use in health care settings.

> *The use of a third person to communicate between e providers and patients who do not speak the same language has been going on for a long time. Unfortunately, however, this process has been fraught with many misconceptions about the nature of interpreter-mediated communication. One of the commonest misconceptions is that anyone with any level of bilingualism is capable of providing effective interpretation. Thus, we see the continued use of children, family members and auxiliary staff (e.g., clerical, custodial, housekeeping) as interpreters. Even an equal level of fluency in two languages, however, is a prerequisite but a not a sufficient skill for interpreting. In addition, an interpreter must be able to convert messages uttered in one language into the appropriate sociolinguistic framework of another language . . .*
>
> *These misconceptions are further exacerbated when the parties most affected by the interpretation lack the skills to judge its quality. Neither the patient nor the provider can monitor the accuracy and completeness of the interpretation, since each speaks only one of the languages. Neither has a way of knowing whether the interpreted message contained omissions, additions, interpreter opinions, guesses or other distortions that could result in serious miscommunication.*[2]

As the clinical interview between patient and provider relies heavily on language for much of its information gathering,[3,4] the presence of a qualified interpreter, who has demonstrated the

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1 Avery, Maria Paz. The Role of the Health Care Interpreter: an Evolving Dialogue. The National Council on Interpreting in Health Care. April, 2001.
2 Massachusetts Medical Interpreters Association and Education Development Center, Inc. Medical Interpreting Standards of Practice. 1996.
3 MMIA and EDC, 1996
4 Putsch, 1984

capacity to interpret accurately and completely, is absolutely essential to the provision of quality health care.

The goal of this paper is to offer a process by which a health care organization can evaluate its existing structure and capacity for providing linguistically and culturally appropriate care and accessibility at all levels. This initial evaluation will help identify actions needed to improve quality of care, clinical outcomes, service delivery, cost containment, and regulatory compliance. It will also set forth standard evaluation parameters and considerations that provide a nationally uniform approach to the evaluation of language access. The National Council on Interpreting in Health Care (NCIHC) welcomes feedback on this paper and suggestions toward making this tool even more useful for health care administrators.

Why is an evaluation process needed?

Both federal and state laws mandate that health care organizations provide appropriate linguistic access for limited English proficient (LEP) patients. Accreditation agencies such as the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the National Committee on Quality Assurance (NCQA) set standards and monitor compliance in language services, as in all other areas of operation. What is needed is a nationally uniform approach for health care organizations to guide them in successfully complying with the task set before them. The Office for Civil Rights' Guidance Memorandum on Language Access, most recently released in August of 2000, states that "Recipients (those health care providers who are recipients of federal dollars) are more likely to utilize effective communication if they approach this responsibility on a structural rather than an ad hoc basis." The DHHS Office of Minority Health funded project "CLAS" (Cultural and Linguistic Competence Standards and Research Agenda Project), also published in 2000, recommends that organizations have a "comprehensive management strategy to address culturally and linguistically appropriate services." [5]-[6]-[7]

Currently across the United States, the level of preparedness of health care organizations to serve diverse language needs is much more developed in some regions than in others. In some parts of the country with older immigrant populations, such as California and Massachusetts, many institutions took the steps to establish "language services programs" over twenty years ago. In areas with more recently arrived immigrant populations, such as Georgia, the first hospital language services program was not formed until early 2000. The establishment of language services programs in health care organizations is the first step in a complex process of addressing language needs. Such programs can quickly become fragmented and inefficient without a comprehensive organizational plan.

This evaluation tool walks health care organizations through their systems in a way that addresses all points of service, answering to the needs of patients and the organization's staff. It is a comprehensive approach, the development of which draws on the experience and expertise of leaders in the field of

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[5] **http://www.hhs.gov/ocr/lep/guide.html** Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency.

[6] **http://www.hhs.gov/ocr/lep/press.html** Written Guidance for Health and Human Services Providers To Ensure Language Assistance for Persons with Limited English Skills.

[7] **Http://www.hhs.gov/gateway/language/languageplan.html** Strategic plan to improve access to HHS programs and activities by limited English proficient (LEP) persons

medical interpretation. It should be evident that creating a linguistically accessible health care organization requires a review of relevant policies at all levels as well as support from the senior leadership.

This evaluation tool does not dictate how each organization should respond to its patient population, but rather points to the questions that need to be asked to fully explore, examine and anticipate how the arrival of patient groups of diverse languages and cultures invite a broadening of the concept of patient care. Further, the evaluation tool does not prescribe the "right way" services should be provided; that is left up to the institution. Hopefully a thorough evaluation will lead the institution to develop the best approach for its own unique LEP patient population. The evaluation tool also does not evaluate the wider theme of general cultural competency and cultural awareness training. While the tool does refer to these elements, the proper evaluation is left to a more specialized process. Also, this evaluation does not address other technologies such as video interpreting or electronic translation to provide communication. These areas may need to be added at a later date, as more understanding of their efficacy and cost efficiency is determined.

What is the role of the NCIHC?

The National Council on Interpreting in Health Care (NCIHC) is a leading national organization representing the field of medical interpreting.
The NCIHC is a multidisciplinary organization, whose mission is to promote culturally competent professional medical interpreting as a means to support equal access to health care for individuals with limited English proficiency.

As an authoritative voice representing the broad spectrum of expertise in the field of health care interpreting, the NCIHC is the primary advocate for the development of national standards that will further the quality of communication and understanding between the health care provider, the interpreter and the LEP patient. Further, it promotes the profession of health care interpreting, recognizing the interpreter as an integral member of the health care team.

In keeping with its mission, the NCIHC recognizes that a nationally uniform evaluation process is needed through which hospitals and health care organizations can effectively evaluate their abilities to meet the needs and improve access for their culturally diverse patients and to assure that health care providers can communicate with their patients to offer appropriate health care.

What are the expected outcomes?

It is the intent of the evaluation process to provide hospitals and health care organizations a means to identify:

1. the strengths and limitations of existing linguistic services,
2. risks to the organization,
3. cost drivers,
4. qualitative issues in care delivery,
5. the impact on care outcomes,
6. regulatory compliance issues across ethnic patient populations,
7. a better understanding of ethnic community needs, and
8. internal and external resource availability and allocation.

The list of questions is designed to assure that key parameters are addressed in the evaluation process. It takes into consideration not only the provision of services but also the cost effectiveness and efficiency of service delivery. In today's health care environment, the total cost of providing care is a key element in an organization's ability to provide access to a culturally diverse community.

Parameters and Considerations for Evaluation

The development of the evaluation categories and questions is a synthesis of current thinking about what comprises a competent medical interpreting program. It also draws on work done by such organizations as the DHHS Office of Minority Heath (OMH), the Office of Civil Rights (OCR), the National Health Law Program, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Quality Improvement System for Managed Care (QISMIC) standards released by HCFA (http://www.hcfa.gov/quality/3a.htm), the Massachusetts Medical Interpreting Association (MMIA) Standards of Practice for Health Care Interpreters (http://www.mmia.org) and others. *(Please see the Bibliography for further references.)* This evaluation tool however, is not static and will continue to evolve as new approaches are piloted and understanding is gained on how best to provide access to a culturally diverse society. Specific questions of various types of individuals e.g. physicians, nurses, admitting staff etc, within an organization are not included at this time. Future work will develop those questions most likely to provide as an objective assessment as possible.

The evaluation tool is divided into four major sections that examine the myriad of issues in providing comprehensive multi-linguistic services. The questions establish a framework with which to identify both structural and substantive issues in meeting the needs of LEP patients. The framework includes an organizational overview towards services and resources for LEP patients and helps organizations identify the issues involved in the requirements, operation and capabilities of bilingual staff and providers along with face-to-face and telephonic interpreting and translation services. External interpretation agencies, providing both face-to-face and telephonic interpreting services are also incorporated into the evaluation.

Organizational Evaluation Instrument

Organizational Overview

This section is the largest and covers the global approach taken by the organization in addressing the multilingual needs of the patient, including an evaluation of the demographics in the community the institution serves and that of the patient population receiving care within the institution. It further takes into consideration the organization's approach and commitment towards cultural diversity both in terms of organizational structures, as well as the ways in which staff and physicians interact with limited-English-speaking patients on the organizational "front line." By "structures" we mean questions relating to organizational leadership, policies on cultural and linguistic competencies, providers as champions, training, performance appraisals, quality assurance criteria, language tracking of LEP patients/clients, protocols for accessing interpreters, interpreter protocols, hiring and training, and ethno-cultural community involvement.

Bilingually Provided Services

One model of the provision of linguistic access depends on the use of bilingual professionals who provide their particular service directly in the language of the patient. The bilingually provided services section will help shed light on the actual practices of organizational staff members and providers in their interactions with LEP patients/clients. Further, it evaluates how training and testing of language proficiency, if any, is conducted.

Health Care Interpreting Services

Face-to -ace Interpreting Evaluation

The predominant way that LEP patients meet their communication needs is through an on-site or face-to-face interpreter. The evaluation process focuses on the quality of the interpretation as well as the attitudes of staff towards interpreters, all of which are key elements in providing an effective interpreter program. It also looks at the relationship and integration of internal staff interpreters (if available) to those of agency staff that may be utilized. A key issue for organizations is the disparity in the quality of interpretation across various language groups, and how these discrepancies are addressed.

Telephonic Interpreting Evaluation

With the ever-present pressure placed on health care institutions to lower the total cost of care to their patients, there is a movement toward a greater reliance on the use of telephonic technology. Often, telephonic interpreting makes the interpreter more immediately accessible to the provider, particularly in time sensitive situations. In addition, telephonic services can often find interpreters in less common languages. As more institutions look to control their cost of providing interpreting services they are looking at ways to reduce the encounter cost. Telephonic interpreting can help control costs, depending on the per-minute pricing structure. However, little is known about how the shift to a telephonic mode of interpreting may affect the quality of the interpretation, the content of the patient-provider communication, the ability of the patient to navigate the health care system, or patient/provider satisfaction.

How to decide when telephonic or face-to-face interpretation is most appropriate is, at this time, an open question. The evaluation process included here asks questions about the way in which telephonic service is provided, however, how staff utilizes it and under what situations it is limited in scope. The questions asked look at the institution's written policy and procedures to assess if there is any criteria established to provide guidance in determining when telephonic interpreting is used. Further, the evaluation looks at the training and understanding of its use by staff and the level of instruction given the patient who is involved in the interpretation. The tool also directs questions at the level of assessment established to evaluate the training of interpreters used for telephonic interpreting. Whether provided internally or externally assessing training and competency is critical to the successful use of telephonic interpreting.

External Interpreter Agency Evaluation

Most large hospitals and health care organizations today utilize multiple means to meet the growing need for language interpreting. In addition to internal resources, they may include external interpreter agencies, both for-profit and not-for-profit, individually-owned and

community-based agencies, to help meet their interpreting and translation needs. External agencies may provide a full-service approach in which all interpreting or translation needs are managed through one or more agencies, or the external agency may function only in a back-up capacity. In any case, there are few institutions that can internally meet the total need for interpreting and translation services by virtue of the increasing demand for many more languages resulting from changes in immigrant and refugee demographics.

The need to evaluate external interpreter agencies is a critical component in assessing an organization's ability to meet the needs of its LEP patient population. A primary reason for this is the variety in the levels of services and the pool of resources available to meet the demand. Smaller agencies, providing services for a limited number of languages, may not have the resources of mid-size or larger language service agencies to provide the sustained level of testing and training necessary to assure that the interpreter meets the qualifications needed to provide quality interpreting in the medical environment. However, since there are only incipient national standards for medical interpreting, a thorough evaluation of any agency is still needed since the approach and measurement of quality can vary dramatically from agency to agency. In addition, some agencies only specialize in certain areas (e.g. telephonic interpreting), which may limit their ability to comprehensively meet the institution's needs.

While evaluating an external agency's capability it may become apparent that not all of the institutions needs may be met by selected agencies. It is important to work with agencies to foster the quality and service needed by the institution. This will lead to the development of long-term collaborative relationships that are in the best interest of both organizations. Consistency over time is a key component in developing such relationships, leading to higher levels of service and quality in meeting the institutions interpreting needs. This evaluation tool has folding questions about agencies into the sections on face-to-face and telephonic interpreting.

Translation Services Evaluation

Translation of written materials is a vital component in providing LEP Patients access to health care services. Unfortunately, it is often inadequately addressed, particularly for documents such as consent forms, advanced directives, financial materials, and discharge information. In addition, training and education materials commonly provided English-speaking patients are often overlooked. The evaluation tool treats translation in the same context and with the same emphasis as interpreter services, evaluating not only the availability of the material but the process through which new material is identified for translation and made available to patients.

Further, the evaluation looks not only at whether the material is translated, but also the accuracy of the translation. Translation from English to another language is not merely a question of changing from one text to another; it is a very complex process involving consideration of cultural meaning and understanding in a variety of contexts. Assuring accurate translation may involve not just one translation but may in fact require two or three to assure that the proper meaning is conveyed depending on the country and cultural community form which the patient came. While resources may be limited for translating all materials, a careful evaluation will help an institution determine which documents are most critical to assuring quality of care delivery and will help to determine what alternatives may be available. In addition, an evaluation of how non-translated material is interpreted

and by whom is important Face-to-face interpreters are often utilized to provide on-site translation of documents, yet may not be qualified as translators, leading to misrepresentation of the printed material. Further, this can add to the cost of the interpreting encounter.

Conclusion

The evaluation tool that follows, then, is designed to help institutions take stock of how well their systems are providing accurate and timely language access services to LEP patient populations. Of course, an evaluation is only the beginning of the process. Once the institution has pinpointed its strengths and weaknesses, a decision must be made about how to improve services in the areas that are weak. This will be the topic of a separate NCIHC Working Paper. For now, we hope that this tool is useful in helping institutions to evaluate their existing language access programs.

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Organizational Evaluation of Linguistic Access

Introduction

The following questions are arranged based on the three primary means of communicating with LEP patients: that is, through bilingual employees who communicate well enough in a language other than English that an interpreter is not needed, through the use of an interpreter, and through the use of translated material.

In addition to these three main categories, a further break down is presented based on the way in which interpreting is most likely to occur, with specific questions for each category. Since not every institution will utilize every mode of interpreting to facilitate access for its LEP patients, the sections are also arranged such that, if they don't apply, that section can be skipped.

Definition of Terms

These definitions are taken from *The Terminology of Health Care Interpreting: A glossary of terms.* The National Council on Interpreting in Health Care, October 2001.

bilingual provider:

a person with proficiency in more than one language, enabling the person to provide services directly to limited-English-proficient patients in their non-English language.

bilingual worker / employee, or bilingual staff used as an interpreter:

an employee who is a proficient speaker of two languages, usually English and a language other than English, who is often called upon to interpret for limited-English-proficient patients, but who is usually not trained as a professional interpreter.

face-to-face interpreting:

interpreting done by an interpreter who is directly in the presence of the speakers. Also called *on-site interpreting.*

first-person interpreting:

the promotion by the interpreter of direct communication between the principal parties in the interaction through the use of direct utterances of each of the speakers, as though the interpreter were the voice of the person speaking, albeit in the language of the listener. For example, if the patient says, "My stomach hurts," the interpreter says (in the second language), "my stomach hurts," and not "she says her stomach hurts."

Interpreting: (noun)

the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account. [ASTM] The purpose of interpreting is to enable communication between two or more individuals who do not speak each other's languages.

Limited English proficiency (LEP):

a legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter [ASTM] This is a term used in the Policy

Guidance of August 29, 2000 published in the Federal Register, by the Office for Civil Rights (OCR) of the US Department of Health and Human Services.

translation:

the conversion of a written text into a corresponding written text in a different language.

[Within the language professions, **translation** is distinguished from **interpreting** according to whether the message is produced *orally* (or manually) or *in writing*. In popular usage, the terms "translator" and "translation" are frequently used for conversion of either oral or written communications.]

video interpreting:

interpreting carried out remotely, using a video camera that enables an interpreter in a remote location to both see and hear the parties for whom he/she is interpreting via a TV monitor. The interpretation is relayed to the principal parties by speakerphone or through headsets. Two-way interactive television can also be used, so that the other parties can interact with the interpreter as if face-to-face.

I. ORGANIZATIONAL OVERVIEW	Yes	No
Administrative Overview		
1. Is senior management, including the CEO, knowledgeable about cultural and linguistic issues, including the organization's policies and procedures?		
2. Is senior management knowledgeable about the business implications of cultural and linguistic access and services?		
3. Are there one or more physicians/providers who have responsibility for working with language access issues?		
4. Is there a department responsible for linguistic services? - Please describe the operational structure for any such service.		
5. Do all staff with direct patient contact, have a thorough working knowledge about the available linguistic resources?		
6. Is there on-going training for staff and providers including Grand Rounds, seminars etc., on how to work effectively with Limited English Proficient (LEP) patients?		
7. Is there a system established to keep staff and providers informed about language and interpreting issues in care delivery?		
8. Does staff know how to determine whether an interpreter is needed?		
9. Is knowledge about linguistic access included as part of the performance appraisal for managers, providers and staff?		
10. Does the organization assess the needs of its culturally diverse populations?		
11. Have studies of patient health outcomes in relation to the use of trained interpreters been conducted?		
Policy & Procedures		
12. Does the organization have written policies and procedures supporting the provision of linguistically appropriate services such as the use of interpreters?		
13. Do policies for staff and providers explain the regulatory and statutory obligations for providing language access to patients with limited English proficiency (LEP)?		
14. Do policies and procedures specify the way in which interpreting is to be provided? (Telephonic vs. face-to-face vs. translated documents?)		
15. Is the written policy promoted and distributed to staff? - How, when and to whom in the organization is this publicized?		
16. Are contract providers trained in the organization's policy and procedures relating to the use of interpreters? - If so, how is this done?		
17. Are the above procedures consistently adhered to?		
18. Is there a process for monitoring compliance with the policy and procedures?		
19. Is there a written policy and notice to patients relating to the availability, at no cost, of an interpreter? - If there is a policy, how is it made available to the patient? - Is the statement posted prominently at all points of initial patient contact? - Is it translated into the most common languages served by your institution?		
Patient/Member Demographics		
20. Has the organization conducted a demographic analysis of the LEP populations that it serves? - What assessment tools were used?		
21. Are all ethnic and linguistic groups in your catchment area reflected in the profile?		
22. Are there demographic size thresholds for cultural and linguistic communities in your organization's catchment area that determine the organization's activities for providing linguistic services? - If so, explain what they are.		

23. Is each patient's primary language identified? - How and when is this information collected?		
24. Is the patient's primary language consistently noted in the medical record? - Who gathers this information and is this policy consistently applied?		
25. Is there a written plan for assuring equal access to LEP patients for threshold ethnic groups? - If so, how often is it up-dated?		
Patient Services		
26. Are interpreters or bilingual providers available during:		
- the admissions process?		
- the enrollment process?		
- financial services?		
- member services?		
- grievance and complaint processes?		
- other non-care patient interactions?		
27. Are interpreters provided at no cost to the patient?		
28. Have there been any grievances filed due to lack of language access? - Please explain the nature and outcome of such grievances.		
29. Have there been any state or federal complaints filed due to language access questions? - Please explain the nature and outcome of such complaints.		
30. Are there records of complaints, grievances etc. specific to language or cultural issues? - Please explain the nature and outcome of such complaints.		
Care Delivery		
31. Is language access made available during all hours of your institution's operations? If not, during what hours do you make language access available?		
32. Is language access made available in all areas of patient care, including		
- clinic appointments?		
- the obtaining of informed consent for medical treatment procedures?		
- pharmacy?		
- laboratory?		
- diagnostic imaging?		
- emergency services?		
- day surgery?		
- labor and delivery?		
- in-patient services?		
- chaplaincy services?		
33. Do staff/providers know when to call a face-to-face interpreter and when to call a telephonic interpreter?		
34. Are informed consent forms provided in the language(s) of the LEP populations represented in the community in compliance with any threshold demographics?		
35. Are other printed materials provided in the language(s) of the ethno-cultural groups represented in the community in compliance with any threshold demographics? (Such as patient education, pharmacy, etc.)		
Regulatory Review		
36. Are linguistic services incorporated into accreditation compliance activities? Including the reporting requirements for:		
- NCQA		
- JCAHO		
- QISMIC (HEDIS 3.0)		

- Other (please describe)		
37. Are patient satisfaction surveys conducted in any language other than English, including the primary languages served by the organization?		
Financial Analysis of Service Delivery		
38. What is the annual expenditure on interpreter services?		
39. Is the annual expenditure clearly identified in financial statements? - Are charges for telephonic interpreting specifically identified?		
40. Are departments or facilities accountable for expenditures on interpreter services?		
41. Are salary differentials given to train and qualify bilingual staffs that interpret as a part of their normal duties?		
42. What, if any, are the indirect, or unidentified costs associated with interpreter services?		
Data Collection and Reporting		
43. Is data collected on the utilization of interpreter services?		
44. Is data tracked relating to the patient's process through the system and health outcomes, using:		
- Location of medical encounter?		
- Language interpreted?		
- Duration?		
- Time of day?		
- Date?		
- Provider and Department?		
- Staff ?		
- type of interpreter – contract, telephonic, staff?		
45. How is the information collected reported, or used in the organization?		
46. Is the collected data aggregated, analyzed and incorporated into future planning?		
II. BILINGUALLY PROVIDED SERVICES		
Provision of Service		
47. Do bilingual providers and staff utilize their bilingual skills in performance of their routine functions?		
48. What is the profile of bilingual staff? (Create a table by department) -Languages Spoken: Provider Type # of bilinguals Total # Primary care OB/GYN Mental Health Emergency Medicine		
49. Are bilingual providers and staff utilized to perform interpretation? -If so, under what conditions and how often?		
50. Is the ability to speak a second language a consideration in hiring criteria?		
51. Are there qualifications in language fluency, specifically related to health care, required of bilingual providers and staffs? -If so, how are qualifications measured/assessed?		
Policy and Procedures		
52. Are there policies and procedures in place for evaluating individual language skills of providers and staffs? -If so, do they specify when and under what conditions evaluations are conducted?		
53. Are there policy and procedures that specify under what conditions a bilingual provider or staff must use an interpreter in providing care or service?		

Quality Management		
54. Is there in place a mechanism to evaluate the basis language skills and proficiency of staff believed to be bilingual?		
55. Is continuing education provided in language and cultural skills development specific to bilingual staff or providers who use their second language in providing care delivery and services?		
56. Are the following elements assessed of bilingual staff and providers?		
- Confidentiality?		
- Fluency and register of language skills?		
- Medical terminology in the non-English language?		
- Cultural awareness related to population groups served?		
57. Is there a mechanism in place to evaluate the care experience of the LEP patient when provided by a bilingual provider or staff? -If so how and when is the evaluation conducted?		
III. HEALTH CARE INTERPRETING SERVICES		
Face to Face Interpreting ***(if none is used, proceed to the next section)***		
Overview		
58. Are policy and procedures in place related to the use of face-to -face interpreting? - If so do they specify when and under what conditions this form of interpreting is to be used?		
59. Is the use of an interpreter documented in the patient's medical record? - If yes, what is the frequency of compliance?		
60. Do providers and staff received training on the appropriate use of a face-to-face interpreter?		
61. Is the length of the interpreting encounter recorded? - If so, what is the average length of a face-to-face interpretation?		
62. For what types of encounters is face-to-face (as opposed to telephonic) interpreting utilized?		
- clinic appointments		
- the obtaining of informed consent for medical treatment procedures		
- pharmacy		
- laboratory		
- diagnostic imaging		
- emergency services		
- day surgery		
- labor and delivery		
- in-patient services		
- chaplaincy services		
- the admissions process		
- the enrollment process		
- financial services		
- member services		
- grievance and complaint processes		
- other non-care patient interactions		
63. Is there clear documentation to ensure that identified problems are addressed?		
64. Is client data collected in the utilization of face-to-face interpreter services? If so, is it broken down by:		
- Type of encounter		
- Language		
- Duration		
- Time of Day		
- Provider and department		

- Staff		
- Patient ID		
67. Is the interpreter no-show rate recorded? - If so, what is the rate?		
68. What are the driving factors for no shows?		
Bilingual Staff used as Interpreters *(if none are used proceed to the next section)*		
69. Are bilingual staff members used as interpreters?		
70. If staff members are used as interpreters, how does this affect their productivity in their normally assigned work?		
71. Is there qualification in language fluency and health care interpreting that is expected before staff can undertake an assignment?		
72. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
-Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
73. Is there organized and on-going recruitment of bilingual staff?		
74. Is there an ongoing training process in place? -If yes, how often is it presented?		
75. Is there a continuing education program in place for bilingual staff used to interpret?		
76. Does the institution perform an annual review of bilingual staff used to interpret?		
Dedicated Staff Interpreters *(if none are used proceed to the next section)*		
77. Does your institution hire dedicated staff interpreters?		
- Full-time?		
- Part-time?		
78. What languages do your staff interpreters cover?		
79. Is there qualification in language fluency and health care interpreting that is expected of a staff interpreter before hire?		
80. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
- Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
81. Is there organized and on-going recruitment of staff interpreters?		
82. Is there an ongoing training process in place? -If yes, how often is it presented?		
83. Is there a continuing education program in place for staff interpreters?		
84. Does the institution perform an annual review of staff interpreters?		
Independent/Contract Interpreters *(if none are used proceed to the next section)*		
85. Does your institution contract with independent, freelance interpreters?		
86. What languages are provided?		
87. What arrangements are made for languages not provided?		

88. Is there qualification in language fluency and health care interpreting that is expected of an independent interpreter before contract?		
89. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
- Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
90. Is there organized and on-going recruitment of contract interpreters?		
91. Is there an ongoing training process in place? -If yes, how often is it presented?		
92. Is there a continuing education program in place for interpreters?		
93. Does the institution perform an annual review of contract interpreters?		
Agency Interpreters[8] *(if none are used proceed to the next section)*		
94. Is there a contingency back-up system in place when the agency cannot provide services for a particular language? - If so, explain how arrangements are made.		
95. For which languages can the agency provide service on a regular basis?		
96. How does the agency recruit interpreters?		
97. Is there qualification in language fluency and health care interpreting that is expected of agency interpreters before they are contracted?		
98. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
-Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
99. Is there an ongoing training process in place? -If yes, how often is it presented?		
100. Is there a continuing education program in place for interpreters?		
101. Does the agency perform an annual review of its interpreters?		
102. Are there policy and procedures in place for each health organization served? - If so, do they specify how services are to be provided?		
103. Are there healthcare protocols and standards of ethics in place and adhered to by all interpreters from the agency? - If so, what are they and where do they originate?		
104. Is there an organized data collection & reporting process in place at the interpreting agency?		
105. Is there clear documentation to ensure that problems are addressed both by the agency and the institution?		
106. Describe how the following elements are monitored by the agency?		

[8] For an expanded discussion of providing language access through an interpreter agency, see Roat, Cynthia E.: *How to Choose and Use a Language Service,* The California Endowment, 2002.

	-How is information recorded and authenticated? -Adherence to interpreter standards, including confidentiality -Accuracy of interpreting -Professional protocols / conduct -Patient Satisfaction -Provider/staff satisfaction		
107.	Is data collected for face-to-face interpreting that is reported to the client?		
Volunteer Interpreters (if none are used proceed to the next section)			
108.	Does your institution use volunteer interpreters?		
109.	What languages do your volunteer interpreters cover?		
110.	Is there qualification in language fluency and health care interpreting that is expected of a volunteer interpreter before he or she may accept assignments?		
111.	Are the following elements assessed and monitored?		
	- Understanding of the interpreter's role		
	- Adherence to an interpreter code of ethics		
	- Accuracy and completeness of the interpretation		
	- Use of the first person in interpreting		
	- Medical terminology in both languages		
	- Grammar		
	- Register and mode of interpreting		
	- Professional demeanor and comportment		
	- Patient satisfaction		
	- Provider/staff satisfaction		
112.	Is there organized and on-going recruitment of volunteer interpreters?		
113.	Is there an ongoing training process in place? -If yes, how often is it presented?		
114.	Is there a continuing education program in place for volunteer interpreters?		
115.	Does the institution perform an annual review of volunteer interpreters?		
Family and Friends as Interpreters			
116.	Is there a policy in place prohibiting the use of family or friends as interpreters? - What is the level of compliance?		
117.	Is this policy made available to patients in their primary language?		
118.	If a patient insists on using a family or friend as an interpreter, is a professional interpreter required to be present anyway? - If not, under what circumstances? - Are other means for providing professional interpretation presented? - Is there a notation in the medical record made if a professional interpreter is refused?		
Telephonic Interpreting ***(if none is used, proceed to the next section)***			
119.	Is an external agency used for telephone interpreting? - If not, how is service p rovided?		
120.	Is more than one external agency used? - If so, how many agencies? - What languages do they provide?		
121.	Are policy and procedures in place related to the use of telephonic interpreting? - If so do they specify when and under what conditions this form of interpreting is to be used?		
122.	Do the policies and procedures describe specifically how to order a telephone interpreter?		
123.	Is the use of a telephonic interpreter documented in the patient's medical record? - If yes, what is the frequency of compliance?		
124.	Do providers and staff received training on the appropriate use of a telephonic interpreter?		

125.	Is the length of the interpreting encounter recorded? - If so, what is the average length of a telephonic interpretation?		
126.	For what types of encounters is telephonic interpreting utilized?		
	- clinic appointments		
	- the obtaining of informed consent for medical treatment procedures		
	- pharmacy		
	- laboratory		
	- diagnostic imaging		
	- emergency services		
	- day surgery		
	- labor and delivery		
	- in-patient services		
	- chaplaincy services		
	- the admissions process		
	- the enrollment process		
	- financial services		
	- member services		
	- grievance and complaint processes		
	- other non-care patient interactions		
127.	Is there clear documentation to ensure that identified problems are addressed?		
128.	Is client data collected in the utilization of telephonic interpreter services? If so, is it broken down by:		
	- Type of encounter		
	- Language		
	- Duration		
	- Time of Day		
	- Provider and department		
	- Staff		
	- Patient ID		
131.	What type of telephonic equipment is used?		
	- Standard Telephone		
	- Fixed speaker phone		
	- Portable speaker phone		
	- Dual head set phone		
	- Video conferencing		
132.	Is the distribution of telephone interpreter encounters reported by language?		
133.	Is telephonic interpreting reported by language used, by time of day? - If so, what is the language distribution of encounters?		
134.	What is the average per-minute rate for telephone interpreting?		
135.	Is the per-minute rate the same for each agency accessed for interpreting? - If not, describe		
136.	What is the average cost to your institution per encounter?		
IV. TRANSLATION SERVICES			
Provision of Translation Services			
137.	Is there an assigned department for providing translation services? - If not which departments are responsible?		
138.	Is all translation done in-house? - If not, what types of documents are translated in-house and what requires an outside translator?		
139.	Is an external agency used for translation services?		
140.	If yes, is more than one external agency used? - If so how many agencies?		

141.	Are primary materials (including patient instructions, consent forms, and patients' rights) available in all languages, which meet the population thresholds?		
Policy and Procedures			
142.	Are there policy & procedures in place on the use of translation services?		
143.	How do you ensure that staff members adhere to the policy and procedures? - If not, describe how in what capacity.		
Utilization			
144.	Is there an inventory of printed material translated into different languages?		
145.	Is the volume and type of requests for translation identified?		
146.	Is translation of patient information made available to the patient?		
147.	Is signage consistently translated through out the organization for specified languages?		
Quality management			
148.	How does your institution or the translation agency recruit translators?		
149.	Is there qualification in language fluency and translation capacity that is expected of translators before they are contracted?		
150.	Are the following elements assessed and monitored?		
	- Accuracy and completeness of the interpretation		
	- Medical terminology in both languages		
	- Grammar		
	- Patient satisfaction		
	- Provider/staff satisfaction		
151.	Is there an ongoing training process in place? -If yes, how often is it presented?		
152.	Is there a continuing education program in place for translators?		
153.	Does the agency perform a periodic review of its translators' products?		
154.	Is the quality of the translation checked by a second translator? - If not, how do you ensure translation quality?		
155.	Is there clear documentation to ensure that problem areas are addressed?		
156.	Is data collected for face-to-face interpreting that is reported to the client?		
Cost Structure			
157.	What is the cost for translation services? - Per word ____ - Per page ____ - Per job ____		
158.	What is the average cost per request?		