Published in final edited form as:
J Health Care Poor Underserved. 2013 August ; 24(3): 1002–1009. doi:10.1353/hpu.2013.0149.

Implementation of Language Assessments for Staff Interpreters in Community Health Centers

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Summary

Bilingual staff is used to provide interpreter services in community health centers. Little is known about the language proficiency of dual-role staff interpreters. Golden Valley Health Centers implemented a formal language assessment program to improve the number of qualified dual-role staff interpreters and ultimately improve the quality of patient care.

Keywords

Interpreters; language access; dual-role staff; community health centers; underserved

Almost 15 years ago award-winning author Anne Fadiman wrote the book *The Spirit Catches You and You Fall Down*,[1] exposing the complexity and importance of cultural and linguistic barriers to care faced by a Hmong family in rural California. Golden Valley Health Centers (GVHC), nestled in the same community in Central California as the book, has long worked in the trenches to provide high quality care to patients with limited English proficiency (LEP), and has implemented language access programs to ensure that patients receive culturally and linguistically appropriate health care services.

Golden Valley Health Centers is a federally qualified health center (FQHC) system with twenty-six community clinics that provide comprehensive primary medical and dental care to an ethnically diverse population, including migrant and seasonal farm workers, Southeast Asian refugees, and the homeless. This region has a history of longstanding poverty, high unemployment rates, and a high prevalence and burden of chronic conditions and obesity.[2–5] Persons with LEP comprise 60% of the 100,000 patients, with the primary non-English language being Spanish. To be culturally and linguistically responsive to this population demand, 85% percent of the center's medical assistants and nurses are bilingual in English and Spanish. The most common languages spoken by staff are Spanish followed by Vietnamese and Hmong.

Currently the health care industry lacks a standardized systems approach to language access services including language proficiency assessments for interpreters. The objective of this report is to describe the implementation of a language proficiency assessment program for dual-role staff interpreters in a large community clinic system.

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Program Description

Language barriers to care are associated with lower quality of care.[6–9] Title VI of the Civil Rights Law of 1964 requires recipients of federal financial assistance to provide meaningful access to care for patients with LEP. In an ideal environment where funding streams are stable, trained or professional interpreters should be used for all patient care encounters as they are the gold standard when patient-doctor language concordance is not possible.[6, 7, 10–13] In GVHC and FQHCs where revenue is uncertain, the common practice for patients with LEP is the use of bilingual staff (e.g. medical assistant) as interpreters during the clinical visit.[14, 15] This common practice of using dual-role staff interpreters allows for cost savings, as there are substantial costs for use a professional interpreter. Since this norm is far from ideal, the organization sought to assess the care provided to its diverse patient population.

In 2003, GVHC underwent an organizational assessment using the federal Office of Minority Health's national standards for Culturally and Linguistically Appropriate Services (CLAS) framework to enhance patient-centered care and develop a system to provide language services.[16] The assessment included a survey of cultural competency awareness and concerns with 238 staff, key informant interviews with five leadership level staff and an organizational cultural competency interview with the Chief Medical Officer. Staff was asked to identify areas of culturally competent care that needed improvements and they identified interpreter services as a high priority (Table 1). The assessment provided high-level buy-in and support within the organization for the provision of high quality care consistent with CLAS standards, and a multidisciplinary committee was formed to guide the development of a robust program through a systems approach that would address identified barriers (Table 1).

The results of this organizational assessment helped clarify that there was a need to focus on dual-role interpreters and to systematically improve language access programs (Table 1). In safety-net systems, the use of only professional interpreters is not an economically feasible solution to language barriers to care. Our experience suggests that language resources should be focused on the medical assistants or dual-role staff because of the cost of professional interpreters, the sizable pool of bilingual employees, and the need to know which employees were proficient in Spanish and could interpret for a large Spanish-speaking population.

Language assessments overview

Golden Valley Health Center's language assessment program to improve linguistically and culturally appropriate care begins when a candidate applies for employment. The overall goals of the language program are to: 1) to establish an entry level assessment for applicants in bilingual positions or who will need to interpret; 2) to provide bilingual staff with an assessment of their Spanish language skills and the areas in which they need to continue their professional development; and 3) to assess language services with a standard of quality.

Pre-screening interview—The first part of the program consists of a pre-employment screening phone interview. The telephone screen identifies the most proficient Spanish-speakers before the job application is reviewed. This requires a fluent Spanish-proficient individual guiding the conversational exchange which is completed entirely over the telephone and measures conversational fluency in a variety of topics and takes about 10–20 minutes to administer. The screen measures the ability to sustain a clear and understandable conversation in the target language (pronunciation, intonation, clarity, fluency), thought process, understanding of the question, knowledge of terminology in the target language and target position, and ability to state short statement as accurately as possible in the target

language. New applicants or current staff can be scheduled at any time to take the assessment. The screens are used to establish appropriateness of a potential employee for bilingual positions with a job description that requires communicating in a second language or interpretation as part of their contact with patients.

Spanish proficiency assessments—The second part of the program consists of a written Spanish-language proficiency assessment designed to assess an individual's linguistic ability in Spanish. The assessment was adapted from the Connecting Worlds Partnership[17, 18] test language proficiency assessment (English and Spanish), and was tailored to the needs of the community health center – assessing the language ability of staff that may also be called upon to interpret by incorporating specific material directly related to staff job roles. Its components include medical term definition matching, common colloquial term identification, grammar assessment, verb conjugation, terminology assessment, and translation of common questions. In the GVHC assessment, staff can score a total of 55 points and based on the scoring is categorized as *Basic* (0–25), *Intermediate* (26–44), or *Advanced* (45–55). The skill levels corresponding to the proficiency categories are: basic (cannot read fluently; frequent pauses, lack of cohesion; not familiar with common idioms; or severely limited vocabulary and dialect), intermediate (reads fluently, few errors; speaks fluidly enough to present complex ideas; understands cultural references and proverbs; or good range of vocabulary, and advanced (reads and follows instructions without difficulty; uninterrupted, eloquent speech; expresses complex ideas, provides examples in a cultural context; or wide range of vocabulary, register, and dialect). The written Spanish language assessment takes about 45 minutes to complete and is administered by trained staff. After completing a language proficiency assessment, individual's deficits are identified and are addressed through individualized feedback.

We adopted four major bilingual staff profiles identified by the Connecting Worlds Partnerships[17, 18] to simplify the heterogeneity in bilingualism (Table 1) within the organization. These include: 1) bilingual staff with strong English language skills but limited non-English language; 2) bilingual staff with strong non-English skills but limited English language skills; 3) bilingual staff with limited knowledge of patient's culture but strong bilingual skills; and 4) bilingual staff with limited knowledge of medical terminology and health concepts, but strong bilingual skills and cultural knowledge.

Preliminary Outcomes

Since the program began in 2006, three hundred and forty individuals received and passed the telephone screen and went on to complete the Spanish language assessment. Of these, 61% scored in the Intermediate range and 32% in the Advanced level for Spanish language proficiency.[19] Just because a medical assistant did not score at an Intermediate or higher level does not mean they were not hired. Rather, they were placed in a job with duties appropriate to their level of language proficiency. Subsequently, a 12 month pre- post-pilot evaluation of 100 medical assistants[18] showed a 10% increase from 60% to 70% in the number of bilingual medical assistants achieving an appropriate language proficiency level (*Intermediate*) needed to interpret compared to the organizations pre intervention baseline. The change was observed in the number of medical assistants in the *Basic* and *Intermediate* levels and in the *Advanced* category. The pre intervention baseline was obtained from 88 language assessments. The continued discrepancy is partially mitigated by identifying those with inappropriate proficiency levels that and are not qualified to interpret.

Elements contributing to the language assessment programs' preliminary results are listed in Table 1 and categorized as barriers and facilitators. We have addressed barriers related to

sustainability and heterogeneity in staff bilingual skills, but we continue to work on other barriers including documentation of interpreter use,[20] staff turnover, and funding (Table 1).

Lessons Learned

From our experience, we learned key lessons that were important to implementing the language assessment program.

1. Not all bilingual staff will be able to interpret for providers, nor should just anyone who is bilingual be asked to interpret for providers

Too many resources are required to enhance bilingual staff from low language proficiency to a level required for interpreting in their health care teams. Having an accessible and updated list of dual role staff members that meet the minimum qualifications to be interpreters is important for providers and to ensure smooth clinic workflows. Staff often struggles to grasp the concepts related to interpreting and apply them to their job duties. This is why the program implemented the pre-employment telephone screens. GVHC now focuses resources (e.g., trainings and assessments) based the major language staff profiles.

2. We selectively tailor the language services program based on the staff member's skills, qualifications, and language abilities and to fit the bilingual employees' specific jobs and duties (Table 1)

For example, a front office care team member (e.g., receptionist) who will not interpret for medical providers but needs to communicate effectively with patients receives language assessments but is not required to have the same language proficiency level required for a medical assistant who interprets. Additionally, since bilingual job positions must reflect realistic expectations of staff at different levels of language proficiency; these are revised periodically as job roles evolve.

3. Assessments of language proficiency should be part of the hiring process

In resource limited settings, language proficiency assessments should be performed before conducting resource intensive interpreter trainings. Language proficiency ability and interpreting duties need to be clearly stated in the job description for those staff that will be called upon to interpret (Table 1).

4. A reliable feedback system (e.g., multidisciplinary committee) allows staff and providers to discuss workflow issues and a willingness to engage in process improvements such as documenting the use of interpreters and the service delivery mode (e.g., in person, or telephone)

Feedback on the use and availability of interpreters as perceived by patients are critically important. Patient feedback can be obtained by incorporating questions about language services from validated questionnaires (e.g., Consumer Assessments of Healthcare Plan Survey)[21] into customer satisfaction surveys, or by conducting patient focus groups. GVHC conducts monthly telephone patient surveys about their recent visits. Access to telephone and contract interpreters for less commonly used non-English languages should also be included in service options.

Conclusion

Effective doctor-patient communication is at the center of the clinic encounter. Yet for patients that need interpreters, improving patient-centered care has to include effective communication throughout the care-delivery system and not solely during the clinical encounter.[22] GVHC is creating a culture of safety that calls for interpreters to be assessed in

order to ensure the quality of interpretation and discourage the common practice of using untrained staff as interpreters.

Few organizations that we are aware of have implemented language assessments for staff.[15, 23] The Joint Commission standards of care and the nation's growing LEP population provide an opportunity for health centers and other ambulatory care practices to institutionalize language programs.[16, 22, 24, 25] Implementing robust language access programs are the first step in delivering culturally and linguistically appropriate services and help improve patient experiences with health care.

Acknowledgments

Funding for Golden Valley Health Center (GVHC) cultural competency and language access programs was provided by the Office of Minority Health, Kaiser Permanente, and the California Endowment. Dr. Gerardo Moreno received support from the California Endowment. GVHC thanks Connie Diers, the Staff Development Committee, community partners and Stergios Roussos.

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Table 1

Barriers and Facilitators to Implementation of a Language Assessment Program for Bilingual Staff in Community Health Centers

Barriers	Facilitators
Overall program sustainability	Strong clinic leadership (CEO, Deputy CEO, and CMO) as well as quality care and patient safety champions within the organization.
	Multidisciplinary functional committees (e.g. Human Resources, Nursing & Health Promotions).
	Imbed program in human resources processes
Heterogeneity in staff bilingual skills	Incorporate language program into hiring process and tailor services and training based on job and baseline ability
	Revise job descriptions to include language requirement
	Organization commitment to set minimum language proficiency standards for dual-role staff interpreters
Documentation of interpreter use	Provider trainings
	Limit staff turnover
Staff turnover	Growth opportunities within organization
	Recognition program
	Compensatory pay
Funding support	External foundation grants
	Community partnerships