Limited English Proficiency as a Barrier to Family Planning Services

FINAL REPORT

Prepared for the
U.S. Department of Health and Human Services
Office of Population Affairs
4350 East West Highway, Suite 200
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Limited English Proficiency as a Barrier to Family Planning Services

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Preface

This deliverable presents the findings of the *Limited English Proficiency as a Barrier to Family Planning Services* study conducted by COSMOS Corporation for the Office of Population Affairs (OPA), Office of Public Health and Science, U.S. Department of Health and Human Services. The study was supported under a task order contract with the Department of Health and Human Services (Task Order No. 12, Contract No. 282-98-0027).

The project could not have been conducted without the cooperation and support of the clinic directors and coordinators of the family planning clinics that participated in the study. Clinic staff provided insightful information on the language assistance services being provided by their clinics and offered valuable recommendations for improvement of services through training and technical assistance. We also must acknowledge the invaluable information provided by the study’s key informants and the family planning professionals who offered important guidance in the design and report writing phases of the study. The final report reflects their extremely helpful comments as well as those of Evelyn Kappeler, the project Task Order Officer.

The various clinics and innovative language assistance services profiled in the report have the potential to improve the health care delivery system for underserved and vulnerable populations such as limited English proficient (LEP) individuals. Today’s rapidly changing health care environment creates an urgency and an opportunity to build a health care system that gives America’s underserved populations access to high quality reproductive health care. This is the spirit with which this project was undertaken and is presented in this document. We hope that this effort contributes to the flow of ideas and strategies for providing accurate and consistent language assistance services in all Title X family planning clinics throughout the country.

The COSMOS study team, led by Oscar Espinosa, M.A., included Angela Ware, Ph.D.; Katherine Page, M.S.Sc.; Daniela Hanson, B.A.; Bob Johnson, B.A.; and Bonnie Senteno, B.S.
Acknowledgments

The study team has benefitted from the leadership of the Office of Population Affairs and the guidance of the Task Order Officer, Evelyn Kappeler. The study team also would like to thank the study key informants for their guidance and assistance during the design phase of the study. The participants are listed below.

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EXECUTIVE SUMMARY

The Limited English Proficiency as a Barrier to Family Planning Services study reviews and assesses the language assistance services and activities being provided to limited English proficient (LEP) individuals in seven Title X-funded family planning clinics. The study findings present an illustrative sampling of services, activities, and procedures reflecting innovative strategies being used by Title X clinics to meet the growing demand for language assistance in their communities. In addition, the study describes the common barriers faced by clinics as they strive to comply with federal and state mandates requiring the provision of language assistance services to their LEP clients, as well as the barriers experienced by LEP individuals who are accessing family planning services.

FINDINGS

The study provides a valuable baseline analysis that points to areas of success, as well as barriers to systemic support, in implementing effective language assistance services. Specifically, the study sought to answer the following research questions:

- What are the language assistance services, activities, and procedures used by Title X clinics to ensure effective access to family planning services for people with limited English proficiency (LEP)?
- What are the barriers experienced by clinics in providing language assistance services?
- What are the innovative language assistance services and strategies being adopted by selected clinics?
- What are the relative costs of the different language assistance services offered by clinics?
- What are the barriers experienced by LEP individuals accessing family planning services?
- What are clients' perceptions of the effectiveness of language assistance services?
- Are there significant differences in the amount of time required to treat LEP and non-LEP clients?
What are the language assistance services, activities, and procedures used by Title X clinics to ensure effective access to family planning services for people with limited English proficiency (LEP)?

Title X family planning clinics provide their LEP clients with unique language services designed to bridge the language gap and facilitate communication between clinic staff and clients.

- **Title X clinics employ a combination of language assistance services and strategies to comply with Title VI requirements.** Clinics provide language assistance by employing bilingual staff, staff interpreters, and contract interpreters; using language line services; and having on-site translation services available to translate client education materials and forms.

- **Title X clinics offer LEP clients innovative language assistance services.** In addition to the language assistance services recommended by OCR, clinics have designated bilingual staff as backup interpreters and have developed and maintain a pool of volunteer interpreters trained in medical interpretation. Clinics with larger budgets have developed, or have access to, state-of-the-art remote telephone interpreter services and others provide interpreter services using teleconference technology.

- **Title X clinics have adopted innovative language assistance activities and procedures.** All clinics display a number of multilingual signs designed to inform LEP clients of clinic services. Clinics also provide educational videos in multiple languages, provide their staff with training in cultural competence and medical interpretation, have language banks available, and many clinics have developed strategic partnerships with community-based organizations (CBOs) to augment their language capacity.

- **Clinics have high-levels of bilingual staff language capability.** Clinics employ bilingual staff that reflect the LEP community in their service area. However, clinics are experiencing shortages in bilingual technical staff such as registered nurses, nurse practitioners, and physicians.
What are the innovative language assistance services and strategies being adopted by selected clinics?

- **Development of a strategic partnership with an area hospital.** One of the clinics visited by the study team has established a strategic partnership with an area hospital to provide the clinic with bilingual physicians fluent in various languages. The agreement stipulates that all clients requiring follow-up care be referred to the hospital and assigned to a provider who speaks the client’s language.

- **Design of clinic services based on findings from client focus groups.** One of the clinics designed all of its clinical services based on the results of multiple focus groups conducted with community members and clients. Some design considerations included the clinic’s location, its architecture, theme of art work displayed, size of in-take and examination rooms, and the use of an appointment line that is not menu-driven.

- **Interpretation using teleconference technology.** A clinic has adapted teleconference technology to provide language assistance to LEP clients. The clinic uses its language bank to identify individuals fluent in the language required for interpretation and links the client and interpreter via a high-speed Internet connection that transmits simultaneous video and audio signals.

- **Remote telephone interpretation.** LEP clients who require language assistance at one clinic are provided with in-house interpreters trained in medical interpretation who are in a centralized location. High-quality interpretation is provided via a speakerphone and dual headsets, which are used to minimize concerns over confidentiality.

- **Mobile health van.** A family planning clinic that serves a rural population provides language assistance to difficult-to-reach LEP clients using a health van staffed by bilingual providers, medical assistants, and in-take personnel.

- **Provider training in communicating through an interpreter.** In order to increase the quality and effectiveness of interpreting encounters, a family planning clinic’s delegate provides in-house training for physicians and nurse practitioners on how to correctly use an interpreter during an examination.
**Off-site interpreter program.** Staff from one clinic provide language assistance to LEP clients throughout all phases of the clinical visit and even accompany the client off-site for follow-up care.

**What are the relative costs of the different language assistance services offered by clinics?**

Title X clinics expend great amounts of resources to provide language assistance services to their LEP clients. The following table summarizes estimated costs associated with delivering language assistance using various methods.

### Exhibit 1

#### ESTIMATED COSTS OF LANGUAGE ASSISTANCE SERVICES

<table>
<thead>
<tr>
<th>Method of Providing Language Assistance</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretation</td>
<td></td>
</tr>
<tr>
<td>Bilingual Staff</td>
<td>$18-$87k/year*</td>
</tr>
<tr>
<td>Staff Interpreters</td>
<td>$27-$57k/year + stipend ($50-$500/month)</td>
</tr>
<tr>
<td>Contract Interpreters</td>
<td>$35-$40/hour</td>
</tr>
<tr>
<td>Language Line</td>
<td>$2.50-$4.50/minute ($50-$60/call)</td>
</tr>
<tr>
<td>Remote Telephone Interpretation</td>
<td>$20-$30/call**</td>
</tr>
<tr>
<td>Volunteer Interpreters</td>
<td>$250-$650/volunteer***</td>
</tr>
<tr>
<td>Interpretation via Teleconference</td>
<td>$5-$15k/connection + interpreter fees</td>
</tr>
<tr>
<td>Translation</td>
<td></td>
</tr>
<tr>
<td>On-site Translation</td>
<td>$30-$50k/year + stipend ($50-$150)</td>
</tr>
<tr>
<td>Outsourced Translation</td>
<td>$0.12-$0.25/word</td>
</tr>
</tbody>
</table>

* Salary range based on clinic administrators’ estimates.
** Average call estimate based on anecdotal information presented by clinic staff at Santa Clara Valley Health and Hospital System.
*** Estimate includes cost of providing training in medical interpretation.

**What are the barriers experienced by clinics in providing language assistance services?**

The study team queried clinic staff regarding the barriers they have encountered providing language assistance services to LEP clients. Clinic staff cited two distinct categories of barriers that affect a clinic’s ability to adopt and effectively manage language assistance services: 1) client and 2) resource-focused barriers.

**Client-focused barriers that affect the provision of language assistance services.** Staff identified three main LEP client
characteristics that directly affect their ability to provide effective language assistance. These characteristics include: 1) linguistic differences, 2) cultural differences, and 3) having low levels of health literacy.

- **Resource-focused barriers that affect the quality and effectiveness of language assistance services.** Clinics experience a number of barriers related to a clinic’s limited resources such as: direct costs associated with interpreter and translation services, the limited availability and cost of bilingual staff and volunteers, and numerous time constraints associated with treating LEP clients.

Are there significant differences in the amount of time required to treat LEP and non-LEP clients?

The study team queried staff on their perception of how much time is required to treat a client in each phase of the clinical visit. Staff members were asked to provide their best estimate for time required to treat both LEP and non-LEP clients. Exhibit 2 shows that it takes clinic staff twice as long to treat a LEP client.

**Exhibit 2**

<table>
<thead>
<tr>
<th>Phase of Clinic Visit</th>
<th>Clincs</th>
<th>Non-LEP</th>
<th>LEP</th>
<th>Diff.</th>
<th>Non-LEP</th>
<th>LEP</th>
<th>Diff.</th>
<th>Non-LEP</th>
<th>LEP</th>
<th>Diff.</th>
<th>Average Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-take</td>
<td>1. Tremont Center</td>
<td>20</td>
<td>40</td>
<td>20</td>
<td>45</td>
<td>65</td>
<td>20</td>
<td>15</td>
<td>30</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>2. Centro de Salud Clinic</td>
<td>15</td>
<td>30</td>
<td>15</td>
<td>40</td>
<td>60</td>
<td>20</td>
<td>15</td>
<td>25</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>3. Stafford Clinic</td>
<td>15</td>
<td>25</td>
<td>10</td>
<td>45</td>
<td>60</td>
<td>15</td>
<td>10</td>
<td>25</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>4. Valley Health Center at Lenzen</td>
<td>20</td>
<td>35</td>
<td>15</td>
<td>35</td>
<td>45</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>5. San Marcos Clinic</td>
<td>20</td>
<td>45</td>
<td>25</td>
<td>25</td>
<td>45</td>
<td>20</td>
<td>12</td>
<td>25</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>6. Southeast Heights Clinic</td>
<td>20</td>
<td>40</td>
<td>20</td>
<td>35</td>
<td>55</td>
<td>20</td>
<td>10</td>
<td>30</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>7. La Clinica del Pueblo</td>
<td>15</td>
<td>25</td>
<td>10</td>
<td>20</td>
<td>35</td>
<td>15</td>
<td>15</td>
<td>30</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Average</td>
<td>18</td>
<td>34</td>
<td>16</td>
<td>35</td>
<td>52</td>
<td>17</td>
<td>13</td>
<td>27</td>
<td>14</td>
<td>16</td>
</tr>
</tbody>
</table>

*Time estimates are expressed in minutes and are based on estimates reported by staff involved in different phases of a family planning visit. Estimates for in-take were provided by front-line personnel (e.g., receptionists, medical assistants, etc.) and are based on a first visit. Exam and treatment estimates were presented by providers (e.g., nurses, nurse practitioners, and physicians) based on a clinical visit where a procedure had been scheduled. Follow-up estimates were provided by both providers and in-take staff.*

*COSMOS Corporation, March 2003*
What are the barriers experienced by LEP individuals accessing family planning services?

The study team queried focus group participants about barriers they have encountered when accessing family planning services at Title X clinics. Clients reported multiple barriers including: linguistic, cultural, legal, economic, and educational. These barriers are manifested during different phases of the clinical visit and are shown in Exhibit 3.

Exhibit 3

<table>
<thead>
<tr>
<th>BARRIERS FACED BY LEP CLIENTS ACCESSING FAMILY PLANNING SERVICES, BY PHASE OF CLINIC VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase of Clinic Visit</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Outreach</td>
</tr>
<tr>
<td>In-take</td>
</tr>
<tr>
<td>Medical History and Financial Screening</td>
</tr>
<tr>
<td>Provider Examination and Treatment</td>
</tr>
<tr>
<td>Instructions for Follow-up Care and Medication Usage</td>
</tr>
</tbody>
</table>

What are clients' perceptions of the effectiveness of language assistance services?

The study team queried focus group participants about their perceived effectiveness and usefulness of various language assistance services. Clients perceive bilingual staff to be the most effective method of delivering language assistance and find multilingual signs and client education material to be very useful in facilitating the clinical visit. Exhibit 4 presents the clients’ perceived strengths and weaknesses of each method used to deliver language assistance.
Exhibit 4

PARTICIPANTS’ PERCEIVED STRENGTHS AND WEAKNESSES OF VARIOUS METHODS FOR DELIVERING LANGUAGE ASSISTANCE

<table>
<thead>
<tr>
<th>Method of Delivering Language Assistance</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual Staff</td>
<td>• Expedited appointments</td>
<td>• Confidentiality can be compromised</td>
</tr>
<tr>
<td></td>
<td>• Able to ask questions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feel less dysfunctional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Body language exchanged</td>
<td></td>
</tr>
<tr>
<td>Telephone Interpreters</td>
<td>• More privacy during exams</td>
<td>• Limited privacy</td>
</tr>
<tr>
<td></td>
<td>• Expedited appointments</td>
<td>• Feel rushed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Impersonal</td>
</tr>
<tr>
<td>Face-to-Face Interpretation</td>
<td>• Able to ask questions</td>
<td>• Feel rushed*</td>
</tr>
<tr>
<td></td>
<td>• Body language exchanged</td>
<td>• Less privacy</td>
</tr>
<tr>
<td>Translated Client Education Materials</td>
<td>• Provide good visual</td>
<td>• Lacks new contraceptive methods</td>
</tr>
<tr>
<td></td>
<td>• Used for reference</td>
<td></td>
</tr>
<tr>
<td>Multilingual Signs</td>
<td>• Orient clients to clinic services</td>
<td>• Do not help clients with low-literacy</td>
</tr>
<tr>
<td></td>
<td>• Inform clients of their right to</td>
<td>• Restricted to 3 languages</td>
</tr>
<tr>
<td></td>
<td>language assistance</td>
<td></td>
</tr>
<tr>
<td>Multilingual Videos</td>
<td>• Provide good visual</td>
<td>• Language too technical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cannot be referenced</td>
</tr>
</tbody>
</table>

*Applies only to contract interpreters.

METHODS

The Limited English Proficiency as a Barrier to Family Planning Services study provides a baseline examination of the range of language assistance services being provided by Title X family planning clinics. The study employed qualitative data collection methods such as document reviews, telephone and face-to-face interviews, and focus groups. The study team developed guides to conduct semi-structured interviews with study key informants and clinic staff and to guide the focus groups with family planning clients.

Site Selection

To ensure that study results provided OPA with an accurate snapshot of the barriers Title X clinics face in assuring access, as well as knowledge of innovative practices, the study employed a site selection methodology that accounted for clinic characteristics such as: evidence of having an innovative language assistance service, the clinic’s service area
experiencing high LEP growth,\(^1\) whether the clinic serves multiple languages, inclusion of all types of clinics,\(^2\) regional representation (public health service regions), and the inclusion of at least one clinic serving a rural community.

**Site Visits**

The study team conducted site visits from July to October 2002. Two-person teams conducted two to three-day site visits. Activities accomplished during the site visits included:

- Conduct face-to-face interviews with clinic staff to identify and describe language assistance services being provided to the LEP population. Discuss the barriers faced by staff in providing language assistance to a growing LEP population.

- Collect and review documentation that describes the LEP population being served and review documents that describe how language assistance services are administered.

- Conduct focus groups with family planning clients regarding their perceptions of the effectiveness and usefulness of language assistance services and perceived barriers to accessing clinic services.

**Data Collection**

Data collection occurred through face-to-face interviews with clinic staff, reviewing documentation, and conducting focus groups with family planning clients.

**Clinic Staff Interviews.** A site visit protocol guided on-site data collection. The protocol instrument included procedures to conduct document reviews, adhering to the staff interview schedule, and included the study team’s topics of inquiry or lines of questioning. The study team conducted interviews with clinic staff including: clinic directors, executives, administrators, and staff who provide family planning and language assistance services.

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\(^1\) Refers to an area or community that has experienced a recent influx of people that speak a language the clinic has not served.

\(^2\) Clinic typology is based on the clinic’s primary affiliation, e.g., university, hospital, community-based organization, etc.

*COSMOS Corporation, March 2003*
**Review of Documentation.** The study team reviewed a number of documents from each of the seven clinics. These documents included: administrative documents, statistical reports describing the population served, internal policy and procedural guides, and translated client education material such as documents, flyers, and handouts.

**Direct Observation.** The study team made direct observation throughout the site visit at each of the participating clinics to observe the placement and quality of multilingual signs used throughout the clinic. The study team also observed the procedures and protocols followed by staff to ascertain how the services were made available to the client.

**Focus Groups with Family Planning Clients.** The study team convened four focus groups with family planning clients to obtain in-depth information about the clients’ experiences with barriers to services and on the perceived effectiveness of various language assistance services. The study team used a focus group discussion guide to lead the discussions.
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SECTION 1

Introduction
1. INTRODUCTION

The United States is home to millions of individuals who have limited English proficiency (LEP). These individuals include those who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with individuals who do not speak their native language. The family planning clinical visit requires health professionals to establish a close relationship with the client based on empathy, confidence, and mutual trust. Such a personal relationship depends on the free flow of communication, which is difficult when the two parties involved speak different languages. Language barriers often result in LEP individuals experiencing denials of service, considerable delays, and receipt of care based on inaccurate or incomplete information.

Recipients of federal financial assistance have an obligation to reduce language barriers that can preclude meaningful access to important services. Since the enactment of Title VI of the Civil Rights Act of 1964 and the signing of Executive Order 13166—signed August 11, 2000—the federal government has required that agencies and programs take steps to ensure that federally funded activities are accessible to all eligible LEP clients. In order to be in compliance with the legislative requirements, family planning clinics funded by Title X have adapted their service delivery by designing and incorporating language assistance services and activities into their standard operating procedures.

The purpose of the final report for the Limited English Proficiency as a Barrier to Family Planning Services study is to present a description of the innovative language assistance services and activities being provided by Title X-funded family planning clinics. The report also describes the common barriers faced by clinics as they strive to comply with federal and state mandates requiring the provision of language assistance services to their LEP clients. The report also makes recommendations on appropriate training and technical assistance opportunities that should be made available to Title X grantees, delegates, and clinics, in order to better prepare staff to treat their respective LEP clients.

The remainder of this section describes the reproductive health care services provided by Title X family planning clinics and the important role they play in the overall health of the nation and the federal language access requirements to which they are bound. Section 1 also presents the study questions which will be addressed in the remainder of the report, as well as a review of relevant literature. The methodology adopted to guide the study is described in Section 2, and the main study findings are presented in Section 3. Section 4 includes profiles of the clinics visited by the study team, and findings from the focus

---

1 The definition of a LEP individual includes hearing and speech impaired people that require interpretation using American Sign Language (ASL).
groups conducted with LEP clients accessing family planning services are discussed in Section 5. Finally, Section 6 presents recommendations that describe training and technical assistance opportunities for Title X clinics.

1.1 THE ROLE FAMILY PLANNING CLINICS PLAY IN MAINTAINING AND IMPROVING THE OVERALL HEALTH OF THE NATION

For over 30 years, Title X of the Public Health Service Act (42 USC 300 et seq.) has been the nation’s major program to reduce unintended pregnancy by providing contraceptive and related reproductive health care services to low-income women. The program is administered by the U.S. Department of Health and Human Services (HHS), Office of Family Planning, within the Office of Population Affairs (OPA). Title X supports 88 service grantees in all 50 States, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin through a network of approximately 4,500 clinics (OPA, 2001).

A significant number of the Healthy People 2010 objectives for “promoting health and preventing illness, disability, and premature death” are addressed through the clinical and educational services provided by publicly subsidized family planning programs. For instance, family planning services prevent an estimated 1.3 million unintended pregnancies per year. Thus, for every dollar spent on publicly funded contraceptive services, it is estimated that three dollars are saved in Medicaid bills for pregnancy-related health care and medical care for newborns. In addition, when seeking contraception at local family planning clinics, clients also receive many other reproductive and preventive health care services. For example, in 1999, the Title X program provided nearly 3 million Pap tests and 2.8 million breast exams. There were nearly 4.8 million tests for sexually transmitted diseases (excluding HIV) and an additional 366,000 HIV tests provided to both male and female users of services in Title X clinics. The Title X program also has established widespread cervical cancer screening which has led to a 20 to 60 percent reduction in cervical cancer death rates (AGI, 2000).

In addition, many family planning clinics receive federal funding through the Centers for Disease Control and Prevention (CDC) to screen women at risk for chlamydia. Blood pressure screening and breast exams/self breast exam education also are required services in Title X subsidized clinics. It is reported that more than 14 percent of women of reproductive age who receive Pap tests and treatment for gynecological infections receive these services in family planning clinics. The percentage of these women obtaining HIV tests from clinics is even higher—25 percent—and over 33 percent receive other sexually transmitted disease (STD) services at publicly supported family planning clinics (AGI, 1997).
1.2 THE INCREASING NEED FOR LINGUISTICALLY APPROPRIATE FAMILY PLANNING SERVICES

A rapid multi-cultural shift in the U.S. population has resulted in more culturally and linguistically diverse clients being served in Title X-funded family planning clinics. According to the U.S. Census Bureau, ethnic or racial minorities represented 28 percent of the U.S. population in 1990. The 2000 Census reports that the U.S. gained more immigrants in the 1990s than in any previous decade, and that more than 10.5 million people reported that they speak little or no English—up from 6.5 million in 1990. Census data also show that over 300 languages are spoken in the United States, with 17.6 percent of the population speaking a language other than English at home—up from 13.8 percent in the previous Census. Furthermore, estimates indicate that by 2010, the U.S. minority population will have increased by 60 percent, resulting in hundreds of languages being spoken in both urban and rural areas throughout the United States. Consequently, trends in the number of minorities served at publicly funded agencies also are experiencing significant changes.

Title X-funded clinics are required to comply with national standards ensuring uniformly provided care, scrupulous maintenance of quality assurance standards, and guaranteed access to a broad range of comprehensive family planning services. In addition, Title X-funded clinics are required to provide language access to their LEP clients. The language access responsibilities that apply to entities receiving federal financial assistance, including Title X family planning clinics, are discussed in the following section.

1.3 FEDERALLY MANDATED LANGUAGE ACCESS RESPONSIBILITIES

Title VI of the Civil Rights Act of 1964 (42 USC 2000d et. seq.), and its implementing regulation at 45 CFR Part 80, stipulate that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives federal financial assistance (Federal Register, 2000). Under Title VI, hospitals, health maintenance organizations (HMOs), social service agencies, and other entities receiving federal financial assistance from HHS are required to take the necessary steps to ensure that individuals with LEP have complete access to programs and services. Not only should people with LEP have access to programs, but the access to services and benefits should be meaningful and equal. In addition, states and local agencies also have enacted laws and ordinances to ensure language assistance services (Youdelman, 2002).

The HHS Office for Civil Rights (OCR) plays dual roles as an administrator with oversight authority over Title VI regulations and as a resource and provider of technical assistance (TA). Title VI regulations require that OCR conduct an investigation whenever it receives a complaint, report, or other information alleging or indicating possible noncompliance with Title VI regulations. If the investigation discovers noncompliance,
OCR informs the entity receiving federal funds of the areas of noncompliance and the steps that must be taken to correct the noncompliance. OCR usually secures voluntary compliance through informal means.

As a provider of TA, OCR has developed policy guidance that outlines the general parameters of funding recipients’ obligation to provide language assistance, and gives examples illustrating both the importance of the services, as well as the flexibility that recipients have in meeting those obligations. Although the scope of the TA serves to clarify the language access requirements and to assist entities in fulfilling their responsibilities to LEP clients, it does not offer specific strategies or provide entities with language assistance service models that are outcomes-based or that have been proven to work in specific circumstances. In addition, it has been OCR’s view that while all entities receiving federal financial assistance should work toward building language assistance services that ensure access for LEP individuals, the implementation of a comprehensive language assistance service tailored to the increasing number of LEP individuals is a process that will evolve over time as it is refined and periodically reevaluated.

The present study was conducted to provide Title X providers with a collection of the innovative language assistance services and practices that have been successfully designed and implemented by selected family planning clinics. The study’s ultimate goal is to provide grantee organizations and clinic directors with several options (in addition to recommendations provided by OCR) that will help them to further refine and adapt their selected method(s) of providing language assistance as they attempt to keep pace with an ever increasing number of LEP clients. The following section describes the study questions and objectives.

1.4 STUDY QUESTIONS AND OBJECTIVES

In an effort to gain a better understanding of the rapidly changing types of language assistance services clinics are providing their LEP clients, OPA contracted COSMOS Corporation to review and assess the language assistance services and activities in selected family planning clinics. The study provides a valuable baseline analysis that points to areas of success, as well as to barriers to systemic support, in implementing effective language assistance services. Specifically, the study addresses the research questions listed in Exhibit 1-1.
Exhibit 1-1

PRIMARY STUDY QUESTIONS

1) What are the language assistance services, activities, and procedures used by Title X clinics to ensure effective access to family planning services for people with LEP?

2) What are the barriers experienced by clinics in providing language assistance services?

3) What are the innovative language assistance services and strategies being adopted by selected clinics?

4) What are the relative costs and benefits of the different services offered by clinics?

Informed by the results of the interviews with the study key informants, the study team incorporated additional study questions in order to provide a more balanced perspective of the barriers faced by clinics that provide language assistance services, and to acquire an equally balanced understanding of language access issues from the clients’ point of view. The following three additional study questions, presented in Exhibit 1-2, also will be addressed in the remainder of the report.

Exhibit 1-2

ADDITIONAL STUDY QUESTIONS

1) What are the barriers experienced by LEP individuals accessing family planning services?

2) What are clients’ perceptions of the effectiveness of language assistance services?

3) Are there significant differences in the amount of time required to treat LEP and non-LEP clients?
1.5 DATA LIMITATIONS

Two primary characteristics of the study directly limit the ability to generalize the study findings to all Title X clinics. First, given the contract requirements, the study team is reporting only the innovative language assistance services identified in seven Title X family planning clinics. Therefore, this report should not be considered a complete inventory of innovative language assistance services. Rather, it is an illustrative sampling of services, activities, and procedures reflecting diverse strategies being used by Title X clinics to meet the growing demand for language assistance in their communities. In addition, the present study reports anecdotal information which is not representative of all clinic staff members, nor does it capture the experiences of all Title X clinics and their respective LEP clients.

Second, clinic staff were unable to provide the study team with direct costs associated with specific language assistance services. Therefore, the analysis of relative costs is based on the national averages for staff members and certain services and, thus, is not reported using actual clinic expenditures. Title X clinics are funded by multiple programs, and the costs for individual language assistance services are drawn from multiple funding streams and are not reported in aggregate form. In addition, an important study finding is that clinics have adopted multiple language assistance models involving in-house staff who function in multiple capacities. Together, these two findings have limited the analysis of the cost of language assistance services.

1.6 REVIEW OF THE LITERATURE

Limited English proficiency as a barrier to accessing health care services and, specifically, family planning services, is a topic for which there is limited literature. Many studies acknowledge the general need for language services and document a growing need for culturally competent health care. In addition, there also are few studies that focus on issues surrounding access to health care and describe how LEP is a barrier to receiving quality health care services. However, there are a small number of publications that describe the needs of LEP individuals and their experiences accessing reproductive health care services. The majority of the research literature focuses on culturally competent family planning and reproductive health for women in developing countries, and has

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2 Title X clinic funds are drawn from both public and private sources that support family planning and other clinic services. Public sources include Title X family planning funds, Medicaid reimbursements, Maternal and Child Health (MCH) and Social Services block grants, and Bureau of Primary Health Care Funds. Private sources include patient fees, donations, and insurance receipts.

3 Staff members at certain clinics are not compensated for interpretation and translation services. Some clinics offer bilingual staff a stipend to translate, while some clinics have full-time interpreters and translators.
limited coverage of the experiences of recent immigrants, refugees, and residents in the United States who have LEP. Although recent studies do focus on the need for culturally competent reproductive health care, they do not analyze the delivery of specific services or make recommendations on which service models should be provided and how effective they are in certain situations. Nor do the studies recommend specific models for effectively serving particular racial and ethnic populations.

1.6.1 The Importance of Providing Language Assistance Services in Family Planning Clinics

Given the sensitive nature involved in a family planning clinical visit, cultural and linguistic competency in service delivery is imperative. Often there is a reluctance to speak of intimate sexual matters; in some cultures certain exposure or touch is taboo; STDs, number of sexual partners, and homosexuality may be stigma-causing subjects; also there are differing world views on contraception—all of which cause even greater complications for interpretation and translation. Consider a Muslim woman’s point of view: “If I am not comfortable exposing my body or hair in public, then what makes you think I’ll be comfortable with a vaginal examination?” With refugee women, there also may be issues of rape, sexual torture, or female genital cutting (FGC) that will affect a woman’s willingness to seek care and to speak openly. In addition, colloquialisms may exist in some languages to speak of sexuality and reproduction, further obstructing the flow of information between client and provider.

Multiple studies cite occasions where a child, family member, or stranger from the waiting room was asked to interpret for a patient which resulted in negative experiences. For example, some studies have shown that by using a child as a translator, the family structure may be disrupted. The parents may not wish to disclose details of their sexual history to the children. Also, children may not be able to provide a medical translation, and the personal information they are exposed to could cause psychological damage, e.g. feeling responsibility for the stillbirth of a sibling. In addition, family members may edit the doctor’s words or may wish to shield the patient from bad news. Untrained strangers may not have an understanding of the medical terminology and may provide an incorrect or incomplete translation, for example, a misinterpretation of orders for x-rays as orders for being microwaved. Whether by family member or stranger, ineffective interpretations may have dire consequences on the patient, and the use of such an individual may violate patient-doctor confidentiality. Some studies have found that the mere presence of an untrained third party may disrupt the already difficult exchange of information between patient and doctor due to the exchange of sensitive and personal information.

1.6.2 Traditional Methods of Delivering Language Assistance in Health Care Clinics

Language proficiency takes years to achieve, and even for native English speakers, medical terminology can be difficult to understand. For people whose primary language is
not English, written instructions on medication usage, even in their own language, may present problems due to low education levels of the clients who typically access family planning services in Title X clinics. Many studies cite not only linguistic barriers to accessing health care but cultural barriers as well. For instance, when a person nods in response to a question, the nod may not mean an affirmative answer, but only a polite gesture to indicate attentiveness. The person may be too embarrassed to admit not understanding or may be adhering to a cultural norm of not providing a negative response in the fear of appearing confrontational or uncooperative.

Studies have shown that even physicians who have had basic high school or college language training have not developed their skills to effectively communicate the complexity involved in gathering and relaying medical information. Interpreters have the dual role of translating the words between provider and patient and converting the messages between cultural contexts, as well as assessing the patient’s level of understanding, attitudes toward the body and health care, and facial expressions and gestures.

Many studies have documented the correlation between doctor-patient understanding and treatment compliance and patient satisfaction. Studies have shown how clients’ misunderstanding could lead to significant delays in treatment, doctors misdiagnosing clients, and clients not being given all available options for care and misunderstanding their treatment. In addition, inappropriate or inaccurate interpretations and translations have been shown to increase costs. When doctors do not understand the clients’ symptoms or are unable to get a complete list of symptoms, patients have to return to the clinic multiple times and in many occasions receive incorrect diagnoses or unnecessary and expensive medical tests.

A number of organizations have evaluated the effectiveness of various types of language assistance services. In January 1999, the Bureau of Primary Health Care (BPHC) requested patient satisfaction survey results from all of its grantees. Later that year, BPHC produced a standardized survey for assessing patient satisfaction based on criteria developed from the grantee surveys to assess patient satisfaction with aspects of care such as ease of accessing care, waiting time, facility staff, payment transaction, confidentiality, and suggestions for improvement. In addition, the National Health Law Program has a language access questionnaire for managed care providers receiving federal funds, guided by Title VI requirements for non-discrimination and equal access. The National Council on Interpretation in Health Care employs a process for health care organizations to evaluate their capacity for linguistic and culturally appropriate care. The process helps organizations identify actions to improve their quality of care, understanding of community needs, clinical outcomes, service delivery, regulatory compliance, and cost containment with relation to care for LEP patients. The Agency of Health Care Research and Quality produced the Consumer Assessments of Health Plans Study (CAHPS) to measure patient satisfaction through life cycles and in different patient circumstances. The
CAHPS® survey, or a version thereof, has been used by Medicare, Medicaid of various states, the Office of Personnel Management, and the National Council on Quality Assurance.

1.6.3 Innovative Methods of Delivering Language Assistance in Health Care Clinics

Language assistance services that use technology in creative ways, such as interpretation via a language line and videoconferencing technology, are proving to be effective in minimizing language barriers in health care services. The AT&T Language Line, for instance, is a for-profit venture providing 24-hour interpretation services in over 140 languages. Studies evaluating its services have reported that, although interpreters lack formal training in medical interpretation, they are effective when clinics are in dire need of basic interpretation. Other studies have uncovered some drawbacks to telephone interpretation, including high costs (though less than having an interpreter physically in the exam room) and the inability of the interpreter to observe the patient’s body language.

Studies analyzing language assistance service delivery via teleconference technology have reported that both clients and providers indicated high satisfaction with videoconferencing services. Patients liked the privacy of not having an extra person in the room during examinations and that they could see the interpreter on a video screen and understand clearly the interpreter’s words. However, videoconferencing technology is not yet widely available due to the prohibitive cost of installing high speed Internet lines, and studies also have documented that videoconferencing equipment has had high rates of failure.

Some clinics have formed partnerships with community organizations, not only to provide translation services, but also to assist in cultural understanding and in discovering community wants and needs. Facilities have been collaborating with community healers who practice traditional medicine and offer healing techniques such as acupuncture and herbal medicine. Some clinics focus on developing educational materials designed for specific populations and are conducting research on diseases that are more prevalent in certain populations, like tuberculosis and cervical cancer.

The Association of Asian Pacific Community Health Organizations, conducts an ongoing investigation of issues concerning the community and keeps track of best practices in outreach for different populations. Some studies now report the experiences of clinics that have designed services which create a more welcoming atmosphere to specific groups by decorating and furnishing the facilities in a “homey” and comfortable fashion, incorporating ideas such as Feng Shui, adding an Islamic prayer room, or integrating other culturally-specific design components.
ENDNOTES


1 Bonder, Bette, Laura Martin, and Andrew Miracle, “Achieving Cultural Competence.” Diaz-Duque, O.F., “Overcoming the Language Barrier.”

6 Collins, Karen Scott, and et al., *Diverse Communities, Common Concerns.*


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Health Access, “Videoconferencing Medical Interpretation.”


Harborview Medical Center, “Language Services,” no date.

Association of Asian Pacific Community Health Organizations, “Technical Assistance to Community and Migrant Health Centers,” no date.

Ibid.

Bourbon, Julie, “Arlandria Clinic Meets Desperate Need.” Bureau of Primary Health Care, “Cultural Competence.”
SECTION 2

Study Design and Methodology
2. STUDY DESIGN AND METHODOLOGY

The Limited English Proficiency as a Barrier to Family Planning Services study is an exploratory research effort designed to provide a baseline examination of the range of language assistance services being provided by Title X family planning clinics. COSMOS staff designed the study to employ qualitative data collection methods such as document reviews, telephone and face-to-face interviews, and focus groups. Guides were developed to conduct semi-structured interviews with study key informants, clinic staff, and to guide the focus groups with clinic clients. The methodologies developed and used to conduct the various data collection activities are described in the following section, and are listed in Exhibit 2-1. The timeline for all information gathering activities is included in Exhibit 2-2.

2.1 INTERVIEWS WITH FAMILY PLANNING PROFESSIONALS

Prior to all data collection, the study team conducted an initial round of telephone interviews with a select number of family planning professionals. Individuals contacted included OPA regional program consultants (RPCs) and regional training consultants (RTC) representing different public health service regions (see Appendix A for a complete list of individuals contacted). The interviews provided the study team with a beginning base of information from which the design was completed, and also with a list of knowledgeable professionals to be included in the pool of study key informants. All interviews were conducted using a written guide that included an interview script to maintain consistency throughout and to minimize error resulting from interviewer bias (the guide is included in Appendix B).

In collaboration with OPA, the study team identified a list of nine family planning professionals to be contacted for key informant interviews. Key informants were selected from a pool of nationally recognized professionals specializing in either family planning or language assistance service delivery (the complete list of key informants is contained in the acknowledgments section of the report). The goal was to select a group of individuals who would offer first-hand knowledge of Title X grantees’ language assistance services and staff training needs, and who were representative of public health service regions.
Exhibit 2-1

STUDY METHODOLOGY

List of Nominated Clinics
Criteria for Clinic Selection

Initial Contact with Clinic Directors:
- Clinic screening
- Schedule site visits
- Recruit focus group participants
- Develop tentative agenda and interview roster

Introductory Letter Sent to Nominated Grantees:
- Purpose of study
- Importance of their participation
- Possible uses of information gained

List of Nominated Key Informants:
- Geographic representation
- Experience with clinics in multiple regions

Telephone Interviews with Family Planning Professionals (Title X Regional Training Grantees, Program Consultants):
- Purpose of the study
- Determine appropriate key informants to contact
- Orientation to family planning landscape

Telephone Interviews with Selected Key Informants:
- Obtain clinic nominations
- Discuss criteria for clinic selection
- Solicit feedback on study design and instruments
- Gather information on language assistance services

Site Visits

Focus Groups
### 2.2 KEY INFORMANT INTERVIEWS

In an effort to increase the practical utility of data, the study team conducted semi-structured telephone interviews with the nominated key informants. Interview findings helped guide the development of the study design and data collection instruments, as well as to secure nominations for Title X family planning clinics offering innovative language assistance services. A major task of the key informant interviews was to identify an appropriate sampling strategy for selecting the seven clinics. The study team used the most current copy of the OPA 2001/2002 Directory of Family Planning Grantees to verify the contact information of the recommended clinics. Nominated sites included clinics serving populations with a high concentration of non-English speaking individuals and which study key informants considered to have implemented innovative language assistance services.

An interview guide was used to conduct all interviews with the study key informants. The guide included an introductory script with greeting, interviewer identification, purpose of the call, consent to interview, and a thank-you statement. The interview guide was comprised of a series of open-ended and probe questions designed to elicit responses on recommendations for clinic selection criteria, clinic nominations, and any issues of concern with the study methodology (see Appendix C for the Key Informant Interview Guide). Given their experience and exposure to multiple language assistance services in various public health service regions, key informants were asked to nominate clinics that they considered to have innovative language assistance services or practices. The nominated clinics were pooled and arranged by the selection criteria (see Appendix F for the list of nominated clinics).
2.3 CLINIC SELECTION METHODOLOGY

To ensure that study results provided OPA with an accurate snapshot of the barriers Title X clinics face in assuring access, as well as knowledge of innovative services or strategies, the study employed a site selection methodology accounting for clinic characteristics such as: number of languages served, clinic location and affiliation, and whether the immediate service areas had experienced a recent influx of LEP populations. The recommended site selection criteria are included in Exhibit 2-3.

Exhibit 2-3

RECOMMENDED CRITERIA FOR CLINIC SELECTION

- Evidence of having an innovative language assistance service;
- Clinic’s service area has high LEP growth;\(^1\)
- Serves multiple languages;
- Inclusion of all types of clinics;\(^2\)
- Regional representation (public health service regions); and
- Inclusion of at least one clinic serving a rural community.

The clinic selection criteria took into consideration that clinics that have served multiple languages would be better prepared to deal with LEP clients and have more experience offering different types of language assistance services. Consequently, clinics in communities that have not experienced a recent increase in their immigrant population will have less experience treating clients with LEP. The same is true for clinics in rural and urban settings. The criteria assumed that clinics in rural areas will have less experience treating clients with LEP, and therefore have been exposed to very different types of barriers to providing language assistance to their LEP population. Exhibit 2-4 shows the selected clinics arranged by the selection criteria. All clinics are located in areas that have undergone high increases in the growth of their LEP populations, and all clinics selected serve multiple language groups. In accordance to the site selection methodology at least one clinic, the San Marcos Clinic, serves a rural LEP population. In addition, clinics represent all clinic types and are drawn from a varied mix of public health service regions. The geographic location of all participating clinics is displayed in Exhibit 2-5.

\(^1\) Refers to an area or community that has experienced a recent influx of people that speak a language the clinic has not served.

\(^2\) Clinic typology is based on the clinic’s primary affiliation, e.g., university, hospital, community-based organization, etc.

*COSMOS Corporation, March 2003* 2-4
Exhibit 2-4

DESCRIPTION OF CLINICS, BY SELECTION CRITERIA

<table>
<thead>
<tr>
<th>Clinics</th>
<th>High LEP Growth Area</th>
<th>Multiple Languages</th>
<th>Reach*</th>
<th>Type**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tremont Center</td>
<td>Yes</td>
<td>Yes</td>
<td>U</td>
<td>CBO</td>
</tr>
<tr>
<td>2. Centro de Salud Clinic</td>
<td>Yes</td>
<td>Yes</td>
<td>U</td>
<td>PP</td>
</tr>
<tr>
<td>3. Stafford Clinic</td>
<td>Yes</td>
<td>Yes</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>4. Valley Health Center at Lenzen</td>
<td>Yes</td>
<td>Yes</td>
<td>U</td>
<td>H</td>
</tr>
<tr>
<td>5. San Marcos Clinic</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
<td>CHC</td>
</tr>
<tr>
<td>6. Southeast Heights Clinic</td>
<td>Yes</td>
<td>Yes</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>7. La Clínica del Pueblo</td>
<td>Yes</td>
<td>Yes</td>
<td>U</td>
<td>PP</td>
</tr>
</tbody>
</table>

* Describes the clinic’s location (R=Rural, U=Urban)
** Refers to the clinic’s structural base or primary affiliations (CBO=Community-Based Organization, H=Hospital System, U=University, CHC=County Health Center, PP=Planned Parenthood)

Exhibit 2-5

GEOGRAPHIC LOCATION OF STUDY CLINIC SITES VISITS*

Columbia Health Center
Seattle, WA
Dropped from sample

Centro de Salud Clinic
Minneapolis, MN
August 6-8

Tremont Center/
MIC-Women’s Health Services
Bronx, NY
July 8-9

Valley Health Center at Lenzen/Santa Clara Valley Health & Hospital System
San Jose, CA
August 21-23

San Marcos Clinic/
North County Health Services
San Marcos, CA
August 28-29

Southeast Heights Clinic/
UNM Maternal and Infant Care Project
Albuquerque, NM
September 11-13

La Clinica del Pueblo
Washington, DC
September 17-18

Stafford Clinic/
University of Texas-MB
Stafford, TX
August 12-14

Title X Regions: 1 2 3 4 5 6 7 8 9 10

* Dates indicate the days in which the study team conducted the site visit at each of the clinics.
2.4 METHODOLOGY FOR CONDUCTING THE SITE VISITS

Based on information learned through the key informant interviews, the study team developed a Site Visit Protocol Instrument which guided the on-site data collection. The site visit protocol included procedures to be used during on-site data collection (e.g., document reviews, adhering to the staff interview schedule, etc.) and the site visit team’s topics of inquiry or lines of questioning (see Appendix D for the Site Visit Protocol Instrument).

Prior to scheduling site visits, the study team used a Clinic Screening Protocol to verify the information that led to each particular site being selected (e.g., to confirm that the clinic serves a large number of non-English speaking clients) and to inquire about the availability of focus group participants. Interviewees included clinic staff (e.g., director, executives, or administrators, etc.) and those providing family planning and/or interpreter services (e.g., practitioners, nurses, in-take personnel, and interpreters), as well as staff working at the delegate and grantee level. Focus groups with actual clients from four of the seven sites were also conducted, and the methodology used to conduct the site visits is discussed in the following section.

On-site visits were first scheduled for each of the seven participating clinics. The visits lasted for two days for clinics that did not include a focus group, and three days for clinics that did include a focus group. Two-person teams—a field team supervisor and a field team member—conducted the site visits.

The topical nature of the study created two staffing considerations for conducting the site visits. First, the study team was sensitive to the fact that many people still view family planning as a “woman’s issue.” This factor was important to clients when planning site visits, because some female clients may have been less forthcoming (or even offended) in a focus group composed of an entirely male site visit team. As such, every site visit in the study was conducted by at least one female team member at each site. Second, the site visit team hired a consultant proficient in the respective language(s) of the clinics’ service populations to aid the team in reviewing translated documents and to provide translations during focus group meetings.

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3 Interviews at the Valley Health Center at Lenzen include those conducted at the Santa Clara Valley Hospital, the clinic’s delegate, where the remote interpretation division is located. Also, the site visit to the Southeast Heights Clinic also included interviews at the University of New Mexico Hospital (the grantee organization) which operates off-site interpreter and translator services for their satellite clinics.

4 The only language consultant that was required was a trilingual medical interpreter who was hired to lead the focus group with Urdu speakers in Stafford, Texas.
Study findings that identify promising practices (in any field) are more credible when the voices of those being served by the practice or activity are included in the assessment. The following section describes the methodology used to conduct the focus groups with family planning clients.

2.5 METHODOLOGY FOR CONDUCTING THE FOCUS GROUPS

The study team convened four focus groups with individuals who had accessed or were currently receiving family planning services at one of the selected Title X clinics. Focus groups were conducted to inform the study on clients’ perceptions of access to services, experiences with barriers to services, and the perceived effectiveness of various language assistance services offered by family planning clinics. The methodology was selected in order for the study team to elicit more precise and in-depth information about the experiences and opinions of a difficult-to-reach population.

Focus Group Participant Recruiting. Study key informants advised study team members that participants would be difficult to recruit given clients’ lack of trust of researchers. In addition, key informants advised the study team that differing values and social, cultural, religious, and spiritual beliefs related to health care usually inhibit or prevent certain individuals and groups from participating in data collection efforts. Also, members of diverse racial and ethnic groups who have recently immigrated to the U.S. may neither have the necessary literacy skills nor be accustomed to participating in traditional U.S. data collection efforts such as completing questionnaires, surveys, or participating in focus groups. In order to help minimize those limiting effects, the study team took special care in recruiting participants with the help of a “gatekeeper,” or someone within the community who is trusted, respected, and who at times is sought out by community members needing aid and advice by the potential participants (Krueger, 1998).

The study team asked clinic directors to nominate a staff member who had the most familiarity and contact with clients. Once clinic staff members were identified, the study team drafted a letter explaining the purpose of the focus groups, what participants could expect when attending a session, and specific instructions on who to ask to participate. The recruiter also received specific instructions to over-recruit in order to reach the target of 6-12 participants per focus group. Recruiters were asked to select participants both old and new to clinic services, and to not to limit recommendations to individuals with whom they were most familiar or had close relationships. They also were asked to include participants with varying education levels.5

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5 Recruiters were not provided with any guides for assessing education levels, but only asked to estimate their levels based on prior interactions with clients.

COSMOS Corporation, March 2003 2-7
Conducting the Focus Groups. A COSMOS senior technical staff member who is a bilingual health researcher conducted three focus groups in Spanish. However, for the focus group conducted at the Stafford Clinic in Stafford, Texas, a professional medical interpreter fluent in Urdu and Punjabi was hired to lead the focus group. The study project director trained the interpreter. The interpreter conducted a forward and backwards translation of the Focus Group Discussion Guide to ensure that all questions were appropriate in the translated language and to rehearse the phrasing of all questions and probe questions. The focus groups were conducted on the last day of the site visit in order to allow the site visit team to ask participants questions about specific language assistance services offered at that particular clinic.

The focus groups included discussants, a moderator, and an assistant moderator. The moderator used a Focus Group Discussion Guide (see Appendix E), which served as an agenda of topics to be discussed, and included probe questions which allowed the site visit team to capture more detail on certain aspects of the discussion. The study team developed the Focus Group Discussion Guide with information obtained in the key informant interviews, and by collecting information on specific language assistance services offered at participating clinics. The discussion guide included: 1) an introduction describing the goals of the study; 2) ground rules for the discussion; 3) key issues to be discussed; and 4) probe questions. The focus group meetings lasted 60 to 90 minutes and were recorded using audiotape for later analysis. The audio recorder was clearly displayed, and verbal acknowledgment was given to inform participants that the discussion was being recorded.6

At the beginning of each discussion, the moderator established a rapport with participants by offering them refreshments, allowing them time to feel at ease, and began introducing the project midway through the snack. The moderator then described how each participant’s contribution would be shared with others in the group as well as with the moderator and assistant moderator, and that the tape recordings would not be shared with individuals outside of the project, but would only serve to clarify the notes being taken by the assistant moderator. In addition, the study team would maintain their anonymity by not using names or other personal identifiers. The introduction provided participants with a clear explanation of the purpose of the study, goals of the sessions, and a brief introduction of the study team members. The moderator also discussed the importance of adhering to the ground rules. Participants agreed to be polite and not interrupt other participants even if they were in disagreement.

At the conclusion of the sessions, the moderator thanked the participants, distributed honoraria, and debriefed the assistant moderator. The debriefing allowed for fact

6 The focus group conducted in Urdu at the Stafford clinic was not recorded at the request of one of the participants.
checking and provided the moderator and the assistant an opportunity to make any necessary clarifications. The moderator read a brief summary of key issues discussed and asked participants to confirm the statements. Findings from the focus groups are described in Section 5.
SECTION 3

Study Findings
3. STUDY FINDINGS

Title X family planning clinics offer LEP clients a wide spectrum of language assistance services designed to help them overcome linguistic and cultural barriers. Clinics have adopted various approaches to provide LEP clients with oral interpretation, to translate client education materials, and to conduct outreach to LEP individuals by effectively using their resources, as well as the resources available to their delegates and grantees.

Family planning clinics employ a combination of language assistance services and strategies to comply with Title VI requirements and have designed innovative services and strategies to expand their coverage, reduce response time, and adjust the standard of interpretation to best meet the needs of their clients. Language assistance services adopted by the clinics are directly related to a number of factors including: the clinic’s economic capacity, the level of support provided by the delegate or grantee, and the size and number of the LEP language groups served. The following section describes the range of language assistance services offered by Title X clinics. It provides a description of the various types of language assistance activities and procedures, as well as their strengths and limitations, and presents the relative costs for providing each of the language assistance services. The section also describes the different barriers clinics experience as they provide language assistance services to an increasing number of LEP clients.

3.1 LANGUAGE ASSISTANCE SERVICES OFFERED AT SELECTED TITLE X-FUNDED FAMILY PLANNING CLINICS

Title X family planning clinics provide their LEP clients with unique language services designed to bridge the language gap and facilitate communication between clinic staff and clients. The methods of providing language assistance include:

- Bilingual staff;
- Staff interpreters;
- Contract interpreters; and
- Language lines.

In addition, some clinics have designated bilingual staff members as backup interpreters and have developed and maintain a pool of volunteer interpreters trained in medical interpretation. Clinics with larger budgets have developed, or have access to, state-of-the-art remote telephone interpreter services, and others provide interpreter services using teleconference technology. In addition, many family planning clinics, regardless of size or type, have developed strategic partnerships with community-based...
organizations (CBOs) to augment their language capacity. Exhibit 3-1 illustrates the language assistance services, activities, and procedures offered by the family planning clinics visited by the study team.

Exhibit 3-1 shows that clinics have adopted multiple methods of language assistance. This finding is consistent with current research which states that a combination of models or approaches constituting a “multifaceted model” provides the best solution for eliminating linguistic barriers to health care (Downing and Roat, 2002). In addition, Title X clinics also have innovated certain language assistance services which go above and beyond services recommended by OCR. The various methods employed by clinics to provide language assistance are described below.

Exhibit 3-1

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Bilingual Staff</th>
<th>Staff Interpreters</th>
<th>Contract Interpreters</th>
<th>Language Line</th>
<th>On-site Translation Service</th>
<th>Dedicated Backup Interpreters</th>
<th>Remote Telephone Interpretation</th>
<th>Volunteer Interpreters</th>
<th>Interpretation via Teleconference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tremont Center</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Centro de Salud Clinic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Stafford Clinic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>4. Valley Health Center at Lenzen</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5. San Marcos Clinic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>6. Southeast Heights Clinic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. La Clínica del Pueblo</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

OCR Recommended Services | Other Innovative Services

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1 OCR has developed guidance on appropriate language assistance service options and requires that clinics adopt at least one of the recommended language assistance services that are included on the left column of Exhibit 3-1.

*COSMOS Corporation, March 2003*
3.1.1 Bilingual Staff

The most frequently encountered method of providing language assistance was through the use of bilingual staff. Exhibit 3-1 shows that all participating clinics employ bilingual staff to provide clinical services in the LEP person’s primary language. This method requires that clinics, directly or indirectly through their delegate or grantee, recruit and hire bilingual clinical staff.

**Strengths.** Using bilingual staff to provide language assistance offers the maximum opportunity to communicate effectively with the client. Clients report being able to establish a more trusting relationship when staff speak their language, especially when staff are from the same racial and ethnic group as the client. In this instance, both culture and language can be addressed by a single staff member.

As a result of increased levels of trust, clients report feeling more secure in their interaction with staff and ask more questions regarding their care. This increased interaction often leads to enhanced levels of quality health care (Cooper-Patrick, et al., 1999), as well as fewer incidences of provider error in diagnosis and treatment (Howard, et al., 2001). This is due, in part, to the effective exchange of body language during the interaction and the staff’s ability to place more attention on human relationships.

**Limitations.** There are three main limitations to providing language assistance using bilingual staff. First, given that the pool of qualified bilingual health professionals is quite limited, clinics experience great difficulty in recruiting and retaining bilingual staff—especially health professionals. The study team queried clinic directors and administrators regarding the language capability of their staff. Exhibit 3-2 shows that Spanish is the most widely spoken language by all types of clinic staff. The exhibit also shows that the more technical the position (e.g., registered nurses and physicians), the less language capability is available. This points to a major barrier faced by clinics providing language assistance services, which will be discussed in Section 3.4.

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2 Bilingual staff include both support staff (e.g., in-take and other support staff) and medical providers (e.g., nurse practitioners and physicians).

3 These findings were confirmed by focus group participants who view bilingual providers as more compassionate and understanding than staff who communicate using interpreters. These findings are discussed in greater detail in Section 5.
## Exhibit 3-2

### CLINIC STAFF LANGUAGE CAPABILITY

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Receptionist</th>
<th>In-take Worker</th>
<th>Medical Assistant</th>
<th>Registered Nurse</th>
<th>Physician</th>
<th>Interpreter/Translator&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Other Staff&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tremont Center</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S, F, CR</td>
<td>S, CR</td>
<td>S, C</td>
</tr>
<tr>
<td>2. Centro de Salud Clinic</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S, HM</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>3. Stafford Clinic</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S, C, U</td>
<td></td>
</tr>
<tr>
<td>4. Valley Health Center at Lenzen</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S, P</td>
<td>S, V, R</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>5. San Marcos Clinic</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>6. Southeast Heights Clinic</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S, V, N</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>7. La Clínica del Pueblo</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S, F</td>
<td>A, F, S, M, P</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>Refers to on-site interpreters and translators and does not include language line or remote interpreter service.

<sup>2</sup>Other staff include: outreach workers, volunteer interpreters, and translators.

Key: S=Spanish; V=Vietnamese; R=Russian; C=Chinese; U=Urdu; P=Portuguese; HM=Hmong; F=French; CR=Creole; N=Navajo; A=Amharic

Another limitation results when a clinic serves a variety of LEP language groups. In cases such as this, using bilingual staff to provide language assistance may be insufficient to meet the needs of all LEP clients, as most bilingual health professionals have the capability of addressing, at most, two to three languages. Once clinics begin to serve more than three language groups, this strategy becomes too costly.

Finally, this method has the potential to introduce interpreter error if staff members are not carefully screened or tested for other language proficiency. Staff members who have studied the language of their clients in high school or college might regard themselves as bilingual, while they might not have achieved the proficiency level required to be an effective interpreter—especially one who interprets medical terminology.
3.1.2 Staff Interpreters

The use of staff interpreters is another widely-used method of providing language assistance. This approach requires bilingual staff to serve as interpreters in addition to their regular job duties, but differs from the bilingual staff method because Title X clinics that employ this approach require that staff interpreters undergo a language proficiency screening and training in medical interpretation. Furthermore, staff interpreters are designated as interpreters and receive additional compensation for their language skills. Using staff as interpreters is appropriate when there is a frequent or regular need for interpreting services in a dominant language, or when there is a sudden surge or overflow of a language uncommon to clinic staff.

**Strengths.** The staff interpreter method of providing language assistance creates efficiency within the clinic, because there are usually established protocols for staff interpreters. Thus, if a staff person is asked to interpret for a co-worker, there usually will be a backup to assume the staff person’s primary job. Scheduling is facilitated and quality control is easier to manage because the staff’s language competence has been predetermined through screening. Also, staff interpreters become increasingly proficient over time in working with other staff professionals (e.g., staff physicians or nurses) and also become familiar with the colloquialisms used by their LEP clients.

**Limitations.** Clinics that have adopted this method of providing language assistance report a number of limitations. First, as stated in the bilingual staff model, bilingual health professionals are in short supply in the U.S. Also, when staff are required to interpret, they often confront complex issues and ethical dilemmas that they otherwise would not face if they did not have the added duty of interpreting. Clinic administrators, therefore, recommend that staff members receive training in medical interpretation in order to provide them with strategies to confront difficult situations. Hence, another limitation of adopting this strategy—the need to train staff in either medical or interpreter training—requires staff members to spend time away from their regular job duties to attend training sessions. Finally, there also are costs associated with lost work time when staff are taken away from their primary jobs to fill requests for interpretation—leading at times to job conflicts.

3.1.3 Contract Interpreters

Some Title X clinics provide language assistance using contract interpreters or individuals with training and experience interpreting who are outsourced from an interpreter agency. This method is usually adopted by clinics with an infrequent need for interpreter services, less common LEP language groups in their service areas, or the need to supplement their in-house capabilities on an as-needed basis.
**Strengths.** Adopting this method of language assistance requires that a clinic restrict an interpreter’s role to the sole function of interpreting. Therefore, interpreters are more readily available, encounter less interruptions, and are able to focus more on the client. In addition, clinics have more flexibility in selecting experienced interpreters who have received training in medical interpretation.

**Limitations.** Interpreters can be difficult to supervise and manage. As one clinic director stated, “How do you know they are doing a good job if they are the only ones at the clinic who speak the language?” Contracted interpreters also require an additional level of effort to manage, as clinic appointments need to be coordinated for three individuals (e.g., clients, providers, and interpreters). When clinics experience no-shows, contract interpreters are usually paid a minimum fee for a full hour and reimbursed for their travel expenses.

### 3.1.4 Volunteer Interpreters

The use of *volunteer interpreters* has been a common method of augmenting a clinic’s language assistance capability. However, to effectively use volunteers, Title X clinics have invested resources at start-up to train volunteers in medical interpretation and to develop an efficient method of managing the pool of available volunteers. Also, clinics have developed formal agreements with individuals as well as community-based organizations in which volunteers agree to abide by certain protocols. Clinic directors mentioned that a proper scheduling system is essential in order to use *volunteer interpreters* efficiently and effectively. The scheduling system is reinforced by providing volunteer interpreters with periodic briefings that stress their obligation to be prompt for appointments, the importance of maintaining client confidentiality, and overall professionalism.

**Strengths.** An obvious strength of using *volunteer interpreters* is that they are not salaried staff, so there is no direct expense for interpretation services.

**Limitations.** Although there are great cost benefits to using *volunteer interpreters*, there are hidden expenditures, such as management costs, training expenses (e.g., interpreter training or training in medical interpretation), and maintaining interpreter skill level through periodic refresher courses. Some clinics have experienced difficulty in scheduling volunteers given their limited availability. In addition, many do not have a professional’s sense of responsibility to provide timely services. Also, *volunteer interpreters* are difficult to retain, especially those who have received training in medical interpretation. Once they have served for an extended period of time, volunteer interpreters become highly marketable and are recruited as professional interpreters.
3.1.5 Language Lines

The method of providing language assistance through a language line is commonly used by clinics to provide clients with interpretation via telephone. The service is obtained through contacting an interpreter agency specializing in interpretation (e.g., AT&T Language Line, or Pacific Interpreters) and involves interpreters located in a remote location providing interpretation to a clinic via a speakerphone. The speakerphone is usually located in in-take and exam rooms. This service is used by clinics as a supplemental system, most useful when a clinic encounters a language that it has never served, a language that is in low-demand, or a language that can no longer be served due to increased demand or overflow.

**Strengths.** Providing language assistance using language lines offers clinics a large variety of languages and usually can provide a quick response to requests. Thus, they are often used when it will take too long to get an interpreter in-person or for low-demand languages where a local interpreter is not available.

**Limitations.** Although language line services employ competent individuals with fluency in various languages, these services rarely provide employees with training in technical terminology (e.g., medical terms). However, none of the Title X clinics offer language assistance through language lines as the only method of assistance—only when other language assistance options are unavailable.

3.1.6 On-site Translation Service

Some Title X clinics operate an on-site translation service which designates bilingual staff to translate application forms and instructional, informational, and other written materials into appropriate non-English languages. All clinics visited by the study team provided LEP clients with translated documents for all of the major language groups served by the clinic in accordance to OCR established thresholds. The clinics that do not employ an on-site translation service obtain translated written materials from various

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4 This method of providing language assistance also is known as remote consecutive interpretation.

5 OCR will consider an entity to be in compliance with its Title VI obligation to provide written materials in non-English languages if: the entity provides translated written materials, including vital documents, for each eligible LEP language group that constitutes 10 percent or 3,000 clients, whichever is less, of the LEP population served by the clinic. When a LEP language group constitutes five percent or 1,000 clients, whichever is less, the entity should provide clients with at least, vital documents translated into appropriate non-English languages. Whenever other documents are needed, they should be provided orally, and for language groups with fewer than 100 people, clinics are not required to translate written materials but only required to provide written notice in the primary language of the LEP language group of the right to receive competent oral translation of written materials.
sources including: their grantee or delegate organization, the state health department, or outsourced to a company that provides translation services.

**Strengths.** An important benefit of having an in-house translation service is that clinic staff are able to tailor documents and signs to address the language needs of the specific LEP populations they serve and can include specific colloquialisms and terminology common to particular language groups.6

**Limitations.** The study team observed that the more complex or well-funded the clinic, the longer it takes for documents or signs to get translated and approved. The protocol for translating a document in-house usually involves a number of reviews, edits, and drafts. Although these quality control steps are necessary, they increase the turnaround time for translating materials.

**3.1.7 Dedicated Backup Interpreters**

Some clinics have designated certain bilingual staff members to serve as backup interpreters. These individuals are used on an as-needed basis, usually when a clinic experiences overflow in a specific language. The Title X clinics queried have written procedures that describe the situations in which these individuals provide services, and stipulate a slight pay differential for their services.

**Strengths.** In addition to staff interpreters, some clinics designate staff as dedicated backup interpreters. Backup interpreters are usually bilingual staff who have little or no training in medical interpretation, but who do have practical experience interpreting. They only provide language assistance to LEP clients during instances when clinic staff are unable to schedule staff interpreters (i.e., when a clinic has a walk-in or during instances of high demand for interpreters).

**Limitations.** A major limitation of this method is that job conflicts sometimes develop when backup interpreters are taken from their normal job duties. However, Title X clinics have minimized these limiting effects by having written protocols for requesting a backup interpreter and providing them with a stipend for their extra efforts.

**3.1.8 Remote Telephone Interpretation**

One of the clinics visited by the study team had access to interpreter services via a remote telephone interpretation service staffed and operated by its grantee. Remote interpretation is a real-time language service that enables speakers of different languages

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6 Although the Centro de Salud Clinic does not have a formal translation service, their staff edit all translated documents and incorporate the idioms used by their LEP clients.

*COSMOS Corporation, March 2003* 3-8
to communicate by telephone with the assistance of an interpreter via a three-way conference call transmitted to the examination room through a speakerphone. This language assistance service is different than a language line, because the interpreters are full-time staff members. Thus, interpreting engagements are not constrained by per minute charges. The remote telephone interpretation service is the most complex of all other services and is managed by the largest grantee queried by the study team.

**Strengths.** There are three main strengths associated with providing interpreter services using remote telephone interpretation. First, the system provides its clients with fast turnaround on requests. Once the provider and client are ready for the service, the interpreter is called and the session is initiated. Clinics that do not employ this service require that clients wait for an interpreter and also wait for the attending physicians or nurse practitioners to arrive. Thus, the remote telephone interpretation service maximizes the interpreters’ time by minimizing their down time, as well as the time spent transferring to various appointments. Second, because remote telephone interpretation services are managed in-house, there can be more rigorous requirements for interpreters, including required language proficiency tests in two or more languages and training in medical interpretation. Such requirements raise the level and quality of the interpretations provided by staff. Third, the service allows an organization to provide high-quality language assistance to a high volume of LEP clients in a cost-effective manner.

**Limitations.** Although the remote telephone interpretation service has some attractive features, there are a few limitations to its use. For instance, in order to maintain confidentiality during an interpreter engagement, the speakerphone must be placed in an enclosed area. However, some rooms and spaces that do provide confidentiality have high levels of noise and echo. Another limitation is the inability of the interpreter to observe the client’s non-verbal communication. It is difficult for the interpreter to take into account the emotional content of a discourse without seeing the patient’s body language and gestures. This observation was made by both clinic staff, as well as focus group participants, and is consistent with early studies focusing on communication which found that more than 75 percent of emotional content is transmitted non-verbally (Mehrabian, 1972).

### 3.1.9 Interpretation via Teleconference

Providing language assistance using video teleconferencing technology avoids some of the limitations imposed by both language lines and remote telephone interpretation services. This language assistance service allows skilled interpreters located off-site to provide face-to-face interpreting services for patient and medical provider through the use of specialized computer software and a video recorder, connected through high-speed Internet lines.
**Strengths.** Providing *interpretation via teleconference* allows the interpreter to observe the provider and patient and to use visual cues, such as body language and facial expressions, to more effectively assess non-verbal communication patterns. In addition, results from an unpublished pilot study indicated a high level of satisfaction among healthcare providers, patients, and interpreters regarding the ease and quality of interpretation via teleconference. Another study conducted by the Robert Wood Johnson Foundation found that LEP clients do not find the use of videoconferencing equipment intimidating, and that the absence of a third person in the examination room adds to their level of privacy during an examination (Howard, 1998).

**Limitations.** The cost of video and computer equipment necessary for teleconferencing is relatively affordable. However, the quality of video transmission via telephone lines is inadequate for interpreting, so an efficient system requires the installation of T-1 high-speed Internet lines. The cost of installing high-speed Internet lines in multiple rooms within a clinic is a large part of the expense. In addition, there are monthly dues for accessing the Internet, and clinics are still required to pay for the interpreter services used.

### 3.2 LANGUAGE ASSISTANCE ACTIVITIES AND PROCEDURES THAT PROVIDE CLIENTS GREATER ACCESS TO CLINIC SERVICES

As part of their overall language assistance services, Title X clinics are involved in various activities and have developed and implemented procedures to maximize clinic resources in order to provide greater access to clinic services. For instance, clinics have developed signs and educational videos in multiple languages to inform clients of services available to them, and clinics also provide their staff with training in cultural competence and in medical interpretation. In addition, clinics are maximizing available resources within the community by developing strategic alliances with CBOs and volunteer organizations which augment their language capacity and effectiveness of their outreach efforts. These activities and procedures are described in the following section and presented in Exhibit 3-3, by clinic.
Exhibit 3-3

LANGUAGE ASSISTANCE ACTIVITIES AND PROCEDURES

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Language Assistance Activities and Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multilingual Signs</td>
</tr>
<tr>
<td>1. Tremont Center</td>
<td>✓</td>
</tr>
<tr>
<td>2. Centro de Salud Clinic</td>
<td>✓</td>
</tr>
<tr>
<td>3. Stafford Clinic</td>
<td>✓</td>
</tr>
<tr>
<td>4. Valley Health Center at Lenzen</td>
<td>✓</td>
</tr>
<tr>
<td>5. San Marcos Clinic</td>
<td>✓</td>
</tr>
<tr>
<td>6. Southeast Heights Clinic</td>
<td>✓</td>
</tr>
<tr>
<td>7. La Clinica del Pueblo</td>
<td>✓</td>
</tr>
</tbody>
</table>

3.2.1 Multilingual Signs

Title X clinics display a number of signs in various languages designed to inform clients of clinic services and of their right to an interpreter. For instance, all clinics in this study use language identification cards (e.g., “I speak” cards), which allow staff to identify LEP clients and their language and invite the LEP person to identify their primary language. In addition, many clinics post multilingual signs in regularly encountered languages other than English in waiting rooms, reception areas, and other initial points of entry to the clinic (see Appendix H for a sample of multilingual signs encountered by the study team).

**Strengths.** These posted signs inform clients of the various family planning services available to them and their right to free language assistance services. In addition, the information contained on the signs also is included in brochures, booklets, outreach and recruitment information, and other materials that are routinely disseminated to the public.

**Limitations.** There are two main limitations with posting signs in multiple languages. There are limits on the size of signs, which restricts the number of languages
The study team also encountered another limitation of multilingual signs in New Mexico. Some Native American languages have not, until recently, been written. Thus, older clients who speak Navajo tend not to read the language. Appendix H includes a sign designed for Navajo speakers which illustrates how to ask for an interpreter.

3.2.2 Multilingual Client Education Videos

Some clinics use instructional videos to help clients understand the importance of preventive reproductive health care and explain the implications of not having clinical exams (e.g., Pap test) conducted on a periodic basis.

**Strengths.** The use of these videos provides a good visual and entertaining alternative to written client education materials. A client’s exposure to such videos increases their awareness of important healthy behavior, such as hygiene and proper use of contraceptives.

**Limitations.** Focus group participants reached consensus in all four focus groups that the videos, although very informative, present too much information in a short span of time (client education videos are usually about 15-20 minutes long). Clients prefer to have pamphlets that include illustrations that they can review at their leisure and use as a reference. Clinic staff were not able to provide the study team with estimates on video production costs.

3.2.3 Training in Medical Interpretation and Cultural Competency

Title X clinics are providing training for bilingual staff members and volunteers in medical interpretation and cultural competency. Health researchers are discovering that medical interpretation is necessary during all phases of the clinical visit. Training in medical interpretation provides them with the ability to describe and explain terms, ideas, and processes that lie outside of the linguistic systems of clients, including how to recognize and reconcile divergent world views. Furthermore, extensive questioning during interviews may prove perplexing to clients or interpreters who lack experience with biomedical inquiry and medical terminology (Putsch, 1985). Therefore, if bilingual staff and interpreters lack these types of skills and knowledge of medical terminology, it can lead to gross errors in communication.

In addition, training in cultural competency allows staff members to deliver more culturally relevant and competent care by exposing staff to different cultural beliefs and practices. This type of training also develops their ability to handle cross-cultural

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7 The study team also encountered another limitation of multilingual signs in New Mexico. Some Native American languages have not, until recently, been written. Thus, older clients who speak Navajo tend not to read the language. Appendix H includes a sign designed for Navajo speakers which illustrates how to ask for an interpreter.
communication, and the ability to tailor their clinical skills and practices in a way that makes them more responsive to the culture and diversity within the LEP groups served.

**Strengths.** Training in these two areas makes interactions between clients and providers more effective at all phases of the clinical visit. The training also helps staff to understand cultural meaning of terms that have no direct translation to English. Being able to effectively communicate these terms to a provider is very useful to effectively treat a LEP individual.

**Limitations.** The two limitations on this type of training are cost and staff’s time away from work required to attend trainings. Cost issues will be discussed in the following section.

### 3.2.4 Language Banks

The oldest language assistance activity for dealing with language barriers in health institutions is the development of a *language bank* (also referred to as an employee language bank). This strategy requires developing a database containing the names and contact information for staff members with other language capability. This service has traditionally used bilingual staff members who are tasked with the dual role as clinic staff and as interpreters for other employees on an as-needed basis.

The Title X clinics visited have taken this activity to a higher level of complexity, as they have added community members with fluency in various languages, and some have a large network of volunteers trained in medical interpretation. Also, some clinics have avoided the pitfalls that earlier language banks experienced by formalizing their structure and assigning coordinators to manage them. These language bank coordinators also assess the language and interpretation skill level of its members. Clinics have found *language banks* to be a useful and effective backup to other language assistance strategies.

**Strengths.** One particular strength of this activity is its low cost, since no extra staff need to be hired to provide interpretation services. Another strength is that language bank interpreters are usually readily available since they are employees of the organization.

**Limitations.** The limitations of *language banks* are evident when clinics allow employees to self-assess their level of language proficiency. Also, if language bank members lack training in medical interpretation, they can severely limit the overall effectiveness of interpreters. Another limitation is that *language banks* have often led to job conflicts resulting from instances when staff are called away from their regular duties to provide interpretation to a fellow employee. Supervisors may reprimand the interpreter for time spent away from their regular duties, which often leads to a negative work environment.
3.2.5 Development of Strategic Partnerships

In order to expand their language assistance capacity, Title X clinics have developed strategic partnerships with community organizations. Some clinics have reached out to CBOs to identify potential sources for qualified bilingual staff, as well as volunteer interpreters. These partnerships include referral of clients between organizations, formal partnerships with hospitals which provide clinics with bilingual and bicultural providers in exchange for referring clients to the hospital for follow-up care, as well as exchange of volunteers.

Strengths. Strategic partnerships do not require a financial investment from clinics, but do require that clinic administrators and outreach workers invest time and effort to conduct outreach in the community and attend community events to search for potential partner organizations.

Limitations. The one limitation of this strategy is that organizations have varying levels of language proficiency requirements for their staff and volunteers. Therefore, partner organizations need to inform their partners of the expectations regarding language proficiency and training, especially if an organization requires staff to be trained in medical interpretation. Some Title X clinics have made special provision in agreements to have one organization cover the costs for interpreter training in exchange for exclusive use of the volunteer or bilingual staff person on an as-needed basis.8

3.3 RELATIVE COSTS OF LANGUAGE ASSISTANCE SERVICES

Title X clinics expend great amounts of resources to provide language assistance services to their LEP clients. A recent study showed that costs are increasing exponentially as the demand for language assistance increases. The study cited a Title X grantee whose budget for interpretation services alone—not including the cost of the additional staff time needed to provide management services—has tripled between 2001 and 2003 (Benson-Gold, 2002). Given the large increases in the cost of providing language assistance and the broad array of language assistance options available, it is important to identify the costs of these services in order to provide Title X clinics with some general parameters of the relative costs associated with typical services.

To arrive at fair cost estimates of language assistance services, it is important to first have a clear understanding of how the service is organized and how it functions. For this,

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8 The Tremont Center in the Bronx, New York, has a formal agreement with an area hospital requiring all providers to have training in medical interpretation.
some important questions about all language assistance services need to be asked, including:

- How much of the service is available through full-time employees (FTEs)?
- How much time is allotted for contract staff?
- How much of the service is provided by volunteer staff?
- Is language assistance provided by bilingual providers? and
- Who manages the logistics of the language service?

In addition, to further refine the estimate, it is necessary to aggregate the three main cost components of a language assistance service—direct interpreter costs, overhead and benefits, and interpreter management costs. Direct interpreter costs include the interpreter’s fixed salary and can include overtime pay, travel and parking expenses, and interpreter training. Overhead rates account for an increase of 50 to 75 percent of an interpreter’s salary and benefits, which can increase a salary by 25 to 30 percent.

Since clinics were unable to provide actual cost data for language assistance services (see Data Limitations in Section 1.5), costs are reported using secondary data sources, such as national averages from official government listings, estimates provided by recent research studies, and best estimates provided by Title X clinic administrators. The following section describes the costs for each language assistance service provided by Title X clinics.

### 3.3.1 Cost of Interpreter Services

**Bilingual Staff.** As mentioned in Section 3.1.1, a strength of providing language assistance using bilingual staff is that it maximizes staffing roles by consolidating the functions of an interpreter and a clinical staff member. This allows for a considerable savings of direct interpreter costs, which are already included during an interpreting engagement. Bilingual staff salaries vary according to position, experience, and number of languages spoken. The more experience and more languages a staff person has, the higher the salary. Exhibit 3-4 shows that the salary range for bilingual staff varies considerably. This variability reflects the inclusion of both support staff and providers in the bilingual staff category. Clinic directors reported that clinical staff are able to negotiate higher salaries given their additional language skill. However, there is no accurate estimate of a salary differential between bilingual and monolingual clinical staff of similar experience and skills.

In addition, there are other hidden costs and activities involved in providing language assistance using bilingual staff. First, bilingual staff are more difficult to recruit and retain and, therefore, additional staff time is required to conduct these management activities.
Also, bilingual staff who are involved in medical exams need additional training specific to medical terminology.

**Staff Interpreters.** Staff members designated as interpreters tend to be mid-level employees who have received training in medical interpretation. Their job descriptions are more specific in terms of their interpretation duties, and they receive a stipend, which can range from $50 to $500 per month depending on the need for interpreters at the clinic. As Exhibit 3-4 shows, the salaries of bilingual staff vary more than for staff interpreters. The range of salaries is greater, because bilingual staff can be any level staff person from in-take personnel to a physician; while staff interpreters are usually medical assistants.

### Exhibit 3-4

**ESTIMATED COSTS OF LANGUAGE ASSISTANCE SERVICES**

<table>
<thead>
<tr>
<th>Method of Providing Language Assistance</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretation</td>
<td></td>
</tr>
<tr>
<td>Bilingual Staff</td>
<td>$18-$87k/year*</td>
</tr>
<tr>
<td>Staff Interpreters</td>
<td>$27-$57k/year + stipend ($50-$500/month)</td>
</tr>
<tr>
<td>Contract Interpreters</td>
<td>$35-$40/hour</td>
</tr>
<tr>
<td>Language Line</td>
<td>$2.50-$4.50/minute ($50-$60/call)</td>
</tr>
<tr>
<td>Remote Telephone Interpretation</td>
<td>$20-$30/call**</td>
</tr>
<tr>
<td>Volunteer Interpreters</td>
<td>$250-$650/volunteer***</td>
</tr>
<tr>
<td>Interpretation via Teleconference</td>
<td>$5-$15k/connection + interpreter fees</td>
</tr>
<tr>
<td>Translation</td>
<td></td>
</tr>
<tr>
<td>On-site Translation</td>
<td>$30-$50k/year + stipend ($50-$150)</td>
</tr>
<tr>
<td>Outsourced Translation</td>
<td>$0.12-$0.25/word</td>
</tr>
</tbody>
</table>

* Salary range based on clinic administrators’ estimates.
** Average call estimate based on anecdotal information presented by clinic staff at Santa Clara Valley Health and Hospital System.
*** Estimate includes cost of providing training in medical interpretation.

**Contract Interpreters.** National labor statistics show that interpreters make a mean hourly wage of $16.13, or an estimated annual salary of $31,500. However, these estimates are affected by geographic region, as well as the interpreter’s skill level, number of languages known, and type of employer. For instance, the average salary for an interpreter with five years’ experience in California is $37,389 per year, roughly $7,000

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*COSMOS Corporation, March 2003*
more than the national average.\textsuperscript{10} Employing interpreters full-time increases the total cost, as benefits and overhead need to be included. Benefits often increase salaries by 25 to 30 percent and overhead rates can add another 50 to 75 percent, which can bring the total cost of a contract interpreter to $35 to $40 per hour. However, a \textit{staff interpreter} can easily carry the same or an even higher cost per hour than a \textit{contract interpreter} due to the benefits and overhead linked with having full-time employees. Some studies report that a \textit{contract interpreter} costs, on average, roughly $10 more per hour than a full-time staff member (Youdelman, 2002).

\textbf{Language Lines}. Companies that offer this service, like the AT&T Language Line or Pacific Interpreters, provide clinics with a fast response to requests (average response rate is under two minutes) and have the capacity to provide interpretation in roughly 140 languages. However, clinics that use \textit{language lines} incur high direct costs ranging from $2.50 to $4.50 per minute, depending on the language being interpreted and the time of day service is requested. Thus, an interpretation in Spanish will be on the low end of the range, while Mandarin or Bosnian will be on the high end. There are no studies reporting the average length of calls Title X clinics place to language lines. However, the study team queried clinic staff regarding the average cost of a typical call placed to a language line. Clinics report an average cost of $50 to $60 per call, depending on the phase of the clinical visit and the health literacy of the LEP client. For instance, clinic staff stated that first visits are usually the most costly, given that clients need to complete a number of forms required for financial screening and medical history.

Although direct costs might seem high, \textit{language lines} only bill for actual minutes spent with the interpreter, whereas \textit{contract interpreters} require a full hour’s pay even if the interpretation lasts a few minutes. In addition, \textit{contract interpreters} require that their travel expenses, such as mileage and parking, be reimbursed. \textit{Language lines} present a lower cost alternative to hiring a \textit{contract interpreter}. However, this service should only be used as a backup to control for overflow or when there is need to interpret in a language that is in low-demand.

\textbf{Remote Telephone Interpretation}. For clinics that provide language assistance to a high volume of LEP clients, the most effective method of providing language assistance is through an in-house telephone interpretation system. To quote the program director of the largest grantee visited by the study team:

\hspace{100mm}

\textsuperscript{10} Based on the LA Times report on projected 2002 annual salaries for interpreters in the Los Angeles area.

\textbf{COSMOS Corporation, March 2003} 3-17
“If we didn't have this system in place, we would only be able to meet 50 to 60 percent of the need. There is higher return for interpreter salaries and time. The staff is more efficient and is spared wasting time waiting for MDs to be ready or walking to and from buildings.”

The main difference between a language line and a remote telephone interpreter service, is that a language line uses contracted interpreters, while the remote telephone interpretation is an in-house system consisting of FTEs. Based on total service costs, there is about a $30 difference in total cost per call between the two services. However, the remote telephone interpretation service visited by the study team served a high volume of clients. Once the volume of clients is high enough, this service provides a better return on direct interpreter salaries. For instance, the study team queried the director of interpreter services, asking for an estimate on the total cost per call. The director’s estimate on the total number of calls handled by FTEs was compared to what a language line would charge. On average, the remote telephone interpretation service was about half ($20-$30) per call versus the $50 to $60 per call estimated for language lines.

**Volunteer Interpreters.** There are no direct costs for providing language assistance using volunteer interpreters. However, there are management costs, as well as costs for providing the volunteers with training in medical interpretation. The cost for training in medical interpretation ranges from $300 to $600 depending on the curriculum selected. The variability in price is due to the number of participants and number of training modules selected. For instance, La Clínica del Pueblo provides its volunteer interpreters a full 40-hour training in medical interpretation using the Bridging the Gap curriculum. Training using this curriculum is at the high end of the range, around $600 per participant. Training in medical interpretation that is not as intensive can be obtained for as little as $300 per participant.

**Interpretation via Teleconference.** Providing language assistance using teleconference technology is one of the most promising methods of delivering language-assistance encountered by the study team. Teleconference technology requires an estimated start-up investment for hardware ranging from $5,000 to $15,000. Other costs include network charges (estimated at $450 per month) and T-1 line fees of $700 per

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11 Estimates for training in medical interpretation included: Northern Virginia Area Health Education Council, Bridging the Gap, $600; Asian Health Services, Across Language and Culture, $300; Cross-cultural Health Care Program, Bridging the Gap, $300.

12 The UTMB regional director provided the estimate of $15,000 for start-up investment, based on costs incurred in 1999. Thus, the estimate is high considering that teleconference hardware prices have been reduced considerably in the last year.
A recent study that tested an interpretation service that uses videoconferencing technology shows that currently available technology such as personal computers, existing hospital computer networks, wireless connections, along with relatively inexpensive videoconferencing equipment has an estimated cost of approximately $5,000 per connection (Paras, et al., 2002). The study claims that this technology can enhance access to medical interpretation for LEP clients in a cost-effective manner.

However, the cost of hiring either staff interpreters or contract interpreters needs to be added into the estimate. If a clinic were to combine teleconference technology and share interpreter costs, or share volunteer interpreters with other organizations, this method could present the best option. However, for this to occur the partner organization must also have the teleconference equipment.

As technology advances and creates more economical and better performing components, more organizations will be able to acquire teleconference technology which may lead to providing interpretation via teleconference as one of the most cost-effective language assistance services available.

**Language Banks.** A basic language bank has minimal direct costs. The service requires a half-time employee to manage the database and to continually update the contact information. However, more complex or formal language banks, like the one operating in Santa Clara Valley Health and Hospital System, requires that a FTE assess the language and interpretation skill level of employees and volunteers included in the language bank.

### 3.3.2 Cost of Translation Services

**On-Site Translation Service.** Translators make an average salary similar to an interpreter’s, which is also determined by geographic region, as well as the interpreter’s skill level and experience. For instance, a translator with five years’ experience can make an annual salary of $44,518.14 Most of the clinics visited do not hire translators. Instead they use bilingual staff to translate documents, consent and in-take forms, and even educational materials for clients. Clinic staff reported that the only additional cost associated with having an on-site translation service is to provide translators with a stipend ranging between $50 to $150 per month, depending on need for and volume of a clinic’s translation work.

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13 Estimated charges provided by a financial analysis of teleconference technology conducted by the Nebraska Information Technology Commission in 2001.

14 Based on the *LA Times* report on projected 2002 annual salaries in the Los Angeles area.
**Outsourced Translations.** Companies that provide language translations typically price their work per word. Estimates are provided to clients by considering a number of factors including language, length of document, and technical level of writing. Thus, a three-page document translated into Spanish would be on the low end of the range, while having the same document translated into Somali would be on the high end of the range. According to clinic staff, the strength of having documents outsourced is quality control. Quality is usually higher when outsourced given that these types of companies hire professionals who deliver work in a timely manner.

Although the estimated costs for providing language assistance seem high, studies show that clear communication afforded by an interpreter usually leads to lower reproductive health care costs in the future (Hampers, 1999). In addition, there are financial benefits to providing language assistance services in terms of reduced costs for unnecessary lab tests including Pap tests, x-rays, and other diagnostic and treatment services. A medical doctor provides the following perspective:

“If one thinks of an interpreter-assisted history as a diagnostic test, there are virtually no significant tests in medicine that are cheaper. Costs, in general, compare roughly to the costs of the cheapest blood test that physicians order ($28 for a complete blood count). An organized system of professional medical interpreter services will lead to better access for our patients, better quality across the board, and ultimately to cost savings when all sources of waste, duplication, and missed opportunity for diagnosis and treatment will have been documented.”

3.4 BARRIERS FACED BY CLINICS PROVIDING LANGUAGE ASSISTANCE SERVICES

The study team queried clinic staff regarding the barriers they have encountered providing language assistance services to LEP individuals. Clinic staff identified two distinct categories of barriers that affect a clinic’s ability to adopt and effectively manage language assistance services—client- and resource-focused barriers. These two barrier categories are not mutually exclusive but will be discussed separately to provide a broader understanding of their causes and effects. Discussing barriers in two separate categories also will allow the study team to provide recommendations targeting specific types of barriers.

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15 Quote provided by Eric Hardt, M.D., Clinical Director of Geriatrics and Medical Consultant to Interpreter Services at Boston Medical Center.
3.4.1 Client-focused Barriers

Client-focused barriers refer to a set of LEP client characteristics that affect the provision of clinical services, including linguistic, cultural, and barriers related to low levels of health literacy. Exhibit 3-5 presents an illustration depicting the various phases of a typical family planning clinical visit. On the right side of the exhibit is a list of types of client-focused barriers, with a series of numbers identifying individual examples of barriers cited by clinic staff. The exhibit also shows the phases in which each of the barriers occur and affect service delivery. The following sections will describe each of the barriers and provide examples of their manifestation in the clinical setting.

Exhibit 3-5

CLIENT-FOCUSED BARRIERS THAT AFFECT THE PROVISION OF FAMILY PLANNING SERVICES

<table>
<thead>
<tr>
<th>Clinical Visit Phases</th>
<th>Barrier Types</th>
<th>Low Levels of Health Literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Linguistic</td>
<td>Cultural</td>
</tr>
<tr>
<td>Outreach</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>In-take</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medical History and Financial Screening</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provider Examination and Treatment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Instructions for Follow-up Care and Medication Usage</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Linguistic Barriers.** Barriers that are directly influenced by a LEP client’s language capability are present in all phases of the clinical visit. Clinic staff described instances of discordance between medical terminology used by medical interpreters and bilingual providers and the LEP client’s use of slang and colloquialisms to describe body parts, medical tests, and procedures. For instance, Spanish speakers refer to Pap tests as “papanicolaou,” “prueba del pap,” “prueba cytologica,” or even “prueba del cancer” (the cancer test). Also, clinic staff have noticed that LEP clients do not use a clinic’s appointment line when the automated menu is in English. Some LEP clients also experience confusion, even through a medical interpreter, when receiving instructions for medication usage, because they lack experience using the U.S. system of measurement. At outreach, potential clients that are not able to read will not become aware of clinic...
services or their right to an interpreter because they are unable to read brochures, signs, and other written material.

In addition, LEP clients who have low reading levels in their own language experience great difficulty in completing in-take forms. When clients are unable to complete forms on their own, staff read the questions to the client. Together, linguistic barriers result in added time required to complete each phase of the clinical visit.

**Cultural Barriers.** Barriers directly related to a LEP client’s culture also are present at all phases of the clinical visit. Clinic staff report that many LEP clients have certain cultural beliefs and myths related to family planning that prolong the visit and make it less effective. For instance, it was reported that some LEP clients believe birth control pills should be taken only before having intercourse; thus, the clients disregard the providers’ directions for taking the pills, resulting in negative consequences for clients like unintended pregnancies.

In addition, certain cultural and religious beliefs dictate that females can only be examined by female providers and require that the husband be present in the examination room. These cultural differences have interrupted many medical screens and exams, and have resulted in clinics experiencing a serious backlog of appointments. In addition, cultural beliefs related to traditional medicine may have negative consequences on the clinic visit. Female genital cutting (FGC) and coin-rubbing practices, among other traditional health practices, have received much media attention recently. Some providers who have treated women who have undergone FGC reported to the study team that they reacted in a negative fashion the first time they examined a woman who had been subjected to these types of rituals, because they did not know until recently that these practices took place.

In addition, cultural differences affect how individuals perceive time. Clinic staff report that some LEP clients are unable to answer routine medical history questions, because their answers are dependent on events and not time. Time is one of the fundamental bases on which all cultures rest and around which all activities revolve. There are two types of types of time, monochronic and polychronic. Monochronic time is characterized as linear, tangible, and divisible. Events are scheduled one at a time and the schedule takes precedence over interpersonal relationships. On the other hand, polychronic time is characterized by simultaneous occurrences of many things and by a great involvement with people (Hall, 1990). For instance, the following dialogue between a bilingual in-take worker and a LEP client presents an example of a LEP client who processes questions using polychronic time:
In-take worker: *When did you have your last menstrual cycle?*

LEP Client: *A long time has passed.*

In-take worker: *Would you say about two weeks?*

LEP Client: *No, longer than that.*

In-take worker: *Has it been about a month?*

LEP Client: *It was right after my cousin’s wedding.*

In-take worker: *When was your cousin’s wedding?*

LEP Client: *I don’t know, but not too long ago.*\(^{16}\)

**Low Levels of Health Literacy.** Clinic staff report that the majority of LEP clients have limited experience accessing health care services. This is a significant barrier to providing clinical services, because clients are not able to provide clinic staff with accurate medical histories. Not providing this information can result in a number of negative consequences for the client, including misdiagnosis and ordering of unnecessary medical tests. The publication *Healthy People 2010* defines health literacy as having the capacity to obtain, process, and understand basic health information and services in order to make appropriate health decisions. A study estimates that it costs the U.S. health care system up to $73 billion per year when patients lack skill needed to read, understand, and act on basic health information (CHCS, 1998). During family planning visits, clients need to not only establish clear communication with staff members, but they also need to articulate their health concerns and describe their symptoms accurately, ask pertinent questions, and understand medical advice and treatment directions.

3.4.2 Resource-focused Barriers

Title X providers also experience a number of barriers related to a clinic’s limited resources such as: direct costs of interpreter and translation services, limited availability and cost of bilingual staff and volunteers, and numerous time constraints.

**Cost of Interpreter and Translation Services.** A clinic’s funding is a major limitation to its provision of language assistance services. Clinic staff stated that Title X budgets lack line items for language services, requiring that clinics draw from various sources to cover expenditures related to their language assistance services. Thus, the expense of using language lines, hiring interpreters, and providing staff training are usually drawn from multiple funding sources.

\(^{16}\) Anecdote relayed by a bilingual medical assistant with 15 years’ experience interpreting at the Valley Health Center at Lenzen clinic.
In addition, clinic staff mentioned yet another barrier—the great expense of having vital documents translated, either by in-house staff or by outsourcing the documents to a translation service. The lack of reproductive health education materials and vital documents available to Title X clinics further compounds this barrier.

**Limited Availability of Bilingual Staff and Volunteers.** The recruitment and retention of bilingual and bicultural staff was the most commonly cited barrier to providing language assistance. Clinic staff reported that the pool of qualified, bilingual staff is quite limited. This deficit in the health care workforce has forced Title X clinics to compete with managed care organizations (MCOs) and private practice for a limited number of bilingual staff. In addition, volunteers are difficult to retain, because they are not afforded fringe benefits.

**Time Constraints.** Time is a precious resource for the well-functioning family planning clinic. A clinic’s effectiveness and success is largely dependent on how staff are able to schedule clients, providers, and interpreters. Title X clinics are funded by competing for grant funds. These grants require clinics to treat a set number of clients per year at a fixed cost. However, clinic staff stated that when a clinic serves a high percentage of LEP clients, those numbers need to be adjusted given the extra time that is required for LEP clients to complete a clinical visit. Clinic staff report that this extra time is a direct result of the additional client education and interpretation that is required throughout all phases of the clinical visit.

The study team queried staff on their perception of how much time is required to treat a client in each phase of the clinical visit. In addition, the study team asked clinics to provide estimates for time required for LEP and non-LEP clients in each of the clinic phases. Exhibit 3-6 demonstrates that it takes clinic staff twice as long to treat a LEP client.
### Exhibit 3-6

**ESTIMATED AVERAGE TIME DIFFERENCE FOR THE TREATMENT OF LEP AND NON-LEP CLIENTS, BY CLINIC***

<table>
<thead>
<tr>
<th>Clinics</th>
<th>In-take</th>
<th>Exam &amp; Treatment</th>
<th>Follow-up Care/ Instructions</th>
<th>Average Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tremont Center</td>
<td>20</td>
<td>40</td>
<td>20</td>
<td>45</td>
</tr>
<tr>
<td>2. Centro de Salud Clinic</td>
<td>15</td>
<td>30</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>3. Stafford Clinic</td>
<td>15</td>
<td>25</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>4. Valley Health Center at Lenzen</td>
<td>20</td>
<td>35</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>5. San Marcos Clinic</td>
<td>20</td>
<td>45</td>
<td>25</td>
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</tr>
<tr>
<td>6. Southeast Heights Clinic</td>
<td>20</td>
<td>40</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>7. La Clínica del Pueblo</td>
<td>15</td>
<td>25</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Average</td>
<td>18</td>
<td>34</td>
<td>16</td>
<td>35</td>
</tr>
</tbody>
</table>

*Time estimates are expressed in minutes and are based on estimates reported by staff involved in different phases of a family planning visit. Estimates for in-take were provided by front-line personnel (e.g., receptionists, medical assistants, etc.) and are based on a first visit. Exam and treatment estimates were presented by providers (e.g., nurses, nurse practitioners, and physicians) based on a clinical visit where a procedure had been scheduled. Follow-up estimates were provided by both providers and in-take staff.*
SECTION 4

Clinic Profiles
4. CLINIC PROFILES

This section describes the seven family planning clinics visited by the study team. The profiles describe the clinics’ innovative language assistance service or strategy, as well as other language assistance activities and procedures. The services and strategies represent creative community-driven solutions to major language assistance challenges which have been addressed by building partnerships and identifying resources within the community. The innovative services and strategies were designed and developed to address each clinic’s most significant barriers and can serve as a resource for ideas, lessons learned, and unique approaches to help other clinics deal with the impending diversification of the population served by clinics in all regions of the country. Exhibit 4-1 presents the various language assistance services and strategies adopted by clinics and identifies the barriers they address.

4.1 STRATEGIC PARTNERSHIP WITH AREA HOSPITAL—TREMONT CENTER—BRONX, NEW YORK

The Tremont Center is located in the Bronx, New York, and is part of the Maternal and Infant Care (MIC) Women’s Health Services, Medical and Health Research Association (MHRA)—a network of health centers which serves the New York metropolitan area. The center serves a high volume of LEP clients from diverse racial and ethnic groups. Hispanics are the largest ethnic group in the Bronx, and they represent the majority (65%) of the Tremont Center’s clients. French speakers from African countries and Haiti represent 25 percent of the clients, and 10 percent speak Urdu and Punjabi. It is estimated that 60 percent of individuals that seek family planning services at the Tremont Center require some form of language assistance. Clients have low levels of education, and a large majority (72%) are uninsured. The Tremont Center is funded, in part, by Title X funds, as well as other state government programs including the Prenatal Care Assistance Program (PCAP).
Exhibit 4-1

BARRIERS ADDRESSED BY TITLE X CLINIC’S
INNOVATIVE LANGUAGE ASSISTANCE SERVICE OR STRATEGY

<table>
<thead>
<tr>
<th>Innovative Language Assistance Service or Strategy, By Clinic</th>
<th>Barrier Type</th>
<th>Client-focused</th>
<th>Resource-focused</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Tremont Center</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Strategic Partnership with Area Hospital (Strategy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centro de Salud Clinic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Design of Clinic Services (Strategy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stafford Clinic</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Interpretation via Teleconference (Service)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valley Health Center at Lenzen</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Remote Telephone Interpretation (Service)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Marcos Health Clinic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mobile Health Van (Service)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southeast Heights Clinic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provider Training in Communicating Through An Interpreter (Strategy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>La Clínica del Pueblo</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Off-site Interpreter Program (Service)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


4.1.1 Innovative Language Assistance Service/Strategy

As stated in Section 3, the most frequently cited limitation to providing language assistance services is the recruitment and retention of bilingual and bicultural clinical staff, especially more senior medical providers. In an effort to mitigate this barrier, MIC staff developed a request for proposal (RFP) which was submitted to area hospitals asking them to reply by submitting their capability to provide bilingual physicians fluent in various languages. The agreement allows MIC centers to tailor requests for physicians based on the language skills in demand at the Center. As a result of the 1999 agreement with the Bronx-Lebanon Hospital, the Tremont Center now has access to a large pool of board certified, bilingual providers and medical staff\(^2\) who speak various languages. In

\(^2\) The agreement identifies clinical staff as physicians, nurses, and midwives.

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total, the Tremont Center employs a physician who speaks Spanish and another who speaks Spanish, French, and Creole. The only languages not spoken by attending physicians are Urdu and Punjabi, which are languages that only recently have been in demand at the Center. The Tremont Center has already made a formal request for an Urdu speaker to be assigned to the Center.

Through its strategic partnership with the Bronx-Lebanon Hospital, the Tremont Center also has created a continuum of care for its clients. The agreement stipulates that all Tremont Center clients requiring follow-up medical care are to be referred to the hospital and assigned to a provider who speaks the same language as the client.

4.1.2 Other Language Assistance Services

The Tremont Center has bilingual staff who cover all phases of the clinical visit. For instance, the front-line personnel speak English and Spanish. Front-line staff conduct the in-take and assess language proficiency and education levels, as well as conduct the financial and medical screens. In addition, the clinic has two physician assistants who are bilingual in Spanish and English. The clinic also has technical staff with multiple language capability. As mentioned in the previous section, one of the attending physicians speaks Spanish and English, and another speaks Spanish, French, and Creole. The clinic also has two security guards, one who speaks French and another who is fluent in Arabic.

The clinic also has four staff interpreters trained in medical interpretation. The staff person with the most experience interpreting in a medical setting is designated as a clinical interpreter (interprets only for physicians and nurse practitioners), and the other three are clerical interpreters (who interpret only for front-line staff). Interpreters and translators who work at the Tremont Center must pass a course in medical interpretation administered by New York University. Title X provides some of the funding for the training, and PCAP covers the remaining expenses. The Center provides incentives for staff to participate as interpreters in the form of monthly stipends. The Tremont Center also has a protocol designating certain bilingual staff as dedicated backup interpreters and a language line service as a backup for low-demand languages.

The Tremont Center does not have a formal on-site translation service. However, the translation of client education material is provided by the Center’s grantee, the Maternal and Infant Care Project (MIC). Bilingual staff review the translations and provide their grantee with feedback on the appropriateness of the translation to their LEP clients. In addition, the larger and more technical documents are translated by the New York State Health Center. The Tremont Center has client education material including brochures, posters, and handouts in three languages (Spanish, French, and Vietnamese). Furthermore, the Center provides LEP clients with an orientation packet explaining the use of clinic services, types of birth control methods, and the medical exams provided by

COSMOS Corporation, March 2003

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physicians. Signs in both English and Spanish are clearly displayed throughout the clinic and advise clients of their right for language services.

### 4.1.3 Language Assistance Activities and Procedures

At the grantee level, MHRA developed and maintains an employee language bank that is continually updated to reflect the staff’s current language capability, as well as that of community members who have agreed to interpret on an as-needed basis.

Another set of activities related to language assistance is the Center’s intensive outreach effort undertaken by a full-time outreach worker with a working knowledge of the city’s community-based organizations (CBOs). The individual responsible for outreach is very knowledgeable of the city’s resources and uses them to advertise clinic services in some rather innovative ways. For instance, the outreach worker visits community hair and nail salons (frequented by many potential clients) and provides them with key chains and nail files imprinted with the clinic’s contact information. Also, as part of the outreach program, the MIC central office hosts various health fairs throughout the year and advertises clinic services in small, community newspapers.

### 4.1.4 Relative Costs Associated with Developing An Agreement With An Area Hospital

The development of an agreement with an area hospital is an effective strategy for augmenting a clinic’s bilingual professional staff. The strategy mitigates important barriers to providing effective language assistance services. In addition, the strategy requires no direct costs for its development or execution, since the writing of the RFP and the review of the proposals were undertaken by full-time staff employed by the Center’s delegate. However, direct management costs required to manage the attending physicians need to be acknowledged. These activities include keeping the physicians’ schedules and providing backup physicians when they are unable to attend.

The only limitation of adopting this strategy is that the language capability that a clinic is trying to fill is completely dependent on the area hospitals’ bilingual staff. Thus, a rural clinic with few or no hospitals in the immediate area will find it difficult to locate bilingual physicians and nurse practitioners to meet its language needs.

### 4.2 DESIGN OF CLINIC SERVICES—CENTRO DE SALUD CLINIC—MINNEAPOLIS, MINNESOTA

Centro de Salud Clinic (Centro) was founded in early 2000 and is one of 24 family planning clinics affiliated with Planned Parenthood of Minnesota/South Dakota. The Centro is located in Minneapolis, a city where 15 percent of the population is foreign-born.
and 19 percent speak a language other than English. Although Hispanics compose only eight percent of the city’s population, 97 percent of Centro’s clients are monolingual Spanish speakers from rural areas in Mexico and recent immigrants from Colombia, Argentina, and other South American countries. Three percent of Centro’s clients speak Somali or Urdu.

4.2.1 Innovative Language Assistance Service/Strategy

Centro was nominated for its design of clinic services provided to its LEP population. The design for the Centro de Salud clinic is a direct result of findings from an exhaustive series of focus groups held with community members. Thus, all aspects of reproductive health service delivery at Centro directly reflect the needs of the LEP population. For instance, the clinic is located in a key sector of town that is home to Minneapolis’ Hispanic population. The clinic is strategically located near a major bus route and in a building that houses three other social services organizations.

The clinic’s design also took into consideration cultural and educational differences within the Hispanic community. For example, clinic staff learned that many of their clients struggled with locating addresses and following directions. Staff asked clients what they thought would help them locate the clinic. Focus group participants reached consensus on having four, 12-foot statues representing a Latino family placed outside of the building. The statues now serve as a landmark in Minneapolis and help clients find their way to the clinic, as they are clearly visible from the bus route. In addition, the building’s interior and exterior walls are covered with colorful murals depicting scenes that stress family unity and health. The building itself reflects architecture reminiscent of a pueblo dwelling. Offices where in-take is conducted were designed to be smaller in size and more private in order to provide clients with maximum confidentiality, which clients feel is very important during a family planning clinical visit.

4.2.2 Other Language Assistance Services

Centro de Salud clinic relies on bilingual staff to provide high-quality clinical services to its LEP population. All front-line staff, assistants, nurses, and physicians speak Spanish, and the more senior staff members also are designated as staff interpreters, and some as backup interpreters. Staff are required to attend cultural competency training workshops offered at the Planned Parenthood conference every year. Staff report that some workshops focus on family planning issues and culture. For instance, one workshop cited by staff as being very informative and relevant to their work focused on the differing perspectives concerning the meaning of a family, contraceptive use, and family planning. By participating in these workshops staff report being able to be more considerate of the Somalian and Urdu speakers who on occasion seek services at Centro.
4.2.3 Language Assistance Activities and Procedures

The results of focus groups with community members show that family planning clients would be more willing to attend the clinic if child care was offered or if their visits to the clinic involved other purposes. As a result of this finding, Centro de Salud clinic is housed in a building (Centro de Salud Chicano) which contains two other social service agencies. The consolidation of the three agencies is the result of a strategic partnership between Planned Parenthood and the other organizations. One of the other social service organizations operates an education center for children called “Siembra Early Childhood Education Center” which offers a licensed, bilingual preschool program providing culturally sensitive childcare. It also has an English as a Second Language (ESL) program with group and one-on-one tutoring designed to enhance English proficiency and strengthen employment related vocabularies for monolingual Spanish speakers, as well as an information center where clients can call to obtain answers to their concerns on legal and immigration issues, medical insurance, and mental health counseling.

Although Centro does not have an on-site translation service, bilingual staff periodically review translated written material which is outsourced to various translation companies, and adapt it to their LEP population. For instance, Centro has recently experienced an influx of clients from Chile and Argentina who have higher levels of education and health literacy. These recent immigrant groups tend to use more formal health terminology and, therefore, have had a difficult time understanding translated client education material which was tailored to accommodate the colloquialisms used by the established Hispanic population. As a result of this influx, Centro staff have adapted various brochures to describe clinic services with descriptions that include formal medical terms. Centro has translated the Women’s Health Care Handbook into Spanish and tailored the translation to the LEP population by including common slang terms used by clients. In addition, Centro staff continually update in-take and other vital documents every three months so that written materials reflect the current terms clients are using as the clinic experiences subtle changes in the LEP population.

Centro also has experimented with various outreach strategies designed to attract more males to seek reproductive health care. Staff report that a radio campaign where clinic services were advertised using public service announcements (PSAs) on a local radio station that broadcasts Latino music has produced the best results. As a result of implementing this strategy, staff report a 50 percent increase in the number of males seeking services at Centro.3 In addition, the clinic’s appointment hotline and regular phone lines are always answered by a bilingual staff person, which helps clients who are

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3 This finding was confirmed in the focus group conducted at Centro de Salud Clinic. Two female clients mentioned that they became aware of clinic services through their husbands who had heard the clinic’s PSAs on the radio.
unfamiliar with phone menus to receive better information on the clinic and assistance in scheduling appointments.

4.2.4 Relative Costs Associated with Conducting Focus Groups to Designing Clinic Services

The costs for focus group interviews conducted by the Centro de Salud Chicano were not reported to the study team. Staff mentioned that the expenses were covered by a number of funding sources and never aggregated. Clinics considering this strategy should note that focus group costs can vary considerably depending on a number of factors, such as type of participants, participant recruiting process, total number of groups desired, and honoraria paid. The costs of focus groups also are affected by the type of people who conduct them. For instance, focus group projects that are contracted to a professional research firm may start from $7,000 for a relatively small focus group contract with fewer number of focus groups, and they can reach multimillion dollar figures when the project requires numerous focus groups in different parts of the country. However, some organizations have been able to drastically reduce these costs by involving internal staff (e.g., clinic staff) in various phases of the project (Krueger, 1988). In these cases, organizations involve full-time employees (FTEs) in the process as much as possible (e.g., training and using staff as assistant moderators or participant recruiters), only using consultants with expertise conducting focus groups to provide specialized assistance in critical components of the project, such as developing an appropriate sampling strategy, developing an interview guide, moderating a set number of focus groups, or analyzing and reporting focus group results.

4.3 INTERPRETATION VIA TELECONFERENCE (TELEHEALTH)—STAFFORD CLINIC—STAFFORD, TEXAS

The Stafford Clinic is one of 23 satellite clinics operated by the clinic’s delegate, the University of Texas Medical Branch (UTMB). The clinic is located in Stafford, Texas in Harris County. The county is highly diverse, and over 32 percent of its residents are Hispanic; 36 percent speak a language other than English at home; and 22 percent of its residents are foreign-born. A total of 90 percent of the clients that visit the Stafford clinic speak Spanish; eight percent speak Hindi and Punjabi; and around two percent speak French, Chinese, and American Sign Language (ASL). Most of the clinic’s clients are newly arrived immigrants with low levels of education and health literacy. Clinic staff report a recent influx of South Americans and various Middle Eastern populations that speak Urdu.
4.3.1 Innovative Language Assistance Service/Strategy

The Stafford clinic was nominated for its adaptation of Telehealth technology to provide language assistance to LEP clients. Telehealth is a term used to describe the use of interactive teleconference and data link technology to support long-distance clinical health care, patient and professional health-related education, and public health and health administration. A typical Telehealth unit is comprised of a thin, high-resolution monitor, a personal computer with a high-speed Internet connection, and a high-resolution camera that are retrofitted on a cart to give the unit mobility. All UTMB satellite clinics are equipped with Telehealth, which allows clinic staff to transmit real-time video images and sound over the Internet to all satellite clinics or to the UTMB campus located in Galveston, Texas. Telehealth units were designed by UTMB to facilitate management meetings, as well as to connect clinics with medical specialists from different regions of the country.

The use of Telehealth to provide LEP clients language assistance was first required when a walk-in client needed interpretation in ASL. After searching the UTMB language bank, clinic staff were able to identify a staff member fluent in ASL, but who was located in a clinic that was over two hours away. With a Telehealth connection, the client and interpreter were linked in less than 10 minutes, and the interpretation engagement was a success. Since the initial adaptation, the Stafford clinic and other UTMB clinics have been using Telehealth to provide interpreter service for LEP clients who speak low-demand languages and ASL.

4.3.2 Other Language Assistance Services

The Stafford clinic employs bilingual staff as the primary method of delivering language assistance to its LEP population. Clinic staff follow protocols that charge certain bilingual staff to interpret for nurse practitioners and other staff members requiring assistance. As a secondary method of providing language assistance, the clinic uses the UTMB language bank, a database of UTMB staff with proficiency in a second language. The database also includes the names and contact information for community volunteers who have agreed to provide their language skills on an as-needed basis. The language bank also includes the contact information of partner organizations which exchange interpreters with the clinic when needed.

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4 The Stafford clinic was nominated for its volunteer language line, which was staffed by medical students with knowledge of a second language. The students served as interpreters remotely, providing language assistance over the phone to UTMB satellite clinics. However, the study team was unable to query the volunteer language line administrator because she terminated her position at UTMB during the span that the study team conducted the clinic screening and scheduled the site visit.
As backup to the primary and secondary language assistance services, the Stafford clinic hires contract interpreters and has access to a language line service (Pacific Interpreters) which provide language assistance for LEP clients speaking low-demand languages. Staff report that these services are rarely required but are always available.

4.3.3 Language Assistance Activities and Procedures

The Stafford clinic has established strategic partnerships with universities and churches to provide volunteer interpreters, and has established an internship program for bilingual health care students from local medical training schools. Offering medical students internships has resulted in full-time positions being filled by interns. However, clinic staff report that private practices and large managed care organizations (MCOs) are able to attract many of these interns, as they provide much larger starting salaries and more attractive benefits.

Another language assistance activity that has proven beneficial is the disbursement of Spanish language tapes at no cost to non-Spanish speaking providers. Providers are encouraged to learn basic Spanish in order to make examinations with LEP clients more effective by making them feel more comfortable. Staff report that clients have more confidence in the attending physician or nurse practitioner if they at least greet them with a friendly “hola” (hello) or “como esta” (how are you doing). Clients are able to relax and provide more descriptive feedback to the attending physician or nurse practitioner.

4.3.4 Relative Costs of Using Telehealth as a Method of Delivering Language Assistance

The use of Telehealth as a method of providing language assistance addresses two main barriers faced by clinics. First, Telehealth technology is able to bring interpreters and LEP clients together in an efficient and cost-effective manner regardless of long distances and time limitations. Thus, travel costs are minimized, because using the system reduces the distance an interpreter has to travel to the clinic. This feature is especially useful in remote or rural locations where travel time is more significant, such as in Texas. Second, Telehealth interpretations allow the interpreters and providers to exchange vital non-verbal communication cues, which ultimately affect the quality and effectiveness of the interpretations. However, costs are reduced only when clinic staff are able to combine the technology with either volunteer interpreters or staff interpreters, who would not incur additional direct costs for interpreter services.
4.4 REMOTE TELEPHONE INTERPRETER SERVICE—VALLEY HEALTH CENTER AT LENZEN—SAN JOSE, CALIFORNIA

The Valley Health Center at Lenzen is one of eight community-based satellite clinics which comprise the Santa Clara Valley Health and Hospital System network located in San Jose, California. The city of San Jose is located in the County of Santa Clara, a highly diverse area where 24 percent of the population are of Hispanic or Latino origin. In addition, 34 percent of residents are foreign-born, and 45 percent speak a language other than English at home. As a result of the diverse nature of the county’s residents, the great majority of clients (60%) that seek services at the Lenzen Avenue Clinic are LEP and require some form of language assistance. Clients are mostly Spanish speakers (90%), and the other 10 percent speak Russian, Vietnamese, Laotian, Ukranian, Chinese, and Somalian. Around 30 percent are illiterate, and only five percent have a high school education.

4.4.1 Innovative Language Assistance Service/Strategy

The clinic was nominated for its remote telephone interpreter service which is funded and operated by the Santa Clara Valley Health and Hospital System—the clinic’s delegate. Although clinic clients receive assistance directly from the service, the system is not operated and managed by the clinic, but by the Language Services Department (LSD) within the Santa Clara Valley Medical Center.

The remote interpreter service consists of providing language assistance over the telephone by a number of in-house interpreters trained in medical interpretation. The service employs 22 FTEs: 20 interpreters, one clerk, and one manager. There are 12 Spanish interpreters, six Vietnamese interpreters, one Chinese interpreter, and one Russian interpreter. Interpreters are centralized in LSD and provide both speakerphone and face-to-face interpretation (90% of all interpreter engagements are conducted on speakerphones). LSD now offers dual headsets to locations where confidentiality presents a problem. The dual headset phones allow both parties—client and provider—to communicate without people around them hearing the interpreter’s information.

4.4.2 Other Language Assistance Services

At the grantee level, the Santa Clara Health and Hospital System has a well-organized language bank that includes only certified bilingual employees with appropriate level of oral fluency. Level I staff are deemed to have sufficient language skills to register patients; gather information such as address, insurance status, social security number, and other billing information; provide basic information and directions; and assist with appointments. Only Level II-rated staff are considered to have sufficient skills to assist in medical interpretation. Employees registered in the language bank are provided a monthly pay differential for interpretation and have the capability to provide interpretation.
in 23 languages. The pay differential is provided regardless as to whether or not the employee is actively involved in providing language assistance to patients. There are no records of the number of interpretations provided by employees who are language bank participants. There are no ASL qualified interpreters in the language bank, which requires that the provision of ASL interpretation be provided under contract with an outside organization. Walk-in clients requiring ASL are not able to access clinic services, as appointments need to be made with the ASL interpreters ahead of time.

The LSD designates certain language bank participants as having sufficient written language skills. These individuals are used by LSD to translate internal documents and prepare health forms or other materials.

The clinic uses a language line (Pacific Interpreters) as backup to the interpreter services provided by LSD. Calls may be forwarded to Pacific Interpreters if LSD interpreters are unable to respond in three minutes. This service is a significant additional expense with monthly bills in the $40K to $42K range, averaging nearly $500K per year.

At the clinic level, bilingual staff are employed to cover all phases of the clinical visit (e.g., receptionist, in-take personnel, and nurse practitioners). In addition, certain staff are designated as staff interpreters and have undergone a three-day training in medical interpretation sponsored by the state of California. Staff interpreters provide LEP clients with interpretation throughout all phases of the clinical visit and accompany them to other clinics and a pharmacy housed in the same building as the Valley clinic.

4.4.3 Language Assistance Activities and Procedures

Although the reach and level of professionalism provided by remote telephone interpreters at the grantee level is high, clinic staff report that LEP clients, as well as providers at the Valley Health Center at Lenzen, prefer to use face-to-face interpreters. As a result of this preference, clinic staff formed a strategic partnership with a refugee clinic located in the same building as the Valley clinic. The partnership allows both the refugee clinic and the Valley clinic to exchange interpreters on an as-needed basis. The refugee clinic has two Vietnamese and two Russian interpreters, as well as Bosnian, Laotian, and Cambodian interpreters; the Valley clinic has four Spanish interpreters. The partnership has resulted in positive outcomes, such as decreased response time for interpreters and satisfied clients who felt the telephone interpretation was not sufficient for an effective examination to take place.
In addition, the Valley Health Center at Lenzen clinic provides LEP clients with consent forms and illustrated pamphlets describing birth control methods and diagrams providing instructions for conducting a self-breast examination in Spanish, Vietnamese, and Laotian. The clinic also displays multilingual signs throughout the clinic and has a video in Spanish explaining birth control methods.

4.4.4 Relative Costs Associated with Operating a Remote Telephone Interpretation Service

In fiscal year July 2001 to June 2002, LSD conducted 148,198 phone and face-to-face interpretations. The speakerphone interpretations averaged from three to eight minutes in length, to as long as 45 to 60 minutes depending on the phase of the clinical visit and the client’s level of health literacy. It is important to recognize that during a single visit, a client may experience both speakerphone and face-to-face interactions with bilingual staff. For instance, a LEP client may initiate a clinical visit with interpretation provided by a bilingual support staff member. As the client enters other phases of the visit, a monolingual provider can examine a client with the aid of a staff interpreter or via speakerphone. The remainder of the clinical visit is supported by face-to-face language assistance by staff interpreters or by bilingual support staff members. Given the use of multiple language assistance services and strategies to provide a single LEP client in one clinical visit, it is difficult to track the cost of individual language assistance services by an individual patient visit.

The registration system for Valley has a marker for language. However, it is not a required field and patient registration information is not tied to an appointment system. This makes it difficult to document the number of LEP patients using Valley on a year-by-year basis. However, relative costs associated with this type of language assistance service are described in greater detail in section 3.3.

4.5 MOBILE HEALTH VAN—SAN MARCOS HEALTH CLINIC—SAN MARCOS, CALIFORNIA

The San Marcos Health Clinic is one of five primary care clinics operated by the North County Health Services, a private, non-profit health services corporation. The clinic is located in a rural section of San Diego County, an area where over 20 percent of the population is composed of foreign-born residents and where 33 percent speak a language other than English. The majority of the clinic’s clients are Spanish speakers.

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6 By contrast, in systems that lack a developed speakerphone or other remote interpretation system, a single visit may involve the same interpreter at multiple sites in the care process from the front desk to the exam room, laboratory and even pharmacy. The meaning of a single interpretation in such a system is entirely different.

*COSMOS Corporation, March 2003*
(90%), and 10 percent speak a diverse mix of languages including Chinese, Tagalog, and Native dialects. Most of the clinic’s clients are from rural communities; around 30 percent are illiterate; and all are under the poverty line.

4.5.1 Innovative Language Assistance Service/Strategy

The San Marcos Clinic was nominated for its mobile health van, an innovative service that delivers reproductive health care services to difficult-to-reach LEP populations. The van is staffed by a physician or nurse practitioner, a medical assistant, and an in-take staff person. Language assistance is provided by medical assistants and in-take personnel who are all bilingual, although untrained in medical interpretation. The mobile health van schedules three visits per week to large farms staffed by migrant farm workers who would otherwise not have access to clinic services. Staff conduct educational talks on reproductive health care, self-breast exams, Pap tests, STD counseling, and workshops on how to conduct testicular cancer self-tests. The mobile health van also is equipped to conduct tuberculosis and glucose screenings, as well as mammograms.

The mobile health van has been an effective service for reaching LEP populations due to a number of strategic partnerships that clinic staff have established with farm owners. The partnerships provide clinic staff with access to the farm grounds where they interact with workers during their breaks and after work hours. Staff are permitted to distribute translated reproductive health care literature and schedule appointments for follow-up care. The mobile health van has two main limitations. First, staff report that they are unable to communicate effectively with newly arrived individuals from Southern Mexico and Guatemala who speak native dialects not covered by the AT&T Language line or by their bilingual staff. Clinic staff have conducted extensive searches within the community to locate individuals who speak native dialects, but the results of those searches have been negative. However, staff have realized that recent immigrants travel in groups usually headed by a leader who is bilingual in their native language and who knows some Spanish. Staff have been using these individuals as ad hoc interpreters to communicate with these individuals. A second limitation of the service is that the AT&T language line is difficult to access from remote locations where no cellular service is available.

4.5.2 Other Language Assistance Services

The clinic’s primary method of providing language assistance is through the use of bilingual staff who have received training in cultural competence and medical

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7 The clinic has experienced a recent influx of Central American and Southern Mexican indigenous populations that speak Native dialects which are not supported by bilingual staff or the language line service used by the clinic.

COSMOS Corporation, March 2003 4-13
interpretation. In addition, staff use the AT&T Language Line to provide language assistance to clients who speak low-demand languages. Clinic staff display “I speak” cards at the reception desk, so LEP clients have the opportunity to identify their languages and need for interpreter services.

4.5.3 Language Assistance Activities and Procedures

Bilingual support staff, such as medical assistants and in-take workers who also are designated as backup interpreters, are provided with incentives such as a monthly stipend, and receive periodic training in customer service and cultural competency. Staff are provided written protocols for identifying and treating LEP and illiterate clients. The clinic has a health promotion department which conducts client education workshops and counseling on women’s health, reproductive health, and STDs. The clinic has a number of client education materials in Spanish, including pamphlets on STDs and contraceptive methods.

4.5.4 Relative Costs Required to Operate a Mobile Health Van

The San Marcos Clinic covers the expenses of the mobile health van through multiple funding sources. Clinic staff were not able to report the total cost for developing, operating, and maintaining the mobile health van.

4.6 PROVIDER TRAINING IN COMMUNICATING EFFECTIVELY THROUGH AN INTERPRETER—SOUTHEAST HEIGHTS CLINIC—ALBUQUERQUE, NEW MEXICO

The Southeast Heights Clinic is one of five satellite clinics composing the University of New Mexico School of Medicine’s Family Planning and Outreach Project—its delegate agency. It is located in Albuquerque, New Mexico, a highly diverse state where close to 30 percent of the population speaks a language other than English at home, and almost 10 percent of its residents were born outside the U.S. Ninety percent of the clinic’s clients are Spanish speakers, mainly from Mexico and Cuba. A total of eight percent speak Vietnamese, and two percent speak a mix of other languages. Among the Vietnamese population, 50 percent are illiterate and most have never accessed preventive or any other kind of professional health care service.

4.6.1 Innovative Language Assistance Service/Strategy

The Southeast Heights Clinic was nominated for its innovative approach to increasing the quality of interpreting encounters by providing in-house service training for physicians and nurse practitioners on how to communicate effectively through an interpreter. The training curriculum was developed by the University of New Mexico. 
Hospital’s Care Management Services Department, which is composed of an experienced team of professionals trained in medical interpretation using the *Bridging the Gap* curriculum. The training had its genesis when interpreters noticed that providers were having a difficult time following the protocol set for an interpretation engagement. Interpreters also noticed the adverse effects these breaches in protocol were having on the LEP clients. Interpreters felt that physicians and nurse practitioners did not have a sufficient understanding of the interpretation process and of the adverse consequences that not adhering to certain protocols can have on clients’ health.

The workshop teaches providers the role of an interpreter (e.g., a conduit, clarifier, cultural broker, and advocate). Also, the training describes the different modes of interpretation and provides a better understanding of the causes and effects of language barriers. The workshop has a training component that discusses communication errors and includes an explanation of how cultural misunderstandings can occur when complex medical terminology lacks a direct translation due to cultural differences. Throughout the workshop, providers learn how to assess and acknowledge cultural differences, beliefs, and expressions and how to respond to them. They learn how to respect the speed at which people process information, to pause often, and to avoid using slang, technical language, and complicated sentence structures. Furthermore, they are taught how to break down multiple or complex questions into simple ones and to not interrupt the clients or interpreters.

To date, interpreters have conducted about five training sessions using their curriculum. Staff report that positive outcomes have culminated in observable improvements in the quality of interpreter engagements. This increase in quality is evidence of how training can help LEP clients overcome language, culture, and issues associated with health literacy. As the quality of the interpretation engagement increases, so do the time constraints and costs associated with providing language assistance.

### 4.6.2 Other Language Assistance Services

The Southeast Heights Clinic employs *bilingual staff* as the primary method of delivering language assistance. The clinic also has established a *strategic partnership* with a neighboring clinic to supplement its need for Vietnamese interpreters (its second largest language group) by allowing its Spanish-speaking staff to interpret at the partner clinic. Southeast Heights has an appointment hotline that handles multiple languages including English, Spanish, and Vietnamese.

As a secondary method of delivering language assistance, the Southeast Heights Clinic uses *staff interpreters* to assist providers with interpretations. However, when an individual who speaks a low-demand language becomes a regular, the clinic also employs *contract interpreters* on an as-needed basis and contracts with a community outreach program.
program to provide translation. The clinic also uses a language line service (Pacific Interpreters) to provide language assistance in low-demand languages.

At the grantee level, the hospital system has an on-site translation service that translates all vital documents, forms, and brochures into Spanish and some forms into Vietnamese. More technical documents, like the instructions for certain contraceptives such as the day-after pill, are either outsourced or secured on the Internet and government clearinghouses. Clinic staff report that, although they have access to the translation service, turnaround has been lengthy even on rush jobs. The study team observed that the Southeast Heights clinic had many multilingual signs written by hand. This is due to the signs being delayed at the translation department where they must undergo a number of drafts and edits before approval and printing.

4.6.3 Language Assistance Activities and Procedures

In order to enhance the delivery of clinic services to LEP clients, the Southeast Heights Clinic relocated to a building that houses two other city-sponsored social services agencies that include a child care clinic and a clinic that serves parents. A strategic partnership was then generated between the Southeast Heights clinic and the other clinics to exchange interpreters on an as-needed basis. The consolidation of clinics into one building had positive effects for the clients themselves. For example, focus group participants mentioned that, although the clinic was farther away from their homes, it was easier to access, because it was close to a major bus route. Clients reported that appointments were easier to keep, because they were able to consolidate two clinical visits, their own, as well as their children’s. The following quote is from a woman who has been accessing services at the Southeast Heights Clinic for over ten years.

“I have been coming here for a long time, about ten years. I think when the clinic moved here it made things much better; because now I can bring my kids here when I have an appointment; because there is a child clinic next door, so I try to make an appointment so that my kids see the doctor at the same time as me.”

Also, at the delegate level, interpreters have developed a procedure for all interpreters requiring them to carry a notebook containing a collection of visual aids depicting various diagrams of the human body and illustrated instructions on how to carry out self-examinations and the proper way to use contraceptives and take medication. Interpreters have noticed through many years of practical experience that interpreting is greatly facilitated with the use of visual aids, because the aids provide clients with a reference to better understand medical terms used by physicians. Visual aids also help interpreters identify body parts referenced by clients who use slang or colloquialisms to describe parts of their bodies.
At the grantee level, interpreter language proficiency is determined by an independent testing company (Care Management Services) through the University of New Mexico Health Sciences Center.

The hospital offers a scheduling system that serves all satellite clinics and which receives about 1,500 to 2,000 requests for interpretation. It also has a centralized translation service which translates signs and documents for clients.

4.6.4 Relative Cost of Conducting In-house Training for Providers

Clinic staff report that there are no direct costs associated with conducting in-house training for providers. Both the interpreters who provide the workshops and the participants are FTEs and, therefore, do not require additional pay. In addition, employees must consult with management before these trainings are scheduled if they will require time away from their regular job duties. Trainings can be offered either on the clinic’s time or in the form of a working lunch. The only direct costs incurred are for duplication of training materials, which consist of no more than 15 pages of handouts.

4.7 OFF-SITE INTERPRETER PROGRAM—LA CLINICA DEL PUEBLO—WASHINGTON, D.C.

Established in 1983, La Clínica del Pueblo is a Planned Parenthood affiliated family planning clinic located in a diverse Washington, D.C. neighborhood, where 30 percent of the population is composed of Hispanics, and close to 20 percent speak a language other than English. More than 86 percent of La Clínica’s clients are originally from Central and South America and speak Spanish, and 14 percent speak a mix of languages including Amharic, French, Mandarin, and Portuguese. La Clínica del Pueblo funds its language assistance services and activities through a number of funding sources including Title X, Title I, local foundations, the Government of the District of Columbia, the Office of Minority Health, Managed Care Organizations, and the Cultural Liaison program at Howard University.

4.7.1 Innovative Language Assistance Service/Strategy

La Clínica del Pueblo was nominated for the off-site interpreter program. The language assistance service provides LEP clients with trained and experienced medical interpreters who not only provide interpretation throughout the clinical visit, but also escort clients to appointments when they are referred to private clinics or hospitals for

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8 The clinic also serves LEP clients who are speech- and hearing-impaired and require interpretation in ASL.
follow-up care. The off-site interpreter program addresses five of the six barrier types, making it one of the most comprehensive language assistance services offered by Title X clinics.

The program was conceived after clinic staff noticed that clients were not attending their follow-up appointments and returning to the clinic with the same health problems with which they were diagnosed. Clinic staff report that clients have a great difficulty keeping their follow-up appointments. To minimize no-shows, clinic staff developed a protocol requiring that interpreters call clients the day before appointments to remind clients of their appointments, clarify driving directions, and provide the opportunity to establish rapport with the interpreters. This protocol has resulted in fewer missed appointments and better interaction between the clients and the interpreters.

Different types of interpreters provide off-site interpretation. The clinic has two FTE staff interpreters who are fluent in Spanish and French. The clinic also uses volunteer interpreters trained in medical interpretation who speak languages including Spanish, Amharic, Portuguese, and Mandarin. Volunteer interpreters are recruited through a strategic partnership that was developed with the Archdiocese Health Network, which has a database of trained interpreters who have agreed to volunteer. In addition, La Clínica also has established a strategic partnership with the Area Health Education Center (AHEC), which has a pool of volunteer medical students with other language capabilities.

4.7.2 Other Language Assistance Services

La Clínica del Pueblo uses bilingual staff as the primary method of delivery of language assistance to its LEP clients. Staff members who have received training in medical interpretation are designated as staff interpreters. In addition to their regular job duties, they are called to interpret for physicians and nurse practitioners requiring assistance. When the clinic encounters clients who speak low-demand languages, La Clínica employs contract interpreters on an as-needed basis, especially when the clients have been asked to return for follow-up visits.

Most of the translated written material provided to LEP clients is translated by La Clínica’s on-site translation service. The service translates medical documents, client education materials, and signs into Spanish. Staff members designated as translators are given a monthly stipend to cover translation activities required beyond their regular job duties.

La Clínica has rigorous procedures for hiring interpreters. For instance, both contract and volunteer interpreters are required not only to be fluent in another language, but also are required to have experience treating recent Latino immigrants and experience participating in community events. A language proficiency test also is administered to the candidates and, if passed, the candidates receive an intensive 40-hour training in medical
interpretation using the *Bridging the Gap* curriculum. The training is provided by the Northern Virginia AHEC.

### 4.7.3 Language Assistance Activities and Procedures

La Clínica conducts outreach to the LEP population by using mass media and direct outreach methods; and it has a regular health program on Univisión (a Spanish television station), promotes clinic services at local Latino radio stations, and advertises in Latino newspapers. La Clínica holds monthly health fairs—“Domingos Saludables” (Healthy Sundays)—at local churches and provides informative materials, such as brochures about social services and disease treatment and prevention in English and Spanish.

### 4.7.4 Relative Costs Associated with Providing Language Assistance Through an Off-site Interpreter Program

La Clínica’s off-site interpreter program is a cost effective means of providing quality language assistance to LEP clients. The program maintains low direct costs by relying on its large trained volunteer interpreter base. The most significant direct cost associated with this service is the cost of training volunteers in medical interpretation. The cost of this training varies according to the type of organization providing the training, as well as the area of the country in which it is taking place. La Clínica pays close to $550 per volunteer training. This training employs the *Bridging the Gap* curriculum, one of the most comprehensive training programs available in the country. There are more economical programs in medical interpretation that cost from $300 to $400. A significant limitation of the program is that once volunteers have the training and experience as medical interpreters, they become susceptible to heavy recruiting by private practices, hospitals, and MCOs. Volunteers are difficult to retain, because they are not afforded fringe benefits, a limitation that La Clínica is currently trying to address.

Another cost associated with the off-site interpreter program is the cost of having a coordinator who is responsible for scheduling all interpreter engagements. At La Clínica, the coordinator is a clinic FTE, so there are no direct costs for the position.
SECTION 5

Focus Group Findings
5. FOCUS GROUP FINDINGS

The study team conducted focus groups for the Limited English Proficiency as a Barrier to Family Planning Services study with LEP individuals in their native languages during the months of August through September 2002. Focus group participants were recruited from Title X-funded clinics in four cities including: Minneapolis, Minnesota; Stafford, Texas; San Jose, California; and Albuquerque, New Mexico. The study team conducted the focus groups in Minneapolis, San Jose, and Albuquerque in Spanish, and the Stafford focus group in Urdu.

Focus Group Participant Characteristics. LEP women ranging from 22 to 42 years of age participated in the focus groups, and the focus group conducted in Stafford, Texas included two male participants. Participants’ country of origin included: Mexico, El Salvador, Colombia, Chile, Argentina, Pakistan, India, and Guatemala. The sample of participants included both new clients and those who have accessed family planning services for a number of years. This variability in experience accessing services provided the study team with different perspectives in terms of the changes LEP clients had experienced in the quality of language assistance services they had accessed.

Focus Group Methodology. Project senior technical staff moderated the focus groups by using the Focus Group Discussion Guide (see Appendix E). The discussion guide included questions and probe questions that queried the participants on their perceived barriers to accessing family planning services, experience receiving language assistance at Title X clinics, and recommendations for improving those services.

The issues raised by focus group participants richly detail access and quality issues experienced by many LEP clients accessing family planning services around the country. All participants cited their inability to communicate effectively as a barrier to access and deterrent to receipt of quality services, as well as the important role that language and culture play in the effective delivery of reproductive health services. In addition, participants also identified barriers that were not perceived by clinic staff, which are discussed in Section 4. Participants identified legal issues, economic issues, and low levels of education as major barriers to access family planning services.

The following section summarizes the access and use issues of LEP clients who require language assistance to access family planning services in Title X clinics. The experiences and findings outlined do not necessarily apply to all LEP clients who have accessed family planning services, but should be used to broaden the understanding of the relative effectiveness of the language assistance services and strategies described in Sections 3 and 4.
5.1 BARRIERS FACED BY CLIENTS ACCESSING FAMILY PLANNING SERVICES

The study team queried focus group participants about barriers they have encountered when accessing family planning services at Title X clinics. Clients reported multiple barriers including: linguistic, cultural, legal, economic, and educational. These barriers affected LEP individuals in different ways and are manifested during different phases of the clinical visit. Exhibit 5-1 presents the barriers and indicates the phase in which clients reported the barrier having a direct effect on their ability to access family planning services. It shows that most barriers occur at outreach and in-take, well before the clients interact with medical providers. Linguistic and cultural barriers are more pronounced as the interaction between the LEP clients and clinic staff increases. Following is a discussion of LEP clients’ perceived barriers to accessing family planning services in all phases of the family planning clinical visit.

Exhibit 5-1

BARRIERS FACED BY CLIENTS ACCESSING FAMILY PLANNING SERVICES, BY PHASE OF CLINICAL VISIT

<table>
<thead>
<tr>
<th>Clinical Visit Phase</th>
<th>Linguistic</th>
<th>Cultural</th>
<th>Legal</th>
<th>Economic</th>
<th>Educational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>In-take</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medical History and Financial Screening</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Examination and Treatment</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructions for Follow-up Care and Medication Usage</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

5.1.1 Outreach

Title X clinics expend great effort and resources conducting outreach activities to the LEP population. Examples of common outreach activities include: developing translated written material (e.g., pamphlets, brochures, announcements, and signs), conducting presentations at health fairs and other human services organizations, and supplying LEP clients with promotional items imprinted with the clinic’s contact information. Focus group participants were asked to discuss how they first became aware of clinic services. Participants reported that outreach activities do not influence their decision to access...
Linguistic and Educational Barriers. A client’s language and level of education have a direct impact on the effectiveness of outreach activities. Participants reported that, although they frequently encountered flyers and signs advertising the availability of family planning services, they had a difficult time understanding the meaning of services that referenced family planning or preventive reproductive health care services. Participants mentioned that flyers and signs did not provide an accurate description of services.

“I don’t know what they mean [the signs]. They tell me that they can help with planning my family, but I was thinking I can plan it with my husband; I don’t need anybody to help us. Then my cousin explained what they do here at the clinic.”

Participants mentioned that they first learned of clinic services through a number of methods including: word-of-mouth, referrals, and clinic outreach activities. The most commonly cited method was through word-of-mouth. Most participants reported that they were able to access clinic services through an acquaintance or a family member who was familiar with clinic services. Participants from clinics located close to other social services organizations (e.g., Centro de Salud Clinic, Valley Health Center at Lenzen, San Marcos Clinic, and Southeast Heights Clinic) were referred by staff members in those organizations.

In addition to word-of-mouth and referrals, some participants reported that they became aware of clinic services through an outreach activity initiated by the clinic. Of all the outreach activities discussed, providing outreach through a radio commercial was the most effective strategy employed. This strategy was adopted by Centro de Salud and La Clínica del Pueblo. Six participants from the Centro de Salud clinic became aware of clinic services on a Latino radio station which broadcasted a commercial for Centro’s STD initiative. Of the six participants, two learned of clinic services from their husbands who also listened to the commercial.

When discussing participants’ experiences accessing family planning services for the first time, many reported having trouble finding the clinics, because they were unfamiliar with city streets and public transportation. Centro de Salud Clinic has addressed this barrier by constructing large statues depicting a Hispanic family, which clients use as a reference point to help them identify the clinic building (see Section 4.2). Participants

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1 Anecdotal information provided by a Centro de Salud Clinic client with less than one year’s experience accessing family planning services.
reached consensus on having difficulties locating clinics during their first visit, the following quote describes the difficulty experienced by many first-time clients.

“I had so much trouble getting here; I was about 20 minutes late, and I left my apartment about an hour before the appointment. But then I got lost. I know some people that are so afraid to get lost that they don’t even consider coming to the clinic, even when they really have to.”

**Legal Barriers.** In addition to linguistic and educational barriers, many participants also stated that they dismissed the idea of seeking clinical services because they had a deep concern over immigration status. Some participants cited that a common fear among legal recent immigrants was that seeking government help would affect their immigration status by limiting their opportunity to become citizens, or that seeking government assistance would limit their ability to bring family members to the U.S.

**Economic Barriers.** Another major barrier addressed by participants was the difficulty of finding time to leave work for an appointment. Many participants identified themselves and their spouses as day laborers and commented that they would not receive payment for time lost due to medical appointments. In addition, other participants mentioned that both transportation and child care expenses seriously limited their ability to schedule appointments and arrive on time.

**5.1.2 In-take and Medical and Financial Screening**

Focus group participants were asked to discuss their first experiences accessing family planning services at their respective Title X clinics. Focus group participants report that the second and third phases of the clinical visit is where most barriers are manifest.

**Linguistic and Cultural Barriers.** Participants agreed that a family planning clinical visit is more personal and private than a regular visit to the doctor. In addition, many participants discussed how both linguistic and cultural barriers impact how effectively a LEP individual can provide appropriate information at in-take and during the medical and financial screening. The following quote describes a LEP individual’s negative experience due to language limitations affecting their ability to communicate a critical medical history fact.

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2 Quote provided by a Centro de Salud client with two years’ experience accessing family planning services.

*COSMOS Corporation, March 2003*
“It is very important to complete the medical history out correctly. One of my uncles died because the doctor didn’t understand that he had an allergy to penicillin. And he just died, because when he saw the problem he was too far away from the clinic to get help.”

The following quote describes how language also can affect LEP individuals’ understanding of clinic services and the importance of in-take during a clinical visit. Participants expressed a clear preference for having the opportunity to complete in-take in a private room and not just completing forms at the receptionist’s desk.

“The first visit is the most difficult because there are so many forms, and they are not easy to understand. It took me forever to understand consent. I thought they were going to operate on me then and there. But once you understand the system, it is very easy, and people that work here are very courteous and very respectful. Like when I brought my mother for a Pap smear, she can’t read, but staff made her feel like it was normal for them to fill out the forms instead of having her fill them out.”

Cultural factors also inhibit LEP clients from disclosing important information during medical screens. The following quote describes how varying cultural norms inhibit a LEP client’s ability to provide staff with pertinent information regarding sexual activity.

“The first time I came I felt embarrassed because the lady at front asked me private questions like when was the last time I had sex, and how many sexual partners I had. I didn’t know how to answer, because I never discuss those things with anyone except my mother or aunt. It is not the same as asking me where it hurts; it is a very intimate conversation, so I told her I didn’t know.”

Culture also affects LEP clients’ ability to access services. Participants had to learn how to make appointments, usually with the help of a friend or family member, because they were not familiar with protocols involved in making and keeping appointments. They mentioned that they also had to learn the importance of keeping the appointment. Some clinics only have live multilingual operators who take appointments (e.g., Centro de Salud Clinic and the Stafford Clinic), while other clinics have a menu-driven appointment system. Participants were more likely to call the appointment line when they did not have to go through a menu. They liked having a live person answer the phone right away. Clients mentioned that they now understand the importance of keeping an appointment

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3 Quote related by a client with five years’ experience accessing family planning services at Southeast Heights Clinic.

4 Comment provided by a woman in her early twenties from the Valley Health Center at Lenzen.
and how arriving late to an appointment results in longer wait times for them and for others.

“The first time I came here they told me to come the next day, but I didn’t get here until 20 minutes after. I thought they would still see me, because in my country you just get there and a doctor sees you. But now I know you have to get here on time, or we wait for a long time before they see us.”

5.1.3 Medical Examination

Participants commented that although some providers might think they can speak Spanish, many are not able to communicate with them. For instance, some participants from Argentina mentioned that they were assigned to a Puerto Rican physician because they spoke Spanish. However, the Argentinians were not able to understand, but they did not ask any questions.

“The other day I had a very nice doctor that spoke Spanish, but I didn’t understand a thing that he said. Even though it was Spanish it was very different than what I had heard. But I didn’t want to make him feel bad, so I didn’t tell him I didn’t understand.”

Although some focus group participants were able to speak some English, they admitted that once they were beyond the in-take stage and they needed to interpret body parts, feelings, and emotions, they had a very difficult time expressing themselves. It was at that point in the exam room, that LEP clients realized they needed the assistance of an interpreter.

Quote related by a client from the Southeast Heights Clinic with two years’ experience accessing family planning services.

Comment provided by Centro de Salud client with two months’ experience accessing services.

The Stafford Clinic asks all clients at in-take if they need an interpreter. However, it is not a requirement for providers to remind clients during the exam if they have changed their mind about their need for an interpreter.
“I think the most difficult part of getting services when you have a problem is when my wife needs to tell the nurse how she feels or where it hurts. I don’t know how to say the name of the female parts except the breast, so I have to point and the nurse asks me more questions, and I don’t know how to make them understand. I don’t even understand what my wife means sometimes.”

Another cultural barrier that manifests itself in the exam room is that participants usually refrain from asking questions until the provider has left the room. Participants mentioned that they do not ask questions, because they were raised not to question authority, especially doctors. This cultural barrier is further compounded when participants feel that the clinical visit is running too long, as usually occurs when there is a third person in the room. However, professional interpreters have been trained to exit the room once the provider is finished with the exam and the client has been debriefed. This policy leaves the client with many unanswered questions and doubts regarding their care.

The following is an anecdote provided by a nurse practitioner with eight years’ experience working with LEP clients. She provided the study team with an example that illustrates how linguistic and cultural barriers are manifested during an examination. This also illustrates the importance of having a face-to-face interpreter present during exams.

“I remember examining a Vietnamese man for STDs. When I asked him if he had any problems urinating, he said “no” and responded “no” to everything I asked him. Then I noticed that he grimaced whenever I touch his shoulder. As I made my way down his shoulder to his chest I kept on asking him if it hurt, and he repeated that it didn’t. Then I touched his left pectoral and he grimaced, but said that it didn’t hurt.”

5.1.4 Instructions For Follow-up Care and Taking Medication

An often overlooked phase of the clinical visit involves instructing clients on how to correctly take medication, how to use contraceptives, and scheduling follow-up care. Clients described how language and LEP clients’ economic situations are major barriers to their reproductive health.

**Linguistic Barriers.** Most participants emphasized the need for slow and effective translation of instructions for taking medication and for follow-up care. Participants mentioned that importance should be placed not only on translating vital documents, but
also on distributing instructions that describe how to take medication and use contraceptives.

“I don’t need them to translate the forms. I understand because I know English. But I need to know when I need to come back and how my wife should take the pills. This information is most important, and they need to tell us, and tell us again, you know. We need to know exactly how or the pills don’t work.”

As mentioned in the focus group methodology section, focus groups included a mix of participants who were new clients, as well as participants with many years’ experience accessing family planning services. The following quote describes the great advances that Title X clinics have made regarding the provision of language assistance services since 1990.

“It used to take so long to see the doctor before they had the interpreters. They used to run around looking for someone that spoke Spanish, and they would leave and then the doctor would get very frustrated and just check me really fast and then not even tell me how to take my pills. Sometimes I would have to go back, because I did not take the pills, and my problems were still there. So, the doctor would be mad at me for not taking the pills. But now with the interpreters they explain everything to me, and how to take the medication. Things are much better now.”

5.2 PARTICIPANTS’ PERCEIVED EFFECTIVENESS OF LANGUAGE ASSISTANCE SERVICES

Participants were asked to discuss their experiences with various methods of language assistance provision. In general, all participants expressed a clear preference for bilingual staff over any other language assistance service. They had high levels of satisfaction with language assistance services when they were provided by bilingual staff with whom they were familiar and had learned to trust over the years.

Of particular importance to clients was the ability to establish trust with staff members. With increased levels of trust, clients felt more confident about their abilities to communicate their feelings and emotions and ask in-depth questions that sometimes

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9 Comment provided by a participant whose wife experienced an unintended pregnancy as a result of not following directions for taking oral contraceptives.

10 Quote provided by a client in California with 10 years’ experience accessing family planning services.

COSMOS Corporation, March 2003 5-8
challenged their myths regarding reproductive health—questions they would usually not share with staff in fear of being laughed at or rejected. Exhibit 5-2 lists the various methods of delivering language assistance and describes the clients’ perceived strengths and weaknesses.

Exhibit 5-2

PARTICIPANTS’ PERCEIVED STRENGTHS AND WEAKNESSES OF VARIOUS METHODS FOR DELIVERING LANGUAGE ASSISTANCE

<table>
<thead>
<tr>
<th>Method of Delivering Language Assistance</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual Staff</td>
<td>• Expedited appointments</td>
<td>• Confidentiality can be compromised</td>
</tr>
<tr>
<td></td>
<td>• Able to ask questions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feel less dysfunctional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Body language exchanged</td>
<td></td>
</tr>
<tr>
<td>Telephone Interpreters</td>
<td>• More privacy during exams</td>
<td>• Limited privacy</td>
</tr>
<tr>
<td></td>
<td>• Expedited appointments</td>
<td>• Feel rushed</td>
</tr>
<tr>
<td></td>
<td>• Limited privacy</td>
<td>• Impersonal</td>
</tr>
<tr>
<td>Face-to-Face Interpretation</td>
<td>• Able to ask questions</td>
<td>• Feel rushed*</td>
</tr>
<tr>
<td></td>
<td>• Body language exchanged</td>
<td>• Less privacy</td>
</tr>
<tr>
<td>Translated Client Education Materials</td>
<td>• Provide good visual</td>
<td>• Lacks new contraceptive methods</td>
</tr>
<tr>
<td></td>
<td>• Used for reference</td>
<td></td>
</tr>
<tr>
<td>Multilingual Signs</td>
<td>• Orient clients to clinic services</td>
<td>• Do not help clients with low-literacy</td>
</tr>
<tr>
<td></td>
<td>• Inform clients of their right to language assistance</td>
<td>• Restricted to 3 languages</td>
</tr>
<tr>
<td>Multilingual Videos</td>
<td>• Provide good visual</td>
<td>• Language too technical</td>
</tr>
<tr>
<td></td>
<td>• Cannot be referenced</td>
<td></td>
</tr>
</tbody>
</table>

*Applies only to contract interpreters.

5.2.1 Bilingual Staff

Participants perceived the ability to schedule appointments faster as one of the main strengths of providing language assistance through the use of bilingual staff.

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11 The focus group conducted in Stafford, Texas, did not include participants that had received language assistance using the Telehealth teleconference technology.
“Here we like to make appointments because it only takes one or two weeks to see the nurse. At other clinics it takes even one month, because we have to schedule an appointment with the doctor, and they have to find an interpreter for the same time. That is why I don’t like to ask for an interpreter. I sometimes can’t wait so long for them to have an interpreter for us. At other clinics sometimes the interpreter does not even show up and it takes one more week. I don’t want that. What happens if it’s an emergency?”

Participants also discussed the ability to ask bilingual staff more questions than they can with an interpreter. Having this additional interaction usually leads to higher quality service and ensures clients will comply with follow-up care. In addition, participants acknowledged that they felt dysfunctional when requesting an interpreter.

“Even though I understand the interpreter, there are things that they don’t tell us. So, I have relied on Lupe [bilingual staff] to explain everything to me after the interpreter leaves. Sometimes I have questions, but I don’t want to take up the doctor’s time, or the interpreter’s time, but I do like to understand what is going to happen to me, and all the options that I have when we are selecting birth control.”

According to participants, the only limitation of using bilingual staff was that the more the clients interact with certain bilingual staff, the more the staff know them and their issues. Participants feared that confidentiality in these instances could become a problem, especially when they interacted with bilingual support staff.

“A doctor has more ethics. They are professionals, but someone that isn’t [bilingual support staff], we don’t know who they are or who they are going to tell about our situation. But I still prefer to have someone I can talk to in the room.”

5.2.2 Telephone Interpretation

Participants reported that interpretation over the telephone offered them more privacy, especially during an examination where the interpreter was male. However, as

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12 Quote provided by an Urdu speaker from the Stafford Clinic with six months’ experience accessing family planning services.

13 Comment provided by a client with three years’ experience accessing family planning services at the Valley Health Center at Lenzen clinic.

14 Quote related from a client with three years’ experience accessing family planning services.
discussed in Section 4.4, the remote interpreter service at the Santa Clara Valley Health and Hospital System has experienced privacy issues, as speakerphones are used in the examination rooms; and the clients have noticed that other people can listen to the conversation. There were mixed feelings regarding how quickly interpreter engagements can be scheduled. Compared to a face-to-face interpretation, interpretation via the telephone does offer a more expedited process. However, this method of delivering language assistance requires more time, because it involves a three-way conversation.

Rapport is established between provider and client throughout the different phases of the family planning visit. However, with telephone interpretation, participants are not given the opportunity to establish this rapport. Clients perceived the process to be impersonal and reported feeling rushed.

“\textit{The telephone interpreters are O.K., but they do go a little bit too fast for me. I sometimes need some more time to think when they ask me a question, but I know that I am taking up their time, the doctor’s and the interpreter’s. So, if I have a question, I just don’t ask them unless I think it is very important—but I wish I had the time to ask.}”

5.2.3 Face-to-Face Interpretation

There are two types of interpreters who provide services face-to-face: professional interpreters and clinic staff who are designated as interpreters. Participants stated that staff interpreters were less time conscious and, therefore, did not rush them as much as contract interpreters. In addition, clients stated that it was easier to ask questions while having a face-to-face interpretation engagement.

“\textit{There is a 100 percent difference between having someone interpret over the phone and having a live interpreter [face-to-face]. It is easier to say that I didn’t understand in person, over the phone they go much faster. They are very nice and professional, but it is more difficult to understand because they don’t give you enough time to think about it and ask questions when you don’t understand. It is just embarrassing to admit that you don’t understand.}”

15 Comments provided by a participant from Valley Health Center at Lenzen who has used the remote interpreter service for one year.

16 Quote describes the difference between telephone interpretation via a language line service and face-to-face interpretation. The observation is provided by a participant from the Southeast Heights clinic with three years’ accessing family planning services.
Participants stated that most professional or contract interpreters did not take the time to explain everything the provider said to them. They also mentioned that interpreters spoke at a fast pace and were perceived as being impatient. Also, some participants stated that a weakness of face-to-face interpretation was that the clients were concerned with privacy, especially when they had to undress with the interpreter in the exam room.

Participants indicated that in order to establish trust with interpreters, they wanted to know that the interpreters truly desired to help them to get their point across to the provider. So, not being able to see their face, participants had a difficult time assessing the interpreters’ body language.

“I just don’t feel comfortable talking into a phone when you can’t even see their face. They could be laughing at us or be mad and not be able to translate well for us.” 17

5.2.4 Translated Documents and Client Education Material

Providing clients with brochures that describe clinic services, procedures, and medical tests, has been an effective method of providing clients with important facts that describe their care. In addition, LEP clients also are provided with translated documents deemed vital for an effective clinical visit. Together, these translated documents provide clients with information that will allow them a quicker transition throughout the various phases of the clinical visit.

“Before we didn’t get any documents in Spanish. It took longer because they needed to explain all the papers. It used to take three appointments to finish all the paperwork, but now it is very easy and it takes about 30 minutes to finish all the paperwork.” 18

Participants mentioned that another strength of having translated documents is that they were able to visualize the procedures (e.g., self breast exam, tubal ligation, or colposcopy) when illustrations are provided. In addition, participants cited the ability to share brochures with their spouses and use them as a reference.

17 Quote provided by a participant with five years’ experience accessing family planning services at the Valley Health Center at Lenzen.

18 Comment provided by a participant with over eight years’ experience accessing family planning services at the Southeast Heights clinic.

*COSMOS Corporation, March 2003* 5-12
“They used to not have the papers [brochures] in Spanish when I first started coming here. But now it is much better, because I can understand what the nurse is telling me when she points to the pictures [illustrations]: and I also can take the paper with me, and if I don’t understand I can ask over the phone. Also, I get a chance to think about what I want to do and discuss it with my husband.”

According to participants, the only weakness of the translated documents is that brochures are often outdated. For instance, the brochures that describe various types of contraceptive methods available fail to mention recently approved methods such as “the patch” or the “day-after pill.”

“I wish they had more information on new methods for not getting pregnant. I see the commercials on television, but they don’t tell us about the new methods, and the pamphlets don’t have them, so we can’t consider them.”

In addition, clients discussed their perceptions regarding the differences between what they considered to be a well- and a poorly-translated document. According to participants, a good document uses more illustrations than words, has short phrases, uses bright colors, and outlines the pros and cons of each method. The study team collected brochures and other translated documents considered to be effective by both participants and clients (see Exhibit 6-2).

5.2.5 Multilingual Signs

Strategically placed signs in multiple languages help orient LEP clients who are not familiar with the clinic to the facility and the services available to them—including their right to an interpreter. During the discussion of their first time accessing clinic services, participants described feeling lost, and how having the signs in their language made them feel more comfortable. However, a weakness of multilingual signs is that if they feature more than three languages, they can be confusing. Also, participants mentioned that having signs with fewer words and more illustrations and bright colors makes the signs more effective.

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99 Comment provided by a participant with two years’ experience accessing family planning services at the Valley Health Center at Lenzen clinic.

20 Quote is from a client with three months’ experience accessing services at the Valley Health Center at Lenzen clinic.
“At first I did get lost here at the clinic because all the halls look the same—they are all white. Then someone told me to look at the signs and then I knew where to go. But I think it would help if they had pictures and different colors so you know where you are.”

In addition, participants mentioned that multilingual signs were usually located in the entrance close to the receptionists’ desk. However, they observed that signs would be useful in various stations within the clinic (e.g., in-take room, exam room, etc.).

5.2.6 Client Education Videos

The participants who had viewed educational videos agreed that the videos, although informative, used language that was too technical. Participants perceived the videos to be useful, because they describe procedures and help them understand the need for the procedures. However, the majority of participants preferred to have information presented in the form of a brochure.

“They give us a lot of information here, like pamphlets with drawings [illustrations] that are easy to understand. They explain what symptoms to expect, pros and cons of using specific birth control methods. I like that extra information, because I can take it home and think about it; because when we are here we are given so much information. The clinic also has a video, but I don’t like it too much because I like to read and look at the pictures and think about it at home. If we don’t understand it, we can always read it again and ask people about it.”

5.3 CLIENTS’ SUGGESTIONS FOR LANGUAGE ASSISTANCE SERVICE IMPROVEMENT

Toward the end of the focus group sessions, participants were asked to make recommendations on how to improve the language assistance services their clinics offered them. All participants stated that they were very appreciative of the language assistance they are given, especially those who have been accessing services over five years, as they have seen the enormous strides made throughout the years in service delivery to LEP clients. In addition, many participants made references to other clinics where they received some form of health care and mentioned how much more professional and

21 Quote related by a client with six years’ experience accessing family planning services at the Valley Health Center at Lenzen.

22 Comment provided by a participant with two years’ experience accessing family planning services at the Southeast Heights clinic.

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respectful Title X language assistance providers were than at other clinics. Participants also made some recommendations for service improvement.

First, participants recommended that Title X clinic staff look for volunteers to provide child care for clients. Participants mentioned that one of the primary reasons so many people are not able to access family planning services is the lack of child care resources. Some clinics have mitigated this barrier by relocating to facilities adjacent to other social services organizations that provide free child care (e.g., Centro de Salud Clinic and Southeast Heights Clinic).

Second, participants recommended that clinic staff be provided with periodic courses on customer care or customer service. They believed this to be an important skill for clinic staff to possess, because they have noticed the difference in the way seasoned employees and new staff treat clients. They also cited differences when they have attended other clinics.

“They [staff] think they are more important than us and make us feel like we are wasting their time. When you make an appointment, it is very scary at other clinics, because they make us feel like we shouldn’t be at the clinic, but here they make us feel welcome and at home, like we belong.”23

Finally, participants would like clinics to establish a procedure for clinic staff to advise clients of their right to language assistance throughout all phases of the clinical visit and not only at in-take. Participants stated that if they are offered language assistance at in-take, they usually refused if they knew some English. However, during examinations, they felt the need for assistance, but they felt that it was too late to request language assistance after in-take.

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23 Quote provided by a client from the Centro de Salud clinic.

COSMOS Corporation, March 2003 5-15
SECTION 6

Recommendations
6. RECOMMENDATIONS

The following section provides a description of training and technical assistance (T/TA) suggested by clinic staff during the site visit interviews. The study team asked clinic staff members to describe possible T/TA topics that would help them better serve a growing number of LEP clients. In addition, clinic staff provided descriptions about many areas in which they require T/TA in order to address common barriers effectively. Thus, the recommendations represent T/TA activities that address the clinics’ most pressing needs and most significant barriers. Exhibit 6-1 presents the recommendations and the barrier types which they are intended to address. The recommendations are described in training topics and technical assistance activities with multiple methods of delivery. For example, the T/TA can be delivered in the form of conferences and workshops, production of “How-to Kits,” and dissemination of information to the grantee network through publications that can be made available on-line and in hard copy.

Exhibit 6-1

BARRIERS ADDRESSED BY RECOMMENDATIONS FOR TRAINING AND TECHNICAL ASSISTANCE

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Client-focused</th>
<th>Resource-focused</th>
<th>Client-perceived</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning-specific cultural competency</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cross-cultural communication</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Client care</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Technical Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of multilingual client education material</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dissemination of best practices and strategies</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Development of national-level family planning resources</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

6.1 TRAINING OPPORTUNITIES

One of the major study findings is that language, although a significant barrier to accessing family planning services, is compounded by cultural barriers. Culture goes beyond language, food, dress, religion, and music; it also involves personal characteristics such as subtle rules of authority, eye contact, personal space, body language, learning styles, family structures, and more. In order to provide reproductive health services that are appropriate for all cultural groups, clinic staff should develop an understanding of differing cultural perspectives and respect differences among them. The following section describes training that specifically addresses these issues.

6.1.1 Family Planning-specific Cultural Competency Training

Clinic staff expressed a need to be informed on a number of cultural issues, especially those issues regarding family planning. A bilingual medical assistant with eight years’ experience articulated the need for this type of training:

“It would be very helpful for me to know where these people are coming from. If we [clinical staff] knew how health care and specifically reproductive health is viewed in different cultures we could be more sensitive to their beliefs and, in turn, not offend them in the process. I think this would improve the quality of the health care we provide at Title X clinics.”

Training Components. Family planning-specific cultural competency training should include topics addressing issues and concerns for certain populations such as: how different cultures and subpopulations view birth control and out-of-wedlock children; how to effectively interpret body language; and reproductive health concerns and use of traditional medicine for various cultures (e.g., coin-rubbing). Providers have observed that women of differing faiths are offended by the mere mention of some birth control methods during client education talks that include a discussion of birth control methods. Providers have expressed a need for information that describes the cultural and religious beliefs which may be in conflict with regard to certain birth control methods. In addition, it also is important to include training components that provide clinic staff with techniques on how to deliver bad news to clients (e.g., critical stress debriefing), specifically pregnancy results, HIV-positive diagnosis, and abnormal Pap test results.

Methods for Delivering Training. Untapped resources for trainers with extensive work experience providing LEP clients with family planning services are the physicians and nurse practitioners who have adapted their treatment strategies, through trial and error, to treat specific cultural groups. Providers interviewed during the site visits demonstrated an interest in participating in these types of activities. Therefore, training in cultural competence should be structured in a manner that uses the field experience.
acquired by physicians and nurse practitioners working with specific populations, races, and cultures, so they can share their perspectives with their colleagues in various Title X programs.

**6.1.2 Training in Cross-Cultural Communication**

In addition to cultural competency, training in cross-cultural communication is an important skill for clinical staff to acquire. Training in cross-cultural communication increases the ability of medical staff to communicate with clients of other cultures by making them aware of the differences in communication styles within cultures. For instance, training should address cultural differences in body language, loudness of speech, eye contact, touching, and formality in verbal exchange. Unfortunately, much of the information found regarding health care and cross-cultural communication is anecdotal, rather than outcomes-based. For example, in some Native American groups, a weak handshake is preferred as a sign of humility and respect; some Asian groups smile to mask negative emotions; touching someone with the left hand is inappropriate to some Middle Eastern cultures; and Asian parents believe it is impolite to have someone pat their children on the head; while Latino cultures believe it is impolite not to have their children touched (AMSA, 2003; Lynch, 1998).

Many universities offer courses in international communication, and many companies that do business overseas provide their employees with training in multicultural communication and negotiation styles and body language.¹ If such training is available for other professionals who come into contact with people of other cultures, the same should be available to health care workers in order to improve their quality of service and customer relations.

The study team interviewed a Hispanic physician at La Clinica del Pueblo that described instances when he has had to tailor his service delivery to fit different cultures.

¹ Universities offering courses in intercultural communication include: Barry University and Georgetown University. Companies offering training in business protocol abroad include: Berlitz and Language and Culture Worldwide. Books—such as *Kiss, Bow, or Shake Hands: How to Do Business in Sixty Countries* (Terri Morrison, et al., Adams Media, Inc., 1994) and *Gestures: Do’s and Taboos of Body Language Around the World* (Roger E. Axtell, John Wiley and Sons, 1997)—address nonverbal communication for businesspeople and travelers.
“When I treat my Latino clients they expect me to touch them on the shoulder to reassure them that they are not going to feel pain during an exam. Some of my clients also hug me after the exam, and overall, they expect the physician to touch them in order to treat them. With my Asian clients I do not touch them because it is not polite to touch. Same with my Anglo clients—a touch on the shoulder might indicate a sexual advance to them.”

Clinic staff expressed an interest and need for a How-to-Guide or Primer on how to customize translations for specific population groups (e.g., different language groups, cultures, and sexes). Having sufficient numbers of trained medical and other interpreters is not enough to ensure language access for LEP clients if health care providers and systems do not use them or do not know how to use their resources properly. Many clinical staff acknowledged the need for training on how to use a medical translator effectively (see Section 4.6). A promising practice in this type of training is used by the University of New Mexico Hospital System. The system’s interpreter program has started to train physicians on how to effectively use a medical interpreter. It also has innovated its delivery of language assistance by developing a notebook of visual aids to help clients understand medical terms and processes discussed during an interpretation. Interpreters believe that clients are really at a disadvantage when someone is trying to describe how a procedure will affect their bodies.

“Imagine someone describing something to you that you have never heard about, but with your eyes closed. It is very difficult to visualize your internal body. The client needs to see what the doctor is explaining to them, you also have to remember that a big part of our job is to educate the client because most of them have never received medical services before in their life.”

6.1.3 Other Training Opportunities

Many clinic staff and focus group participants mentioned that clinic staff should receive training in client care. Given that the family planning clinical visit is perceived by many as being more personal than a regular clinical visit, training should be provided on how to handle sensitive information and provide participants with strategies for delivering information to co-workers. For instance, a clinic staff member with over eight years’ experience described the need for client care training:

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2 Quote provided by an experienced full-time interpreter from the University of New Mexico Hospital System.

COSMOS Corporation, March 2003
“Over the years you realize what things are important to clients. When you first start out you think you are doing a good job because you do things fast and you get the client out the door quickly. But I noticed that clients are not worried about time, they are more concerned with keeping their visit private from people in the reception and other staff they don’t even know. So, I have learned to be discreet and reassure the client that nobody will know what tests or what birth control method they selected. I think if we could train new staff so they don’t make the same mistakes I made, we would help the client a lot.”

6.2 TECHNICAL ASSISTANCE OPPORTUNITIES

Clinic staff described a number of subjects in which they require technical assistance in order to address the barriers they currently experience.

6.2.1 Development of Multilingual Client Education Materials

Although clinics have a wide variety of translated client education materials, clinic staff expressed a need for TA on developing or accessing client education materials in various languages that address barriers in all phases of the clinical visit. The study found that most clients accessing family planning services have little or no experience accessing health care services. This client-focused barrier causes costly time delays that affect a clinic’s schedule. Clinic staff agree that increased levels of client education are required during all phases of the clinical visit when treating LEP clients. A provider from the Stafford clinic provided the study team with the following perspective.

“We need to remember that most of the people we serve have never accessed medical services, anywhere, especially not in the U.S. So, we cannot expect them to know how to make and keep appointments and what they should expect regarding their care. However, accommodating clients that are late and no-shows is very detrimental to the daily schedule kept by our clinic, so we could use some TA on methods of reducing or eliminating no-shows and how to reschedule them.”

In order to minimize the time devoted to client education during the family planning visit, clinics need pamphlets and brochures that describe various aspects of the clinical visit to a LEP client. For instance, at in-take, client education material could focus on how to fill out medical history form or a handout which can be part of a packet for first time clients that stresses the importance of keeping appointments. At the examination phase, a document that describes common family planning and body part slang terms used by various populations should be available to clinic staff. At the follow-up and instructions phase of the clinical visit, staff mentioned a need to develop an effective brochure that
describes in easy-to-follow illustrations the *proper way to take medication* and that stresses the *benefits of continuing to take medication or birth control pills*. In addition, staff interpreters mentioned the need for visual aids that can be used during all phases of the clinical visit, especially during telephone and face-to-face interpretations. Client visual aids could be developed in printed format or using multimedia technology to animate certain processes and procedures.

The study team queried clinic staff and focus group participants to describe a good or an effective translated brochure or pamphlet. Both clinic staff and focus group participants agreed that an effective brochure has a number of characteristics, including: the use of large illustrations to confirm direction expressed as text, illustrations that depict a mix of races, short phrases composed of words that are non-technical, and documents that are colorful. Exhibit 6-2 shows a number of client education materials the study team collected at various Title X clinics. The materials displayed were identified by staff and clients as being effective and useful.

**Exhibit 6-2**

SAMPLE OF BEST CLIENT EDUCATION MATERIALS

6.2.2 Dissemination of Innovative Practices and Strategies

The study team interviewed clinic staff members with many years’ experience, and they provided a wealth of information on how to provide language assistance to LEP populations. OPA could fund short issue papers that describe various clinics’ experiences working with different cultural groups. This would allow OPA to inform the grantee network of practices that have been adopted or are working through publications such as *technical assistance bulletins or notes from the field* that describe and report on
contemporary issues in family planning, issues of concern, promising practices, and various issues in the field. For instance, clinic staff mentioned a need to learn how to establish strategic partnerships with community organizations, and what outreach activities are most effective with certain populations. For instance, budgets could be maximized if clinics adopted outreach strategies that have been effective in other clinics (e.g., conducting a radio campaign versus advertising clinic services in a local newspaper).

**Partnership Building Strategies.** An interesting study finding is that all clinics have gone out into the community to fortify their cadres of professional and quasi-professional interpreters. Strategies used by clinics to build partnerships should be evaluated and findings disseminated as recommended strategies in which clinic staff should be engaged. Furthermore, studies could investigate strategic partnerships to define and describe their formations, which could be used to replicate effective partnerships.

**Outreach Strategies.** Best practices in outreach strategies shown to be effective with different groups and subpopulations should also be developed. The TA could include how to craft an effective outreach message, how to select an effective outreach strategy, and how to design and implement a national campaign to develop signs and outreach materials that focus on people’s right to an interpreter. Many times clients are unaware that clinic services exist and that they have the right to an interpreter. This is a major barrier at the outreach phase of the clinical visit.

### 6.2.3 Development of National-level Family Planning Resources

The recommendation cited most frequently by clinic staff was the need for a national resource for translated client education material. Clinic staff mentioned that a Web page could be added to the OPA Clearinghouse that includes reproductive health care education materials and consent forms that have been translated in different languages. Staff report that such a resource would benefit service delivery at their clinics, as well as reduce their in-house costs for translating documents. The study team researched national-level resources for translated documents and found a Web site in Australia that provides the services described by clinic staff. Exhibit 6-3 shows a screen from the New South Wales Multicultural Health Communication Service web site. The service has translated 450 publications on various health issues in 13 languages. The publications are available for download free-of-charge. The exhibit also shows the document titled, “Myths and Facts About Sexual Health,” a topic which staff believe would be helpful to provide LEP clients as well as clinic staff.

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3 The New South Wales Multicultural Health Communication Service is located at: http://www.mhcs.health.nsw.gov.au,

*COSMOS Corporation, March 2003* 6-7
Policy Development and Coordination. As mentioned in Section 3.4, one of the major barriers faced by family planning clinics is the recruitment and retention of bilingual providers. Two ways to mitigate this barrier are for HHS or OPA to foster the adoption of a fast-track certification program for foreign professionals and to facilitate on-the-job training for immigrants with credentials from other countries who have an interest in working in healthcare. Clinic staff mentioned that foreign-trained health care workers can be retrained and used in professional or paraprofessional roles. Special programs can assist them to become certified or licensed in their original profession or can train them for other health care roles, such as physician assistant or community health worker. The Southeast Heights clinic employs a medical assistant who was a physician in Vietnam. After serving as a clinic volunteer interpreter, he received on-the-job training and is considered one of the clinic’s greatest assets given his excellent understanding of the
Vietnamese language and culture and his knowledge of medical terms in both Vietnamese and English.

**Development of Assessment and Planning Tools.** OPA should consider developing an evaluation tool that assesses the language assistance services adopted by Title X clinics, as well as a guide which clinics could use to design their language assistance services. For instance, the National Council on Interpreting in Health Care (NCIHC) has developed an assessment tool to help health care organizations evaluate their existing structure and capacity to provide language assistance services. In addition, the Centers for Medicare & Medicaid Services (CMS) has published a guide for managed care plans that provides a planning process for implementing oral linguistic services. Similar products can be developed to assess the language assistance services offered by Title X family planning clinics, as well as provide them with a step-by-step planning process which they can use to tailor language assistance services to meet the needs of the LEP populations they serve.

### 6.3 OTHER RECOMMENDED ACTIVITIES

#### 6.3.1 Foster Scientific Investigations and Evaluations of Language Assistance Services

The focus of these investigations should be aimed at improving the delivery of family planning and related reproductive health care services to LEP clients. Studies could benefit from the use of organizational assessments which could identify policies and practices that need to be instituted to improve the health care experience of all LEP clients. In addition, studies that document the benefits and consequences of increased or decreased language access to family planning services also should be funded in order to provide a balanced view of the real costs associated with not providing language assistance to LEP clients.

Studies also should involve qualitative data collection, such as national survey data, to serve as an empirical basis for quality improvement initiatives, not just anecdotal data as the present study provides. OPA might consider funding a study to further investigate and validate the findings of the *Limited English Proficiency as a Barrier to Family Planning Services* study. For instance, a survey consisting of a mailed questionnaire

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could be administered to a nationally representative sample of Title X-funded family planning clinics. Such a study could widen the snapshot of innovative language assistance services investigated in the LEP study and allow for findings to be generalized to all Title X clinics. The questionnaire could be developed by crafting items, forced response categories, and open-ended items using information learned from the current study. Questionnaire items could then be grouped by domains reflecting the Office for Civil Rights’ (OCR) four elements to an effective language assistance service described in its policy guidance. These elements include: assessment, development of comprehensive written policy on language access, training of staff, and vigilant monitoring.

In addition, the study could include semi-structured, follow-up telephone interviews with a representative sub-sample of respondents to investigate open-ended responses of interest which could be used to write case studies detailing innovative language assistance services. Such a study might address study questions like:

- What are the language assistance services, activities, and procedures used by Title X clinics to ensure effective access to family planning services for people with LEP?
- What are the innovative language assistance services being provided by Title X clinics?
- To what extent do Title X clinics formally assess their language assistance services?
- To what extent have clinics developed comprehensive written policy on language access?
- To what extent have clinics facilitated training for staff related to providing language assistance to LEP clients?
- To what extent do clinics monitor the quality of their language assistance services?

Study findings could allow OPA to provide clinics with guidance on language assistance services and strategies that have been implemented by other clinics and produced positive outcomes. The case studies could supplement the seven innovative services and strategies that were detailed in the LEP study and would add to OPA’s catalog of innovative language assistance services and strategies. Case studies could be shared with the grantee network and provide a valuable resource from which clinics could attempt to replicate the language assistance services and strategies.
6.3.2 Replicate Innovative Language Assistance Services and Practices

As technology develops, OPA should continue to identify innovative language assistance service models. In addition, case studies that detail a greater number of language assistance services also should be conducted to share information with the grantee network in order to have sufficient information to replicate promising practices around the country. For instance, OPA could provide grantees with technical assistance to implement model language assistance services or to build strategic partnerships within their community. Also, language assistance services should be evaluated by measuring observable outcomes (e.g., decreased response times for interpreters).

Clinic staff also mentioned the need for a standardized and validated translation methodology which could be used by Title X clinic staff to translate client education materials. There also is a need for national guidelines and standards for interpreter training and for assessing interpreter performance.
SECTION 7

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7. REFERENCES


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APPENDIX A

List of Family Planning Professionals Contacted
Appendix A

LIMITED ENGLISH PROFICIENCY AS A BARRIER TO FAMILY PLANNING SERVICES

LIST OF FAMILY PLANNING PROFESSIONALS CONTACTED

Janet Wildeboor
Regional Program Consultant, Region 10

Lucille Katz
Regional Program Consultant, Region 2

Nadine Simons
Regional Program Consultant, Region 9

April Pace
The Center for Health Training Regional Training Grantee, Region 10

Patricia Blackburn
The Center for Health Training
Regional Training Grantee, Region 9

Barbara Cicatelli
Cicatelli Associates, Inc.
Regional Training Grantee, Region 2

Ekem Merchant
Cicatelli Associates, Inc.
Regional Training Grantee, Region 2
APPENDIX B

Family Planning Professionals Interview Script
Appendix B

LIMITED ENGLISH PROFICIENCY AS A BARRIER TO FAMILY PLANNING SERVICES

FAMILY PLANNING PROFESSIONALS INTERVIEW SCRIPT

Interview No. ____________________________________________________________

Interview Date _________________________________________________________

Participant Name _______________________________________________________

Organization/Position ___________________________________________________

Phone Number ( ) ________________________________________________________

Hello, my name is O.E., I’m calling from COSMOS Corporation. Ms. Evelyn Kappeler from the Office of Population Affairs (OPA) suggested that I speak to you. We are currently conducting a study for OPA to assess the language assistance services offered in Title X family planning clinics. And, as a first step in our assessment, we want to ask family planning professionals, such as yourself, to recommend individuals that would be beneficial for us to interview.

Our goal is to interview 9 individuals with experience working with a number of clinics and maybe working in a number of Title X regions. They must be knowledgeable of innovative language assistance practices. These people will be asked to recommend clinics that we should consider visiting in order to document innovative services being offered. They will also be asked to help with the study design. Can you think of any regional program consultants or regional training staff that would be helpful for us to talk to? Remember, this is a national assessment, but we will only be visiting 7 clinics. From these 7 clinics, we will come up with a range of services, as well as provide a catalog of promising practices. So, we need to speak to people that have experience working with a number of clinics, that have seen a range of language assistance services, and maybe have experience working in a number of Title X regions. Anyone come to mind?

Thank you very much for your participation. You have been very helpful. We will be submitting a list of 9 individuals to the OPA for review and will contact them once they are reviewed by our task order officer. Thanks again for your help—have a great afternoon.

COSMOS Corporation, March 2003
APPENDIX C

Key Informant Interview Guide
Appendix C

LIMITED ENGLISH PROFICIENCY AS A BARRIER TO FAMILY PLANNING SERVICES

KEY INFORMANT INTERVIEW GUIDE

Interview No. 

Interview Date 

Participant Name 

Organization/Position 

Phone Number ( ) 

Introduction

Hello, my name is ________________, I am calling from COSMOS Corporation. We are presently conducting a study for the Department of Health and Human Services’s Office of Population Affairs regarding language assistance services offered by Title X family planning clinics. Based on your knowledge of Title X grantees across the country and delegates in your region, ________________ recommended that I speak to you about the study. Are you willing to participate in a brief interview? It will only take about 30 minutes, and all your answers will be kept confidential. Is this a good time for you?

Interviewer: note time and date to call back if not available.

Let me tell you a little more about the study. We are conducting an assessment of language assistance services offered by Title X funded family planning clinics. The study will provide a better understanding of the types and range of language assistance services provided in selected family planning clinics as well as identify barriers to accessing services for family planning clients. We will be visiting 7 clinics to get a sense of the range of services being offered by collecting information on clinic services and interviewing clinic staff. We will also be conducting four focus groups with clients from four of the seven clinics to discuss the perceived accessibility and effectiveness of various language assistance services.

As an initial step in our assessment, we are asking select individuals in the family planning field to serve as key informants to the study. I will be asking you specific
questions relating to the study design, specifically, questions regarding the Site Visit Protocol we are developing (e.g., the kind of questions to ask, the people to interview, and the documents to review). I also will be asking you to nominate specific sites where innovative language assistance services are being offered. And again, I would like to stress that this interview is strictly confidential, and that your help is essential for our investigation. The interview should take about 30 minutes to complete. Before we begin do you have any questions for me?

Questions:

I. First, I would like to ask you about current language assistance services being offered by family planning clinics.

1. What different types of language assistance services have you seen being implemented in the family planning clinics you are familiar with?
   a. Please describe the service as best as you can.
   b. Is there special training or certification involved?
   c. Do you know what the approximate cost for the training/certification is?

2. Would you consider any of these services innovative or promising, and if so, why?
   a. How can you tell the service is innovative or promising?

II. Second, I would like to ask you some questions about barriers clinics face, in providing language assistance services.

1. Have you ever observed any barriers, either policy or program related, which hinder the provision of language assistance services at any of the clinics you are familiar with?

2. At what level are these barriers present (at the grantee, delegate, or provider)?
   a. Is the barrier widely acknowledged or known to other people?

3. Have you witnessed any other types of barriers that clinics or clients face in providing or receiving language assistance services?
III. Now I need to ask you about the site visit protocol we will be using to guide the site visits.

1. What would you use as the criteria to select the seven clinics that will be visited? For example, knowledge of a promising practice, by geographical representation, by language representation, or by Title X region, and why?

   a. Do you think we need to include clinics located in rural areas, and why?

2. In order to obtain the most useful information during the site visits, we plan on interviewing clinic staff including: clinic administrators, practitioners, and clients. Is there anyone else we should be interviewing?

3. A Site Visit Protocol Instrument with specific topics of inquiry will be used to guide data collection during the site visit. Topics to be covered by the instrument include: demographic assessment of the clinic, written policies, staffing patterns, use of interpreter services, use of written translation, and quality monitoring and improvement. What do you think are the most important topics to cover?

   a. What topics would you add or delete from the instrument?

4. Reviewing clinic documents is an important part of the site visit data collection effort. What specific documents do you think are the most important to review?

5. An important component of the site visits includes the convening of focus groups with clinic clients. A Focus Group Discussion Guide will be used to lead the discussions. Topics of discussion included in the guide are: the difficulty of not knowing English in the United States, their first visit to the clinic, language assistance services found most useful, and services that have not worked well. What topics of discussion would you add or delete from the Guide?

IV. Finally, we would like you to recommend family planning clinics that you know have implemented innovative policies or practices that would be important for us to visit (up to 10 sites). Remember we want to visit clinics that have innovative language assistance practices and offer a wide range of language assistance services.

   1. Do you know what languages are served in the clinics you nominated?
   2. Do you know if the clinics you nominated are housed in a local health department, hospital, or are they self-standing?
   3. What clinics would you nominate that are located in a rural area, and why?
Interviewer: note of all relevant contact information including: clinic name, address, phone number, contact person, and other relevant information.

Debriefing

Thank you very much for participating in this interview. The information you have provided will be very useful to our study. We will make a final selection based on feedback provided by yourself and the other key informants. Do you have anything else to add, or do you have any questions? Again, thanks for your help.
APPENDIX D

Site Visit Protocol Instrument
Appendix D

LIMITED ENGLISH PROFICIENCY AS A BARRIER
TO FAMILY PLANNING SERVICES

SITE VISIT PROTOCOL INSTRUMENT

Topics of Inquiry for Site Visit Interviews

The topics of inquiry for the site visit interviews are divided into three sections, covering the contextual conditions, the definition of language assistance services, and the written policies and procedures that guide the services. The topics of inquiry are expressed as a series of questions. However, it should be noted that a protocol’s questions are directed at the investigator (site visit team) but also can be used with specific interviewees.

Contextual Conditions

1. **Demographic Profile of Population Served.** What languages other than English are served by the clinic? What is the race and ethnic composition of the clients? What is the total number of limited English proficient clients served? What is the education level of a typical clinic client? *Probe for any supporting documents (quarterly reports, annual reports, and advisory group documents).*

2. **Community Conditions.** Has the community experienced a recent influx of people that speak a language never before served by the clinic? Are the clients served by the clinic from rural or urban settings? Has the clinic ever established partnerships with community based organizations to aid in the provision of language assistance services? What methods are used by the clinic to determine the need for language assistance services for different languages? *Probe for any supporting documents (i.e., census figures, reports, tables, advisory group documents).*

Definition and Description of Language Assistance Services

3. **Language Assistance Service Implementation.** What type of interpreter services are available to clients (i.e., telephone interpreters, bilingual staff, dedicated on-site interpreters, contracted interpreters, volunteer interpreters)? What other type of language assistance services are available to clients? What were the decisions that facilitated the implementation of the different services? Was there a needs assessment conducted? Were
clients requesting assistance with new languages? What were the barriers that were overcome to implement the services? Were there any factors that facilitated the development of the services (i.e., assistance from the community, establishment of new partnerships with community based organizations, received technical assistance from the delegate, grantee, or the Office of Population Affairs)? Probe for a complete list and description of language assistance services provided.

4. **Language Assistance Service Effectiveness.** How effective are the language assistance services the clinic provides its clients? What is the estimated cost of each of the language assistance services? How useful are the language assistance services to the clients? Are language assistance services offered in all languages served by the clinic? Are services in a particular language not as effective as others? Probe for any client testimonials, specific examples of recognition of service effectiveness from a quarterly report or advisory group document.

5. **Language Assistance Service Quality Monitoring and Improvement.** How are staff that provide the language assistance services monitored (i.e., front-line personnel, interpreters, translators, bilingual providers)? Are there any services that can be improved or that can benefit from technical assistance or training? Probe for any supporting documentation (tables, reports, studies, or advisory group documents).

**Written Policies and Procedures**

6. **LEP Client Identification and Treatment.** What procedures are followed by staff for identifying a LEP client? Are there any procedures for introducing LEP clients to all services offered by the clinic (introductory counseling session, introductory video, or fotonovelas)? Are there any forms that must be completed by the client, are all those forms translated? What staff are responsible for identifying a LEP client? What procedures must be followed to request language assistance services for LEP clients? What procedures are followed to treat a LEP client during the different phases of a clinic visit (i.e., outreach, intake, treatment, and out-take)? Are there any procedures for describing consent forms and specialized consent forms to LEP clients (specialized consent forms include HIV testing consent forms or consent forms to administer emergency contraception or certain prescribed drugs)? Obtain copies of all relevant policies and procedures, including employee manuals, handbooks, the clinic’s organizational chart, and in-take and out-take forms.

7. **Translation and Interpreter Services.** Are there any procedures for interpreters? How are encounters between the clients and the interpreter and clinic staff scheduled? Document barriers to scheduling interpreting encounters. The language consultant should assess if the translated materials are of a good quality. Are the translations customized to
accommodate clients from different education levels? Are translated materials available for all languages served by the clinic? Are the translated materials customized for regional dialects within a language (i.e., Castilian Spanish and Spanish spoken in border towns)? Request samples of translated documents.

8. **Staff Recruiting, Hiring, and Evaluation.** What are the policies for recruiting bilingual staff, both clinical and non-clinical? How are bilingual staff (including interpreters) evaluated? What staff is tasked with evaluating a bilingual employee? What are the barriers to evaluating a bilingual staff person’s performance? *Probe for any documents describing the clinic’s recruiting and evaluation procedures.*
APPENDIX E

Focus Group Discussion Guide
Appendix E

LIMITED ENGLISH PROFICIENCY AS A BARRIER TO FAMILY PLANNING SERVICES

FOCUS GROUP DISCUSSION GUIDE

The topics of inquiry for the site visit focus groups are divided into three sections, covering the introduction and ground rules, defining language assistance services, and the usefulness of language assistance services. The topics of inquiry are expressed as a series of instructions for the focus group moderator and as possible leading and probe questions. It should be noted that a protocol’s questions are directed at the investigator (site visit team), but the questions also can be used like the focus group discussion guide.

Introduction and Ground Rules

1. Introduction. The moderator will provide participants a brief introduction into the study and clearly state the project team’s role in the proceedings. The moderator also will present the goals and expectations of the meeting, and introduce project team members and address confidentiality and anonymity issues.

2. Ground Rules. The moderator will cover ground rules set forth for each focus group, which include no interruptions, observance of courtesy, and that the active participation should occur between discussants and not the moderator or assistant moderator (i.e., the focus group should not result in a group interview between the participants and moderator but rather a discussion between the discussants).

Definition of Language Assistance Services

3. What Are Language Assistance Services. The moderator will briefly discuss the different types of language assistance services typically offered and describe in detail the services offered at the clinic. Have I included all of the services you have experienced at the clinic? Are there any services that you did not know were available?

4. Why Language Assistance Services Are Necessary. The moderator will briefly discuss some of the benefits of language assistance services (allow more people access to reproductive health services, ensure that effective communication is exchanged in order for proper diagnosis and treatment to occur). Can anyone think of other reasons that language assistance services are useful?
Experience with the Clinic’s Language Assistance Services

5. **Initial Visit To The Clinic.** The moderator will ask participants to describe the first time they visited the clinic. Did you know who to see and what to say in order to see a nurse or doctor? Did anyone find that it was difficult to understand what to do in order to see a doctor or nurse?

6. **Language Assistance Services Found Most Useful.** How did the staff help you understand who you needed to see and what services were available? What was the most useful service that helped you understand that you were in the right place for the medical attention you needed? Provide them with examples of services (translators helped you understand, the signs in your language, the translated materials in your language, the video in your language). Did the staff tell you the types of services that were available in the clinic? For those of you who have been going to the clinic for a long time, have the staff been adding different services? Do you like them, or are they better than before?

7. **Services That Have Not Worked Well.** Is there anything that you did not like? The moderator will have to probe with examples (e.g., the translators did not understand you; you did not understand the translated materials, the signs were confusing, etc.).

8. **Recommendations.** Is there any type of help that you would like to have the clinic offer? How would that help you and new visitors to the clinic understand and communicate better with the staff?
APPENDIX F

Description of Nominated Clinics, by Recommended Criteria
### Appendix F

**DESCRIPTION OF NOMINATED CLINICS, BY RECOMMENDED CRITERIA**

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Best Practice(s)</th>
<th>High LEP Growth Area</th>
<th>Multiple Languages</th>
<th>Reach*</th>
<th>Type**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tremont Center</td>
<td>All staff bilingual; language bank; strategic partnership with area hospitals which provide bilingual/bicultural providers</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>CBO</td>
</tr>
<tr>
<td>2. Accomac County Health Department</td>
<td>Rely on trained, volunteer interpreters and social workers for interpretation and translations</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>CHC</td>
</tr>
<tr>
<td>3. La Clinica del Pueblo</td>
<td>Off-site Interpreter program; network of certified medical interpreters and volunteer interpreters; bilingual staff and multilingual signs</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>PP</td>
</tr>
<tr>
<td>4. Loudoun Health District Clinic</td>
<td>All bilingual staff including physicians</td>
<td>Y</td>
<td>N</td>
<td>U</td>
<td>CHC</td>
</tr>
<tr>
<td>5. Mary’s Center for Maternal and Infant Childcare</td>
<td>All bilingual staff including physicians</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>PP</td>
</tr>
<tr>
<td>6. Thomas Jefferson University Clinic</td>
<td>Language specific health promotion events</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>7. Centro de Salud Clinic</td>
<td>Clinic design (highly visible and colorful, culturally appropriate building located next to other public services); bilingual staff and nurse practitioners</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>PP</td>
</tr>
<tr>
<td>8. Options in Reproductive Care</td>
<td>Signs in Hmong explaining in-take procedures; translated forms</td>
<td>N</td>
<td>N</td>
<td>U</td>
<td>FS</td>
</tr>
<tr>
<td>9. Southeastern Minnesota Community Action Clinic</td>
<td>All reproductive health literature in Hmong</td>
<td>N</td>
<td>N</td>
<td>U</td>
<td>CHC</td>
</tr>
<tr>
<td>10. Southeast Heights Clinic</td>
<td>Bilingual staff including physicians; exchange of translators from other clinics; share resources with university hospital</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>11. Stafford Clinic</td>
<td>Interpretation via teleconference, volunteer language hotline, language classes available to staff</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>12. Chinatown Public Health Center</td>
<td>All bilingual staff, including physicians</td>
<td>N</td>
<td>N</td>
<td>U</td>
<td>CHC</td>
</tr>
<tr>
<td>13. Communicare Health Center</td>
<td>Multilingual staff; multilingual signs</td>
<td>N</td>
<td>Y</td>
<td>U</td>
<td>CHC</td>
</tr>
<tr>
<td>14. Delta Health Care</td>
<td>Outreach materials for multiple Asian languages</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>FS</td>
</tr>
<tr>
<td>15. San Marcos Clinic</td>
<td>Mobile health van outreach program</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>CHC</td>
</tr>
<tr>
<td>16. Pediatric &amp; Family Medical Center</td>
<td>Comprehensive outreach program (vending trucks); bilingual staff</td>
<td>Y</td>
<td>N</td>
<td>U</td>
<td>FS</td>
</tr>
<tr>
<td>17. Valley Health Center at Lenzen</td>
<td>In-house network of certified medical telephone interpreters with a capacity of 23 languages; contract with agencies to control overflow; bilingual staff; dedicated medical interpreters for those that prefer face-to-face interpreters</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>H</td>
</tr>
<tr>
<td>18. Stanislaus County Health Services Agency</td>
<td>Actively recruit staff from within the community</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>CHC</td>
</tr>
<tr>
<td>19. Columbia Health Center</td>
<td>Centralized network of translators; dedicated and certified interpreters; contract with agencies to control overflow; bilingual and bicultural staff; centralized translation of documents; welcome videos at in-take</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>CHC</td>
</tr>
<tr>
<td>20. International District Clinic</td>
<td>Multilingual phone system with 18 language capacity, all bilingual staff including Hmong speaking doctor, conduct health promotion events in different languages</td>
<td>N</td>
<td>N</td>
<td>U</td>
<td>CHC</td>
</tr>
</tbody>
</table>

*Describes the clinic’s location (R=rural, U=urban)

**Refers to the clinic’s structural base or primary affiliation (CBO=community based organization, Hospital system=H, FS=free standing, U=University, CHC=county health center, PP=Planned Parenthood).
APPENDIX G

Selected Family Planning Clinics
# Appendix G

## SELECTED FAMILY PLANNING CLINICS

<table>
<thead>
<tr>
<th>No.</th>
<th>Clinic Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>MIC—Women’s Health Services</td>
<td>4006 Third Avenue, Bronx, NY 10457</td>
<td>(718) 294-5891</td>
</tr>
<tr>
<td>2.</td>
<td>La Clinica del Pueblo</td>
<td>1470 Irving Street, NW, Washington, DC 20010</td>
<td>(202) 462-4788</td>
</tr>
<tr>
<td>3.</td>
<td>Centro de Salud Clinic*</td>
<td>1921 Chicago Avenue, South, Minneapolis, MN 55404</td>
<td>(612) 813-8050</td>
</tr>
<tr>
<td>4.</td>
<td>University of Texas—MB*</td>
<td>Stafford Clinic, 2503 South Main, Stafford, TX 77477</td>
<td>(281) 499-3004</td>
</tr>
<tr>
<td>5.</td>
<td>North County Health Services</td>
<td>San Marcos Clinic, 150 Valpreda Road, San Marcos, CA 92069</td>
<td>(760) 736-6700</td>
</tr>
<tr>
<td>6.</td>
<td>Santa Clara Valley Health &amp; Hospital System*</td>
<td>Valley Health Center at Lenzen, Ambulatory and Community Health Services, Family Planning Services, 976 Lenzen Avenue, San Jose, CA 95126</td>
<td>(408) 299-6155</td>
</tr>
<tr>
<td>7.</td>
<td>Columbia Health Center*</td>
<td>4400 37th Avenue, South, Seattle, WA 98118</td>
<td>(206) 296-4650</td>
</tr>
<tr>
<td>8.</td>
<td>Southeast Heights Clinic/University of New Mexico Maternal and Infant Care Project*</td>
<td>7525 Zuni, SE, Albuquerque, NM 87108</td>
<td>(505) 272-2283</td>
</tr>
<tr>
<td>9.</td>
<td>Chinatown Public Health Center/H.C. #4</td>
<td>City and County of San Francisco, Department of Public Health, 1490 Mason Street, San Francisco, CA 94133</td>
<td>(415) 705-8500</td>
</tr>
<tr>
<td>10.</td>
<td>Pediatric &amp; Family Medical Center</td>
<td>1530 South Olive Street, Los Angeles, CA 90015</td>
<td>(213) 747-5542</td>
</tr>
</tbody>
</table>

*Alternates:*

<table>
<thead>
<tr>
<th>No.</th>
<th>Clinic Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Southeast Heights Clinic/University of New Mexico Maternal and Infant Care Project*</td>
<td>7525 Zuni, SE, Albuquerque, NM 87108</td>
<td>(505) 272-2283</td>
</tr>
<tr>
<td>9.</td>
<td>Chinatown Public Health Center/H.C. #4</td>
<td>City and County of San Francisco, Department of Public Health, 1490 Mason Street, San Francisco, CA 94133</td>
<td>(415) 705-8500</td>
</tr>
<tr>
<td>10.</td>
<td>Pediatric &amp; Family Medical Center</td>
<td>1530 South Olive Street, Los Angeles, CA 90015</td>
<td>(213) 747-5542</td>
</tr>
</tbody>
</table>

*The site visit will include a focus group with clients.*

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*COSMOS Corporation, March 2003*
APPENDIX H

Sample of Multilingual Signs
Appendix H

SAMPLE OF MULTILINGUAL SIGNS

<table>
<thead>
<tr>
<th>Language</th>
<th>Sign Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>ترجمة للغة العربية</td>
</tr>
<tr>
<td>Chinese</td>
<td>翻译</td>
</tr>
<tr>
<td>Danish</td>
<td>Traduction</td>
</tr>
<tr>
<td>English</td>
<td>Interpretation Service Available</td>
</tr>
<tr>
<td>French</td>
<td>Interprète disponible</td>
</tr>
<tr>
<td>German</td>
<td>Interpretation Service Available</td>
</tr>
<tr>
<td>Hindi</td>
<td>अनुवाद</td>
</tr>
<tr>
<td>Hungarian</td>
<td>fordítás</td>
</tr>
<tr>
<td>Italian</td>
<td>Traduzione</td>
</tr>
<tr>
<td>Japanese</td>
<td>翻訳</td>
</tr>
<tr>
<td>Lithuanian</td>
<td>Įvertinimas</td>
</tr>
<tr>
<td>Polish</td>
<td>Interpretacja</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Interpretação</td>
</tr>
<tr>
<td>Russian</td>
<td>Перевод</td>
</tr>
<tr>
<td>Spanish</td>
<td>Traducción</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Tạm dịch</td>
</tr>
</tbody>
</table>

¿NECESITA UN INTERPRETE?
El Hospital ofrece un servicio de intérpretes GRATUITO. Para más información llame al 272-2328 y con gusto le atendemos.

CÁN THÔNG DỊCH VIỆN?
Bệnh viện có thông dịch viên miễn phí. Để biết thêm chi tiết, xin gọi số 272-2328.