# MAKING THE BUSINESS CASE FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE:

# CASE STUDIES FROM THE FIELD

Alliance of Community Health Plans Foundation

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# PREFACE

Today there are more than 300 languages that are spoken in the United States. The changing demographics of the country as well as federal and state policies have increased the need for effective and efficient business models that address culturally and linguistically appropriate health services for individuals with limited English proficiency (LEP). In 2000, based on Title VI of the Civil Rights Act, and Presidential Executive Order 13166[1], the Office of Minority Health (OMH) published the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.* These standards have become the clearest, most thorough statement of policy regarding CLAS and they guide health care organizations in addressing the cultural and language needs of the patients they serve. In addition to these recommended service standards, there are intuitively clear quality and efficiency reasons to assure an environment of culturally competent health care that can ultimately contribute to the reduction of racial and ethnic disparities in the health of people living in the United States.

Although there is a moral imperative and a framework of legal and regulatory requirements for addressing the cultural and linguistic needs of LEP patients, health care organizations are at different stages of familiarity and comfort with cultural competency in their work, and many health care organizations are new to the notion of developing programs to address these equity issues. A number of obstacles need to be overcome before health care organizations can develop and operationalize approaches to address the linguistic and cultural needs of their LEP patients. One of the most frequently cited impediments to progress is the reluctance to implement projects that often come with developmental and operational costs, while also having an uncertain business benefit for the implementing organization. Of course, many health care organizations have a rich history of meeting the cultural and linguistic needs of diverse patient populations. However, the lack of even modest information about the business benefits that have been achieved by health care organizations implementing CLAS-related projects has made it difficult for health care organizations that are new to these issues to push through this barrier to culturally competent care.

The Alliance of Community Health Plans Foundation, with funding from the Merck Company Foundation, developed 13 individual case studies and a final report about the "business case" for projects that address one or more of the National CLAS Standards. This report provides some much needed information about business benefits that have been achieved by different types of health care organizations that have addressed one or more aspects of the cultural and linguistic needs of patients. Clearly, there are many creative cost-saving and cost-avoiding approaches to cultural competence that have been quite successful.

We at OMH are pleased to see this information made available, and we hope it will be useful to health care organizations that are struggling to develop and implement projects that address the CLAS Standards.

*Guadalupe Pacheco*
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U.S. Department of Health and Human Services

[1] Civil Rights Forum, Volume 14, Number 3; http://www.usdoj.gov/crt/cor/Pubs/forum/00fall.htm

# EXECUTIVE SUMMARY

With funding from the Merck Company Foundation, the Alliance of Community Health Plans Foundation has identified business benefits achieved by health care organizations implementing one or more of the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care* published in 2000 by the U.S. Department of Health and Human Services, Office of Minority Health (OMH).[2] Government agencies including OMH, the Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ) have pointed out that implementing the CLAS Standards can have benefits in many different areas such as equity, efficiency, quality and reduction of medical errors.

## Overview of Benefits Achieved

The thirteen examples described in this report reflect several different CLAS-related projects implemented by diverse health care organizations that range in size from large integrated health care delivery systems to small satellite community clinics. The implementing organizations point to a range of business successes from these projects. Additional detail on these projects is found in appendices A – M of this report beginning on page 31.

**Increased market share among limited English proficient patients.** Health care organizations implementing CLAS standards have achieved increases in enrollment and patient services among the insured. Cultural competency attracts business.

- ***The Young Children's Health Center (YCHC)*** in Albuquerque, New Mexico created a program to address the communication needs of deaf children and their families who were being treated at YCHC. The program started with 5 children and because it was successful in bridging the communication barrier for hearing impaired children and families, YCHC has become the provider of choice for this population and has increased its insured patient volume from 5 to 70.
- As a part of its commitment to growth overall and also to meeting the cultural needs of a large population of Latina women and their families, ***Holy Cross Hospital*** in Silver Spring, Maryland created 68 individual maternity suites. With a substantial cultural competency component in their design, the maternity suites are also a very attractive care option for everyone. The maternity suites opened in fiscal 2004 and since that time deliveries increased from 7,300 to 9,300 annually.

**Substantial reductions in outsourced language interpretation services and subsequent savings in related costs.** Many health care organizations that address the threshold issue of language services have found very efficient ways to make better use of their own bilingual staff or volunteers, thereby reducing substantial costs of outsourcing interpretation services.

- ***Contra Costa Health Services*** was able to reduce its per minute interpretation costs from $1.69 per minute for contracted services to $.75 per minute through a project with remote video interpretation.
- ***LA Care*** created an alternative approach to interpretation services through which providers and patients access language services via telephonic dual headsets or handsets. The project reduced L.A. Care's reliance on expensive contract interpretation services, reduced the

[2] National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. www.omhrc.gov/assets/pdf/checked/finalreport.pdf

reliance on friends and family members for interpretation, as well as decreasing the use of gesturing and other ineffective communication methods.

- ***Holy Cross Hospital*** uses 175 employee volunteers who speak 60 different languages to provide interpretation services for patients, families, physicians and staff employees. The program achieved significant cost savings by avoiding additional costs for contract interpretation services ranging from $320,000 to $190,000 depending on the circumstances.
- ***The Young Children's Health Center (YCHC)*** estimates that trained in-house staff interpreters have saved the organization more than $50,000 in interpretation costs after adjusting for salary increases.

**Increased patient and provider satisfaction**. A number of health care organizations indicate that projects designed to implement any of the CLAS Standards have improved patient and provider satisfaction with the health care process.

- **Kaiser Permanente** found that in addition to creating a large cohort of trained interpreters, one of the benefits of their Health Care Interpreter Certificate Program was that providers preferred the trained interpreters as opposed to family members or bilingual staff.
- A recent survey of site users of ***UCare of Minnesota's*** Multilingual Health Resource Exchange Program shows that 85.5% found the translated material they were looking for and 98.8% of those surveyed felt that the Exchange site is easy to use.

**More efficient use of staff time by reducing communication delays between patients and providers**. Simply by addressing language issues, providers, provider office staff and patients enjoy reduced delays and a more efficient health care interaction.

- ***Contra Costa Health Services***' Remote Video/Voice Medical Interpretation Project has increased the overall effectiveness and improved the process for interpretation services—now serving 25-30 patients per day as opposed to the 10-15 patients under the old system—at considerable cost savings.
- At ***The Young Children's Health Center (YCHC)*** using trained in-house staff for interpretation has resulted in improvements in the scheduling and process of interpretation. Delays associated with waiting for an interpreter have been largely eliminated.

**Cost-savings resulting from shorter hospital stays and more prompt and efficient patient discharges.** Efficient and culturally competent solutions to providing discharge instructions and education in a language other than English have resulted in improvements in hospital-wide discharge practices and have yielded significant savings.

- By creating group discharge classes for its large Latina population in the private birthing suites, ***Holy Cross Hospital*** has been able to reduce the wait time for an interpreter and as a result has improved the discharge process. Through this program, the hospital has the capacity to discharge an additional 265 women annually. In addition, because of the group dynamic the discharge classes are often more informative and thorough than individual discharges.
- As a result of ***Molina Health Care's*** TeleSalud project, emergency room usage for Spanish-speaking enrollees who had access to TeleSalud from January 1, 2004 through December 31, 2004 was substantially lower—191 visits per member year per 1000 enrollees compared to 217 for those without access; resulting in a use rate for TeleSalud at only 88 percent of the rate for those without such access.

## Major Themes

- ***Minority and LEP Consumers are a Business Market.*** As the US population changes and the LEP population increases, successful health care organizations must develop business strategies to address the needs of these populations. This will become increasingly true as we approach 2050 when the census predictions project that the percentage of minority populations will equal or exceed the percentage of what are now non-minority populations.
- ***Cost-effective Spending Leads to Subsequent Savings.*** Implementing CLAS projects can be cost effective for health care organizations.
- ***Government Requirements Compel Organizations to Take on CLAS.*** Title VI of the Civil Rights Act and the CLAS Standards are required for equity in health care.
- ***CLAS is the Right Thing to Do*.** Many organizations that have engaged in or implemented CLAS standards, as described throughout this report, are doing so because they believe it is the right thing to do, and not because they are required to do so by law or regulation. Organizations with a history of meeting the needs of diverse patient populations view their role in addressing the needs of all patients they serve as an important part of their organizational culture.

## Key Findings and Lessons Learned

This report documents seven key findings and lessons learned on the best ways to implement CLAS in a variety of health care settings. These include:

- ***Linguistically appropriate services may be the first logical step for successful implementation of the CLAS standards;***
- ***Barriers to CLAS implementation (real and perceived) need to be identified and overcome;***
- ***Workforce and bilingual employee development is key to implementing CLAS;***
- ***Exploration and integration of community partnerships and resources is important for successful CLAS interventions;***
- ***Technology can be useful in supporting a system for serving LEP populations;***
- ***Performance measurement should be a component of any CLAS project plan, and***
- ***There are many existing resources that provide information on how to implement CLAS in health care settings.***

Subsequent to the release of the CLAS standards, the number of health care organizations across the country that have voluntarily implemented projects and initiatives aimed at complying with the CLAS standards has grown. Many organizations, including those highlighted in this report, have for years prior to publication of the CLAS standards strived to provide culturally competent care.[3] The foresight and commitment of senior leaders responding to changing U.S. demographics led these organizations to alter the way they provide health care to people outside the majority culture, including those with language barriers.

[3] Cultural and Linguistic Competence in Health - a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Office on Minority Health. http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=11

## Project Goals and Components

The CLAS Standards provide a practical framework and guidance for health care organizations and patient services. Substantial progress has been made in institutionalizing the CLAS Standards, and much more needs to be done. This report was designed to create an information base on CLAS business successes for use by organizations considering implementation of CLAS initiatives.

## Overview of this Report

This report includes background information on the CLAS standards, including the events leading up to their development. Also included are the 14 CLAS standards and some additional resources for promoting the integration of CLAS into health care systems. The state of CLAS in health care is addressed, and the report explains the origins of the case study work described. Following this introductory material are the business cases and a description of cases arranged by CLAS standard. Discussion of the major themes, key findings, lessons learned and recommendations follow the case presentations. A full narrative description of each documented case study is included in the appendices.

Finally, supporting materials are located in the appendices including report references and information on project methodology, and CLAS resources.

We hope that the information contained in this report will support health care organizations in making the case to administrators, providers and others within their organizations that CLAS is an important feature of health care services and administration, particularly in light of rapidly changing US demographics.

# INTRODUCTION

**Highlights:**

- **Overview of U.S. demographic changes and implications for health care organizations;**
- **A brief description of how the government identified CLAS as a priority, and how this was translated into a series of 14 standards for health care organizations;**
- **An explanation of the state of CLAS in health care; and**
- **Information about the origin and goals of this business case study project.**

The U.S. Census has shown a consistent increase in immigrants and LEP populations in the past 20 years, and experts forecast a dramatic increase in these populations over the next 20-40 years. Census experts estimate that by 2050 the proportion of "minorities" in the U.S. will approach and perhaps exceed 50 percent. The rapid increase in population diversity brings with it both opportunities and challenges for health care organizations. For example, the numbers of racial and ethnic minorities, immigrants and LEP populations enrolled in U.S. health plans has increased.[4] The fact that health plans have increased enrollment among LEP populations brings with it a responsibility to meet the language and cultural needs of these new patients.

**Government Activity Supporting CLAS in Health Care**

The Office of Minority Health (OMH), U.S. Department of Health and Human Services, was mandated in 1994 by the United States Congress (P.L. 101-527) [5] to develop the capacity of health care professionals to address cultural and linguistic barriers to health care delivery and increase access to health care for people with limited or no English proficiency. In 1998, the U. S. Department of Health and Human Services reinforced its commitment to health care for all by establishing a Healthy People 2010 objective to eliminate health disparities among racial and ethnic populations in America.[6]

Subsequently, OMH in 2000 published the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.* The document included a set of national standards spelling out legal and regulatory requirements for the provision of health services to individuals with limited English proficiency. [1] The report outlined 14 voluntary CLAS standards organized by three themes: culturally competent care (Standards 1-3); language access services (Standards 4-7) and organizational supports for cultural competence (Standards 8-14). See page 11 for a list of the CLAS standards. The standards were established to systematically change and advance access and provision of health care services for minority and non-English proficient populations. The goals of the CLAS standards are to improve the health of all Americans by aiming to eliminate racial and ethnic health disparities, address the inequalities that currently persist in health care, and to make health care programming more adaptable to the needs of the individual patient.

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[4] *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans*. Summary. February 2003. Agency for Healthcare Research and Quality, Rockville, MD.

[5] About the Center of Cultural and Linguistic Competence in Health Care; http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=16

[6] *Healthy People 2010*; http://www.healthypeople.gov/

**The State of CLAS in Health Care**
In response to publication of the CLAS standards, a number of public and private organizations have adopted the standards and conducted studies on culturally competent care, language access services and organizational supports for cultural and linguistic competence. The vast majority of these activities have focused on language access.

Peer-reviewed health studies have documented that communication with physicians presents a problem for one in five Americans receiving health care. The percentages among non-American-born or LEP patients are even higher (27 percent for Asian Americans and 33 percent among Hispanics).[7] Interpreter service activities have been given attention since 2000 and have been consistently documented to promote CLAS standards in health care. This is evident from training initiatives and publication manuals for interpretation services, including:

- A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations[8];
- Guides to assist managed care plans in planning and providing culturally and linguistically appropriate care;
- Functional Manual for Providing Linguistically Competent Health Care Services as Developed by a Community Health Center[9];
- Best practice recommendations for hospital-based interpreter services;
- A health plan report card for minority populations;
- National Health Law Program (NHeLP) description of language interpretation services in healthcare settings.[10]

In addition to these initiatives, many states have also made CLAS a requirement for health care organizations that wish to provide care to publicly supported beneficiaries.

Progress has been made in implementing CLAS in America; however, much of the work is still in the early stages. Although language services are the most common focus of CLAS standard implementation, wider success in reducing health disparities and providing care for LEP and minority populations will require both linguistic programming as well as broad cultural competency programming.

**Importance of the Business Case for CLAS**
As part of an effort to provide technical assistance to (then) Medicare+Choice Organizations (M+COs), the Centers for Medicare and Medicaid Services (CMS) in 2002, in conjunction with the School of Public Health at the University of North Carolina at Chapel Hill, sponsored a national conference on "Best Practices in Culturally and Linguistically Appropriate Services in Managed Care." The Agency for Healthcare Research and Quality

[7] Minority Americans Lag Behind Whites On Nearly Every Measure Of Health Care Quality. Commonwealth Fund. 2002 http://www.cmwf.org/newsroom/newsroom_show.htm?doc_id=223608
[8] A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations. Office on Minority Health. www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf
[9] Functional Manual for Providing Linguistically Competent Health Care Services as Developed by A Community Health Center The Association of Asian Pacific Community Health Organizations (AAPCHO) and the Asian Pacific Health Care
http://www.aapcho.org/altruesite/files/aapcho/Publications_FactSheets/LEPManual.pdf
[10] Language Access Kit. http://www.cmwf.org/usr_doc/LEP_actionkit_reprint_0204.pdf

(AHRQ) and CMS earlier contracted with Lovelace Clinic Foundation to develop two comprehensive guides for M+COs to use in the implementation of CLAS activities. Following the national conference, CMS sponsored a series of workshops designed to "teach the guides" to M+COs. The OMH and the Robert Wood Johnson Foundation (RWJF) also provided funding support for the workshops, which were conducted between March and November 2003, in Philadelphia, Chicago, San Francisco, Orlando, and Albuquerque.

The workshop series was designed to provide support to plans from all regions of the country and proved successful in further promotion of CLAS in M+COs. Many other health care organizations—hospitals, managed care companies, state and local health departments and other government agencies, non-governmental organizations and advocacy groups, translation companies and others involved in language services -- participated in the workshops as well. Participant evaluations suggested that the guides developed by the Lovelace Clinic Foundation were useful tools for assisting and supporting CLAS efforts.

Several major issues of interest emerged from discussions and evaluations of the workshops, including:

- Organizations need more guidance in data collection requirements and methods
- More sharing of best practices and resources would be helpful
- Finding and using web-based information about CLAS or disparities in health care can help organizations prioritize initiatives
- Organizations need additional documentation about the "business case" for CLAS

Little information - even anecdotal - is available to support the business case for CLAS. Health care organizations need more information about how CLAS activities relate to and affect organizational goals and objectives. Also many CLAS advocates say they support CLAS not just because the standards are requirements, but because they believe adherence to the CLAS standards is the right thing to do and that by doing so they may reduce disparities in access to care and improve health outcomes among minority populations. There is consensus among CLAS advocates that more empirical data are needed to document and support claims of successes.

# NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE

### Culturally Competent Care (Standards 1-3)

**Standard 1.** Health care organizations should ensure that patients/consumers receive from all staff members' effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

**Standard 2.** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

**Standard 3.** Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

### Language Access Services (Standards 4-7)

**Standard 4.** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

**Standard 5.** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

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

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

### Organizational Supports for Cultural Competence (Standards 8-14)

**Standard 8.** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

**Standard 9.** Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

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

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

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

**Standard 13.** Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

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

# THE BUSINESS CASE FOR IMPLEMENTING CLAS

**CLAS Projects Components and Distribution**
The ACHP Foundation in 2005 launched an extensive search documenting examples of organizations that have implemented programs addressing CLAS standards. ACHP has reported findings from 13 projects supporting the business case for CLAS. These projects represent a variety of health care settings. (See *Appendix O* for more details on methodology.)

The organizations interviewed for this project repeatedly noted that it takes time to implement and develop CLAS projects, and that it is important to think creatively and "out of the box" to be effective while managing costs. The projects described in this report are not necessarily extensive or expensive; however, they represent creative thinking, use of strategic partnerships and effective methods of providing CLAS services while attending to business needs. These examples may be models for other health care organizations.

Case studies highlighted address the three themes of the14 CLAS standards: Culturally Competent Care; Language Access Services and Organizational Supports for Cultural Competence. The majority of projects address Language Access Services standards.

Cultural competency is a broadly defined term (See *Appendix* N) that may not be viewed by all health care organizations as something as directly relevant to the provider/patient relationship as, for example, language or interpretation services. However, it makes sense that a health care organization cannot be culturally competent if it cannot assure that providers and patients can communicate and understand one another. As a result, much of the national CLAS effort to date has been focused on language access. Although the organizations involved in this study are involved in activities beyond language services, organization's have found it easier to document the benefits of language services than to document and measure the business benefits of other activities. Also, some of the projects described in this report are sufficiently broad to encompass more than one area of the CLAS Standards.

- **Culturally Competent Care**

The notion of cultural competence has been promoted for many years as the way for health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs of patients. Health care organizations with heavy demands for services from minority or LEP patients require business strategies to ensure their LEP patients receive quality care, have positive experiences and encounters with the staff, and receive care that is compatible with their culture and beliefs.

*Holy Cross Hospital (Silver Spring, MD)*
The *Family Centered Maternity Suites* project at Holy Cross Hospital is a classic example of effective CLAS initiatives that have been implemented to ensure culturally competent care, and that have produced business benefits for the implementing organization. Holy Cross Hospital delivers 9,000 babies annually, 27 percent (approximately 2,430) of whom are born to mothers who speak a language other than English. Holy Cross Hospital recognized the need to accommodate "family involvement" in the birth experience among many of the

hospital's culturally diverse patient populations. This realization and commitment to cultural competency led to the development of a master facility plan that called for 68 private maternity suites to serve a diverse population of women and their families. However, what was targeted to promote culturally competent care for minority populations was also an attractive option for the full range of patients who give birth at Holy Cross. Growth in obstetrics volume among all patients who come to Holy Cross led to overall volume growth and improved financial performance for the hospital.

- **Language Access Services**

Language services are the front line of CLAS. Language barriers, in the absence of adequate interpretation and lack of translated patient information and materials, preclude the provision of equitable, quality health care. Language interpretation errors between health care providers and LEP patients have resulted in dangerous and costly consequences. CLAS Standards 4 through 7 outlines the linguistically appropriate services for health care organizations serving patients with limited English proficiency.

As is the case nationally, the CLAS projects included in this report use a variety of approaches to assure adequate language services. Perhaps because there are many more language services initiatives from which to choose, it was easier to find these cases, describe them, and present more robust documentation about their successes. Finding ways to provide appropriate and thorough language services while simultaneously managing the costs of those services is a common theme. The business cases for Contra Costa (*Remote Video/Voice Medical Interpretation Project*), Holy Cross Hospital (*Volunteer Interpretation Project and Group Discharge Classes in Spanish*), L.A. Care Health Plan (*Health Care Interpretation Project*), and The Young Children's Health Center (*Bilingual Employee Incentive Program*) all provide examples of how the implementation of language access services resulted in quantitative and qualitative business benefits and outcomes.

*Contra Costa Health Services (Martinez, CA)*
Before 2005, Contra Costa Health Services relied on 16 full-time bilingual employees and one full-time supervisor to provide language interpretation services throughout its health care system. To meet the language interpretation needs of the service population, Contra Costa Health Services also contracted with two major language services agencies at an annual cost of over $200,000 and rising. In an attempt to manage these language costs better and to assure culturally competent care for the limited English proficient (LEP) population at multiple sites on a 24 hour basis, Contra Costa Health Services partnered with three Northern California county hospitals (Contra Costa, San Mateo, and San Joaquin) in the creation of the Health Care Interpreter Network (HCIN). The network developed the remote video/voice medical interpretation (RVVMI) project to provide language translation services to patients at their bedside. The RVVMI is a model of shared interpreter services utilizing the most advanced video and voice-over internet protocol (IP) technologies to complement in-person interpretation. Contra Costa Health Services sought to integrate the remote video/voice call center systems throughout its organization and to provide the lowest-cost, highest quality interpretation services at all Contra Costa Health Services care venues.

The project's initial price for the exchange of language service among the tri-partnership was $.75 cents per minute as compared to Contra Costa's previous pricing for contract interpretation services at a rate of $1.55 per minute (cost savings of $0.80 per minute). In

early 2006, Contra Costa assessed the cost value of RVVMI and launched a 10-week pilot test for Spanish speaking patients that achieved an immediate cost savings in contracted interpretation services of over $25,000. The RVVMI project has increased the number of interpretations per day from the previous 10-15 in-person interpretations to as many as 30 remote interpretations per day.

*Holy Cross Hospital (Silver Spring, MD)*
In 2001, Holy Cross Hospital established the *Volunteer Interpretation Project* which coordinates hospital interpretation services by 175 staff volunteers who speak more than 60 languages. These staff volunteers report 10,000-12,000 in-person interpretations annually, ten times the number of telephone interpretations purchased from an outside vendor. The staff interpretations are typically twice as long as telephone interpretations purchased from the vendor. Without the staff volunteers, all interpretation interactions would become contracted telephone interpretation services which now average 20 minutes in length, and the cost to the hospital would be $320,000; if the same calls were kept to the average 12-minutes in length (for the previous telephonic tool used), the cost for contracted telephone interpretations would be $190,000.

*L.A. Care Health Plan (Los Angeles, CA)*
L.A. Care Health Plan has also undertaken a number of initiatives that center around language translation, one of which is the *Traditional Safety Net Telephonic Interpretation Project*—a technology "toolbox" to eliminate language barriers and assist providers in communicating face-to-face with patients who have limited English proficiency, using an over-the-phone interpreter and a dual head set. The pilot project received high marks from both patients and their doctors. The cost to L.A. Care for the interpretation services during the three month pilot test was $939—for the use of telephonic interpretation services used by the three (3) pilot sites participating in the study. The immediate availability of telephonic interpretation services provides a necessary resource for patients who need services in languages that bilingual staff are not available to support. In the cases where on-site interpretation is not available, telephonic interpretation services provides one solution to immediately address a need. In addition, the ease of implementation and the effectiveness of the process have resulted in an increase in use of interpreter services by providers.

L.A. Care also implemented the *Health Care Interpretation Project* and trained approximately 246 health care providers in 2004 and 270 in 2005. With the hiring of one-FTE ($74,480.00) to provide interpretation training of staff in 2004-2005, L.A. Care produced an annual cost savings of $183,500 (the average yearly expenditure prior to hiring the FTE was $258,000.)

*Molina Healthcare, Inc. (Long Beach, CA)*
The *TeleSalud* project was established in 2004 as a separate department within Molina Healthcare of California offering direct accessibility for medical interpretation services to address the health and language needs of the underserved limited English proficient (LEP) Latino population living in the Inland Empire region of Southern California. The project was conceived to provide Molina's members with service in their declared language of preference with 24-hour live and direct access to a Registered Nurse for nurse advice and interpretation assistance. Molina Healthcare implemented the *TeleSalud* project using a two-tiered model with non-clinical staff receiving the intake calls and registered nurses receiving calls

requiring interpretation, clinical assessment or intervention. The two-tiered model provides direct, live access at the point of entry into the health plan.

Based on data collected during December 2004 through February 2005, Molina's *TeleSalud* program produced a cost-savings of $2,448 per month during the pilot phase, totaling an extrapolated annual cost-savings of $29,000. Expansion of the program to cover all of Molina's members in all states yielded a savings ranging from $0.14 to $1.35 per member per year in calendar year 2005-2006, totaling over $750,000 cost-savings. The state with the greatest savings was California, the state with the greatest percentage of Spanish-speaking members. In addition to the fiscal savings, the project's other gains, although less quantifiable, are just as valuable. The *TeleSalud* project has provided other departments in the Molina system numerous value-added services, to include a substantial increase in bilingual capacity for nurse advice services; as a result of TeleSalud the staff is now 100% bilingual in Spanish.

*UCare Minnesota (Minneapolis, MN)*
UCare Minnesota is an independent, nonprofit, local health plan that provides nearly 140,000 Minnesotans with the health coverage plans and services they need to maintain and improve their health. As Minnesota's population increasingly becomes increasingly diverse, so do the information needs of their health care consumers. Production and distribution of materials in the most common of the 124 languages now spoken in Minnesota represents a significant expense, as well as a technical challenge for any one health plan or facility. As a result UCare collaboratively established the Multilingual Health Resource Exchange (Exchange), a web-based clearinghouse for health consumer materials specifically developed for Limited English Proficient (LEP) patients. In order to improve access to health information for LEP members, UCare collaborated with over a dozen other Minnesota health care organizations (including other health plans such as HealthPartners, Blue Cross Blue Shield of Minnesota, and Medica) that contribute annual funding to support a web-based clearinghouse of health resources in multiple languages and make the clearinghouse resources easily accessible to health care providers serving LEP patients.

Exchange partner organizations pay $2,500/organization each year to support the web-based clearinghouse with over 1,600 materials in it. A conservative estimate is that it costs $300 to produce language-specific versions of each material, equally a value of $480,000 roughly to the current Exchange collection of materials. Some of these materials are public domain and available at no cost but many providers do not have the time to explore the internet to find the health topics they need in the languages required by their LEP patients.

- **Organizational Supports for Cultural Competence**

Eliminating health disparities through successful CLAS interventions can be complex and require a self-assessment for CLAS readiness, a strategic plan that includes data collection and long-term partnerships utilizing existing community resources. Faced with increasing language services demands, and in the absence of adequate numbers of on-site qualified health care interpreters, health care organizations are beginning to turn to their own diverse work force for a partial solution. Kaiser Permanente has responded to this situation with a number of initiatives that promote culturally competent care, improve health outcomes, and eliminate health care disparities, including the design and implementation of the *Health Care Interpreter Certificate Program,* and *the Qualified Bilingual Staff (QBS) Model*. The Young

Children's Health Center created a *Bilingual Employee Incentive Program* that credentials and provides salary incentives for existing staff with bilingual proficiency, and a *Bilingual Deaf Access Program* that provides culturally competent outreach services through local partnerships.

*Kaiser Permanente (Oakland, CA) —Health Care Interpreter Certificate Program*
In 1996, Kaiser Permanente in 1996 established the *Health Care Interpreter (HCI) Certificate Program*, a college-level training program designed to provide quality accreditation standards for its providers serving members and patients with limited English proficiency. Recognizing the lack of formally trained health care interpreters, related training programs, and certification standards, Kaiser Permanente designed a model HCI curriculum, in collaboration with the City College of San Francisco (CCSF). The curriculum successfully became a formal 15-credit Health Care Interpreter Certificate Program (HCICP) in 2000, making CCSF the first educational institution in the Western United States to offer health care interpretation training at the college-level. The project results and benefits include the establishment of six internship programs at Kaiser Permanente facilities and hospitals; a partnership with the *Hablamos Juntos*[11] project and the Robert Wood Johnson Foundation to establish 10 additional program sites throughout the country; more than 100 college instructors and staff at Kaiser Permanente's HCI Instructor Institute; and increased patient satisfaction. Based on a Kaiser Permanente research study, providers who used the trained HCIs overwhelmingly prefer them over untrained HCI family members or bilingual staff. The same study shows that patients are able to differentiate trained versus untrained HCIs, and favor trained HCI significantly.

*Kaiser Permanente (Oakland, CA) —Qualified Bilingual Staff Model*
In addition, Kaiser Permanente developed the *Qualified Bilingual Staff Model,* a workforce diversity and development program designed to offer its providers ongoing education and training in culturally and linguistically appropriate service delivery. Kaiser Permanente uses internal resources, trainers, and staff without reliance on external consultants or funding. The CLAS Standards are also incorporated into organizational policy and procedures. The Qualified Bilingual Staff Model is a truly innovative approach and cutting edge solution that leverages the linguistic diversity of the Kaiser Permanente work force by integrating staff development into the day-to-day operations of the Kaiser Permanente health delivery system. Kaiser Permanente is in the process of identifying real cost savings associated with using existing staff to perform interpretation. Other business benefits include increased cultural and linguistic capacity for bilingual (Spanish, Chinese, Vietnamese, Russian, American Sign Language, Tagalog, Hmong, and Punjabi) speaking staff, strategic partnerships with four main labor unions and over a few thousand health professionals trained in Northern California and Mid-Atlantic states and Georgia.

*The Young Children's Health Center (Albuquerque, NM) —Bilingual Employee Incentive Program*
The Young Children's Health Center in New Mexico, Satellite Pediatric Practice Clinic for LEP, serves a primarily Spanish speaking population (>85%). Nearly 50% of this population is monolingual Spanish. In lieu of paying outside contracting interpreters, UNM has developed the *Bilingual Employee Incentive Program,* a staff incentive project to encourage employees to become certified interpreters. The project provides staff members a salary increase as incentive for program participation in exchange for their interpretation skills. This

[11] *Hablamos Juntos*. www.hablamosjuntos.org

has resulted in an average annual cost savings of $50,000. The Young Children's Health Center has also seen an increase in their patient services among new immigrants by word of mouth referrals.

*The Young Children's Health Center (Albuquerque, NM) —Deaf Access Program*
The Young Children's Health Center in New Mexico also developed the *Bilingual Deaf Access Program*, providing medical and sign-language services to LEP in Spanish and creating a relationship with the language department at a local university to provide a new business market to serve deaf children and children with deaf parents. The project began with five young deaf patients and now provides culturally competent health care to over 70 deaf and special health care needs patients and has decreased the number of inappropriate hospital emergency room visits among LEP deaf patients.

# CLAS BUSINESS CASE PROJECTS AND RESULTS

**The following table summarizes CLAS business cases in this report. The table provides:**

- **A brief description of each project;**
- **The organizational setting in which it was conducted; and**
- **Business benefits and other project successes**

**An explanation of cases and related CLAS Standards was provided earlier in this report. Case studies are included in *Appendix A-M*.**

**Summary CLAS Business Case Projects**

| Project | Organizational Setting | CLAS Activity Implemented | Benefits & Results |
|---|---|---|---|
| ***Bilingual Deaf Access Project***<br>**The Young Children's Health Center, Albuquerque, NM.** | Community-based, pediatric medical center, part of Children's Hospital of New Mexico (part of the University of New Mexico Hospital System) that provides comprehensive health services to families with children from birth to young adulthood. The clinic is located in a relatively isolated, impoverished area populated by individuals of many different cultures and ethnicities and is the primary location for child health care. | Established a partnership with the University of New Mexico Department of Language, to provide bilingual and bicultural health care services in Mexican sign language to deaf children and families who are non-English speaking. | • Early identification and access to health care services for children with special needs.<br>• Increased its deaf outreach services from 5 patients to over 70 patients, in two years, all of whom have some form of health care coverage.<br>• Decreased the number of inappropriate hospital emergency room visits among LEP and deaf patients.<br>• Provider of choice for deaf and hard of hearing children and families in New Mexico. |
| ***Bilingual Maternity Discharge Classes***<br>**Holy Cross Hospital, Silver Spring, MD.** | A faith-based, mission-driven community teaching hospital in the Maryland suburbs of Washington, DC, serving primarily the residents of Montgomery and Prince George's Counties. The hospital is a member of Trinity Health of Novi, Michigan, the nation's fourth largest Catholic health care system. | Implemented bilingual-bicultural group discharge classes in Spanish, to provide culturally competent and language appropriate maternity services to their Latina population and to expedite the hospital discharge process. | • 265 women discharged two hours earlier (annually) due to timely provision of discharge classes.<br>• Produced fiscal savings associated with prompt discharge of patients.<br>• Increased improvements in quality of care and customer satisfaction. |
| ***Bilingual Employee Incentive Program***<br>**The Young Children's Health Center, Albuquerque, NM.** | Community-based, pediatric medical center, part of Children's Hospital of New Mexico (part of the University of New Mexico Hospital System) that provides comprehensive health services to families with children from birth to young adulthood. The clinic is located in a relatively isolated, impoverished area populated by individuals of many different cultures and ethnicities and is the primary location for child health care. . | Institutionalized the Bilingual Employee Incentive Program, an incentive program and monetary human resource benefit for bilingual staff who provide Spanish language interpretation services to non-English speaking patients. | • Program saved organization $50,000 in interpretation costs, even after adjusting for salary increases to the employees who are fulfilling the interpretation function.<br>• In addition, by using YCHC employees in the role of interpreters, the scheduling and management of the process has improved.<br>• Delays associated with waiting for an interpreter were largely eliminated. |

| Project | Organizational Setting | CLAS Activity Implemented | Benefits & Results |
|---|---|---|---|
| ***Family-Centered Maternity Rooms***<br>**Holy Cross Hospital, Silver Spring, MD.** | A faith-based, mission-driven community teaching hospital in the Maryland suburbs of Washington, DC, serving primarily the residents of Montgomery and Prince George's Counties. The hospital is a member of Trinity Health of Novi, Michigan, the nation's fourth largest Catholic health care system. | Created a strategic plan to include the development of 68 private and culturally competent family maternity suites to serve the hospital's diverse maternity patients and their families. | • Efficient use of staff, facilities and supplies to reduce cost for the hospitals.<br>• Decreased emergency room visits and readmission to hospital during the post-pregnancy period.<br>• Achieved shorter stays in neonatal care units and cost savings.<br>• Gained the competitive market share among patients in need of local hospital maternity accommodations. |
| ***Health Care Interpretation Certificate Program***<br>**Kaiser Foundation Health Plan, Oakland, CA.** | The nation's largest nonprofit health plan, serving 8.4 million members and 130,000 employees and physicians, in nine states throughout the U.S. (including California) and Washington, DC. | Established a college-level training program designed to provide accreditation standards for interpreters serving Kaiser Permanente health plan limited English proficient (LEP) members and the community at large. | • Established six internship programs at Kaiser Permanente facilities and hospitals.<br>• Partnere d with *Hablamos Juntos*, a project of the Robert Wood Johnson Foundation, to establish 10 additional program sites throughout the country.<br>• Trained and certified more than 100 college-level instructors and staff at Kaiser Permanente's HCI Instructor Institute.<br>• Increased internal Kaiser Permanente workforce diversity by improving HCI skills among employed staff.<br>• Based on a Kaiser Permanente-funded research study, providers who used trained HCI overwhelmingly preferred them over untrained HCI (family members and bilingual staff); based on the same study, patients were able to differentiate trained versus untrained HCI, and favored trained HCI significantly. |
| ***Health Care Interpretation Project***<br>**L.A. Care Health Plan, Los Angeles, CA.** | A public health maintenance organization that serves more than 750,000 people living in Los Angeles County. L.A. Care is one of the state's largest health plans and the nation's largest public health plan. L.A. Care contracts with more than 10,000 health care providers, including clinics and small provider offices. | Initiated and developed a two-part training series at no cost to providers to improve the skills of bilingual staff who serve as interpreters in health care settings. The training was comprehensive and offered continuing education credits. | • Improved communication between providers and limited English proficient (LEP) patients through various techniques, tools, and resources.<br>• Improved patient compliance and satisfaction.<br>• Yielded positive feedback from providers and staff who function as interpreters.<br>* Resulted in an overall cost savings of over $183,500 and trained 258 health care providers. |

| Project | Organizational Setting | CLAS Activity Implemented | Benefits & Results |
|---|---|---|---|
| ***Multilingual Health Resource Exchange***<br>**UCare Minnesota, Minneapolis, MN.** | Minnesota's fourth-largest health maintenance organization, serving nearly 130,000 members in 80 Minnesota counties. UCare works with thousands of health providers across the state. Members have access to more than 14,000 providers. | Developed a web-based clearinghouse for health consumer materials specifically developed for Limited English Proficient (LEP) patients | • Since the Exchange began its work in 2001, it has built a database with over 1,600 materials in the languages needed most often by LEP residents in Minnesota.<br>• Each Exchange partner organization pays $2,500/organization each year to support the web-based clearinghouse, conservatively saving $480,000 with projections indicating that each piece costs $300 to produce language-specific versions. |
| ***Qualified Bilingual Staff Model***<br>**Kaiser Foundation Health Plan, Oakland, CA.** | The nation's largest nonprofit health plan, serving 8.4 million members and 130,000 employees and physicians, in nine states throughout the U.S. and Washington, DC. | Developed a workforce diversity and development program designed to provide ongoing education and training in culturally and linguistically appropriate service delivery to its providers. | • Trained nearly 300 trainers.<br>• Implemented in 51 medical offices throughout Northern California and 22 facilities throughout the Mid-Atlantic States.<br>• Completed over 6,000 assessments as of April, 2006.<br>• Assessed and trained over 3,000 Qualified Bilingual Staff.<br>• Provided over 500 Qualified Bilingual Staff Model training sessions since the program's inception in 2003.<br>• Increased cultural and linguistic capacity for Spanish, Chinese, Vietnamese, Russian, American Sign Language, Tagalog, Hmong, and Punjabi speaking staff.<br>• Collaborated with four main labor unions. |
| ***Remote Video Voice Medical Interpretation Project***<br>**Contra Costa Health Services, Martínez, CA.** | A health plan that operates a 164-bed regional hospital and serves over 65,000 people in Contra Costa County. | Initiated a partnership among four hospitals to develop the Remote Video/Voice Medical Interpretations Project (RVVMI), a remote and mobile voice system supported by voice call centers, to provide language interpretation support services to its providers in two languages. | • Cost-saving partnership price of $.75 cents per minute compared to contracting services rate of $1.55 per minute; pilot test for 10-weeks saved over $25,000.<br>• Increased Contra Costa Health Services' overall effectiveness and process for interpretation services and reached a greater number of patients served in shorter amounts of time.<br>• Decreased interpretation wait time to 4 minutes.<br>• Partnership provides between 30 and 50 patient translations per day, compared to 10–15 before partnership. |

| Project | Organizational Setting | CLAS Activity Implemented | Benefits & Results |
|---|---|---|---|
| ***TeleSalud***<br>**Molina Healthcare, Inc., Long Beach, CA.** | A managed care organization operating in eight states that provides the delivery of health care services to low-income families and individuals eligible for Medicaid and other government-sponsored programs. | Provides members with 24-hour live and direct service ( in their declared language of preference) to a Registered Nurse for nurse advice and interpreting assistance using a two-tiered model with non-clinical staff receiving the intake calls and registered nurses receiving calls requiring clinical interpreting, clinical assessment or intervention. | • Pilot program produced a cost-savings of $2,448 per month, totaling an extrapolated annual cost-savings of $29,000.<br>• Replicated program yielded cost-savings of $750,000 in 2005-2006, ranging from $0.14-$1.35 PMPY across 8 states.<br>• Staff increased from one half-time bilingual employee out of 16 full-time RNs to a 100% bilingual Spanish staff.<br>• Program now serves over 1 million members and has been implemented in all eight states where Molina operates a health plan. |
| ***Traditional Safety Net Telephonic Interpretation Project***<br>**L.A. Care Health Plan, Los Angeles, CA.** | A public health maintenance organization that serves more than 750,000 people living in Los Angeles County. L.A. Care is one of the state's largest health plans and the nation's largest public health plan. L.A. Care contracts with more than 10,000 health care providers, including clinics and small provider offices. | Implemented a technology "toolbox" to eliminate language barriers and assist providers in communicating face-to-face with patients who have limited English proficiency, using an over-the-phone interpreter and a dual head set. | • Reduced the reliance on inappropriate use of friends and family members to interpret and decreased use of gesturing and other ineffective communication methods.<br>• Reduced L.A. Care's reliance on expensive contract services. Cost: during the three month pilot test (June – August 2003) was $939- for the use of telephonic interpretation services used by the three (3) pilot sites participating in the study. The immediate availability of telephonic interpretation services provides a necessary resource for patients who need services in languages that bilingual staff are not available to support. In the cases where on-site interpretation is not available, telephonic interpretation services provides one solution to immediately address a need. |
| ***Volunteer Interpretation Project***<br>**Holy Cross Hospital, Silver Spring, MD.** | A faith-based, mission-driven community teaching hospital in the Maryland suburbs of Washington, DC, serving primarily the residents of Montgomery and Prince George's Counties. The hospital is a member of Trinity Health of Novi, Michigan, the nation's fourth largest Catholic health care system. | Initiated a program by which 175 employees and staff members volunteer their time to be language interpreters for hospital providers and limited-English speaking patients, in over 60 languages. | • Resource of 175 employee volunteers who speak 60 languages and provide interpretation services for patients, families, physicians and staff employees.<br>• Interpretation and translation services increased from 12 minutes to 20 minutes per patient.<br>• To purchase this same level of service from the vendor would cost the hospital approximately $320,000 annually. If kept to the same average 12-minute length of the telephone service, the cost of a contract vendor would be an additional $190,000. |

| Project | Organizational Setting | CLAS Activity Implemented | Benefits & Results |
|---|---|---|---|
| ***Web Repository***<br>**L.A. Care Health Plan, Los Angeles, CA.** | A public health maintenance organization that serves more than 750,000 people living in Los Angeles County. L.A. Care is one of the state's largest health plans and the nation's largest public health plan. L.A. Care contracts with more than 10,000 health care providers, including clinics and small provider offices. | Designed and developed an on-line resource containing over 400 health care documents that are translated in ten languages Translated materials include: informed consent forms, member notification letters, grievance forms and letters, glossary of managed care terms and human anatomy and medical terminology guide. | • Increased organizational branding,<br>• Award winning recognition.<br>• Increased compliance with Federal and State Cultural and Linguistic requirements.<br>• Increased number of registrants for California Medical Association's Certification in Continuing Medical Education, specifically for bilingual health care workers and cultural competency. |

# BUSINESS CASE THEMES, KEY FINDINGS AND LESSONS LEARNED

**This section discusses:**

- **Major reasons organizations pursue CLAS in health care; and**
- **Key findings and lessons learned with regard to implementation of CLAS activities**

## Why Organizations Initiate CLAS in Health Care

While each of the CLAS projects documented in this report was driven by the individual organization's leadership, organizational characteristics and patient needs, four common themes emerged:

**1. Minority and LEP Consumers are a Business Market.** In certain areas of the U.S. "minority" and LEP consumers now constitute a majority. The U.S. Census has shown a consistent increase in the number of immigrants and LEP populations in the past 20 years, and experts forecast a dramatic increase in these populations over the next 20-40 years. Census experts estimate that by 2050 the proportion of "minorities" in the U.S. will approach and perhaps exceed 50 percent.[12] With changing U.S. demographics, health care organizations have an incentive to implement CLAS standards and become culturally competent to increase their appeal to minority consumers and maintain existing patient relationships and increase their market share today and in the future. By advertising, implementing or visually displaying services that are culturally competent, health care organizations could attract the preferred business of specific minority and LEP groups (e.g., the Holy Cross *Family Centered Maternity Suites Project* and *Bilingual Discharge Classes in Spanish*). Health care organizations can use the CLAS standards to draw in new consumers and retain patients who want easier and more comfortable access and quality, culturally competent services. As in the case of Holy Cross, offering CLAS programs to minority patients may also have a spill-over effect into other patient populations and may increase overall business.

**2. Government Requirements Compel Organizations to take on CLAS.** Health care organizations that want to continue receiving public funding or participate in public health insurance programs (e.g., Medicare, Medicaid) are required to provide services for LEP patients by Title VI of the 1964 Civil Rights Act[13], Presidential Executive Order 13166, and federal regulations. Whether this means translating member materials into other languages, offering language translation and interpretation services or other similar types of programming, health care organizations are compelled to participate in CLAS initiatives. Organizations may look to the examples provided in this report for program ideas to meet state and federal requirements.

**3. Cost-effective Spending and Subsequent Savings.** Health care organizations are faced with increasing accreditation demands, diverse patient populations and limited resources with which to provide care. Organizations need to find ways to implement effective program efforts, while at the same time containing or decreasing costs associated with these programs. Culturally *incompetent* care is inefficient and not cost-effective long-term. At a minimum,

[12] Minority Population Growth: 1995 to 2050; www.mbda.gov/documents/mbdacolor.pdf
[13] National Council on Interpretation in Health Care; http://www.ncihc.org/policyissues.aspx

language barriers can increase the length of time for an office visit creating patient and provider dissatisfaction and decreased quality of patient-provider interactions. Improving the overall interaction between provider and patient to remove language barriers will improve the process of care; reduce patient care misunderstandings and miscommunication, and medical errors. Health care organizations implementing CLAS projects may achieve a variety of administrative cost-savings, e.g., in cultural and linguistic trainings for employees (L.A. Care, *Health Care Interpretation Project*), and a decrease in the number of inappropriate hospital emergency room visits among LEP deaf patients (The Young Children's Health Center, *Bilingual Deaf Access Program*). The health care organizations described throughout this report have implemented cost-effective programming while providing care for minority or LEP patients and consumers.

**4. CLAS is the Right Thing to Do.** Perhaps most importantly, the organizations that have engaged in or implemented the CLAS standards, as described throughout this report, are doing so because CLAS in health care is the right thing to do. It is part of each organization's day-to-day operations and goals for providing access and quality care to all populations served. The case studies presented in this report reflect a deep organizational commitment to CLAS. The implementing organizations take pride in having addressed the cultural and language needs of all patients they serve. They have empowered families and providers in their interactions with one another, and have improved both member and provider satisfaction

## Key Findings and Lessons Learned

The cases document successful examples of potential CLAS projects for health care organizations and offer lessons on how best to implement CLAS in a variety of health care settings.

***Linguistically appropriate services may be the first logical step for implementation of CLAS standards.*** While the 14 CLAS standards were represented in the set of projects highlighted in this report, Standards 4-7 (Language Access Services) were addressed more than others. Inaccurate and inefficient communication precludes equity and quality care. Health care organizations, particularly the kinds of organizations described in this final report, need to address language barriers before they can address other aspects of cultural competency. Most of the projects that have been implemented nationally address linguistic services.

***Potential barriers must be identified and overcome*.** While many of the organizations highlighted in this report are well-known and financially stable, each cited funding as the most challenging initial barrier to implementing their CLAS projects. Five received seed funding from outside their organizations to support the initial start-up costs. The other six projects were implemented after being included in the organizations' strategic plans and budgets.

Business benefits of the projects varied depending on organizational mission, time frame for promoting CLAS, and economic conditions affecting their local markets, e.g., health care costs and prices. The financial incentives for implementing CLAS are sometimes not immediately clear and require organizations to put into place methods to measure project effectiveness and cost savings. For example, some CLAS programming designed for a

specific purpose can result in larger benefits such as increased market share, or expansion of services to populations other than LEP and ethnic or cultural minority populations.

***Workforce and bilingual employee development is key.*** Faced with increasing demand for language services, and in the absence of adequate numbers of on-site qualified health care interpreters, health care organizations are turning to their own diverse work force as a means to assure culturally competent care. Health care organizations serving LEP populations are developing their workforces by hiring and training new and existing employees who are either bilingual or interested in becoming bilingual. Employees proficient in a second language provide an internal value and benefit to a health care organization and lead to savings in annual expenditures for outsourced language interpretation services.

The projects highlighted in this report show that organizations can save money and provide effective culturally competent care by improving the language skills of bilingual staff who serve as interpreters. Most organizations will not have the resources to pursue instant across-the-board bilingual or bicultural competency. However, organizations successful in implementing bilingual programming have focused first on those employees who come in direct contact with LEP populations. In addition, cultural competency and language interpretation training are becoming increasingly available through academic institutions, with provider specific continuing medical education credits granted at program completion.

***Exploration and integration of community partnerships and resources is important.*** CLAS Standard 12 speaks to using community relationships and business partnerships in health care to reach patients and consumers. The Young Children's Health Center and Kaiser Permanente used their local universities and colleges to train, educate and develop the language skills of their employees and staff to serve LEP patients. Contra Costa established a partnership with three regional hospitals to purchase low cost language interpretation services and telephone rates; and L.A. Care, with the help of local bilingual providers, developed vital translated medial documents in ten languages.

***Technology can be useful in serving LEP populations.*** Language interpretation lines and satellite technology can help eliminate patient-provider language barriers. With the increased use of cell phones, telephone dual head/handsets and satellite voice speaker phones, health care organizations can operate and update communication technology to eliminate the barriers and challenges related to accessing in-person language interpretation when needed.

***Performance measurement should be a component of the CLAS project plan.*** Health care organizations that want to begin and continue CLAS interventions must take the necessary steps to identify track and document the qualitative and quantitative outcomes of CLAS projects. In addition, those working on CLAS interventions must work as a team with financial staff members, and solicit information from non-programmatic managers and staff to support the continuation of their programs.

***Many CLAS resources are already available.*** Organizations may benefit from case examples provided in this report as well as pre-existing materials on CLAS. (Resources are identified in ***Appendix P***.) The Agency for Healthcare Research and Quality, and the Center for Medicare and Medicaid Services (CMS) published a particularly helpful guide for managed care plans interested in implementing CLAS initiatives. The guide includes information on how to conduct an organizational assessment for CLAS, create a planning team, assess the

needs of a patient population, identify gaps, barriers and priorities, and how to develop areas of focus for CLAS, such as translation services, improving cultural competence and developing a diverse workforce. This guide takes an organization through the steps needed to establish successful programs.[14]

[14] National Study of Culturally and Linguistically Appropriate Services in Managed Care Organizations (CLAS in MCOs Study). US Department of Health and Human Services; Office of Minority Health; August 2003. http://www.cosmoscorp.com/Docs/FR-CLAS-1_ManagedCare.pdf

# CONCLUSIONS AND RECOMMENDATIONS

The rapid increase in minority and LEP populations in the United States, coupled with increased understanding of the importance of patient-provider communication in achieving quality health care, underscores the imperative for health care organizations to develop CLAS interventions. However, many organizations that implement CLAS Standards do so because they have a culture where equity - not the bottom line - is the goal. They implement the projects because they are the right thing to do, not because they expect to achieve savings. As a result, some excellent examples of CLAS projects were not included in this report because the implementing organizations did not have any business benefit data about these projects.

There are two areas for which business benefits were sought but not found. It is particularly disappointing that there was nothing included on the business benefit of improving the cultural competency of physician office visits, nor the benefits of collecting racial and ethnic data. Each of these areas is important for different reasons and seems a logical candidate for more work on developing business benefits information.

This report presents examples of business benefits achieved by organizations that have implemented CLAS projects. Other areas that may yield useful information in the future or that could be useful adjuncts to this project include:

- Benefits and financial costs of implementing a comprehensive, organization-wide approach to cultural competence.
- Factors or forces that encourage management to commit to CLAS initiatives.
- Peer-reviewed papers in journals on business successes of CLAS programs that reach clinicians.

**Summary**

This project was designed to provide information useful for health care organizations considering CLAS Standards-related projects or initiatives. The findings and recommendations of *Making the Business Case for CLAS* provide examples that reinforce the idea that there are financial and other business reasons to pursue the provision of culturally and linguistically appropriate health care services. We set out to capture and provide information that would support new and continued implementation of projects addressing the CLAS Standards.

Collectively, the demographic and market forces that make CLAS in health care an increasingly important enterprise are only one part of the landscape. Equity in access to and use of health services, as well as reduction in racial and ethnic health disparities, are the ultimate objectives. In beginning or continuing the pursuit of these goals, health care organizations need not wait for better or more information about whether to invest in CLAS. There is much work to be done in this area, and to focus on only the potential business benefits from implementing the CLAS standards is an unnecessary constraint to progress.

# REFERENECES


1. Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans. Summary. February 2003. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/about/cods/planclas.htm
2. About the Center of Cultural and Linguistic Competence in Health Care; http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=16
3. Healthy People 2010; http://www.healthypeople.gov/
4. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report, Office of Minority Health http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf
5. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine. 2002. http://www.iom.edu/?id=16740
6. Minority Americans Lag Behind Whites On Nearly Every Measure Of Health Care Quality. Commonwealth Fund. 2002 http://www.cmwf.org/newsroom/newsroom_show.htm?doc_id=223608
7. A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations. Office on Minority Health. www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf
8. Functional Manual for Providing Linguistically Competent Health Care Services as Developed by A Community Health Center The Association of Asian Pacific Community Health Organizations (AAPCHO) and the Asian Pacific Health Care http://www.aapcho.org/altruesite/files/aapcho/Publications_FactSheets/LEPManual.pdf
9. Language Access Kit. http://www.cmwf.org/usr_doc/LEP_actionkit_reprint_0204.pdf
10. IN THE RIGHT WORDS: Addressing Language and Culture in Providing Health Care; http://www.gih.org/usr_doc/In_the_Right_Words_Issue_Brief.pdf
11. Brach C, Fraser C: Reducing Disparities through Culturally Competent Health Care: An Analysis of the Business Case. *Quality Management in Health Care* 2002; 10(4):15-28.
12. Kairys JA, et al: Assessing Diversity and Quality in Primary Care through the Multimethod Process (MAP). *Quality Management in Health Care* 2002; 10(4):1-14.
13. U.S. Department of Health and Human Services (DHHS), Health
14. Resources and Services Administration (HRSA). Definitions of Cultural
15. Competence. Reviewed 2002. http://bhpr.hrsa.gov/diversity/cultcomp.htm
16. Betancourt, J, Green, A, Carrillo, E. Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches. The Commonwealth Fund. October 2002.
17. Lavizzo-Mourey, R, Mackenzie, E. Cultural Competence: Essential Measurement of Quality for Managed Care Organization. Annals of Internal Medicine. 124: 919-921. 1996.
18. U.S. DHHS, Office of Minority Health (OMH). National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. Washington, D.C. March 2001 http://www.omhrc.gov/clas/index.htm
19. The National Alliance for Hispanic Health. A Primer for Cultural
20. Proficiency: Towards Quality Health Services for Hispanics. Washington,
21. D.C. 2001.
22. The White House Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency. August 11, 2000.
23. Diversity Rx. http://www.diversityrx.org/
24. Washington Business Group on Health. http://www.wbgh.com/

# APPENDICES

**APPENDIX A**

# Bilingual Employee Incentive Program
## Young Children's Health Center

**CLAS Standards Met:** 1-6, 9 and 12

**ISSUE.** Fifty percent of patients at the Young Children's Health Center (YCHC) speak only Spanish. YCHC's neighbor communities have the highest rate of new immigrant residency in New Mexico. Due to the increased need for language interpretation resources, YCHC has established the Bilingual Staff Incentive Program encouraging trained staff members to serve as interpreters in exchange for extra salary compensation.

**DISCUSSION.** The Young Children's Health Center (YCHC) is a community-based, pediatric clinic that provides comprehensive health services to families with children from birth to young adulthood. The center is under the organizational umbrella of Children's Hospital of New Mexico, part of the University of New Mexico Hospital System. Services provided by YCHC include home visitation, behavioral health services, and case management. The clinic is located in a relatively isolated, impoverished area populated by individuals of many different cultures and ethnicities and is the primary location for pediatric healthcare.

Many YCHC staff are not bilingual. Due to the increased need for language interpretation, YCHC established a Bilingual Staff Incentive Program, enabling trained staff members to serve as Spanish language interpreters. As part of the program, staff members are certified for medical interpretation through the University of New Mexico Hospital (UNM) and receive extra salary compensation. Priority for training is based on the amount of time staff members spend or plan to spend interpreting in the clinical setting.

The clinic also emphasizes cultural competency in regular staff training and meetings and participates in "Medical Home" training sessions sponsored by the American Academy of Pediatrics.

**BENEFITS/RESULTS.** Eighteen out of 20 YCHC staff members have participated in the incentive program since its establishment. The program has reduced operating costs of the center, saving substantial costs of contracted language interpretation services. YCHC has also changed its hiring policies to encourage all personnel to participate in the incentive program.

YCHC estimates that trained in-house staff interpreters have saved the organization more than $50,000 in interpretation costs after adjusting for salary increases. In addition, by using YCHC employees for interpretation, the scheduling and management of the process has improved. Delays associated with waiting for an interpreter have been largely eliminated.

**LESSONS LEARNED/NEXT STEPS.** The Bilingual Incentive Program is one component of YCHC's commitment to providing culturally competent care. Since establishing the staff incentive program and dramatically reducing language barriers at YCHC, the center

continues to provide linguistically appropriate services and resources compatible with patients' preferred languages.

**WHO TO CONTACT.** For more information about the **Bilingual Employee Incentive Program**, contact Dr. Javier Aceves, Medical Director, The Young Children's Health Center via email at jaceves@salud.unm.edu or (505) 272-4071.

**APPENDIX B**

# Bilingual Deaf Access Program

## Young Children's Health Center

UNM HOSPITALS

**CLAS Standards Met:** 1,4,6,7,11,12 and 14
See page 12 for list of CLAS Standards

**ISSUE.** According to Census 2000 data, an estimated 57,000 people in New Mexico are hearing impaired. The number of Latino newborns who fail hearing screenings within the first month of life and the increased demand for services among children with special health care needs has greatly influenced the Young Children's Health Center (YCHC) to address the importance of accommodating deaf and hard-of-hearing patients and their families in health care settings.

**DISCUSSION.** YCHC is a community-based, pediatric clinic that provides comprehensive health services to families with children from birth to young adulthood. YCHC is under the organizational umbrella of Children's Hospital of New Mexico, part of the University of New Mexico Hospital System. In addition to routine clinical health care, YCHC provides home visitation, behavioral health services, and case management. The clinic is located in a relatively isolated, impoverished area populated by individuals of many different cultures and ethnicities and serves as the primary site for pediatric health care for this population.

More than 90 percent of families treated at YCHC are Hispanic. Fifty percent of those families speak only Spanish. Due to an unidentified reason the number of YCHC newborns who fail the hearing test within one month of birth has been increasing. As a result YCHC has targeted this population for improved and culturally competent health care to create the Deaf Access Program (DAP), a medical home environment for deaf children or hearing children with deaf parents living in the greater Albuquerque area. The goal of the DAP project was to serve pediatric patients with hearing impairments using telemedicine technology, to offer education and support services to other primary care providers around the state, and to coordinate long term follow-up of neonates who had failed the newborn hearing screen.

Due to the shortage of physicians and staff competent in sign language, YCHC established a volunteer partnership with the University of New Mexico's Language Department to schedule appointments and conduct interpretation services during routine visits. In addition to leveraging University capacity, YCHC utilized the American Academy of Pediatrics medical home approach to promote use of electronic telephonic machines to communicate with the deaf patients. They also instituted procedural means to alert patients of "fire drills" and other emergencies. More information about the AAP and medical home primary care initiative is available at the AAP website, http://www.medicalhomeinfo.org/.

In addition, the project established support groups for parents of deaf children to provide information about key issues that can affect their deaf child's development, and offered parents practical tips and strategies for addressing developmental issues.

**BENEFITS/RESULTS.** Early identification and access to health services for children with special needs has fostered early cognitive development which, in turn, promoted a healthy

start for the children at YCHC. The DAP project strengthened institutional support for serving children with special health care needs and children of parents with special health care needs in a culturally appropriate and sensitive manner.

In addition, YCHC grew its deaf outreach services from five patients to over 70 patients, all of whom have some form of health care coverage, in two years. The YCHC has become the provider of choice for deaf and hard of hearing children and families in New Mexico, and has maintained and improved its ability to provide culturally competent care for this population.

**LESSONS LEARNED/NEXT STEPS.** The YCHC continues to take a focused interest in children with special health care needs, including a large number of deaf children and their families. In the future, YCHC plans to use telemedicine to provide education and support services to other primary care providers around the state and to coordinate long term follow up of neonates who failed the newborn hearing screen.

**WHO TO CONTACT.** For more information about the **Bilingual Deaf Access Program**, contact Dr. Javier Aceves, Medical Director, Young Children's Health Center via email at Jaceves@salud.unm.edu or (505) 272-4071.

**APPENDIX C**

# Family-Centered Maternity Suites
## Holy Cross Hospital

**CLAS Standards Met:** 1, 8, 12, and 14
See page 12 for list of CLAS Standards

**ISSUE.** In Montgomery County, Maryland, half of all births are to foreign-born mothers. Holy Cross Hospital is the largest provider of obstetrics services in the state. With a core market area population that is 13 percent Asian American and 17 percent Hispanic American, Holy Cross Hospital embraced cultural values important to its local multicultural community and created private family-centered maternity suites, taking into consideration health beliefs, behaviors and preferred approaches to medical care during child delivery.

**DISCUSSION.** Holy Cross Hospital is a faith-based, mission-driven community teaching hospital in the Maryland suburbs of Washington, D.C., serving primarily the residents of Montgomery and Prince George's Counties. The hospital is a member of Trinity Health of Novi, Michigan, the nation's fourth largest Catholic health care system. Staff at Holy Cross Hospital delivered over 9,000 babies during fiscal year 2006.

The hospital is a principal partner of the Montgomery County Department of Health and Human Services Maternity Partnership program, through which uninsured women in Montgomery County receive prenatal, obstetrical, and post-partum services. The obstetrics and gynecological outpatient clinic at Holy Cross Hospital has been in operation since the hospital opened in 1963. In 1999, the hospital responded to the County's request to increase its service commitment. It increased the number of patients served by 50 percent, from 800 to 1,200 patients per year, leading to the opening of a second outpatient site.

Holy Cross integrated the Maternity Partnership program and anticipated growth in women's services into their strategic planning process in 1999 and their master facility planning process in 2000. As a result, 68 private family-centered maternity suites were built. During fiscal 2006, 2,349 women entered the Maternity Partnership program, nearly three times the number since its inception in 1999. During the last fiscal year, 78 percent of the Maternity Partnership program's patients were Latina.

One of the most significant values in the Hispanic/Latino culture is the importance of the family and family decision making. Family-centered private maternity suites provide a culturally respectful setting for these and other women with a single, high standard of care for all.

**BENEFITS/RESULTS.** Research shows that family-centered maternal care results in efficient use of staff, facilities and supplies and reduces hospital costs. The benefits of family-centered maternity care include fewer emergency room visits and readmission to hospital during the post-pregnancy period, as well as shorter stays in neonatal care units and overall cost savings.

In addition to meeting cultural needs of a diverse patient population, the maternity suites at Holy Cross Hospital are a popular and highly-sought after amenity among all maternity

patients. This has become an attractive component of what Holy Cross brings to the community it serves. With a very large obstetrics patient population (which increased from 6,400 in fiscal 1999 to 9,000 in fiscal 2006), representing a range of cultural and socioeconomic patient backgrounds, the hospital found that its private room facility design was attractive to everyone and made possible the delivery of a single, high standard of care.

**LESSONS LEARNED/NEXT STEPS.** As a result of establishing the family centered maternity suites, Holy Cross is better able to provide care in a manner compatible with their patients' cultural health beliefs and practices. Additionally, the hospital has seen overall growth in obstetrics volume and improved financial performance and patient satisfaction.

**WHO TO CONTACT.** For more information about the ***Family Centered Maternity Suites***, contact Roseanne Pajka, Senior Vice President, Holy Cross Hospital via email at pajkar@holycrosshealth.org or at 301-754-7014.

**APPENDIX D**

# Group Discharge Classes in Spanish

## Holy Cross Hospital

**CLAS Standards Met:** 1, 4-6, 11 and 12.
See page 12 for list of CLAS Standards

**ISSUE.** Holy Cross delivers 9,000 babies annually. At registration, 27 percent of obstetrics patients say they speak or prefer a language other than English and seven percent requested an interpreter. On-site educational and discharge interpretation services for these patients are preferable to telephonic interpretation services. Holy Cross Hospital created group discharge classes in Spanish to enable more patients to be served by bilingual staff and interpreters on a timelier basis. The hospital found the process to be so effective that it offered the group discharge approach to English speaking women as well.

**DISCUSSION.** Holy Cross Hospital is a faith-based, mission-driven community teaching hospital in the Maryland suburbs of Washington, DC, serving primarily the residents of Montgomery and Prince George's Counties. The hospital is a member of Trinity Health of Novi, Michigan, the nation's fourth largest Catholic health care system. Holy Cross Hospital is the principal partner with the Montgomery County Department of Health and Human Services Maternity Partnership program, through which uninsured women in Montgomery County receive prenatal, obstetrical, and postpartum services. The obstetrics and gynecological outpatient clinic at Holy Cross Hospital has been in operation since the hospital opened in 1963. However, in 1999, the hospital expanded its commitment dramatically at the county's urgent request. Holy Cross immediately realized a 50 percent increase in service provision, from 800 to 1,200 patients annually requiring expansion to a second outpatient site. During 2006, 2,349 women entered the Maternity Partnership program, nearly three times the number since program inception in 1999. During the last fiscal year, 78 percent of the Maternity Partnership patients were Latina.

The hospital provides discharge education for all patients. However, due to the number of limited English proficient (LEP) patients in the hospital's all-private maternity suites environment, discharge of these patients was often delayed by limited availability of bilingual staff or until the arrival of an on-site interpreter. The hospital created group discharge classes in Spanish to help improve the process.

**BENEFITS/RESULTS.** If all women who give birth at the hospital were discharged two hours earlier due to timely provision of discharge classes, the hospital projects it could discharge an additional 265 women annually. There is considerable evidence that prompt discharge of patients leads to better quality of care, greater customer satisfaction, and cost savings.

**LESSONS LEARNED/NEXT STEPS.** Group discharge classes are popular with patients and their families. The hospital saves money by reducing the use of interpretation services by holding group discharge classes in lieu of individual discharge counseling. In addition, women are discharged faster. Holy Cross found that the quality of discharge education improved using a group format for reasons associated with group dynamics and improved

information exchange. For example, responses to questions asked by group members may benefit others who may not have thought to ask the same question.

**WHO TO CONTACT.** For more information about the ***Group Discharge Classes in Spanish***, contact Roseanne Pajka, Senior Vice President, Holy Cross Hospital via email at pajkar@holycrosshealth.org or at 301-754-7014.

**APPENDIX E**

# Health Care Interpreter Certificate Program

## Kaiser Permanente

**CLAS Standards Met:** 1-6, 8, 12, and 14
See page 12 for list of CLAS Standards

**ISSUE.** Due to the lack of trained health care interpreters (HCI) and the improper use of unqualified 'ad hoc' interpreters, such as children and family members, Kaiser Permanente established the Health Care Interpreter Certificate Program (HCICP). Studies show that improper interpretation can lead to increased patient confusion, jeopardized patient safety, emotional distress, and prove to be costly to a health care organization.

**DISCUSSION.** Kaiser Permanente is the nation's largest nonprofit health plan, serving 8.4 million members and 140,000 employees and physicians, in nine states throughout the U.S. (including California) and Washington, DC. In 1995, Kaiser Permanente performed a national environmental scan of existing interpreter programs that found: 1) No private or public accreditation program existed for professional HCI and, 2) Interpreters provided by external agencies often lacked sufficient training and demonstrated an inconsistent quality in their interpretation. In addition, there were no existing interpretation accreditation or performance standards. Recognizing the lack of formally trained HCI, related training programs, and certification standards, Kaiser Permanente in 1996 designed a model HCI curriculum. In collaboration with the City College of San Francisco (CCSF), the curriculum, in 2000, successfully became a formal 15 credit unit Health Care Interpreter Certificate Program (HCICP), making CCSF the first educational institution in the Western United States to offer HCI training at the college-level.

The innovative partnership between Kaiser Permanente and CCSF provides a cost-effective and practical solution to training health care interpreters. The goal of the HCICP grassroots curriculum is to develop the cultural and linguistic competency of HCI students and prepare them to work effectively and efficiently in health care settings. Through academic preparation, practical skills training, guest lectures by Kaiser Permanente and non-Kaiser Permanente clinicians, and field experience in various Kaiser Permanente and non-Kaiser Permanente facilities, HCICP students gain additional hands-on experience and real-time practical skills and knowledge to successfully complete their training program.

Success of the HCIP project requires five key resources:

- *Personnel*: Coordinators/instructors from each partnering academic and health care institution; language lab coaches; volunteer lecturers such as physicians and nurses.
- *Financial*: Kaiser Permanente pays for the initial instructor training and provides class materials and space. Grants or other sources of funding help support training and education program.
- *Training*: The HCI Instructor Training Institute trains faculty at partnering academic institutions and improves skills of existing faculty.
- *Support*: Continuous technical support is provided to academic institutions and partner health care institutions.

- *Technology*: A dedicated web site for HCICP (www.kphci.org) was developed and continues to be maintained.

The success of the HCICP over the years and its ongoing expansion to 15 additional geographic areas has shown that partnerships between health care organizations and accredited academic institutions are sustainable and mutually beneficial. Collaborative efforts meet a mutual need by joining the health institutions in need of professional HCI and the academic institutions that train them. Kaiser Permanente encourages and implements ongoing HCICP partnerships outside its service area.

**BENEFITS/RESULTS.**

- Established six internship programs at Kaiser Permanente facilities and hospitals.
- Partnered with *Hablamos Juntos*, a project of the Robert Wood Johnson Foundation, to establish 10 additional program sites throughout the country.
- Trained and certified more than 100 college-level instructors and staff at Kaiser Permanente's HCI Instructor Institute.
- Graduated more than 900 students from HCICP at partnering colleges with a 90 percent successful completion rate.
- Enhanced HCICP students' marketability and readiness for employment in health care while building community capacity to serve limited English populations. Graduates represent the following languages and dialects: Arabic, Cantonese, Farsi, Japanese, Khmer, Korean, Laotian, Mandarin, Portuguese, Russian, Spanish, Tagalog and Vietnamese.
- Increased internal Kaiser Permanente workforce capacity by improving HCI skills among employed staff.
- Based on a Kaiser Permanente-funded research study, providers who used trained HCI overwhelmingly preferred them over untrained HCI (family members and bilingual staff). The same study found that patients were able to differentiate between trained and untrained HCI, and favor trained HCI significantly.

In addition, the HCICP graduates fulfill cultural and linguistic health service needs, contribute to Kaiser Permanente's overarching mission to reduce health disparities and aid in compliance with federal and state mandates such as Title VI of the Civil Rights Act of 1964.

The HCICP project received the NCQA ***Recognizing Innovation in Multicultural Health Care Award*** in 2006 and the AHIP ***Community Leadership Award*** in 2007.

**LESSONS LEARNED/NEXT STEPS.** Surveys are used to continually evaluate the program, monitor employment rates of graduating students, and identify areas for improvements. Program evaluations are also being developed to examine patient care processes and outcomes. In addition, language assessments will be developed to better serve new students, and processes for internship and career placement programs will be further refined.

Lessons learned include recognition of a spectrum of HCI competencies that should be addressed by providing different levels of trainings. Additionally, the HCICP curriculum is updated continuously to reflect changes in heath care and the demographic shifts that may impact the populations served in specific service areas.

The HCICP is in its tenth year and will continue as long as demand exists. The HCICP is a national model with regional and local applicability. It is easily transferable to other health care and academic organizations committed to implementing this partnership training program model. Systems and materials will continue to be refined and improved.

**WHO TO CONTACT.** For more information about the ***Health Care Interpreter Certificate Program***, contact Gayle Tang, Director, National Linguistic and Cultural Programs, Kaiser Permanente via email at Gayle.Tang@kp.org or at (510) 271-6828.

**APPENDIX F**

# Multilingual Health Resource Exchange Project

## UCare Minnesota

**CLAS Standards Met:** 1, 4, 5, 7, and 12
See page 12 for list of CLAS Standards

**ISSUE.** According to a 2003 Minnesota Legislative report, disparities in health status between the majority population and populations of color and American Indians are, in some cases, getting worse. In addition, with 124 languages now spoken in Minnesota (some of the most common being Hmong, Russian, Somali, Spanish and Vietnamese) UCare saw a great need to collaborate with other partners to address these health disparities and overcome language barriers to health care. The production and distribution of health materials for Limited English Proficient (LEP) patients can be a significant expense and logistical challenge for any one health care organization to undertake. UCare invests time and resources to partner with communities to address their cultural and linguistic needs, which is essential to improving their health status. Empowering LEP members is facilitated through collaboratives such as the Multilingual Health Resource Exchange because they increase the number of culturally and linguistically appropriate resources available to the members and, thereby, enhance the members' ability to understand and act on the information they need to stay healthy and to receive care when ill.

**DISCUSSION.** In carrying out it's mission "to improve the health of members through innovative services and partnerships across communities", UCare noted that LEP patients deserve more understandable information about their health and their providers needed better tools to deliver health and social services that are specific to their patients' cultures. Providing multilingual health resources in a user-friendly, central database is one way to address this need. As a way to accomplish this, UCare partnered with some other health plans, hospitals, clinic groups, public health organizations, and other groups to collaboratively establish the ***Multilingual Health Resource Exchange***, a web-based clearinghouse for health consumer materials specifically developed for Limited English Proficient (LEP) patients.

The project began in 2001, with a sharing of health education materials among more than a dozen other Minnesota health care organizations. In 2002-2003 the efforts led to the creation of an internet database of multilingual health resources. The goals of the ***Multilingual Health Resource Exchange*** (Exchange) include:

- Sharing information about all available translated materials;
- Exchange of translated written, audio and video health education resources through an online database;
- Collection of additional resource information about health education approaches that work for patients whose primary language is not English; and
- Conduct a gap analysis of materials to determine what new materials need to be developed in particular languages.

The funding partners make this clearinghouse available to their network of providers at no cost to them. The Exchange web site was developed to allow centralized access for providers to written health materials as well as detailed information about audiovisual materials in various languages, and easy links to other national sources of information about translated health education materials. The Exchange web site is located at www.health-exchange.net. The Exchange partnership requires participating organizations to attend monthly meetings to review existing materials and prioritize needs for new ones. Each year, the primary goal of the Exchange is to produce or collect new printed pieces to add to the database, based on language and topic priorities.

As a result of this project, UCare's experience has shown that it is vital to join resources across health organizations and community systems to address quality concerns and implement improvements in language access services. This collaboration contributes to integrated care across providers and health and human service systems. Coordinating efforts to consolidate multilingual resources for easy access yields a greater capacity to offer resources statewide (especially reaching rural areas that have had limited access to LEP resources and trained interpreters). It is important for health care "competitors" to join efforts in order to better serve LEP patients receiving care across health systems.

**BENEFITS/RESULTS.** Since the Exchange began its work in 2001 and created the web-based clearinghouse in 2002-2003 with an initial start up cost of approximately $43,000 in the first year, it has built a database with over 1,600 materials (as of October 2006) in the languages needed most often by LEP residents in Minnesota. The Exchange has also posted additional resources on the site that guide providers in how to share health information in a manner that accommodates the learning needs of diverse patients. The benefits of this collaboration include:

- LEP patients have the same access to critical health information as those who read and speak English fluently—access that is their legal right.
- Health educators developing new materials are guided by research on readable and culturally appropriate materials.
- Health care organizations share information and resources to prevent costly duplication.

Each Exchange partner organization pays $2,500/organization each year to support the web-based clearinghouse. By participating in the ***Multilingual Health Resource Exchange*** each organization saves thousands of dollars annually. As of October 2006, the Exchange database has over 1,600 materials in it. If one conservatively assumes it costs $300 to produce language-specific versions of each material, this would give a value of $480,000 to the current Exchange collection of materials.

**LESSONS LEARNED/NEXT STEPS.** The Exchange has established an Advisory Committee that now meets bimonthly to continue a gap analysis to identify additional health materials needed for particular language groups in Minnesota. The Exchange is adding approximately 65 new translated pieces to its online library each month. The Advisory Committee is currently working on marketing the Exchange and promoting utilization of the web site by more providers throughout the state. A recent survey of Exchange web site users found that 85.5% found the translated material they were looking for and 98.8% of those surveyed felt that the Exchange site is easy to use.

**WHO TO CONTACT.** For more information about the ***Multilingual Health Resource Exchange***, contact Carol Berg, Public Health Manager, UCare Minnesota via email at cberg@ucare.org or (612) 676-3635.

**APPENDIX G**

# Qualified Bilingual Staff Model

## Kaiser Permanente

**CLAS Standards Met:** 1, 2,3,4,6 and 8
See page 12 for list of CLAS Standards

**ISSUE.** To ensure access to linguistic services at every point of contact, health care organizations must address multiple unique encounters that span the patient and family health care experience. Each point of contact may be specialized and require its own level of linguistic competency. Faced with increasing language service demand, and in the absence of adequate numbers of on-site qualified health care interpreters, health care organizations are turning to their own diverse work force for practical solutions. To promote access to linguistic services, Kaiser Permanente developed the Qualified Bilingual Staff (QBS) Model to *Identify, Qualify, Educate/Enhance, Mobilize, and Monitor* an internal workforce as a key strategy to promote culturally competent care, improve health outcomes and reduce health care disparities.

**DISCUSSION.** Kaiser Permanente is the nation's largest nonprofit health plan, serving 8.4 million members and 140,000 employees and physicians, in nine states throughout the U.S. and Washington, D.C. Kaiser Permanente has made significant progress in providing language interpretation certification through its evolving Health Care Interpreter Certificate Program. In addition, the organization has also established the QBS Model to expand the ways it provides culturally and linguistically appropriate care services and training to its staff and providers serving limited-English proficient patients. Specifically, the QBS Model aims to: 1) Identify work force capacity; 2) Qualify levels of linguistic competency; 3) Enhance linguistic capabilities, 4) Mobilize QBS within the care system; and 5) Monitor to ensure continuous quality improvement and patient safety. Three levels of staff training for the model include: 1) Bilingual Staff – Language Liaison, 2) Bilingual Staff – Language Facilitator and 3) the Designated Interpreter. The QBS Model is complete with an internally developed training curriculum, resources and materials.

The QBS Model is open to all members of the Kaiser Permanente workforce who seek to enhance their linguistic competency. Currently, the Model targets the plan's threshold languages including Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, Tagalog, Russian, Hmong, Punjabi and ASL. The QBS Model enhances bilingual communication within the staff's scope of practice or clinical specialty. QBS staff and clinicians can serve in dual roles where one role services a functional need, the other a linguistic need.

The Model also promotes CLAS standards by embedding the standards as a core-element learning objective in each level of the curriculum. It provides a systematic approach to bridge health practice with health training by institutionalizing a skill enhancement process that internal workforce staff can use.

The development of the QBS Model required the participation of national, regional, and local staff, project leads, executives, business managers, union leaders, and community advocates. The QBS Model introduced a fundamental change in organizational culture by investing in

its internal expertise to meet the needs of linguistically diverse populations. The QBS Model was initiated in 2003 and has gained momentum as it is replicated within the organization in different regions. The QBS Model complies with the CLAS standards and federal and state mandates such as Title VI of the Civil Rights Act of 1964.

**BENEFITS/RESULTS.**
The QBS Model has been successfully implemented in Northern California, the Mid-Atlantic States, Georgia and Southern California Regions. Kaiser Permanente Regions have been exceptionally successful in the implementation of the QBS Model. The QBS Model has been recognized both internally (recipient of Kaiser Permanente's prestigious internal R.J. Erickson Award) as well as externally (recognition by patient rights leaders, advocates, and community organizations.)

In 2006, the QBS Model Program received the NCQA ***Recognizing Innovation in Multicultural Health Care Award.***

Northern California Region (3.2 million members):

- Implemented the QBS Model in 2003;
- Trained **75 Level 1** trainers and 50 Level **2 trainers**;
- Implemented in 51 medical offices throughout Northern California;
- Completed 6,173 assessments as of April 30, 2006;
- Assessed and trained 3060 QBS staff with approximately 1,517 **Level 1** and 1,543 **Level 2**;
- Provided over 388 QBS **Level 1** training and 119 **Level 2** training sessions since the program's inception in 2003;
- Increased cultural and linguistic capacity for Spanish, Chinese, Vietnamese, Russian, American Sign Language, Tagalog, Hmong, and Punjabi speaking staff; and
- Collaborated with four main labor unions.

Mid-Atlantic States Region - Washington D.C, Virginia, and Maryland (500,000 members):

- Implemented the QBS program in 2004;
- Trained eight certified facilitators;
- Implemented in 22 facilities;
- Trained 102 QBS staff with approximately 15 **Level 1** and 87 **Level 2**; and
- Increased cultural and linguistic capacity for Spanish, Chinese, and Vietnamese speaking staff.

**LESSONS LEARNED/NEXT STEPS.** Kaiser Permanente plans to add additional languages into the QBS Model depending upon patient demand. The QBS Model continues to flourish in an environment of strong organizational commitment and continues to gain momentum in regions that recognize potential program benefits. The Model will continue to succeed as a viable and cost-effective solution to meeting the needs of Kaiser Permanente's diverse multilingual and multicultural population, reducing the need to outsource services while maintaining the health plan's standards. Leadership at the various Kaiser Permanente Regions throughout the country, coupled with collaboration and agreements with partnering labor unions reinforce the effort to develop the linguistic competency of internal staff.

Regional and labor union partnerships also provide monetary rewards as recognition for the provision of QBS services.

A fully developed curriculum and related program support material allow the Model to be replicated across the organization. Policies and procedures are in place to govern and monitor the standards for on-going assessments and training. These guide delivery and expansion of the QBS Model.

**WHO TO CONTACT.** For more information about the ***Qualified Bilingual Staff Model***, contact Gayle Tang, Director, National Linguistic and Cultural Programs, Kaiser Permanente via email at Gayle.Tang@kp.org or at (510) 271-6828.

**APPENDIX H**

# Remote Video/Voice Medical Interpretations Project

## Contra Costa Health Services

**CLAS Standards Met:** 1 and 4-7
See page 12 for list of CLAS Standards

**ISSUE.** Safety net health care providers with limited language interpretation skills serving low-income and uninsured populations in northern California are overwhelmed in their efforts to treat immigrant limited English proficient (LEP) populations. The numbers are staggering; from 30 percent to 60 percent of the patient population in the county health care systems of San Joaquin, Contra Costa and San Francisco are LEP. The patient base includes at least 20 languages spoken in regular clinical encounters, including Spanish, Vietnamese, Cantonese, Mandarin, Russian, American Sign Language, Hmong, Mien, Farsi, Hindi, Korean, Arabic, Amharic, and others.

**DISCUSSION.** Contra Costa Health Services is a health care organization that operates the Contra Costa Health Plan serving more than 65,000 people in Contra Costa County and the Contra Costa Regional Medical Center, a 164-bed hospital located in Martinez, California. To help provide interpretation services for its patient population and to assure the provision of culturally competent care, Contra Costa Health Services has pursued a number of initiatives, including the development of the Health Care Interpreter Network (HCIN) and the Remote Video/Voice Medical Interpretations (RVVMI) project. Since 2005, Contra Costa Health Services, through the RVVMI has worked with two partnering hospitals to provide language interpretation services in Spanish, Hindi, Hmong, and Cambodian, and to create a model of shared interpreter services utilizing the most advanced video and voice-over internet protocol (IP) technologies.

The core of the RVVMI is a successful Internet Protocol Video and Voice Call Center for interpreter services that automatically and simultaneously routes requests for interpreters within the Contra Costa service area, and the San Mateo and San Joaquin hospitals. The call center hardware and software is hosted in a Network Operating Center (NOC). The Project has established a secure broadband connection between the servers at the NOC and the three participating public hospitals through a private multiple layer switch network provided by Southwestern Bell Communications. The project has also established the training and quality specifications of participating interpreters, liability arrangements, pricing structures, operating processes and possible contracting methodologies to operate this system in a sustainable manner.

Contra Costa Health Services received grant funding to establish the RVVMI and to cover the testing of the model and initial equipment purchase at partnering hospitals. However, the cost of the equipment purchase and initial start-up was modest.

**BENEFITS/RESULTS.** Contra Costa Health Services providers and their patients have gained access to trained medical interpreters through a combination of video and telephone

technologies. Specifically, the RVVMI enables Contra Costa Health Services to access its partner interpreter resources prior to utilizing high cost contracted interpreter services.

Contra Costa Health Services has already realized organizational benefits and cost savings as a result of the RVVMI. The Project's initial cost for language service within the partnership was $.75 per minute, in contrast to the rate of $1.69 per minute for contracted services. During the initial test of RVVMI in 2006, Contra Costa Health Services launched the project during their interpretation peak hours (8 a.m. – 5 p.m., Monday through Friday) for Spanish speaking patients with an immediate reduction in contracted services for the 10-weeks and savings of more than $25,000.

The RVVMI has increased the overall effectiveness and process for interpretation services at Contra Costa Health Services, serving a greater number of patients in less time. The technologies employed can successfully route calls from all targeted access points, via videoconferencing or telephone equipment, to available qualified interpreters. Calls are routed from Contra Costa Health Services to a partnering hospital, and then connected to a contracted service provider within 4 minutes.

Providers and patients who have used these systems have improved satisfaction with interpreter services. For example, through the HCIN partnership, one full-time Contra Costa Health Services Spanish interpreter using the video/voice call center completes between 25 to 30 patient visits per day. That compares with previous in-person employee interpreters who provided a maximum of 10–15 visits per day. In addition, a Contra Costa Health Services remote interpreter is available to the entire Contra Costa Health Services system (including one hospital and 3 satellite clinics), while an in-person interpreter provides service to staff at one site only.

**LESSONS LEARNED/NEXT STEPS.** The RVVMI collaboration has amassed more than five years of experience in video conference-based medical interpreter systems. Project staff will use this experience to design and grow the call center, to develop shared training sessions and quality assurance measures, and to share interpreter services (especially in languages which may not require full-time interpreters within any one hospital system). In the fall of 2006, Riverside County and Rancho Los Amigos in Southern California will become the fourth and fifth hospitals to join the RVVMI.

**WHO TO CONTACT.** For more information about the ***Remote Video/Voice Medical Interpretations Project***, contact José Martín, LMFT, Reducing Health Disparities Initiative Leader, Contra Costa Health Services via email jmartin@hsd.co.contra-costa.ca.us or at (925) 957-5426.

**APPENDIX I**

# Staff Volunteer Interpretation Program

## Holy Cross Hospital

**CLAS Standards Met:** 1, 4-7
See page 12 for list of CLAS Standards

**ISSUE.** Holy Cross Hospital's core market area demographics include 13 percent Asian Americans and 17 percent Hispanic/Latino Americans. Over the past five years, Holy Cross has spent thousands of dollars paying for contract language interpretation services to serve its limited English proficient (LEP) patients. With a diverse and multilingual employee population, Holy Cross implemented the **Staff Volunteer Interpretation Program** as a language services improvement project and a potential cost-saving initiative.

**DISCUSSION.** Holy Cross Hospital is a faith-based, mission-driven community teaching hospital in the Maryland suburbs of Washington, D.C., primarily serving the residents of Montgomery and Prince George's Counties. The hospital is a member of Trinity Health of Novi, Michigan, the nation's fourth largest Catholic health care system.

Holy Cross Hospital's core market has a large and growing immigrant population with significant economic and health care disparities. Seventeen percent of patients who come to the hospital speak or prefer a language other than English and four percent of all patients request an interpreter. Initially, Holy Cross chose to contract for professional interpretation services. However, the demand for consistent and reliable language interpretation services has grown. The hospital recognized the limitations of telephonic interpretation services and the advantages of interpretation services by staff volunteers.

To improve the process of communication for LEP patients and those providing their care, Holy Cross hired a manager of Multicultural Services and launched the Office of Multicultural Services. The office established and now coordinates the Staff Volunteer Interpretations Program, an initiative to help hospital patients with limited English proficiency access and use the hospital and its programs.

Volunteer interpreters were identified and trained in patient confidentiality issues and accompanied existing interpreters until they were experienced enough to interpret on their own. Holy Cross discourages patients from using family members or friends as interpreters. The hospital meets the language needs of its patient population and their families in a number of ways, including bilingual staff, contract interpretation services, and volunteer interpretation. Patients are informed of their rights to these services and are told that they need not rely on family members to be interpreters.

**BENEFITS/RESULTS.** After establishing the Staff Volunteer Interpretation Program, Holy Cross Hospital in fiscal year 2005 had:

- An active in-house language resource of 175 employee volunteers who spoke 60 languages and provided interpretation services for patients, families, physicians and staff employees.
- In-person volunteer interpretation services averaging 20 minutes per patient.

- Significant cost savings: without staff volunteers, the hospital would have had to contract for interpretation services at an additional projected cost of $320,000 for calls averaging 20 minutes or $190,000 for calls at the usual average vendor length of 12 minutes per call.

**LESSONS LEARNED/NEXT STEPS.** Holy Cross is continually building its knowledge base through experiences in providing culturally and linguistically appropriate services for their patients.

**WHO TO CONTACT.** For more information about the ***Staff Volunteer Interpretation Program***, contact Roseanne Pajka, Senior Vice President, Holy Cross Hospital via email at pajkar@holycrosshealth.org or at 301-754-7014.

**APPENDIX J**

# TeleSalud
## Molina Healthcare Inc.

**CLAS Standards Met:** 4,5 and 7
See page 12 for list of CLAS Standards

**ISSUE.** In 2002, a review of utilization statistics from Molina Healthcare's outsourced nurse advice line was significantly underutilized by Spanish-speaking members (Latinos). The report showed that although 45% of Molina's membership is Latino (primarily of Mexican origin), with a declared Spanish language preference, requests for a Spanish interpreter constituted less than two percent of calls. Molina concluded that this low utilization suggested a barrier to members in accessing nurse advice services. Previous internal research supported the finding that while English speaking populations would use automated phone services, Spanish speaking populations were more likely to hang up when reaching automated services. The practice of waiting in line for service was not congruent with the Latino culture, which could adversely affect their access to healthcare.

**DISCUSSION.** Molina Healthcare, Inc., headquartered in Long Beach, California, is a multi-state managed care organization that arranges for the delivery of healthcare services to low-income families and individuals eligible for Medicaid and other government-sponsored programs. In an effort to decrease the number of Spanish speaking patients hanging up when reaching automated services the *TeleSalud* demonstration project was formed in 2004 as a separate department within Molina Healthcare of California to offer direct accessibility for medical interpreting services to address the health and language needs of the underserved Limited English Proficient Latino population living in the Inland Empire of Southern California.

*TeleSalud* was started as a program component under the *Hablamos Juntos* demonstration project grant, funded by the Robert Wood Johnson Foundation to expand the language access services capacity in the Inland Empire region of Southern California. The *TeleSalud* demonstration project began as a 24-hour contact center to enable direct access to a Spanish-speaking Registered Nurse to help address a Spanish-speaking members' health and interpreter needs at all times. *TeleSalud* initially offered three primary services exclusively in Spanish: nurse advice, medical interpretation, and member services. The *TeleSalud* Spanish nurse advice program was implemented in several phases. The launch date was earlier than originally planned due to operational considerations, and so was initially staffed by nurse practitioners and physicians. No advertising was done during this phase, as part of what was being monitored was member awareness of information printed on their cards. Phase 2 began in October 2004, with launch of computerized protocols and a fully trained nursing staff. Because the program was so well received, in November 2004, the decision was made to open the *TeleSalud* project beyond the Inland Empire area, to all California members on January 1, 2005; the original pilot group only included 80,000 members in the Southern California counties of Riverside and San Bernardino.

**BENEFITS/RESULTS.**
There are many indirect cost benefits that have been identified with *TeleSalud*. The project's gains are multi-faceted, and the bilingual capacity of the *TeleSalud* staff has been valuable to

other departments in the company as the scope of functionality has broadened The outsourced nurse advice vendor had only one half-time employee that was bilingual out of 16 full-time RNs. In the current *TeleSalud* staff, 100 percent of the operators and 50 percent of the RN staff is bilingual in Spanish.

In 2004, Molina Healthcare analyzed emergency room usage data for Spanish-speaking enrollees who had access to *TeleSalud* from January 1, 2004 through December 31, 2004. The data concluded that the emergency room usage rate was substantially lower for Spanish-speaking enrollees with access to *TeleSalud*- 191 visits per member year per 1000 enrollees compared to 217 for those without access; resulting in a use rate for *TeleSalud* at only 88 percent of the rate for those without such access. Callers who had originally intended to go to the Emergency department reported that after speaking with a nurse, they were able to have their needs met by going to the physician's office, or able to take care of their concerns with nurse advice through education and home measures.

In addition, Molina conducted a cost-savings analysis study for *TeleSalud*. Based on data collected during a three month pilot period, December 2004 through February 2005, Molina's *TeleSalud* program produced a cost-savings of $2,448 per month, totaling an extrapolated savings of $29,000 annually. Other cost savings related to emergency room visits were realized and contributing factors to call center efficiency and have to helped make *TeleSalud* a success.

**LESSONS LEARNED/NEXT STEPS.** Since going live in April 2004, Molina Healthcare has made significant improvements to the call center infrastructure. *TeleSalud* has evolved into a multi-tasking call center offering many services such as the *TeleSalud* Nurse Advice, Nurse Advice services in English, a Member Appointment Center, and after-hours utilization management support and member services support. Molina's current total and overall call volume for its call centers is approximately 36,000 calls per month, of which 9,000 (25 percent) are Spanish speakers served via a dedicated phone line. The *TeleSalud* Nurse Advice program now serves over 1 million members and is operational in all eight states serviced by Molina health plans (to include California, Indiana, Michigan, New Mexico, Ohio, Utah, Texas, and Washington.)

**WHO TO CONTACT.** For more information about ***TeleSalud***, contact Martha Bernadett, MD, Executive Vice President of Research and Development via email martha.bernadett@molinahealthcare.com or at (562) 435-3666 extension 111148.

**APPENDIX K**

# Traditional Safety Net Telephonic Interpreting Project—Dual Head Set And Hand Set Interpretation

## L.A. Care Health Plan

**CLAS Standards Met:** 1 and 4-6
See page 12 for list of CLAS Standards

**ISSUE.** Language needs of limited English proficiency (LEP) patients enrolled in L.A. Care Health Plan (L.A. Care) exceeded available licensed bilingual providers. As a result, untrained staff members, family members and children were being used for language interpretation during medical visits. Research indicates that sometimes family members, children and friends may: 1) not give the patient a provider's complete explanation, 2) potentially be embarrassed to admit they do not understand what is being said, 3) find the nature of the conversation embarrassing, 4) not agree with the provider, and 5) miscommunicate the patient's message, preferring that the provider hear their version of the situation. In addition, family members and child interpreters may lack understanding of the medical and non-medical vocabulary, whether in English or their own language.

**DISCUSSION.** L.A. Care Health Plan (L.A. Care) is a public health maintenance organization serving more than 750,000 people in Los Angeles County. L.A. Care contracts with more than 10,000 health care providers annually, health plans, Independent Provider Associations (IPA's) and Medical Groups, community clinics and hospitals. The health plan serves large populations with limited English proficiency. More than 55 percent of patients prefer a language other than English, including Spanish (45 percent of enrollees), Cantonese, Korean, Mandarin and 27 others.

In 2003, L.A. Care developed and implemented the Traditional Safety Net Telephonic Interpreting Project to eliminate language barriers within the patient-provider relationship and to reduce errors in medical language interpretation. The project targeted L.A. Care's network of county and community clinics and provider groups within Southern California. The purpose of the project was to assist LEP patients in communicating with their providers, while reducing the administrative time involved in obtaining interpreting services. When using this system, providers and patients need not pass a telephone or headset back and forth nor use a speaker phone. Providers and patients accessed language services using telephonic dual headsets or handsets when a bilingual health care provider or on-site interpreter was not available. The hand/headsets are compatible with most telephone systems.

L.A. Care made equipment, training, and technical support available to its participating providers at no cost. The dual handset equipment itself was priced at approximately $14 per unit, depending on the model and make of phone and type of handset needed. In addition, a limited number of dual headsets assisted by the use of high quality amplifiers were implemented in County and community clinics which had a need for hands free communication with patients. The price per unit for this model was approximately $178 per

unit. L.A. Care also covered the costs of interpreter services for L.A. Care members enrolled in the Medi-Cal and other state funded programs.

Providers used an internal coding system to designate usage for their patients. L.A. Care partnered and negotiated a contract with Pacific Interpreters to provide interpreter services to all L.A. Care providers involved in the telephonic interpreting project. The partnering agency's capacity included: 1) being HIPAA compliant, 2) having a quality monitoring process, and 3) operating a disaster recovery center in England should delivery of services be disrupted in the United States.

**BENEFITS/RESULTS.** L.A. Care launched this project following pilot testing at three sites, including: 1) a comprehensive care center with multiple clinics within the main facility, 2) a safety net clinic, and 3) a family care provider group. The majority of calls were for language services in Spanish and Korean. The total cost of telephone interpreter services for all three sites during the pilot period (June–August 2003) was a modest $939.75. The pilot test showed that dual hand-sets reduced the reliance on friends and family members for interpretation, as well as decreasing the use of gesturing and other ineffective communication methods. In addition, use of the dual headsets and handsets reduced L.A. Care's reliance on expensive contract interpretation services.

**LESSONS LEARNED/NEXT STEPS.** While many L.A. Care patients initially attempted to use family, friends, and minors as interpreters during medical visits, they were receptive in participating with the dual headset communication device. Methods of discouraging family members, children and friends from serving as interpreters need to be documented more clearly in case studies, emphasizing evidence-based research and best practices for all languages in use in the health plan.

**WHO TO CONTACT.** For more information about the ***Traditional Safety Net Telephonic Interpreting Project***, contact Jennifer Cho, Manager of the Cultural & Linguistic Services Department, at L.A. Care Health Plan via email at jcho@lacare.org or at (213) 694-1250 Ex. 4327.

**APPENDIX L**

# Training for Interpreters in a Health Care Setting

## L.A. Care Health Plan

**CLAS Standards Met:** 3, 4-7, 8
See page 12 for list of CLAS Standards

**ISSUE.** The language needs of limited English proficient (LEP) patients enrolled in L.A. Care Health Plan (L.A. Care) exceed available bilingual providers. To better meet the challenge of providing culturally and linguistically appropriate care for a growing number of immigrant and LEP patients, L.A. Care initiated a number of programs to improve the cultural competency within the provider network, including Health Care Interpreter Training courses offered to bilingual employees in the L.A. Care network.

**DISCUSSION.** L.A. Care Health Plan (L.A. Care) is a public health maintenance organization serving more than 750,000 people in Los Angeles County. L.A. Care contracts with more than 10,000 health care providers annually, health plans, Independent Provider Associations (IPA's) and Medical Groups, community clinics and hospitals. The health plan serves large populations with limited English proficiency. More than 55 percent of patients prefer a language other than English, including Spanish (45 percent of enrollees), Cantonese, Korean, Mandarin and 27 others.

As part of the Cultural and Linguistic Services (CLS) Department's strategic plan to incrementally achieve culturally and linguistically appropriate services, the Department designed and implemented the Health Care Interpreter Training project through which qualified and experienced interpreters teach the basic principles of converting messages from one language to another in a health care setting. Classes are provided at no cost to participants. The curriculum is mobile and the instructor travels to clinic, hospital, and provider sites to better accommodate participants.

The CLS Department developed a short class for providers (up to 4 hours) on patients' rights to interpreter services and how to work with interpreters, as well as a longer, 40-hour course, is offered to bilingual employees serving as interpreters. Continuing education credits are offered for successful course completion. Participants in the short class include administrators, physicians, physician assistants, nurse practitioners, registered nurses, medical assistants, pharmacists, and health educators. The training explains the legal obligations to provide access to language services and discusses the impact of language and culture on the medical visit. The training also offers information on ethical principles for health care interpreters and the benefits of working with a trained health care interpreter. Other key topics discussed during this training include: 1) Tips for health care providers on how to work effectively with an interpreter, 2) Tips for bilingual staff on how to work effectively as an interpreter, and 3) Tips for using telephonic interpreters.

The longer course was designed for introductory level training. It is divided into five (5) sessions of 8 hours each. Each session focuses on a specific theme, allowing participants to gradually advance from basic to more complex subjects. It is an interactive course including

lectures, demonstrations, group activities, videos, and practice exercises aimed at helping participants become more effective and professional when facilitating communication between health care providers and LEP patients. One goal of the course is to offer participants opportunities to practice interpreting skills in a safe and supportive environment. This training is not intended to serve as an accreditation or a language enhancement program. The courses are conducted in English with resource materials and practice exercises available in nine languages. The training was pilot tested in 2001 at various levels of health plan operations before being made available throughout L.A. Care's contracted provider network.

Topics addressed in the 40-hour training include:

- The Right to an Interpreter in a Health Care Setting
- Ethical Principles of Health Care Interpreting (based on the California Standards for Health Care Interpreters developed by the California Healthcare Interpreting Association [CHIA])
- Elements of Message Clarifying
- Memory Development
- Interpreting Protocols
- Sight Translation
- Practice Dialogues and Basic Medical Terminology in English and Languages Other than English
- Culture and Its Impact on Communication
- Patient Advocacy
- Tips for Professional Development

**BENEFITS/RESULTS.** Participants who complete the course help raise awareness throughout the system about the importance of providing trained and qualified interpreters to patients and their providers, an outcome that gives their organizations additional protection from liability. The project yielded positive feedback from providers and staff who were already functioning as interpreters. Many were especially appreciative of the opportunity to be formally trained in skills they were already struggling to apply informally and found the training to be a forum to express concerns about practices for which there were often no written policies or manuals to guide them. Administrators at one of the larger hospitals in the county saw the program as a way to support larger institutional changes underway in the delivery of services, and plan—in just one hospital alone—to send 1,000 bilingual employees through the training courses.

Despite limitations of a brief 40-hour course, many graduates of the program find they are able as a result to serve more effectively as interpreters in their workplaces. They rely less on telephone interpreters, saving money and improving services to patients in areas where they were previously lacking.

Training focuses on improving communication between providers and LEP patients. Better communication results in higher quality care, improved patient satisfaction, better patient compliance, improved health outcomes, and increased provider compliance with state and federal laws and insurance contracts.

The project began with a consultant that L.A. Care retained to conduct a series of health care interpreter trainings and to develop materials that the health plan could use for presentation

and training purposes. From 2001 through 2004, 246 bilingual employees in its network completed the 40-hour course while 425 completed the 4-hour course. In 2005 270 employees completed the 40-hour course and 350 completed the 4-hour course. The average cost for 40 hours of outsourced health care interpreter training is $1,000 per person. The cost to participants or their sponsoring organization is often double or even triple that amount when paid time off, travel and hotel costs are included. Using one full-time employee with salary and benefit requirements of $74,480, L.A. Care established a cost effective and consistent way to deliver trainings, resulting in an overall cost savings of more than $183,000.

**LESSONS LEARNED/NEXT STEPS.** Repeating the courses frequently and in different locations enriches the original curriculum as each group and every participant brings their unique experiences to the course. Practice informs instruction, and as a result, course materials, while fundamentally the same from month to month, are a work in progress. The original curriculum, which was on overhead slides, is being transferred to Microsoft Power-Point. Developing a consolidated and fully electronic version of the curriculum will make it easier to train new trainers in the future and is expected to meet future needs as demand for instruction increases.

**WHO TO CONTACT.** For more information about the ***Health Care Interpreter Training (HCIT)***, contact Jennifer Cho, Manager of the Cultural & Linguistic Services Department, at L.A. Care Health Plan via email at jcho@lacare.org or at (213) 694-1250 Ext. 4327.

**APPENDIX M**

# Web Repository
## LA Care Health Plan

**CLAS Standards Met:** 4, 5, 7 and 13
See page 12 for list of CLAS Standards

**ISSUE.** The language needs of the limited English proficient (LEP) patient population enrolled in L.A. Care Health Plan (L.A. Care) exceed available bilingual providers. To better meet the challenge of providing culturally and linguistically appropriate care for a growing number of immigrant and LEP patients that the organization serves, L.A. Care has initiated a number of innovative programs. Among these programs is the creation of a Web Repository of plan materials that have been translated into many of the different languages spoken by plan enrollees.

**DISCUSSION.** L.A. Care Health Plan (L.A. Care) is a public health maintenance organization serving more than 750,000 people in Los Angeles County. L.A. Care contracts with more than 10,000 health care providers annually, health plans, Independent Provider Associations (IPA's) and Medical Groups, community clinics and hospitals. The health plan serves large populations with limited English proficiency. More than 55 percent of patients prefer a language other than English, including Spanish (45 percent of enrollees), Cantonese, Korean, Mandarin and 27 others.

The Cultural and Linguistic Services Department (CLS) at L.A. Care worked internally, with other L.A. Care departments and externally, at the health plan, provider clinic, Individual Practice Associations (IPAs), and county/private hospital levels to identify commonly used written patient information forms and materials. L.A. Care then coordinated the translation and cultural competency review of the selected documents. Finally, a cross departmental team composed of CLS members and Marketing and Information Systems staff worked externally with a web developer to complete the development of the Provider and Member Web Repositories of translated materials.

The Web Repository Project was completed in 24 months. CLS spent the first 12 months seeking assistance from health care providers to select appropriate materials for the Repository. The next six months were spent on translation of the materials and the conceptualization of user friendly methods to search for translated materials online. In the final phase, L.A. Care and the web developers worked on building the Repository.

Included in the repository are a number of language tools including the Glossary of Managed Care Terms and Human Anatomy and Medical Terminology Guides. L.A. Care was also successful in achieving its original goal of developing a web resource that enhanced the delivery of culturally and linguistically appropriate services. Originally, L.A. Care envisioned a single database of translated materials available only to the providers, with approximately 20 documents in seven threshold languages. The final product included two different repositories with over 400 translated materials in ten languages.

**BENEFITS/RESULTS.** Over the past two years, L.A. Care has provided written translated materials to the provider community and aided in the provision of culturally and

linguistically appropriate services for LEP individuals. In addition, the health plan points to an increase in organizational branding, document recognition and understanding, helping its members make more informed decisions about their health care needs. Additionally, the translated forms found on the Web Repository have led to increased compliance with Federal and State regulations. L.A. Care has also been able to generate an unforeseen benefit of increases in numbers of registrants for California Medical Association's Certification in Continuing Medical Education, specifically for bilingual health care workers and cultural competency.

**LESSONS LEARNED/NEXT STEPS.** Due to the dynamic nature of the project, the Repository continues to add new translated materials. L.A. Care conducts regular assessments of its providers' and members' cultural and linguistic needs and access to care issues. In response to needs, L.A. Care develops and enhances its cultural and linguistic services and programs for its participating providers. L.A. Care encourages the use of the Repository by other health plans, medical groups, provider clinics, and community based organizations in need of translated materials in multiple languages to facilitate patient care.

**WHO TO CONTACT.** For more information about the ***Web Repository Project***, contact Jennifer Cho, Manager of the Cultural & Linguistic Services Department, at L.A. Care Health Plan via email at jcho@lacare.org or at (213) 694-1250 Ext. 4327.

# APPENDIX N- *Glossary*

**CLAS standards.** The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. *(OMH, 2000)*

**Cultural Competence.** Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities. *(OMH, 2000)*

**Culture.** "The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture" *(OMH, 2000; Katz, Michael. Personal Communication, November 1998*).

**Culturally and Linguistically Appropriate Services.** Health care services that are respectful of and responsive to cultural and linguistic needs. *(OMH, 2000)*

**Interpreter.** A person who translates orally from one language to another. *(OMH, 2000)*

**Translation.** Translation entails transferring ideas written in text from one language (the source language) to another (the target language). *(Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans, CMS, 2000)*

# APPENDIX O- *Project Methodology*

The Alliance of Community Health Plans (ACHP) Foundation with funding from the Whitehouse Station, NJ-based Merck Company Foundation (the philanthropic arm of pharmaceutical company Merck & Co., Inc.), undertook an assessment to provide information about CLAS projects that produced a business benefit so that organizations pursuing CLAS in health care would have information for planning and decision-making about implementation of CLAS in their organizations.

In 2005, ACHP empanelled an advisory committee of health plan and other experts in CLAS activities to help guide the process of collecting from health plans and other health care organizations information that identifies benefits that have been realized from implementation of CLAS Standards-related projects. The meeting focused on both descriptive and quantitative information available. ACHP used the partners to help identify: 1) important topics to address, and 2) the kinds of information available in their plans or organizations (or elsewhere) that could be included in this project. This group included ACHP member plans, non-member health plans and providers, and others with a history of substantial involvement and success in CLAS implementation.

Early tasks for this project included a review of existing literature. Selected materials were annotated and shared among ACHP staff and used to inform interview questions and design a business case study format. In addition, staff reviewed notes and discussions from the ACHP CLAS advisory committee from 2005. A broad list of organizational contacts were developed using peer-reviewed documents, internet search using "CLAS" and health as key words, news articles about clinics implementing language interpretation services for LEP, attendance to national conferences and contacts from CLAS experts in the field.

Through these activities, ACHP identified 42 projects that have been documented in the literature for engaging and implementing CLAS standards (with 90% primarily documented for interventions in language access services, CLAS Standards 4 through 7). All Forty-two projects were contacted. Many of the projects did not have information on the costs and benefits of their initiatives and as a result were not considered further for the ACHP project. Of the list of 18 projects, 13 projects were selected for business case analysis and highlighted in this report.

ACHP developed a one page questionnaire and provided it to each participating organization to access the depth of information available. Organizations highlighted include managed care organizations, hospital systems and a rural community pediatric clinic. Comprehensive telephone and in-person interviews were conducted as well.

ACHP project staff worked with health care organizations to obtain and develop relevant information from their experience in implementing CLAS. Such information ranged from information about system changes that promoted improved quality in service delivery, to quantifiable results from CLAS implementation that affect reduction of disparities or achieve financial business objectives.

Following the design and completion of the 13 business cases, each case was presented to a small committee of health professionals for external review. This final report was also reviewed by the same external committee.

# **APPENDIX P-** *CLAS Resource & Links*

***Agency for Healthcare Research and Quality***

*Setting the Agenda for Research on Cultural Competence in Health Care*. U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality http://www.ahrq.gov/research/cultural.pdf

***Center for Medicare and Medicaid Services***

Centers for Medicare & Medicaid Services: M+C National Quality Assessment Performance Improvement (QAPI) Program. *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans* http://www.achp.org/library/download.asp?id=6999 , and *Providing Oral Linguistic Services: A Guide for Managed Care Plans, Center for Medicare and Medicaid Services* http://www.achp.org/library/download.asp?id=7000

***Health Resources Services Administration***

*Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements.* Health Resources and Services Administration, U.S. Department of Health and Human Services, 2001 http://www.hrsa.gov/financeMC/ftp/cultural-competence.pdf

*Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*. Health Resources and Services Administration U.S. Department of Health and Human Services, April 2002. http://www.hrsa.gov/OMH/cultural1.htm

***Office of Minority Health***

*A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf

*A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care*
http://www.omhrc.gov/assets/pdf/checked/CLAS_a2z.pdf

*Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies*. US Department of Health and Human Services; Office of Minority Health; December 2003.
http://www.omhrc.gov/assets/pdf/checked/LPHAs_FinalReport.pdf

*A Family Physician's Practical Guide to Culturally Competent Care.*
https://cccm.thinkculturalhealth.org

*National Standards for Culturally and Linguistically Appropriate Services in Health Care.* US Department of Health and Human Services; Office of Minority Health; March 2001.
http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

*National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary*, Office of Minority Health
http://www.omhrc.gov/assets/pdf/checked/Executive%20Summary.pdf

*National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Office of Minority Health
http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

*National Study of Culturally and Linguistically Appropriate Services in Managed Care Organizations (CLAS in MCOs Study).* US Department of Health and Human Services; Office of Minority Health; August 2003
http://www.cosmoscorp.com/Docs/FR-CLAS-1_ManagedCare.pdf