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Organizational Responses to Address Access and Quality of Care Issues for Limited
English Proficient (LEP) Patient Populations

By

Fátima Marinely Rodríguez

A dissertation submitted in partial satisfaction of the
requirements for the degree of

Doctor of Public Health

in

the Graduate Division

of the

University of California, Berkeley

Committee in Charge:

Professor Joan Bloom, Chair
Professor Lonnie Snowden
Professor Kurt Organista

Fall 2011

Organizational Responses to Address Access and Quality of Care Issues for Limited English Proficient (LEP) Patient Populations

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by Fátima Marinely Rodríguez

Abstract

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Doctor of Public Health

University of California, Berkeley

Professor Joan Bloom, Chair

Limited English proficiency is a risk factor affecting millions of persons living in the United States. It can compromise the person's access to care as well as the health provider's capacity to deliver high quality, safe, and cost-effective care. This study investigates the environmental influences (i.e., regulatory, socio-demographic factors) to which health care delivery organizations and public health departments must respond to meet the needs of limited English proficient (LEP) patients, and identifies organizational strategies employed in diverse settings. In-depth interviewing of key stakeholders from diverse organizations was utilized to gain perspectives on language access issues. Organizational theory, specifically open systems and resource dependence theories, guided this study, and helped to illuminate the exchanges between these organizations and tactics used to mitigate potential losses of power and autonomy. This study identified interagency collaborative efforts in language access policymaking and practice that varied in scope, formality, and resources. In general, collaboration was viewed favorably, and was an important vehicle to address health equity, limited resources, and increasing regulatory and financial pressures. However, administrators often found it difficult to secure leadership engagement and resource support, as well as maintain language access as a high priority issue within their respective organizations and across partner organizations due to competing and changing priorities. Further research is necessary to explore enabling factors in language access, in light of an ever increasing demand for linguistically appropriate services and limited resources within and across organizations.

Dedication

Dedico este esfuerzo a mi mamá y papá quienes vinieron a este país con un sueño y mucha ambición. Sacrificaron todo para sus tres hijos y las generaciones que siguen. Gracias por abrir la puerta a un mundo de oportunidades.

To my Mom and Dad who came to this country with a dream and ambition, and sacrificed their lives for their three children and future generations. Thank you for opening up a world of possibilities.

Table of Contents

Abstract	1
Dedication	i
List of Figures	iii
Acknowledgments	iv
Chapter One: Introduction	1
<i>Persons with Limited English Proficiency and Health Impact</i>	1
<i>Provider Responsibility and Language Access Policies</i>	2
<i>Organizational Responses to Policy</i>	9
<i>Collaboration and Coordination</i>	10
<i>Addressing Gaps in Research</i>	11
Chapter Two: Theoretical Frameworks	12
<i>Organizational Theory</i>	12
<i>Resource Dependence</i>	14
<i>Collaboration</i>	15
<i>Study Purpose</i>	16
Chapter Three: Methods	18
<i>Study Design</i>	18
<i>Participants</i>	19
<i>Procedures</i>	20
<i>Measures and Qualitative Data Collection</i>	21
<i>Data Analysis</i>	22
Chapter Four: Results	24
<i>Strategies to Meet the Linguistic Needs of Patients</i>	24
<i>Environmental Influences and Challenges in the Provision of Language Assistance Services</i>	26
Patient Demographics	26
Compliance.....	29
Organizational Mission and Values.....	31
<i>Interagency Collaborative Efforts in Language Access</i>	33
Health Maintenance Organization (HMO) Report Card	33
California Senate Bill 853	37
Emerging Collaborative Model in Language Access.....	41
<i>Personal Connection and Commitment to Ensuring Language Access</i>	43
Deep Understanding of the Immigrant Experience	43
Belief in Collaboration	45
Chapter Five: Discussion	47
<i>Research Questions</i>	47
<i>Strengths and Limitations</i>	49
<i>Implications for Policy and Program Implementation</i>	50
References	53
Appendix A	59
Appendix B	63

List of Figures

Figure 1. Recipients of Federal Assistance.....	2
Figure 2. DC and States Directly Reimbursing for Language Services.....	8
Figure 3. Ten Essential Public Health Services.....	11
Figure 4. Organizations by Stakeholder Groups.....	19
Figure 5. Language Access Strategies.....	24
Figure 6. Public Health Departments: Awareness and Experience.....	25

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Chapter One: Introduction

Persons with Limited English Proficiency and Health Impact

Limited English proficiency (LEP) is a risk factor affecting millions of persons living in the United States, which adversely and disproportionately affects immigrants and ethnic minorities. According to the US Census, over 21 million persons in this country do not speak English well (Shin & Bruno, 2003; M. K. Youdelman, 2008). They may be unable to speak, read, write, or understand English well enough to interact effectively (Carter-Pokras et al., 2004). In health settings, limited English proficiency often translates into a communication barrier that compromises the ability of non-English speaking patients to access the care that they need, and the health provider's capacity to deliver high quality, safe, and cost-effective care.

At all points of contact—when calling to make an appointment, registering at the reception desk, obtaining care from health care providers, reading medication labels, and giving informed consent—limited English proficient (LEP) patients may experience language barriers. According to the Institute of Medicine's landmark report, Unequal Treatment:

“Language barriers [can] affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor decision-making, or ethical compromises” (IOM, 2003).

Language access in health care has been framed as a quality of care and patient safety issue (Johnson & Kanitsaki, 2006). Language barriers are also increasingly viewed as a potential source of racial and ethnic disparities in health and outcomes (IOM, 2003). As a result, there has been a growing emphasis on understanding the impact of language on health care access, health-seeking behaviors, and health care outcomes. Over the years, language access has garnered significant research and policy attention, inspiring inquiry, dialogue, and action among a diverse set of stakeholder groups. Consequently, the field of linguistic and cultural competency has “evolved from a fledging concept to a recognized intervention in the quest for health equity” (Federal Register, 2010).

A growing body of evidence finds that LEP patients bear the heavy burden associated with a language gap. A review of the literature reveals that persons with limited English proficiency tend to have poorer health status, less access to preventive and primary care, poorer communication with their provider(s), worse health outcomes, lower satisfaction with the care they receive, among other indicators than their English speaking counterparts. LEP persons are also less likely to have a regular source of care, thereby compromising continuity of care and the receipt of high quality care (Shi, Lebrun, & Tsai, 2009).

Disparities in care and access across LEPs from different linguistic groups have been documented. For example, women who primarily speak Mandarin, Cantonese,

Vietnamese, and Korean had the lowest rates of pap tests in a California study (Ponce et al., 2006). Latinos with fair or poor English proficiency were found to have significantly less physician visits (about 22% less visits) than English speaking, non-Latinos (Derose & Baker, 2000).

In a study conducted by Wilson and colleagues of eleven language groups, LEPs were significantly more likely to report not fully understanding a medical situation, being confused about how to take medication, and understanding a medication label (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). Even after controlling for potential confounders,¹ LEPs reported having had an adverse reaction to medication because they did not understand the instructions.

Provider Responsibility and Language Access Policies

In addition to problems faced by the patient, language discordance also impacts health care providers – from hospitals, health plans to solo practitioner offices. Federal and state regulations mandate that virtually all health care organizations assume the responsibility and liability for ensuring language access.

At the federal level, provisions in The Civil Rights Act of 1964, and specifically, Title IV, Section 601, indicate that:

“No person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance” (“U.S.C.,” 2000d).

The courts, including the U.S. Supreme Court, and U.S. Department of Health and Human Services (DHHS) have interpreted this statute to protect national origin minorities who do not speak English (Project, 2004; M. K. Youdelman, 2008). Title VI requires that organizations receiving federal funds ensure LEPs with *meaningful* access to their services and programs. Title VI affects a range of public, private, non-profit and for-profit organizations at federal, state, and local levels. The U.S. DHHS identified various types of entities that may be recipients of federal assistance.

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| <ul style="list-style-type: none">• Hospitals• Physicians and other providers• Nursing homes• Managed care organizations• State Medicaid organizations | <ul style="list-style-type: none">• Home health agencies• Social service agencies• Programs for families, youth, and children• Head Start Programs• Universities and other entities with health or social service research programs |
|--|---|

Figure 1. Recipients of Federal Assistance (Federal Register, 2003; Project, 2004)

¹Age, sex, education, income, insurance, time in the United States, usual source of care, and language/ethnicity.

As a way to “recommit the federal government to improving accessibility of government funded services” for LEP persons, in 2000, President William Clinton passed Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency (M. Youdelman & Perkins, 2002), and President George W. Bush upheld, revised, and reissued the Order in 2001 (Chen, Youdelman, & Brooks, 2007).

Among the stipulations, the Executive Order gives the Department of Justice (DOJ) the “responsibility for approving (federal) agencies’ recipient guidance and serving as a central repository of agencies’ plans” (Government Accounting Office, 2010). The DOJ convened the Federal Interagency Working Group on LEP to develop a website, LEP.gov, where such LEP plans are published, and agencies can find numerous resources, including planning tools, reports, frequently asked questions, press releases, and links to organizations addressing language access issues (Department of Justice, 2010). Based on a review of completed guidance documents, as of December 2009, 22 federal departments and independent agencies submitted their LEP guidance for posting on the DOJ website (Government Accounting Office, 2010). The U.S. DHHS is one of the 16 executive-level agencies that posted their LEP guidance online (Department of Justice, 2010; Federal Register, 2003; Government Accounting Office, 2010).

To date, the DOJ continues to provide expertise to federal agencies in meeting Title VI and related statutes and Executive Orders. On August 19, 2010, Assistant Attorney General Thomas Perez issued a memo to all Federal Funding Agency Civil Rights Directors, which restated DOJ’s role in coordination and enforcement efforts, and identified key areas of service for its Federal Compliance and Coordination Section (FCS). FCS is charged with developing and delivering further guidance, technical assistance, Title VI training for Federal agencies, as well as the coordination and clearinghouse for complaints (Perez, 2010). Additionally, DOJ has the authority to review and clear any federal agency documents that have civil rights enforcement elements to ensure greater consistency and effectiveness, and the Attorney General can initiate civil rights litigation in federal court. The DOJ is also responsible for collecting reports or Implementation plans, detailing the previous year’s performance and upcoming plans to implement Title VI and related statutes from agencies administering federally assisted programs (Perez, 2010).

Another monumental policy published by the Office of Minority Health (OMH) in 2001, the Culturally and Linguistically Appropriate Services in Health Care (CLAS) Standards, has also raised the level of importance of addressing the diverse linguistic needs of patient populations. The OMH envisioned the Standards as a “means to correct inequities that currently exist in the provision of health services, and to make services more responsive to the individual needs of all patients/consumers” (Office of Minority Health, 2000).

“The CLAS Standards represent the first national standards for cultural competence in health care and offer comprehensive guidance on what constitutes cultural competence service delivery”...[consisting] of 14 guidelines,

recommendations, and mandates that serve to inform, guide, and facilitate implementation of culturally and linguistically appropriate services in health care” (Federal Register, 2010).

The standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Four of the fourteen standards (4, 5, 6, and 7) are mandates that specifically address Language Access Services. According to these four standards, health care organizations must: 1) offer and provide language assistance services, 2) provide both verbal offers and written notices informing patients of their right to receive language assistance services, 3) assure the competence of language assistance, and 4) 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 (Office of Minority Health, 2000).

For almost a decade, the CLAS Standards continue to have enormous policy and operational impact. The Standards have served as a framework for health care organizations to develop organizational structures and implementation plans for culturally and linguistically competent systems of care. They have set forth a model other policymaking bodies have followed, including government and accreditation agencies. Nonetheless, some have argued that the Standards provide guidance that is vague, and they have not been implemented universally (Shi, et al., 2009), nor systematically within health care organizations. Furthermore, “adoption of more widespread, explicit and stringent CLAS Standards may be required” (Shi, et al., 2009).

Efforts are currently underway to revisit and enhance the CLAS Standards, in light of the constantly evolving field of cultural and linguistic competency and other changes in the health care environment, including health care reform. To garner input from a diversity of stakeholders, including individuals and organizations, a national review process with a period for public comment took place from September 20 through December 31, 2010. Comments were received online as well as through three meetings in cities across the country (Baltimore, Maryland; Chicago, Illinois; San Francisco, California). A National Project Advisory Committee with leaders in the health care industry with representation from government, health plans, hospitals, and other agencies was also formed to allow for additional input before final publication (Federal Register, 2010). The CLAS Standards Enhancement Initiative is intended to result in “broader awareness of the Department of Health and Human Services’ interest in CLAS”, as well as updated national standards for the “adoption or adaptation by stakeholder organizations and agencies” (Federal Register, 2010).

States have also developed language access policies that clarify or broaden federal requirements (M. K. Youdelman, 2008). According to a review of legislation by the National Health Law Program, the number of laws promulgated across the country varies by state, with all states having at least two language access laws, some states having less than 10 (i.e., Wyoming, Georgia, Hawaii, South Dakota), and one state, California, having more than 100 language access policies in place (J. Perkins,

Youdelman, & Wong, 2008). This review also found that state laws vary in their level of comprehensiveness, with some focusing on a particular health care provider (i.e., health plan, government program) or patient group only (J. Perkins, et al., 2008).

California is by far the most regulated state for language access, and has been viewed as the “most comprehensive state approach”, as it includes a “Title VI look-alike that prohibits national origin discrimination in any program or activity conducted, operated, or administered by the state or by any state agency”(State of California; M. K. Youdelman, 2008). Additionally, other California policies concentrate requirements on particular agencies and programs, such as Dynamally-Alatorre Bilingual Services Act of 1973 for state and local agencies, and California’s Medi-Cal Managed Care Division (MMCD) policy letters² of 1999 and 2002, which address managed care plans serving Medicaid patients. In 2003, California passed Senate Bill 853, the Health Care Language Assistance Act (known as SB 853), the first policy of its kind in the nation to extend cultural and linguistic requirements to all commercial plans and insurers. Prior to SB 853, only health care organizations receiving federal and state funding in California were subject to cultural and linguistic requirements. In a state as diverse as California, with an LEP population representing approximately 20% of its residents (U.S. Census Bureau, 2006), these requirements address a demographic reality with growing health communication needs.

Despite such great strides at the federal and state levels to provide policy mechanisms to improve equity, serious challenges remain. Regardless of efforts to raise awareness, there continues to be a lack of knowledge of requirements, as well as barriers to implementation and enforcement, which “leave millions of people with LEP unable to obtain the same quality of care received by English speakers” (M. K. Youdelman, 2008). Complementary forces are thus necessary to achieve the intended impact of federal and state policies.

Accreditation agencies have stepped in and supplemented federal and state requirements by setting industry standards, conducting research, as well as promoting education and models of care for linguistically and culturally appropriate services. The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations), responsible for accrediting and certifying more than 18,000 health care organizations (including hospitals) and programs in the United States, has released patient-centered communication standards covering a range of areas. These include, but are not limited to: qualifications for language interpreters/translators; identification of patient’s oral and communication needs (including patients preferred language for discussing health care); and addressing communication needs (through provision of interpreting and translation services) (Cordero, 2010). The monograph entitled, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, provides a comprehensive approach to understanding and integrating Joint Commission Standards into the care continuum,

²MMCD PP-02: Health Education and Cultural and Linguistic Group Needs Assessment, MMCD 99-03: Linguistic Services, MMCD PP-04: Translation of Written Informing Materials, MMCD 99005: Cultural Competency in Health Care—Meeting the Needs of a Culturally and Linguistically Diverse Population.

from admission, assessment, treatment, end-of-life care, discharge and transfer, and organizational readiness (The Joint Commission, 2010).

To advance research in systems and leadership and more fully promote the systematic application of practices that support patient safety goals and quality of care processes, the Joint Commission has also collaborated with numerous organizations such as the National Health Law Program, Office for Civil Rights, hospitals, and academic institutions. Through their *Speak Up Initiative*, the Joint Commission is also improving patients' understanding of their rights and questions to ask their doctors and other caregivers that relate to communication barriers and needs.

The National Committee for Quality Assurance (NCQA), an accreditation agency for numerous entities (including health plans), is also involved in improving health care quality by promoting Multicultural Health Care (MHC). Since 2006, NCQA has lauded health plans for their efforts in culturally and linguistically appropriate care through its *Recognizing Innovation in Multicultural Health Care* award. These awards serve many purposes:

“Identify models for potential replication in other settings and for shared learning; provide a forum for dissemination and recognition of health plans’ efforts to address culturally and linguistically appropriate services and reduce disparities among their members and communities; and support the development of voluntary standards for multicultural health care” (NCQA, 2010a).

In July 2010, NCQA launched a MHC Distinction program that supports rigorous standards in race/ethnicity and language data collection, access and availability of language services, practitioner network cultural responsiveness, and culturally and linguistically appropriate services programs (NCQA, 2010b). The MHC Distinction Program is voluntary at this time, and there is an application process, a web-based survey tool to respond to each of the MHC standards, and associated fees.

While there has been significant movement in the policy and implementation arena, the current predicament in language access has been called a national healthcare system failure (Partida, 2007). There is still an absence of *universally* available language services, and this situation is not “simply” an oversight at the clinical level, but an inconsistent response and commitment across organizations to make the provision of interpreter and translation services an institutional or health care industry priority. In this environment, resources are generally not available at an adequate level, and the provision of language services is often disorganized and haphazard.

A multilingual study uncovered another aspect of the language access dilemma that relates to the fact that more needs to be done to increase awareness of language laws and empower LEP communities in California. Only 38% of LEP survey respondents were aware of the legal protections that afford them the right to a health care interpreter. Furthermore, awareness of language access policies was not associated with

interpreter utilization, but with having a provider that speaks the LEP patient's non-English language (Grubbs, Chen, Bindman, Vittinghoff, & Fernandez, 2006).

The costs associated with delivering linguistically appropriate services and care have also been raised as a concern or barrier to consistent and widespread implementation. Although somewhat dated now, prior to the passage of Executive Order 13166 in 2000, the Office of Management and Budget (OMB) conducted a cost-benefit study examining the implications of implementing the Executive Order. This cost-benefit study utilized various methodologies³ and involved in-depth case studies of four sectors (health care, welfare, transportation, and immigration). The provision of language assistance services in health care was found to be the most costly. OMB estimated costs of \$268 million a year for interpretation services in inpatient hospital, outpatient physician, emergency departments, and dental visits (Office of Management Budget, 2002). The average interpretation cost was \$4.04 per visit or 0.5 percent of the total cost of the visit⁴, with expenditures varying widely. Costs for such services have increased since the time of the study, and the demand has grown as well.

Further exacerbating this issue is the fact that there is limited or no financial support from the government to cover interpretation and translation services. Language access policies are often unfunded mandates, and most health care providers and organizations must absorb the "additional" expense for language assistance services. Particularly in times of decreasing budgets and fiscal crises, the implementation of a comprehensive language assistance program contributes to the overall cost of delivering health care, and often seems prohibitive. Nevertheless, litigation due to discriminatory practice and non-compliance with language access policies can represent an even greater financial consequence or threat to physicians and health care organizations.

In a review, four areas of legal concern related to ineffective communication were identified with real-life examples of the human and financial impact: medical malpractice suits; legal vulnerability due to lack of informed consent; breach of the duty to warn of risks associated with treatment methods and medications; and breach of the patient's privacy rights (Van Kempen, 2007). The tragic case of an 18 year old who was rushed to the emergency department with his mother and girlfriend is introduced to demonstrate a communication-related medical malpractice suit:

"The young man was unconscious, and the only clue to his condition was the use of the Spanish word "intoxicado" by his mother and girlfriend. As no one in the ED spoke Spanish, hospital staff interpreted the word to mean that the boy was intoxicated or, more specifically, suffering from a drug overdose. What the women had intended to convey, however, was that the boy was nauseated, not intoxicated. Nearly three days after his admission, all the while being treated for a drug overdose, the doctors ordered a routine neurological test. The test showed

³Study methodologies included extensive literature review, surveys of federal/state agencies, public comment through the Federal Register, rough numerical estimates of national costs and qualitative assessments of national benefits, and in-depth case studies.

⁴These figures account for the services of professional interpreters contracted at a rate of \$20 to 26 per hour, and the cost of telephonic interpreter services of \$2.20 per minute (or \$132/hour).

two blood clots in his brain, the result of a break in an artery that had been defective since birth. Finally receiving appropriate treatment for his condition, the boy regained consciousness, but was left with quadriplegia. He ultimately sued the hospital, the paramedics, the ED, and attending physicians for medical malpractice, and his settlement topped \$71 million” (Van Kempen, 2007).

To demonstrate a lack of informed consent, Van Kempen discusses *Quintero v. Encarnación*, in which Rita Quintero was taken into protective custody after having been found roaming the streets of a town in Kansas. She was involuntarily committed, and remained institutionalized at the Larned State Hospital for 12 years from 1983 to 1995. During this time, Ms. Quintero was given treatment for schizophrenia, and she developed tardive dyskinesia, a condition often resulting from long-term or high-dose use of anti-psychotic medications. Ms. Quintero only occasionally received the support of Spanish interpreters, and it was discovered that she did not speak Spanish. Ms. Quintero spoke Ramuri, a Mexican indigenous language of the Uto-Aztecan language family.

“The physicians [defendants in this case] argued that they had met the requirement of informed consent by offering all of the relevant information to Quintero, albeit in English or Spanish...The court held that informed consent could not be obtained if the explanations were conducted in a language the patient did not understand and allowed Quintero to proceed with her suit” (Van Kempen, 2007).

Van Kempen asserts that the legal risks of ineffective communication between doctor and patient may vary; however, they are avoidable, if the proper precautions are taken. [Moreover], *“while access to interpreters is sometimes limited or cost prohibitive...their use can actually save costs and improve treatment outcomes” (Van Kempen, 2007).*

Currently, reimbursement for language services is only available in the District of Columbia and 12 states under Medicaid and the State Children’s Health Insurance Program (Chen, et al., 2007; Ku & Flores, 2005; Project, 2004).

- | | | |
|------------------------|-----------------|--------------|
| • District of Columbia | • Massachusetts | • Virginia |
| • Hawaii | • Minnesota | • Washington |
| • Idaho | • Montana | • Wyoming |
| • Kansas | • New Hampshire | |
| • Maine | • Utah | |

Figure 2. DC and States Directly Reimbursing for Language Services

Notably absent from the states reimbursing for language services is California, one of the most diverse states in the country and verifiably one of the states with the greatest demand. The California Department of Health Services convened a Medi-Cal Language Access Taskforce in 2007 to explore reimbursement options; however, the state has yet to authorize reimbursement for language assistance services.

Medicare, a federal program created to provide greater access to health services for the elderly, does not pay for interpretation services. This is a significant issue, as a large number of seniors (approximately 2.3 million) are limited English proficient (Ku & Flores, 2005), and their health care needs tend to be more complex. Additionally, with changes to Medicare, in particular prescription drug benefits, Medicare beneficiaries and their caregivers are experiencing major problems with understanding the Program, covered benefits, and services.

Organizational Responses to Policy

The operational challenges of implementing federal and state language access policies, as well as accreditation/regulatory requirements are complex, and require a diversity of strategies that often need to be employed simultaneously to meet the growing demand for services in a multitude of non-English languages. For instance, health care organizations can assign patients to bilingual clinicians (if they have this resource within their institution and/or network), and this approach is considered the gold standard for communication (Tang, Lanza, Rodriguez, & Chang, 2011). They can also utilize bilingual staff as ad-hoc interpreters, hire on-staff salaried interpreters, contract with independent vendors for telephonic and face-to-face professional interpretation, as well as work with community language banks (Carter-Pokras, et al., 2004).

All of these approaches require both fiscal and human capital, which are in limited supply and vary in terms of quality and cost. Moreover, while linguistic concordance between clinician and patient is considered the best approach in ensuring effective communication (Green et al., 2005), unfortunately, there is a dearth of bilingual health care providers, and the pipeline for developing a diverse workforce is flawed and inadequate to meet current and projected needs.

The deployment of bilingual staff to serve as ad-hoc interpreters is thus a common practice in many health care organizations. While this strategy may address some of the language needs of patients, it presents certain limitations and challenges. Bilingual staff are not consistently available to provide linguistic support because their primary duties are not to provide interpreter services. Another complication is that bilingual staff may have little or no training to perform the duties of an interpreter and/or any background about the ethical principles guiding health care interpreters (Carter-Pokras, et al., 2004). Two movements in the field of language access are attempting to address such challenges: the development of national certification programs for interpreters and national standards for health care interpreting programs.

Regardless of the challenges associated with the use of bilingual staff as interpreters, they have become invaluable resources in many health organizations. Some institutions have established policies and procedures to allow bilingual staff to step away from their primary role in the health care setting to provide language assistance. Some institutions offer training, as well as a bilingual salary bonus or premium to compensate for the additional service provided by bilingual staff.

On-staff salaried interpreters tend to be trained professional interpreters, who are more readily accessible and understand the organizational setting since they work in the setting. They are usually hired for more commonly encountered languages, and charge between \$10 and 32 per hour. Independent contractors are usually freelance interpreters or employees of a language agency, with varying training and expertise, especially in the health care field. They charge between \$12 and over \$50 per hour for providing face-to-face interpretation services. Travel may complicate the ease of use, and arrangements in advance are required, which is often not possible for drop-in or emergency care.

Over the phone interpretation services may be one of the most expedient options that can provide access to hundreds of languages in a matter of seconds or minutes. The rate for telephonic interpreters reported by the OMB study was \$132 per hour or \$2.20 per minute.⁵ The utilization of such approach has some inherent challenges: the variability of training, knowledge of medical terminology, and experience of telephonic interpreters; consultation rooms without a dedicated phone line; the awkwardness of using a phone during the physical examination, loss of visual cues, as well as lack of continuity, if a patient is required to go to another appointment and needs to be connected again to another telephonic interpreter.

Although highly discouraged by language access advocates, family members and friends continue to be utilized as interpreters in health settings. In many circumstances, health care providers and staff may perceive family and friends as being readily available, and perhaps even as a more timely and cost effective option in the clinic setting. This perspective is often inaccurate and shortsighted. The quality of interpretation by untrained family members and friends can be poor, biased, and lead to omissions, errors and misdiagnoses. Use of family members and friends can translate into patient safety, cost, and quality concerns. Moreover, in California, it is against the law to use children as interpreters.

Collaboration and Coordination

There is a growing sentiment among health care leaders and organizations that collaboration should be explored more fully to better serve LEP populations. The concept of sharing resources in a systematic fashion has been postulated as creating a mutual benefit for the patient and the health care provider community (Au, Taylor, & Gold, 2009). Collaboration models include: community based organizations collaborating with hospitals and clinics to train and certify volunteer interpreters (Ku & Flores, 2005); pooling interpreters for a shared statewide network; hospitals working to develop language service performance measures (Regenstein, 2007); learning networks of hospitals to develop and test effective and efficient ways to provide language services in clinical settings (Lavizzo-Mourey, 2007). The Director of *Hablamos Juntos*, a Robert Wood Johnson Foundation Program, emphasizes that:

⁵In some cases, health care organizations are negotiating lower rates.

“There is no valid reason that healthcare organizations should independently develop, from scratch, the resources needed to provide language access for LEP patients. Lack of coordinated efforts is wasteful and contributes to wide variations in quality of interpretation, and ultimately, in quality of care and health outcomes” (Partida, 2007).

Working in isolation can be fiscally inefficient, and organizations also lose the opportunity to leverage economies of scale, such as exploring ways of maximizing bargaining power with regards to contracted interpreter and translation services, as well as tapping into content expertise in language access that is highly specialized, and varies across institutions.

Addressing Gaps in Research

The majority of existing research examines language access from the perspective of health care organizations and the delivery of clinical services. Information about the role of public health departments in ensuring language access is limited and should be explored further, particularly as language access relates directly to the ten essential public health services (Lee & Paxman, 1997) and eliminating racial and ethnic disparities in health.

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower power about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services, and
10. Research for new insights and innovative solutions to health problems

Figure 3. Ten Essential Public Health Services

The study places special attention on the role of collaboration within and across these two sectors. While there are key examples of collaborative models in language access, most of these occur at the national level and among similar types of organizations, such as through hospital collaboratives. There is little understanding of whether collaboration is feasible and favorable across institutions, such as between public health departments and health care delivery organizations, and what it takes to pursue these types of arrangements.

Chapter Two: Theoretical Frameworks

The theoretical conceptualization for this study is multi-faceted. It incorporates key organizational theories and concepts, a conceptual framework, and a rationale for a particular analytic approach to investigate the growing importance of language access and the potential role of collaboration between two types of institutions that are tasked with ensuring the health of diverse communities: public health departments and health care organizations. This study also examines the influence of the environment in shaping organizational responses to language access policy – primarily interpreter and translation services, as well as other language-related programs and initiatives that are aimed at improving care and service delivery for limited English proficient populations.

Organizational Theory

Organizational theory provides a critical lens through which one can view and better understand the culture, structure(s), and actions (i.e., behaviors, strategies) of organizations. Organizations are social structures that affect most, if not all, sectors of modern society, and represent a diversity of missions, goals, and arrangements. Organizations are one mechanism by which contemporary life is organized to “achieve goals that are quite beyond the reach of any individual” (Scott & Davis, 2007). They are generally known for their durability (persistence over time); reliability (production of goods and/or services in the same way over and over again, largely due to formalization, authority structures, culture(s), etc.); and accountability (through adherence to guidelines that allow for an accounting of past, present, and future behavior) (Scott & Davis, 2007).

In classic work, Walter Buckley states, “That a system is open, means not simply that it engages in interchanges with the environment, but that this interchange is an essential factor underlying the system’s viability” (Buckley, 1967). As such, an open systems perspective emphasizes the exchange or continual flow of materials, energy, and information across institutions and their environments (Levine & White, 1961); (Scott, 2003). While organizations are bound by their structures, open system theory indicates that these boundaries are permeable for the entry and exit of materials, energy, and information. Moreover, the environment is both a place from which organizations can acquire resources, and/or distribute products and services.

Open systems theory recognizes the influence of the environment in shaping organizations, and the role that organizations play in affecting the environment (Powell & DiMaggio, 1991). This relationship has been described as a bi-directional causal arrow of influence (Scott, 2003), with the environment acting as a driver of system maintenance (for longevity and survival) and diversity of organizations (Scott & Davis, 2007).

In the context of the current study, open systems theory speaks to various exchanges that occur in a complex public health and health care delivery system. Specifically, four types of interactions are examined, which occur between: 1) public health departments and health care delivery organizations, 2) public health departments and the

environment, 3) health care organizations and the environment, as well as 4) the exchange that occurs when all settings (public health departments, health care delivery organizations, and the environment) interact.

An understanding of both macro and micro level factors is required given the dynamics and interplay between organizations and the environment. The environment is composed of a multitude of social, cultural, economic, technical, and political influences. Some examples include: fiscal or economic constraints and/or opportunities; demographic shifts; American politics, values, and priorities; as well as federal, state, and local policies. These forces represent direct and indirect pressures on public health departments and health care delivery systems. Furthermore, they often contribute to different organizational strategies, and produce a range of organizational, population-based, and individual health outcomes.

An example of an environmental pressure that targets the public health field and health care industry directly is language access policies that impose requirements for the delivery of services that are culturally and linguistically responsive to the needs of multi-ethnic and multi-lingual populations. For example, federal and state policies are in place around the hiring and training of bilingual providers and staff in the area of cultural competence and language services; utilizing interpreters and/or bilingual providers and staff at all points of entry (i.e., places where communication is critical to patient decision-making and care); as well as increasing the availability of written information in languages other than English, such as signage in hospitals and other care settings and the translation of consent forms, pre-operation instructions, etc.

There are also environmental influences that may have indirect but significant effects on public health departments and health care organizations. For instance, while federal policies around immigration may not be aimed at the delivery of public health and health care services to specific populations, such as limited English proficient patients, they may lead to changes in public program requirements and result in funding cuts that can create additional access problems for historically underserved and vulnerable populations.

W. Richard Scott offers an analytic framework to understand organizations, and introduces the three pillars of institutions that work to constrain and constitute organizations: regulative, normative, and cultural-cognitive (Scott, 2001; Scott & Davis, 2007). The regulative pillar emphasizes the role of regulatory guidelines, procedures, laws, and rules in driving organizational behavior. Based on this view, there is a prominence of rule-setting, monitoring, and sanctioning activities, and organizations act “out of expediency to garner awards or to avoid sanctions” (Scott, 2001; Scott & Davis, 2007). The normative pillar “contain(s) an evaluative and obligatory dimension” (Powell, 2007), and organizational behavior is “guided by a sense of what is appropriate, by one’s social obligations to others, by a commitment to common values” (Scott & Davis, 2007). The third pillar, the cultural-cognitive pillar relates to shared conceptions and frames through which meaning is understood by organizations. “For cultural-cognitive theorists, compliance occurs in many circumstances because other types of behavior

are inconceivable; routines are followed because they are taken for granted as “the way we do these things” (Scott, 2001).

Resource Dependence

Resource dependence is an open systems model that underscores the importance of conditions in the environment, and provides insight into how organizations *manage* relationships with other organizations and the environment for survival (Aldrich, 1979). As stated by open systems theory, the resource dependence perspective acknowledges that “no organization is completely self-contained” or self-sufficient, and many organizations engage in exchange to acquire needed resources (Levine & White, 1961; Pfeffer & Salancik, 1978; Powell & DiMaggio, 1991). In theory, this exchange relationship is not problematic if resources or supplies are consistently available and accessible; however, Pfeffer and Salancik (1978) indicate that such is not always the case:

“Environments can change, new organizations enter and exit, and the supply of resources becomes more and less scarce. When environments change, organizations face the prospect of not surviving or of changing their activities in response to these environmental factors” (pg.3).

Thus, problems of dependency are probable, and organizations can experience a loss of autonomy, power, and control over their existence. As such, various safeguards and survival mechanisms are employed. Organizations can be loosely coupled from elements in the environment; meaning, that they can be connected (to other organizations) but not in a deterministic manner (Scott, Ruef, Mendel, & Caronna, 2000). For example, physician-hospital organizations are more loosely coupled than integrated health care organizations. As such, physician-hospital organizations can establish a variety of joint ventures, including freestanding ambulatory care centers or physician office buildings, whereas integrated health care organizations combine physician, hospital, and insurance services into a single entity (Scott, et al., 2000).

Many organizations develop strategies for acquiring information from the environment for protection from external influences, such as developing subunits that can be sensitive to shifts and have the ability to respond appropriately (Pfeffer & Salancik, 1978). In many health care delivery organizations and public health departments, cultural and linguistic services and/or diversity departments have been designed to serve this strategic purpose. They are responsible for having knowledge of current and proposed cultural and linguistic policies and regulations, as well as developing programs and services to address the diverse cultural and linguistic needs of patients. Most work in this area, however, happens within an organization, and often times in silos. Most public health departments and health care delivery organizations tend to develop strategies that first and foremost prioritize their institution’s particular language assistance services and programs.

According to Pfeffer and Salancik (1978), organizations seek to reduce resource dependence and maintain their autonomy. This may appear to be contradictory to cooperation. Eugene Bardach in his book, Getting Agencies to Work Together, suggests that interagency collaboration may be able to simultaneously achieve organizational goals that are both *agency-protecting* (which can buffer against the formation of dependencies) and *value-creating* (Bardach, 1998). With regards to the latter, interagency collaboration may enhance organizational resources, if agencies work together to mobilize talent, finances, and political will for an issue (Wandersman, 1993). For example, several organizations in California have been working collectively over the years to develop strategies and gain support for language services reimbursement from the government. Other organizations are exploring approaches to share interpreters across health systems using video medical interpreting technology.

Resource dependence theory also points to other types of survival tactics for organizations, which may serve as potential options for public health departments and health care delivery agencies, particularly those that are facing major challenges with respect to the provision of cultural and linguistic services. Examples of survival strategies include: the creation of action sets, which are defined as “groups of organizations coming together for a specific purpose within a limited time frame” and consortia, representing “a large number of organizations (that can) pool their resources for providing a collective service to members that no single organization could manage” (Pfeffer & Salancik, 1978).

Collaboration

Collaboration is an important framework to address this language access challenge, and represents a promising organizational survival strategy. In this context, collaboration refers to “the notion of collective actions by individuals or their organizations for a more shared community benefit than each could accomplish as an individual player” (Ansari, Phillips, & Hammick, 2001). The study explores whether collective action might advance work in language access, specifically whether language access strategies can be promoted and shared across organizations for the benefit of patient populations and the health care provider community.

A growing body of literature makes compelling arguments for promoting collaboration because many of the solutions for today’s complex social problems “go beyond the capacity, resources, or jurisdiction of any single person, program, organization, or sector to change or control” (Lasker & Weiss, 2003). For example, in order to effectively address problems such as poverty and violence that do not necessarily fit within our bounded systems and programs, more transdisciplinary thinking and action are required. Collaborative arrangements and practices may provide a forum for such work, and involve communities and organizations in the form of coalitions, partnerships, and consortia to deal with very complex social issues, and potentially address the root causes of disparities (Lasker & Weiss, 2003; Sullivan, 1998; Wandersman, 1993).

Collaborative arrangements are also viewed as a strategy that can allow the pooling of (organizational) resources, create access to more capital (e.g. human, financial, technical), and lead to improvements in our delivery systems. Lasker and colleagues describe the power of collaboration between public health and medicine to enhance the effectiveness of individual-level and population-based services through better supports for clinical services, wrap around services (that address logistical and cultural barriers, such as transportation and language assistance programs), outreach services, and social services (Lasker & Weiss, 2003). Many proponents of collaboration also consider this approach as having an impact on cost savings, which is powerful in times of economic and fiscal crises. To this end, collaboration can also lead to a reduction of duplication of efforts and services across institutions (Halverson, Mays, Kaluzny, & Richards, 1997; Wandersman, 1993). In the context of language assistance services, collaboration may also advance “solutions [that] leverage economies of scale across the health care industry or within regions or communities” (Partida, 2007).

Collaboration and coordination of language services across public health departments and health care delivery organizations (i.e., hospitals, clinics, managed care plans) at the local, regional, or state level may be possible and favorable for interpreter and translation services and health care interpreter training programs. Theoretically, collaboration “has the potential to enhance the ability of communities to achieve critical health and health system goals” (Lasker & Weiss, 2003). In the context of the study, collaboration may facilitate organizational compliance with federal, state, and local cultural and linguistic requirements, as well as address quality of care, patient safety, and cost-containment issues. Nonetheless, the challenges of collaborative work are important to keep in mind, and they are a focus of this work, particularly because not all organizations are engaging in this approach.

Study Purpose

The current study examines organizational strategies to provide linguistic services in two important settings, where patients receive clinical and health education services: health care delivery organizations⁶ and public health departments.

The current study aims to address six research questions:

1. What strategies are employed by health care delivery organizations and public health departments to address the need for language assistance services?
2. What influences health care delivery organizations and public health departments to provide language assistance services?
3. What challenges do health care delivery organizations and public health departments face to provide linguistically appropriate care?

⁶Health care service delivery organizations include: health plans, hospitals, and clinics.

4. How do health care delivery organizations and public health departments collaborate to address the linguistic needs of patients?
 - 4a. What structural/organizational factors must be in place to work collaboratively?
 - 4b. What individual level factors amongst the actors in the organizations (i.e., administrators, providers, and staff) must be in place to work collaboratively?

Chapter Three: Methods

Study Design

Qualitative research methods were used to investigate the dynamics and meaning of interactions within and between health care delivery organizations, public health departments, and the larger environment in which health care organizations and public health departments operate. In-depth interviewing, often considered one of the bedrocks of qualitative research (Ulin, Robinson, & Tolley, 2005) was used to gain a deeper understanding of language access issues from the perspectives of key informants or stakeholders within these organizations. For the purpose of this research, stakeholders are defined as persons or groups that “have an interest in the actions of an organization...and [have the ability to influence it” (Savage, Nix, Whitehead, & Blair, 1991).

Stakeholder analysis is the primary analytical approach to examine the multiple perspectives of actors involved in language access, from policy to implementation. Stakeholder analysis has been used by many disciplines, including policy and management, for a range of purposes that are relevant to this study:

“...for generating knowledge about actors – individuals and organizations – so as to understand their behavior, intentions, inter-relations and interests; and for assessing the influence and resources they bring to bear on decision-making or implementation processes” (Varvasovszky & Brugha, 2000).

Stakeholder analysis has been a useful tool for policy analysts that have long recognized the central role of interest groups in shaping policy agendas, decision-making, and implementation strategies. In policy circles, stakeholder analysis has served to: “characterize and categorize levels of interest and power of groups involved in the policy process” and examine relationships across groups and organizations, while keeping in mind the “impact of policy within a broader political, economic, and cultural context” (Brugha & Varvasovszky, 2000).

Stakeholder theories and approaches have also been useful to the field of management because they help determine the interest and influence of key actors, which in this area often includes customers, employees, the general public, and shareholders (Brugha & Varvasovszky, 2000). Managers use stakeholder analysis for strategic planning and analysis, in particular to identify threats and opportunities for change within the organization, as well as in the environment. Additionally, stakeholder analysis is often used to gauge the importance of actors in decision-making and their interest in supporting a specific issue or outcome. This approach is also instrumental in identifying stakeholders’ “capacity and willingness to mobilize resources towards a particular goal, and the ‘mapping’ of actors both in terms of the relationships between them, their potential for developing alliances with each other, and in their relationship to the desired outcome” (Brugha & Varvasovszky, 2000). Such knowledge can be critical to managers

as they determine which stakeholders to target; in other words, with whom they should concentrate their efforts to accomplish their agenda(s) or objectives.

Stakeholder analysis helps to examine different perspectives from leadership in a diverse set of organizations, in particular their roles and levels of influence to mobilize resources in the formulation, implementation, and monitoring of language access policy. Through stakeholder analysis, it is possible to determine whether stakeholder groups intervene to influence policy and practice for the delivery of culturally and linguistically appropriate care in public health and health care delivery systems.

Participants

Participants represented a diverse array of stakeholders that were organized into five categories: 1) state government agencies; 2) health plans; 3) hospitals; 4) local public health departments; and 5) community-based, advocacy organizations. Professionals from five stakeholder groups were interviewed predominately at the state and local levels. Study in these geographic areas is critical. California has great linguistic diversity, and it is also the most highly regulated state in the country with regards to making linguistic services available to LEP patients (Perkins & Youdelman, 2008).

Interviews were completed between February 2009 and May 2010. Twenty organizations from government, health plans, hospitals/clinics, public health departments, and community-based advocacy organizations participated in this study. The sample included a diverse mix of non-profit and for profit health care organizations.

A total of 23 interviews were conducted with professionals in middle management, including Directors, Managers, and Program Coordinators (Figure 4). These administrators have the ability to respond to questions pertaining to the strategic planning and operationalization of language access policies. Additionally, they are the primary actors involved in the visioning and day-to-day work of collaboration, if that is a strategy employed by the respective organization.

Stakeholder Groups	No. of Interviews
1. State government agencies	2
2. Health Plans	6
3. Hospitals/Clinics	5
4. Local public health departments	7
5. Community-based, advocacy organizations	3

Figure 4. Organizations by Stakeholder Groups

- Within the state government agencies group, there were two departments with oversight, monitoring, and reporting responsibilities for language access.
- Five health plans were included that operate nationally (2), statewide (2), and at a county level (2).

- One statewide provider association and four hospitals from four counties participated.
- Interviews with four local public health departments in four counties were conducted.
- Three community-based organizations with a specialized focus on language access were also represented that work at a national, state, or local level.

A set of organizations is excluded from this research due to feasibility issues and the diversity of unknown infrastructures, processes, and dynamics that would be introduced. Excluded were solo practitioner offices, preferred provider organizations (a form of managed care), dental organizations (inclusive of dental health maintenance organizations, dental offices and clinics), and pharmacies. However, it is important to note that all of these organizations are affected by federal, state, and other policies related to the provision of linguistically appropriate services. They could potentially benefit from collaborative efforts in language access. For the purposes of the current research, these organizations fall outside of the scope of inquiry.

Based on Human Subjects protections, the identities of individuals interviewed are protected. In most cases, the names of the organizations have been guarded, unless there is a particular relevance in identifying the entity given their role and the fact that no other organization of its kind exists in the State.

Procedures

Convenience sampling was used to identify the key stakeholder population. First, a list of leaders in the language access field was developed of personnel at various institutions from the five stakeholder groups who are involved in decision-making, research, advocacy efforts, legal/regulatory activities, and the delivery of culturally and linguistically appropriate care. Snowball sampling, which is iterative in nature, was also employed, so that additional candidates for interviews emerged over time. Snowball sampling allows a more inclusive pool of stakeholders, and decreases the omission of key players in this work (Varvasovszky & Brugha, 2000). Snowball or chain sampling begins with the identification of a few members of a group to be interviewed, these individuals identify others, these others point to more people who can shed light on the issue, and so on and so forth (Kuzel, 1999). This technique creates an opportunity to include individuals that initially may have been overlooked.

To achieve a multi-level perspective, informants from different stakeholder groups were targeted, with at least two organizations selected from each stakeholder group. Concerted efforts were taken to include different geographic areas of California (i.e., counties) given the diversity of organizational entities and populations across the state. A national agency was targeted given its close watch on policy issues in California and active role in the policy arena.

Once identified, study participants were recruited by phone and through electronic communication. In-depth stakeholder interviews were conducted over the phone or in-person that lasted between one and one-half hours.

Measures and Qualitative Data Collection

Based on an extensive literature review and the researcher's engagement in this field, a semi-structured interview guide was developed with open- and closed-ended questions (see Appendix A). The interview guide was designed to direct the conversation towards areas of interest in this study; however, there was an intentional and balanced effort to not approach:

"...stakeholders with too narrow or tight a focus (as that) may prematurely determine which issues and questions are important, and where levels of consensus or disagreement may need to be established. (On the other hand), too broad or loose a focus may allow the process to be chaotic; stakeholders may see no overall aim or justification for involvement and giving time to the process, and may lose or make no commitment to it" (Varvasovszky & Brugha, 2000).

Prior to deployment, the guide was field tested with two administrators: a public health department employee who works with a predominately Spanish speaking population and a health plan administrator who oversees numerous diversity and language-related projects.

The major categories within the interview guide are:

1. Demographics of the organization

It was important to identify the type of setting: whether the organization is public or private, a health care service delivery organization, public health department, advocacy organization, and government, as well as the geographic coverage. Additionally, it was necessary to determine the type of services rendered; some of the organizations provide clinical care, prevention services, research, policy, and/or advocacy for LEP populations.

2. Demographics of patients and members

Understanding the language needs of patients is of primary importance in the research, as well as their race and ethnicity. The organization's knowledge of the demographics of its patient population lends insight into the demand for language services and strategies required to address the communication and health needs of LEP populations.

3. Strategies employed by organizations to meet the linguistic needs of patients

Language assistance could be interpreted in many ways by stakeholders: interpreting services; translations; training programs for providers and staff, etc. Given the

exploratory nature of this study, it was important to let the interviewee speak to the strategies that his/her organization employs, rather than being directed to a particular organizational approach.

4. Main environmental influences or factors for providing linguistic services and/or informing language access policies

While compliance has been identified as an important force or motivator, other factors could be revealed by the exploratory nature of the interviews.

5. Challenges in making language assistance services available to LEP patients

The identification of challenges might inform whether and how organizations are working collaboratively to address growing linguistic demands and resource constraints.

6. Scope and level of stakeholder involvement in policy, implementation, and/or advocacy: locally, regionally, and/or nationally

It was likely that stakeholders might be involved in numerous activities and work at different levels, thereby influencing their knowledge and experience in language assistance services and policy.

Data Analysis

Each interview session was transcribed, and the transcriptions were reviewed to ensure completeness and accuracy of data. Two forms of qualitative data were collected and analyzed: 1) transcripts of all the stakeholder interviews and 2) field notes or memos that document any insights that arose during data collection.

Given the large amounts of data that were collected for this study, manual and computer-assisted methods were used. A qualitative software program, Atlas.ti, was the primary data management tool that allowed coding data, grouping data, connecting themes or categories, and displaying data. Coding was completed by the researcher only.

Coding involved “mining the data and digging beneath the surface” to discover meaning, and reveal any categories, themes, and patterns (Corbin & Strauss, 2008). To begin the coding process, a list of codes was derived from the literature and prior research, and applied to the data. Open-coding, “the analytic process through which concepts are identified and their properties and dimensions are discovered” (Strauss & Corbin, 1998) was employed. Line-by-line coding, which may be the most time-consuming but also most productive approach, was used, especially at the beginning of the analytic process. Additionally, coding by analyzing a whole sentence or paragraph helped to identify the major idea(s) brought out in the sentence or paragraph. This approach was useful when there were several categories and the analyst wanted to code specifically in relation to them (Strauss & Corbin, 1998). Another coding strategy was to “peruse the

entire document and ask, 'What is going on here?' and 'What makes this document the same as, or different from, the previous ones that I coded?'....[The answers to these questions prompted the analyst to] return to the document and code more specifically for those similarities and differences" (Strauss & Corbin, 1998).

Although the process described above seems rather linear, "good qualitative research is always more of a circular process...[and reflects a] spiral movement of hermeneutic research from understanding to interpretation to deeper understanding to more comprehensive interpretation"(Addison, 1999). Revisions to the codes occurred based on further exploration and immersion in the data. Eventually concepts (or codes) were grouped into categories and themes that reflect more abstract, explanatory terms.

Triangulation was possible in this study given the multiple stakeholder interviews conducted. The different sources of information from diverse organizational perspectives, and in some cases, within organizations, helped to corroborate, elaborate, or illuminate the research (Corbin & Strauss, 2008).

Chapter Four: Results

The results of this study are organized into four main sections: 1) Strategies to Meet the Linguistic Needs of Patients; 2) Environmental Influences and Challenges in the Provision of Language Assistance Services; 3) Interagency Collaborative Efforts in Language Access; and 4) Personal Connection and Commitment to Ensuring Language Access.

Strategies to Meet the Linguistic Needs of Patients

Research Question 1: What strategies are employed by health care delivery organizations and public health departments to address the need for language assistance services?

The types of language access strategies that are implemented by the health care delivery organizations and public health departments in this study are similar to those identified in the literature (Figure 5). However, when unraveling the details of how language assistance services were operationalized, many models emerged.

- | | |
|--|--|
| <ul style="list-style-type: none">• Bilingual providers• Bilingual staff• Dedicated staff interpreters | <ul style="list-style-type: none">• Telephonic interpreter services• Community based language banks• Video medical interpreting networks |
|--|--|

Figure 5. Language Access Strategies

The level of sophistication of language assistance services and organizational investments varied widely. Some health care delivery organizations had a formal infrastructure with dedicated staff and resources, as well as executive leadership support and buy-in. A hospital administrator shared that her department:

“...started back in the 1970s, and it was part of a Patient Advocate Office. It’s evolved since then. It’s now its own separate unit,” reporting to both Hospital Administration and Nursing.”

The fact that it was a dedicated unit with a reporting structure to the Chief Operations Officer and Chief Nursing Officer positioned the work well, and also reflected the criticality of the services to hospital operations and patient care. This department had a large staff of dedicated interpreters (over 20 full-time employees) who are available from morning to midnight. During afterhours, the hospital transitioned to a contracted telephonic interpreter service. The hospital also leveraged the language skills of its bilingual providers and staff. To expand the availability of interpreters, they used various technologies, such as telecom phones and video medical interpreting equipment.

Another hospital shared a very similar story about how their Language and Cultural Resource Center served as the central resource for interpreter services, translation services, and cultural diversity training. The administrator reiterated the importance of

having leadership endorsement, and mentioned that the Chief Executive Officer provides relentless guidance and support. *“I still meet with him to talk about our services, and he shows interest and also provides advice that is needed. He is so very much involved.”* There was a sense of pride in the work and the strong organizational commitment to ensuring effective communication and quality care. Whenever there are *“local, state, national visitors, my office is one of the places that they [visit] to see our services and explain to them how important it is to provide the service to LEP patients and how we provide that.”*

A few hospital administrators identified video medical interpreting (VMI) as an emerging strategy to address the increasing demand for interpreter services. Some hospitals and clinics are using video conferencing devices to tap into a shared pool of health care interpreters who work at the hospitals and clinics in a VMI network. See section, *Interagency Efforts in Language Access*, for more detailed information.

Health plan administrators in this study described formal systems with dedicated departments and/or staff with responsibilities for language assistance programs and services. Some of the departments include: Cultural and Linguistics Unit, Cultural and Linguistic Services, and Diversity and Cultural Competence. Staff oversaw and managed interpreter and translation services, and/or facilitated education and training for providers and staff on language access and cultural competency issues. The Director of a health plan with such a unit elaborated on the structure in her organization:

“We have a centralized individual who is a Master’s level linguist who is responsible for translations services. So, not only is she responsible for receiving and being the gatekeeper, but manages contracts with translation service vendors and translating documents. She’s also a consult to other departments that are looking to translate documents.

And, we also have a central location or individual that’s responsible for coordination of interpreting services for our members.

We also have a person responsible for overseeing compliance with [our network], including medical groups, Managed Service Organizations (MSOs). [Another staff] is responsible for providing cultural and linguistic competency training.”

When examining the public health departments in this study, it became obvious that they could not be compared to health plans and hospitals, or with each other (Figure 6).

- Two public health departments were well versed in language access policies and mandates, and had experience with implementation strategies.
- One public health department had experienced a steep learning curve in the past few years, and started a language assistance program from the ground up.
- One public health department described a fairly informal and emerging program.

Figure 6. Public Health Departments: Awareness and Experience

The formality of approaches for delivering linguistically appropriate services in public health departments also varied. Two public health departments had specialized units, and the work was part of diversity and/or connected to refugee programs. One public health department described language access strategies as being integrated into the delivery of traditional public health programming, as well as in its sister hospital and clinics. The second public health department admitted that her area was in the process of taking on a more formal role to ensure language access. At the time, the second public health department's focus was on written communication materials only, and the health clinics did more around oral communication or interpreting.

"We don't have a system right now...It's not so much saying that everyone's not doing a great job. There isn't a formal system in place."

It is important to note that collectively public health departments in this study were employing a range of strategies to meet linguistic needs. They used bilingual providers (specifically public health nurses and mental health professionals), bilingual staff, contracted interpreter services (eg. community-based language banks) and advocacy organizations to meet the needs of LEP patients. Additionally, some public health departments had stronger ties to the county hospitals and clinics that allowed them access to language and cultural resources.

Environmental Influences and Challenges in the Provision of Language Assistance Services

Research Question 2: What influences health care delivery organizations and public health departments to provide language assistance services?

Research Question 3: What challenges do health care delivery organizations and public health departments face to provide linguistically appropriate care?

Stakeholder interviews revealed three main environmental influences that pressure health care delivery organizations and public health departments to provide language assistance services: 1) Patient Demographics, 2) Compliance, and 3) Organizational Mission and Values.

Patient Demographics

Patient demographics represented a strong influence for providing language assistance services. Some stakeholders demonstrated high levels of awareness and sensitivity to the cultural and linguistic backgrounds of patients and the resultant demand for linguistically appropriate care and services. When asked about the makeup of their patient populations, many administrators identified the race, ethnicity, and language ability of their patients:

"Four percent of our patients speak English with difficulty" (Local public health department administrator).

“About 60% of our patients are Latino, and about three-fourths of those patients are of limited English proficiency. Overall, about 35% of our patients are LEP. Our patients are largely uninsured, and only 35% have Medi-Cal, and a very small proportion have other kinds of insurance” (County hospital administrator).

“Half of our patients are limited English proficient patients. 40% speak Spanish, 2% Korean, and 5% represent about 60 languages” (Hospital administrator).

“Our patient population is over 50% Latino and 50% speaks a language other than English at home. So language is a really big component of the advocacy work that we do...” (Provider advocacy organization).

“Our two main languages are Cantonese and Spanish. The top five languages are Cantonese, Spanish, Vietnamese, Mandarin, and Russian” (County hospital administrator).

“Our members speak over 130 languages, and read and write in over 100 languages. Even though keeping accurate numbers in the languages that our members speak is important, our organization goes by the ‘rule of 1’. This means that we make every possible effort to accommodate the language needs of our patients...” (Health plan administrator).

Such statements provided a snapshot of the linguistic diversity of populations served and the different concepts used to describe and measure language ability and/or preference: difficulty with English; limited English proficiency; language(s) other than English spoken at home; primary language; and preferred spoken and written language in health care.

Many stakeholders acknowledged how critical it is to keep a constant pulse on patient demographics; it is a moving target. Administrators indicated that they want to be as prepared as possible, especially considering the fact that many had experienced increasing demand and sudden influxes of particular immigrant and refugee communities. One local public health department administrator shared that:

“Just when you’re right there [in meeting a need], all of a sudden it changes... from being Russian to Croatian”.

“About six years ago, I started noticing that more Mayan speaking people who didn’t speak Spanish, and clearly didn’t speak English, started appearing in our clinics... The people were coming from Mexico and Central America.”

As such, it was imperative to develop effective sensors or data collection strategies for race, ethnicity, and language. However, technical and operational challenges were noted, and levels of sophistication varied across health care delivery organizations and public health departments. One county hospital administrator pointed to the difficulty of asking the “right” questions.

“...right now we ask patients about their race, ethnicity, and language...but, we are not getting the best information, so we are trying to improve that...we have a problem with the way we ask the questions” (County hospital administrator).

Another hospital administrator echoed similar challenges with data collection.

“We are trying really hard to get accurate information when a patient comes to register for their first appointment and then on-going, in terms of demographics, race, and preferred language. And, we are trying to formalize that a little bit more to make sure that the questions are asked correctly...”

Stakeholders shared their struggles with determining what language questions yielded the most actionable data. For example, do organizations mirror government questions: How well do you speak English? What language other than English is spoken at home? Or, would more operations-oriented questioning be preferable, such as: What language do you prefer to speak or read when receiving health care?

A public health department administrator questioned the usefulness of data collected by her organization. Based on a review of patient demographic information, she appeared frustrated by the lack of specificity or granularity and methodology employed.

“... with regards to [responses in the] Unknown category, what are the Asian languages? We don't know that. Does the 4% English difficulty reflect an undercounting?...It is very difficult to depend on data like this for program planning because you can't really tell if that reflects most of the populations that we are serving...we serve mostly serve low-income, minority, and non-English speaking populations.”

This public health department shared a predicament faced by many organizations. How can you make a case for language assistance services, if you do not have the data? The administrator indicated that “it doesn't make sense for us to put a lot of resources into something that is not driven by data”.

Some stakeholders indicated that even if they had some language data, it was “not readily available” and/or up-to-date. One public health department administrator stated that language reports were not part of the regular reports that the department generated. At the time of the study, many organizations were still relying on external, government sources like the 2000 US Census. It is important to point out that some health care delivery organizations (mostly the larger health plans) had or were building the internal capability and directing resources to produce ‘real-time’ reports from their own databases and IT systems.

Other methods were identified that augment understanding of linguistic needs, such as asking staff about languages encountered, as well as monitoring utilization of contracted interpreter and translation services.

Compliance

The conversation about patient demographics seemed to go hand-in-hand with compliance. For example, one of the hospital administrators shared that the “*LEP patient population is huge,*” and her hospital was subject to Title VI and the CLAS Standards, specifically Standards 4 through 7.

“As a federally funded hospital, we need to provide patients interpreter services; otherwise, we can be at risk for a lawsuit. At the same time, we want to provide better care for all our patients” (Hospital administrator).

Another hospital administrator shared that they needed to do a better job at data collection, and that liability was an impending threat.

“We needed to figure out a way to serve our non-English speaking patients, or we might get sued. I mean, we were doing something that was not, you know, in line with the law. So, our CEO was willing to take a risk and make worthwhile changes.”

Health plans face increasing legal and regulatory pressures for language access. Throughout many interviews, health plan administrators identified key federal and state policies, specifically Title VI, the CLAS Standards, and California Senate Bill 853.

“We have to comply with all the Medicare and Medi-Cal mandates because our health plan oversees medical care, so we have to comply with those and whatever others...There is some federal law in Title VI of the Civil Rights Act. And, there are 150 different provisions in the state law....And the County Health Services Policy says that this agency provides interpretation and translation of materials to ensure access to services and effective, accurate, and timely communication with all non-English proficient patients, clients, including those who are deaf and hearing impaired” (County health plan).

Of the public health department personnel interviewed, only a couple identified compliance as a strong motivator. One public health department administrator indicated that instead of the state exerting pressure on organizations with mandates, she relayed the fact that community advocates were directly involved in creating the impetus for such policy. This administrator alluded to her dual role as public health official and community advocate.

““The State didn’t come up with it. It’s almost always generated by community advocates....So, advocates such as myself, in different role, go to the source, the codes, and say, “okay, you have to change this, and then it trickles down, and we say, ‘yes, sir’, and we make it happen” (Public health administrator).

Another public health department administrator said that standards and policy for language access often created “good pressure” in organizations by increasing

awareness of the linguistic needs of patients and emphasizing organizational responsibility. Years ago, when this administrator assumed the responsibility for language access, she was given the directive to develop health department standards because none existed in her County.

“...I found CLAS immediately. I wondered, ‘why are you just not using the CLAS standards?’ The biggest thing is that the CLAS standards are very clinical. They are really made for hospitals in clinical settings, so public health staff felt they could not relate to it necessarily.... I basically took the national CLAS standards and also [those developed by] Los Angeles County [Public Health]. I used their verbiage and kind of made something that sense for our health department...So it was big, it was a big deal, when [our] standards came out. They were adopted as a health department [with Senior leadership endorsement].”

Many stakeholders, mostly health care delivery organizations, viewed legislation and regulatory requirements as playing a very influential role in language access strategies. However, various concerns were raised about the tendency of a narrow interpretation of legal and regulatory requirements.

“I’ve gotten [questions] from administrators and providers about ‘what is the minimum I have to do?’ They always want to know the floor...legal requirements establish the minimum....I don’t think [the minimum is] enough. It’s far from ‘enough’ to really meet the needs of the LEP population” (Advocate).

“There are questions about how numbers are determined to meet the threshold...For Medi-Cal, the concentration of threshold languages is 3,000 eligibles per county, 1,000 per zip code, and 1,500 per contiguous zip codes. That is very specific. Many [plans] want use enrolled numbers, and so it’s obviously understated, right?” (Advocate).

A government official also shared that *“...once [an organization] reaches that threshold, they are going to say, ‘Okay, fine, [we met the requirement].”*

In this light, policy creates a push and a pull effect: it can be viewed as a motivator and also a deterrent for change. There might be some level of motivation to reduce legal and financial risks. As was mentioned previously, health care delivery organizations and public health departments can be sued by the patient(s), and federal and state agencies can impose fines. At the same time, the financial costs of policy implementation often impede organizations from going beyond a threshold or minimum requirements.

While stakeholders pointed to compliance as a main driver; monitoring and enforcement mechanisms were described as ineffective. Federal and state audits do take place; however, these activities vary in scope, methodology, and frequency. The audits described focus on health plans, hospitals, and clinics. For example, the Medi-Cal Managed Care Division (MMCD), in conjunction with the California Department of Managed Health Care (DMHC), performs joint audits and investigations for Medi-Cal

Managed Care plans on a range of contract stipulations. Language access is only one area reviewed during this joint audit.

“Formal audits of our health plans [are conducted] to ensure a number of requirements are being adhered to in the contract, one of them being members rights, which therefore entails the language services. So that’s a very formal audit that both of those entities conduct of our health plans” (State government official).

In addition, another unit within the MMCD conducts a review to determine compliance, and provides education and technical assistance to health plans.

“Staff review plan documents, and approve them. If needed, the staff will send back the plan submission of policy and procedures and request them to adjust them so they match the contract and if they obtain assistance to comply with linguistic interpretive services, among other things” (Another state government administrator).

A few caveats were raised about the existing auditing processes. Even when health plans (in this case) are reviewed, it is still not clear whether or not real access occurs at the encounter level.

“If you look at their records, it’s all there. The [language assistance] program is all there, but is it really working? I think you have to go to the patients. If you don’t get complaints...how else would you find out how it’s working?” (Government administrator).

Enforcement mechanisms rely too heavily on patient/consumer action. There is concern among health care delivery organizations, government, and advocates that most patients are not aware of their rights to free interpretation and translation services. Even if patients know about their rights, they are not likely to complain to federal and state agencies and/or the health plan about a lack of access.

“It’s the patient or member who complains that can generate very specific enforcement...but patients rarely complain” (Government administrator).

Additionally, no auditing body was identified during stakeholder interviews that specifically targets public health departments in this area.

Organizational Mission and Values

For many health care delivery organizations and public health departments, there were clear alignments between the organization’s mission, values, and priorities and the provision of linguistic services to a diverse patient population. Equal access was deeply rooted in organizational culture.

“Our mission is to maintain optimal health for all people” (Public health department administrator).

“Our mission is to provide each patient with superior medical services in a culturally sensitive environment...being limited English does not mean getting lower care” (County hospital administrator).

“[We] operate to basically meet the community’s needs, and to make sure that we are meeting our mission to provide cultural services to meet needs...” (County hospital administrator).

“To provide access to quality health care for [the] County’s vulnerable and low income communities and residents and to support the safety net required to achieve that purpose...[a] “commitment to cultural diversity and the knowledge necessary to serve our members with respect and competence” (Local health plan administrator).

Many health care delivery organizations and public health departments articulated the importance of having leadership recognize the connection between the organization’s mission and values and strategies for ensuring equal access for LEP populations. Leadership endorsement resulted in greater levels of resources and support for the integration of linguistic services in care delivery. Executive support was critical because linguistic services often competes with other organizational priorities, and requires an annual budget that can range between thousands and millions of dollars. Moreover, awareness building about language access requires constant provider and staff training and education, regardless of explicitness in the organizational mission and culture.

During the discussion, an interesting theme emerged related to how language access was conceptualized by public hospitals and public health departments. These organizations used a social justice and health disparities framework, identifying root causes for unequal access and care.

“Health disparities and inequities boil down to isolation and social injustice...” (Public health department administrator).

Limited English proficiency was viewed as creating greater disadvantage for many communities, and public health department administrators saw it as *“our obligation to create equal access, and use an upstream approach to our work”*. Guided by this orientation, the work with LEPs was very broad and encompassing. Language and culture opened a portal to truly connect with patients, and address social determinants of health. Linguistic services in a clinic or office setting was perceived as critically important but somewhat narrow or limiting. In the view of many public health department administrators, a more comprehensive and progressive approach was necessary to move towards health equity.

“We really need to focus on the things that are enabling people or hindering them from being able to control their lives. So it’s almost like a huge leap upstream than what we normally look at in terms of language [services].”

“When we are working with a non-English speaking person or LEP family, we are also addressing issues of income, poverty, housing, environmental pollution, and all of those other issues” (Public health administrator).

One public health department administrator introduced a novel concept for how they were infusing the value and importance of language and language assistance services in the organization.

“We are looking at [language services] as gas or utilities. In order to run a house...or a department, communicate with patients, you need this service.”

This department’s position shows a mission and values-driven agenda that shifts thinking about this issue.

Interagency Collaborative Efforts in Language Access

Research Question 4: How do health care service delivery organizations and public health departments collaborate to address the linguistic needs of patients?

Numerous stakeholders identified the existence of interagency collaborative efforts to improve language access in California. Two examples were highlighted in which government, health care service delivery organizations, and advocacy groups worked together to develop language access metrics with a reporting mechanism and state policy. An emerging collaborative model in language access was also acknowledged that leverages people and technology.

Health Maintenance Organization (HMO) Report Card

In the early 2000s, the State of California experienced major health reform, which changed the way millions of insured Californians received health care. Medi-Cal beneficiaries were moved from a traditional fee-for-service system to managed care as a cost-saving strategy and potentially a better model for health care delivery. From the very beginning, many advocates and consumers expressed concern about how beneficiaries, whom include low-income and minority populations, would fare in this transition. Would they receive equal access and quality health care? Would they understand their rights (i.e., benefits, coverage, and services)? Would decisions about patients’ health care be completely clinical and/or based on making money? Many of the managed care plans in the State were for-profit.

Such issues and questions paved the way for a greater focus on HMO regulation and protections for HMO enrollees. In July 2000, the Office of the Patient Advocate (OPA), an independent state office, was established in conjunction with the Department of

Managed Health Care (DMHC), a first-in the-nation HMO consumer rights organization. OPA has:

“a general mission to inform and educate HMO’s about their rights and responsibilities and how to get good quality care... In California, roughly about seventeen million people are in HMOs. When you look at Medi-Cal (Medicaid in California), it is about three million. Medicare is a little over a million. About twelve million are commercial members, and Healthy Families is another million...so it’s a lot of people” (Government administrator).

Given this great responsibility, OPA was quickly approached by advocates. A government administrator indicated that advocates:

“Rightfully and smartly identified an opportunity to promote or to advocate for the language access issue. In California, almost one fourth of HMO enrollees speak a language other than English, and about a million of them are monolingual, non-English speaking. There is another group of people who don’t speak English very well and may also be at risk.”

Although the Federal Civil Rights Act was seen as a protection for LEPs, advocates indicated that there needed to be proactive and systematic ways to assure access than simply wait for each individual [LEP] patient to experience problems. The existing mechanism placed the onus on patients to complain and demand their rights.

“If you couldn’t get language access, [patients] would need to complain to the Feds and go through their process, and it [became] a one-on-one issue. And, that’s how you got access” (Government administrator).

In fact, one health plan administrator indicated that *“the assumption is that all is good unless a complaint comes in.”* For many advocates, this approach was too passive and ultimately unacceptable. Moreover, given the large numbers of people who experience communication and other access barriers in the State, serious risks remained.

Advocates urged the OPA to respond to these language access issues more systematically, and OPA indicated that they could do so through two program elements:

“One was quality reporting through an HMO report card and the second was consumer education. [OPA] was funded to specifically do both of those things...advocates decided that the report card would be a good venue to look at, in terms of creating incentives for health plans and ultimately the people who contract with the physicians and the hospitals to do something more with language access than what had been done historically” (Government administrator).

The HMO report card was a form of public reporting that represented accountability and positive or negative visibility for California’s health plans. The HMO report with a section

on language access, often referred to as the Cultural Linguistic Access Survey, would create a rating system for HMO enrollees to make more informed decisions about what plan to select based on services rendered in non-English languages.

Because the completion of the report card was voluntary, OPA recognized the importance of working with health plans and consumer advocates for buy-in and greater participation. To this end, a Cultural & Linguistics (C&L) work group, composed of government officials, health plan administrators, researchers, and advocates, was established to foster discussion and movement towards greater acceptability of this language access information and reporting mechanism.

“[The HMO Report Card] was the only report card in the country that has this kind of information on it and we helped develop along with all the managed care plans. And, I have to say there were like a handful of advocates, and there were probably about 20 health plans... that came to these meetings” (Advocate).

The C&L workgroup met frequently (initially on a monthly basis), and discussed many aspects of the focused Cultural Linguistic Access Survey: from survey instrument development, scoring methodologies, to reporting strategies.

“The first year, it was a simple survey of I think eight questions of: What do you do? Do you provide medical interpreters? Do you provide translation materials? So...really basic stuff. And what we found out was that they couldn’t answer the question yes or no because it depended on a lot of things” (Government administrator).

Over the years, the questions became more specific and detailed. The complexity of the survey seemed to mirror the convolution of our health care delivery system. Language assistance services varied across plans and product lines, and there was a need to make distinctions between plans by product line. For example, some plans offered a mix of product lines or only one type: Commercial, Medi-Cal, Medicare, Healthy Families (State Children’s Health Insurance Plan in California), and others. Additionally, there was a need to look at availability of language assistance services by language, and stratification for Medi-Cal was also necessary by county (a total of 40 in the State of California) given threshold languages vary across the State.

With these examples, the government administrator shared that it was not too difficult to imagine the increasing complexity and sophistication of the survey, analysis, and reporting. In fact, the final survey was lengthy, and many individuals within an organization needed to be involved in its completion:

“It’s twenty-some pages, and not just one person sits there and marks the boxes. They have to send it to their Legal, to their Patient Education, etc. It’s a big coordination issue for them at the plan level” (Government administrator).

Equally if not more challenging were the dynamics of interactions between workgroup members. There was often a 'push and pull' between all involved. For example, there were intense debates between the health plans and the advocates. OPA often served as an arbitrator, and a government administrator depicted the discussions as negotiating sessions. In most cases, there was a need to find middle ground, and determine what would prevent an impasse.

Despite this very monumental effort, response to an HMO report card with a focus on language access received mixed reviews with supporters and detractors. In general, language access advocates pushed for the report card, and viewed it as an enforcement tool. One advocate indicated that the report card could increase consumer awareness of language assistance services and thereby created greater consumer choice. For example, if a consumer reads in Chinese, it would be helpful to know whether Health Plan X provides documents in Chinese and Health Plan Y doesn't, so they could choose Health Plan X. The report card also gave advocates a lot of good valuable data that helped [develop] and implement California Senate Bill 853.

On the other hand, a government administrator also indicated that "*many of the plans really didn't want to [participate in the voluntary report card initially] because it created pressure for them to do things, and it also cost money.*" At the same time, however, the government administrator stated that:

"Plans that serve Medi-Cal and Healthy Families - did a lot more for those enrollees than they did for anyone else because those purchasers, those programs, in their contracts and the purchasing contracts said you had to do X, Y, and Z... mostly the Medi-Cal plans- said yes to survey participation because they had data, and they were doing more to serve diverse patient populations."

OPA's approach to reporting was very straightforward; they reported on the plans that provided data, and they indicated that other ones were not willing to report on their practices. It was a struggle for OPA to get to get all plans to report. An advocate indicated that "*perhaps a lack of data was interpreted as being negative, and ignited a competitive spirit*". From one year to the next, "*there was a kind of a turning point where collectively [all] decided they were going to do this...Everybody reported, and [OPA has] had 100% reporting since then*" (Government administrator).

An advocate indicated proudly that after many struggles:

"We developed the Cultural Linguistic Access Survey that the health plans have to complete, and [OPA] started from nothing because there was also no model for that. And so we [collectively] created that survey over the years, and tried to improve it over the years. It went out of every year, and that's how [OPA] got their information around what the plans were doing in terms of providing [language assistance] services."

A total of twenty-seven health plans across the State participated. Language services data reported at the OPA website is from the last survey conducted in 2008 (Office of the Patient Advocate, 2011a). Consumers can view information for language services by product line: Group or Individual Plans; Medicare; Medi-Cal, Healthy Families, and Healthy Kids. For all product lines, consumers can determine the availability of interpreter services and bilingual staff, translated written materials, and web site information for eight languages only: Armenian, American Sign Language (ASL), Chinese, Korean, Russian, Spanish, Tagalog, and Vietnamese. Reported data for groups and individual plans, Medicare, Healthy Families, and Healthy Kids reflects the plans in the entire state. Medi-Cal data is reported for each county in the State. Consumers can also view whether the plan: monitors language services complaints; offers staff and provider training; and has instituted language services operations and plan policies (See Appendix B).

As stated by advocates, the success of the HMO report card with language access information created a window of opportunity for interagency dialogue and input, as well as represented a precursor to Senate Bill 853, a monumental policy for language access in California.

California Senate Bill 853

After many years of efforts to create a state health policy that addressed language access issues, California Senate Bill 853 was passed in 2003. SB 853 was the first policy of its kind in the country to hold “health plans accountable for the provision of linguistically appropriate services [and required] the California Department of Managed Health Care (DMHC) to develop standards for interpreter services, translation of materials, and the collection of race, ethnicity, and language data” (California Pan-Ethnic Health Network, 2009).

Stakeholders groups in this study (government agencies, health plans, and advocacy organizations) played a significant role in influencing the final SB 853 policy and regulations. As stated by a C&L workgroup member during an interview, many of the organizations that had worked to develop the linguistic access survey for the HMO Report Card were involved in the formulation of SB 853. In fact, SB 853 seemed to be a natural extension of the report card.

“Whether it’s voluntary public reporting or whether it’s a statutory regulation standard, we’re trying to solve the same problem, the same [language access] issue. It’s just a different approach” (Government administrator).

Similar to efforts directed at the development of the report card on language access, advocacy organizations and health plans provided input drawing from their areas of expertise and organizational realities. For example, advocacy organizations worked to ensure the incorporation of key elements that would extend equal access to LEP populations and create system change: notification of the availability of language assistance services; interpreter services; translation; and quality assurance and interpreter proficiency. As part of their role, advocacy organizations exerted

considerable pressure on the Department of Managed Health Care. An advocate described the relationship with government as complex, dynamic, and influenced by many factors.

“It is not unusual that we work with state agencies, and try to be cooperative...work with them. But sometimes, when they are more distant, then we have to be in an adversarial role, and hold them more accountable to things. So, it depends on the position that they are taking, the particular public official in charge, and how supportive he/she is” (Advocate).

Given formative work in this area, the relationship between DMHC and advocate groups was a mutually supportive relationship. DMHC often turned to advocates for technical advice and support. There was recognition of the advocacy groups’ content knowledge and connections with the communities affected.

Advocacy organizations informed the bill when it was introduced in the Legislature, and they were also involved in making sure the bill would be implemented as intended. When the first draft of the regulations was released in February 2007, CPEHN (which is California’s only statewide multicultural health advocacy organization) acted to ensure that the final regulations were strong. They mobilized communities to raise their voices, and “with the help of organizations, such as Asian Health Services, PALS for Health, and La Clínica de la Raza, [they] organized community members to testify at public hearings DMHC held across the state”(California Pan-Ethnic Health Network, 2009).

“There were press conferences, and LEP patients testified...In fact, Cindy Ehnes, Director of DMHC, said that hearing the testimony of LEP patients and their stories really helped her understand the need for this” (Advocate).

An area that CPEHN lobbied was the need to require health plans to collect race and ethnicity data of their enrollees. Some health plans; however, expressed concern over data collection efforts.

“The first reaction was, ‘well we don’t think it’s legal to ask people their race. We don’t think it is legal because it might lead to discrimination because we have an identifier, and if you want to discriminate against something, you can tell who is who and you can discriminate’...Okay, that one was fallacious. That’s not true legally. The second was, ‘The patients aren’t going to feel comfortable telling us their race. If we say, what’s your race, they are going to think that we’re discriminating and so we don’t want to ask, or certainly we don’t want to require it” (Government administrator).

Public health researchers presented testimony of the importance of data collection and its potential in racial and ethnic health disparities reduction strategies (California Pan-Ethnic Health Network, 2009). The collective voices from health plans, advocacy groups, researchers, and the community led to a second draft of regulations with a data collection requirement for race and ethnicity.

At the same time that the advocacy organizations were petitioning the support of communities, some health plans were launching their own efforts, and lobbying to address their concerns with the feasibility of implementation. Plans submitted letters expressing support for some components of the law, and concern about others. Insurers estimated the cost of the scope and task of operationalizing SB 853 to be about \$25 million. Nicole Kasabian Evans, spokeswoman for the California Association of Health Plans, stated: “Obviously, we know this is a diverse state and people speak many different languages...The insurers’ concern was about balancing access and affordability” (Calvan, 2009).

One key example of operational and financial challenges relates to provisions for the notification of the availability of language services in numerous languages. One health plan administrator indicated that there was a lot to take into consideration, including but not limited to IT infrastructure, work with print vendors, etc. She added that the systems within her organization were complex, and the law affected so many different areas.

“The plans fought [the initial notification requirement], and I think the Department eventually capitulated to the plans, and so that’s not there” (Advocate).

Instead of requiring health plans to distribute notices in ten or more languages, the third draft of the regulations only required notifications to be sent in the plan’s threshold languages. Based on algorithms for different enrollment levels, the threshold languages represented either one or two languages other than English for each plan. In the eyes of advocates, the third draft of regulations was weaker than earlier versions.

The final regulations were approved, and full implementation was slated for January 1, 2009. This target date caused health plans to mobilize within their organizational walls, as well as across similar organizations. An administrator from a commercial plan indicated that SB 853 rallied the attention of many individuals and departments within her organization.

“We had a staff, a huge team. We had daily meetings, almost every hour, different groups on the team consisting of between 50 to 100 people...for a year and a half that worked on building the process to be able to implement the language law” (Health plan administrator).

For many plans, especially those larger in size and also operated outside of California, trying to implement a California-specific policy represented a huge feat. An administrator from a large health plan shared that the “*systems are so complex in a national plan, and the law affects so many different areas. And, all those areas have different platforms...So it was very difficult to build the infrastructure so everything would work properly*”. Getting people to work together, whom had not worked together in the past, seemed to be an easier accomplishment in comparison.

A Medi-Cal plan administrator commented that “*when SB 853 came about, her organization already had a lot of things in place*”. Medi-Cal managed care plans had

language access policies since 1999, and they already were doing a C&L group needs assessment, offered interpretation and translations services, as well as instituted C&L training for providers and staff. Local managed care plans also pointed to language access requirements for Healthy Families.

During many of the interviews, stakeholders identified “ICE,” the Health Industry Collaboration Effort⁷, as playing an important role in the implementation of SB 853. A Cultural and Linguistics Team within ICE, composed of people with diverse backgrounds, such as Health Education, Compliance, Education and Training, Quality were involved and represented between 10 and 30 plans. This Team developed all of the products that were necessary for the SB 853 implementation. An example of ICE’s work focused on the language notification requirement.

“We didn’t want for the physicians [within the plans’ provider networks] to have different notices from all the different plans, and drive them crazy, so we worked with the Department of Managed Care and the California Department of Insurance and developed a standardize notice that could be used for all. We shared the cost for the translation, so that helped to reduce costs for all of the health plans...the DMHC notice was split by the health plans” (Commercial health plan administrator).

Collectively, the plans also recognized that training was an integral part of ensuring successful implementation of SB 853. An ICE member shared that *“one of the things that we do is train staff on cultural competency, working with interpreter services, working with limited English proficient customers. So we worked together to develop some of the training materials”* (Health plan administrator).

“...so everywhere we could, if there was a document that needed to be developed, we did it as a group so that we were all following the law; making sure that we were meeting all of the regulations, and making things as easy as possible for the customer to understand and as easy as possible for the physicians, so that it wasn’t a hardship on them” (Health plan administrator).

When asked what motivated this type of collaborative effort, a response from one of the health plan administrators was simple and straightforward:

“For this particular area, Cultural and Linguistic Services, where there’s a law in place, it was a benefit to everyone to participate...it would have been impossible for health plans to have completed all of the things that needed to be done singularly without the support of the other plans” (Health plan administrator).

To date, ICE continues to have a C&L Team, and meets regularly to keep abreast of policy developments, and work together to “interpret regulations, new or existing

⁷ ICE is a California nonprofit public benefit corporation that mobilizes volunteers from health care industry stakeholders (health plans, provider organizations) to develop educational and “best practice” materials for increased awareness and the implementation of policy and regulations on a range of issues, and not limited to language access.

legislation and standards related to the delivery of culturally and linguistically appropriate care; assist in the development of tools and guidelines to improve compliance and standardization with regulatory bodies such as the Centers for Medicare and Medicaid Services (CMS), Department of Managed Health Care (DMHC), Managed Risk Medical Insurance Board (MRMIB), and state Department of Health Care Services (DHCS), as well as, accrediting organizations (i.e., National Committee on Quality Assurance [NCQA]) related to cultural and linguistic requirements” (Industry Collaboration Efforts, 2011).

Emerging Collaborative Model in Language Access

A few public hospitals identified video medical interpreting (VMI) as an emerging technology that enables a collaborative model in language access. This model leverages people and technology to create a pool of health care interpreters that can be shared across organizations. VMI pools are being employed in numerous health care delivery organizations⁸ in California; however, not all organizations participate in the same interpreter network.

“With a push of a button a provider can get either a voice or a voice and video interpreter within a minute in almost any language” (County public hospital administrator).

If interpreter services are required for an appointment and VMI is used, the call is routed to an available interpreter from the shared pool of health care interpreters. The VMI system first checks on the availability of interpreters in the organization originating the request. If there is no internal resource for the requested language, the system searches and connects to an available interpreter in a participating organization within the network or a contracted interpreter services vendor.

“[This work] is a collaborative process. And, the network is helping us work together” (County public hospital administrator).

Numerous benefits influenced the decision of many hospitals to participate in a shared pool. Hospital administrators stressed the model’s contributions to increasing linguistic capacity and improving organizations’ ability to respond to increasing needs. Many felt that the strategy was a viable option, considering that the demand for interpreter services often outpaces the current supply.

“We don’t have enough resources, and also it’s good to share and not to reinvent the wheel. Maybe [another hospital] already has someone, and we can use that resource” (County hospital administrator).

Through a shared pool, a hospital administrator indicated that over 150 languages were covered in her network, including languages of lesser diffusion, for which there were no

⁸The stakeholders who raised this as a strategy mostly constituted public hospitals; however, this model is also being expanded to public clinics, public health departments, and health plans.

internal resources available at the hospital. Moreover, the shared interpreter pool increased coverage and the reliability of interpreter services.

“...we get a variety of languages and more coverage, including weekends and evenings. The more hospitals we get, the more scope we have...”

In addition to these benefits, some hospital administrators pointed to cost savings and greater organizational efficiencies, such as increased interpreter productivity and improved oversight and monitoring capabilities.

“We anticipate saving a lot of money because more phone calls will be taken care of, and we would have a much lower cost [for those involved], when we use each other’s service.”

“What is really exciting about having this technology is that you are able to do more tracking, monitoring, and seeing if there are gaps in meeting the demand for services.”

A hospital administrator, however, stated emphatically that: *“We are not trading quantity for quality [with this approach]. We want to make sure that our patients get quality care and that they understand.”*

Research Question 4a: What structural/organizational factors must be in place to work collaboratively?

Several structural/organizational factors were identified as being critical to advancing a successful collaborative arrangement. Executive leadership and sponsorship created organizational commitment, greater visibility, and resource support. For example, in order to operationalize the VMI model, a complex people-technology program, executive leadership from potential collaborators needed to be at the table from the very beginning. One administrator indicated that when they were in the process of discussing and rolling out a VMI strategy, *“top people from many institutions came together, and [there was a recognition that] you can’t do this unless your CEO is involved and a couple of Vice Presidents.”*

Additionally, administrators leading interagency efforts needed to develop and articulate a strong business case had that clearly demonstrated the strategic purpose and benefits of employing collaboration, as well as any defining costs and expected return on investment, if any. This business case was paramount to identifying and securing resource needs, which often include funding and staffing.

For the VMI model, clear and formal contractual arrangements needed to be established between organizations. A couple of hospital administrators noted that when establishing partnerships, it was paramount to determine the mix of organizations in the pool and their contributions to avoid over-taxing a particular institution.

“If you have one hospital that has all the interpreters, you’re going to get drained [by the other partners]... We need to make sure that we are first totally able to meet the needs here at our hospital” (County hospital administrator).

At the same time, this administrator noted that, “if you have someone who can help you with one of your smaller languages, then you don’t have to hire, for example, an Arabic interpreter. If one hospital can share their Arabic interpreter or a sign language interpreter through video, it really makes a lot of sense.”

It is important to point out that not all collaborative efforts in this study were as formal as the VMI model example. Collaboration can be informal and temporal. They can be set up to share lesson learned, best practices, and tools for implementation of language assistance services and programs.

Personal Connection and Commitment to Ensuring Language Access

Research Question 4b: What individual level factors must be in place to work collaboratively?

Stakeholder interviews uncovered very powerful individual level forces that drive the language access agenda in health care delivery organizations and public health departments. Key commonalities among stakeholders contextualized the organizational journey of language access, and presented a picture of health care and public health professionals with high levels of personal and professional engagement and commitment to serving LEP communities. A deep understanding of the immigrant experience and belief in collaboration increased the likelihood that administrators in this study actively pursued and maintained collaborative efforts.

Deep Understanding of the Immigrant Experience

Many stakeholders shared personal stories about their deep connection to immigrant communities and LEP populations. It was not uncommon to discover that administrators had at some point in their lives served as an interpreter for a loved one. One hospital administrator recalled an early childhood experience when she was the interpreter for her mother.

“I’m very passionate about this work. I have to tell you, I was an interpreter for my mother at age 12 when she came to this hospital after her insurance ran out in the private sector. And, I remember standing in the hallways...And, not having an interpreter available for my mom was very hard because I was 12 years old. Even though the doctor was talking in medical terms, I did my best but I never really knew. ‘Did I interpret correctly? Is she going to get sick because I didn’t say the right word?’ All those horror stories you hear about children interpreting. You know, I never forgot that.”

Even at an early age, she knew that she wasn’t the best person to do the interpretation; however, there were no alternatives. This experience had such a defining impact that it

influenced her career path and decision to assume a professional role that ensures direct communication between LEP patients and providers.

“I knew that when I grew up that I wanted to work in the medical field, and I didn’t know what would happen, but I ended up working here, where I had some of my very early experiences. So, that is my story.”

A public health department administrator indicated that her decision to work in language access and health disparities work was also largely influenced by a personal experience.

“There’s a lot of personal engagement. When you look at the lives of a lot of people who become innovators or change agents, what they wind up doing is very much impacted from their beginnings, very much so. And, when you finally make the connection, ‘oh my gosh, I am doing this because my mom didn’t have access to health care’...”

A second hospital administrator shared her personal journey and deep understanding of limited English proficiency and challenges faced by refugees.

“I came here as a refugee, and know how hard it is to communicate. [Refugee patients] are going through a lot of stress coming to a new country, let alone, they cannot communicate.”

Several administrators also communicated the experiences of their LEP parents, and the challenges they face in trying to integrate into this society, and navigate complex health care and public health systems.

“My parents speak two or three languages but limited English...My mother and father are learning English. They have all the tapes and videos at home to learn. I myself do not want them to go [to the doctor] if I am not sure I can get an interpreter for them. I might take a day off to go with them.”

This daughter/hospital administrator stated that it would be very risky for her parents (and other LEPs) to try to speak with their doctor without an interpreter. Health care was not the place for patients and providers to practice their language skills. There was a great sense of responsibility to ensure clear and effective communication for all LEP patients.

“My belief is that this population needs to be served, and they have the same quality of care that everyone has. So, that’s why I believe in the job that I’m doing, and still will continue to do that” (Hospital administrator).

A health plan administrator added that his professional work is fixing a problem that directly affects his parents, who are also members of the plan where he works.

“My parents, who are LEP, are my community. If I can make a difference for them, then it will create a ripple effect, and improve things for others.”

Belief in Collaboration

A personal belief in the importance of language access and collaboration seemed to propel language access efforts even further. Many of the administrators saw the value of collaboration, and they identified numerous reasons why they are personally involved in driving interagency efforts in language access.

“We need to be up to date with what is going on, and what other people have already done...it is important to share the resources and get what is there and also to work together to achieve what we need” (Hospital administrator).

“We have been here for a long time, and new programs might have their unique thing that we can help them with, and they can get help from us or we can get help from them...” (Hospital administrator).

“Working together invigorates/re-invigorates the work...There is no need to reinvent the wheel, and duplicate efforts” (Health plan administrator).

“We are trying to make the resources stretch, which makes sense” in a changing and resource limited environment (Public health administrator).

Collaboration was described as being deliberate, and interviews revealed a strong personal motivation. There were concerted efforts to make connections and explore partnerships with other organizations.

“It is not part of the job description that you must collaborate, but when you work more and more in this area, you find that it's really beneficial to be collaborating. We need to expand more in this language access area” (Hospital administrator).

Though important, collaboration was not an easy feat, and stakeholders were unwavering in their efforts given internal and external organizational pressures and challenges.

“If you don't have the commitment, [collaboration] probably isn't going to work” (Hospital administrator).

“Collaboration is sometimes impacted by other organizational priorities. Sometimes we are working with a partner organization, and an issue comes up internally...We have to switch gears. That can halt collaboration, but we believe it is so important to work together that we pick up where we left off, and keep on going” (Health plan administrator).

Regardless of whether the stakeholders worked in a health care delivery organization or public health department, they expressed sincere empathy and concern for LEP patients, and their stories demonstrated a relentless devotion to advancing this work.

“It is our obligation to provide equal access...We want a healthy community, and we want to make sure that we have a health community” (Public health administrator).

Chapter Five: Discussion

The main purpose of this study is to determine how health care delivery organizations and public health departments address the increasing demand for linguistically appropriate services, specifically exploring whether these organizations are involved in collaborative efforts to ensure language access. This chapter organizes the discussion by 1) Research Questions, 2) Study Strengths and Limitations, and 3) Implications for Policy and Program Implementation.

Research Questions

What strategies are employed by health care delivery organizations and public health departments to address the need for language assistance services?

What challenges do health care delivery organizations and public health departments face to provide linguistically appropriate care?

This study found that health care delivery organizations and public health departments addressed the linguistic needs of their LEP patient populations through numerous organizational strategies, with varying levels of formality and resources. Some organizations had little or no formal systems in place, and faced considerable challenges in identifying the linguistic needs of patients and operationalizing language assistance services. Administrators in these organizations indicated that they were often reacting to immediate needs, and it was difficult to address issues effectively.

On the other hand, some organizations in this study had formal, dedicated units with staff that managed and implemented interpreter services, translations, and/or cultural and linguistic competency training. As described by Pfeffer and Salancik (1978), these organizations were better equipped to protect the organization from environmental influences, such as regulatory and socio-demographic shifts. Staff within these dedicated units acted as language access sensors for the organization, providing content expertise related to existing and emerging language access policies and strategies.

Regardless of the organizational approach and formality, administrators in health care delivery organizations and public health departments noted the need to continually optimize services for LEP populations. Most administrators recognized the value of learning from each other, and they saw the potential of collaboration to leverage limited health care interpreter, translations, and training resources. A few administrators indicated that they did not want to “re-invent the wheel”. Collaboration was viewed as a vehicle to advance the language access agenda through learning and sharing of promising practices, challenges, and opportunities to develop and test new interventions and strategies.

What influences health care delivery organizations and public health departments to provide language assistance services?

This study found that different environmental influences prompt health care delivery organizations and public health departments to provide language assistance services. Patient demographics, language access laws and regulations, and organizational missions and values emerged as key influences, and they correlate with W. Richard Scott's regulative, normative, and cultural-cognitive pillars of organizations that constrain and constitute behavior (Scott, 2001; Scott & Davis, 2007). For instance, health care delivery organizations experienced greater levels of legislative and regulatory pressures than public health departments. As a result, health care organizations tended to not only have more formal language access programs, they also had a greater stake in the health policy making process. The establishment of normative systems was also fundamental to language access. Many administrators in public health departments and health care organizations stressed social justice and health equity values and norms on how language assistance services should be delivered in their organizations. Administrators worked diligently to embed language access strategies into daily operations to ensure that providers and staff used acceptable methods to meet the linguistic needs of LEP patients.

How do health care delivery organizations and public health departments collaborate to address the linguistic needs of patients?

Three examples of interagency collaborative efforts in language access were identified related to the HMO Report Card, California Senate Bill 853, and the Video Medical Interpreting (VMI) network model. As stated in the literature, this study found that alliances reflected efforts to strategically adapt to environmental changes (Shortell & Kaluzny, 2006). Additionally, collaborative arrangements varied depending on purpose and needs of participating organizations. They can be short-term to long-term and informal or formal in nature. The development of the HMO Report Card and Senate Bill 853 demonstrated how different stakeholder organizations came together for a strategic purpose to inform language access reporting and policy development. Their interactions were voluntary, and endured until the objectives were achieved. The Video Medical Interpreting network model presented a more long-lasting collaboration that required formal agreements on resource investments and costs for organizations sharing technology and a pool of interpreters.

Resource dependencies were limited in the first two examples of interagency efforts, whereas the VMI network model posed a potential threat to individual organizational autonomy, and represented a potential drain to resources that are shared across organizations. To mitigate a loss of power and autonomy, participating health care delivery organizations in a VMI network model established protections through formal agreements and the maintenance of alternatives in language assistance services (Scott & Davis, 2007). For example, these organizations employed numerous mechanisms to ensure that their organizations' interpreting needs were met first. For instance, they maintained contracts with telephonic interpreter services vendors to serve in a supporting function.

Collaboration was portrayed as an exciting endeavor in this study. As stated by Bardach, interagency collaboration may be able to simultaneously achieve organizational goals that are both *agency-protecting* (which can buffer against the formation of dependencies) and *value-creating* (Bardach, 1998). Future research is necessary to examine the benefits and risks of the VMI collaborative model over time, especially as it propagates across the state with similar or different types of organizations. For example, what is the impact of VMI on health care quality, the availability of interpreter services, and costs? If and how, will partnerships agreements between participating organizations change over time? The literature indicates that the stability and longevity of collaborative arrangements are largely influenced by whether they are voluntary or mandated by an external group (Oliver, 1990).

What structural/organizational factors must be in place to work collaboratively?

What individual level factors amongst the actors in the organizations (i.e., administrators, providers, and staff) must be in place to work collaboratively?

Administrators stressed the criticality of executive leadership and sponsorship for language assistance services and programs, and collaborative efforts in particular. Competing priorities often made it difficult to raise the level of importance of this work within an organization, and it was also challenging to keep collaborative partners engaged at the same level. As such, it is important to further examine some of the reservations identified that relate to the time and resource commitments necessary to effectively and successfully lead interagency collaborative efforts in language access.

Middle management, represented by those interviewed in this study, were key champions. Many administrators pushed the language access agenda because of their personal and professional connection to this issue and belief in collaboration. Their efforts went beyond the “normal call of duty,” and epitomize language access advocacy. This finding was illuminating; however, it presents some conceptual and operational challenges. As language access becomes more mainstream, if and how will changing leadership and stakeholders affect the language access movement?

Strengths and Limitations

This is the first study of its kind to examine language access strategies, environmental influences, and challenges from the perspectives of administrators in government, health care delivery organizations, public health departments, and community-based, advocacy organizations. Most studies focus exclusively on one type of organizational setting, such as hospitals only or managed care organizations only. Findings make an important contribution to a burgeoning field of cultural and linguistic competency, and present a more expansive view of organizational challenges, opportunities, and strategies to improve access and quality of care for LEP populations.

There are also some limitations to this study. While different organizational realities were presented, the limited number of organizations and types of health and public health professionals interviewed limit the generalizability of findings. In most cases, only

one professional from an organization was interviewed. As a result, the responses from one administrator per organization were assumed to reflect the position and reality of an organization. Due to the sampling approach and efforts made to select knowledgeable administrators who play pivotal roles in leading language assistance programs and services, threats to validity are addressed and hopefully minimized.

It is important to note that administrators in this study were not physicians or senior executives. Health care providers tend to raise the importance of and intersections between language access and clinical care; these issues did not emerge as major themes as compared to other environmental influences or pressures (i.e., changing demographics and compliance). Senior executives are integral to the success of organizational initiatives and programs, lending critical resources, support, and visibility. Thus, a more comprehensive study could examine additional stakeholders' perspectives on these issues.

Topics that might be considered sensitive were discussed during the interviews. Despite the fact that the study design protected the anonymity and confidentiality of participants, it is probable that stakeholders did not reveal specific issues regarding non-compliance with federal, state, and accreditation requirements. Disclosure of this and other delicate information could paint their organization in a negative light, and have unintended consequences, such as exposing their employer to legal and regulatory action. At the same time, administrators could represent their work more favorably. It was however interesting to learn that some organizations, such as public health departments and government, spoke very positively about organizations in this study, in particular the work of some hospitals and health plans.

Implications for Policy and Program Implementation

Language access is an evolving field and a moving target. During the time this study was conceptualized and implemented, there were numerous developments in policy, research, and organizational strategies that elevated the level of attention on this issue, and generated a greater sense of urgency for health care delivery organizations and public health departments to respond proactively in a changing landscape.

Over the past few years, policies have been enacted that have a direct impact on the language access agenda. As described in this work, the passage of California Senate Bill 853 established health plan accountability in the provision of linguistically appropriate services, and activated organizational responses related to interpreter services, translation of materials, and collection on race, ethnicity, and language data across the state. An infrastructure needed to be developed and/or strengthened, and this work continues to date.

At a national level, health care reform, specifically the Patient Protection and Affordable Care Act (ACA) signed by President Obama in 2010, is influencing how health care delivery organizations and public health departments provide care and preventive services to millions of Americans, many of whom are uninsured and underinsured.

Efforts within both the policy and practice sectors are currently underway to interpret the ACA, analyze operational and fiscal impacts, and determine national, state-based and organizational strategies to achieve the aspirational intent and scope of this far-reaching policy.

Key provisions within the ACA will likely benefit people of color and LEP populations (The Henry J. Kaiser Family Foundation, 2010). Health coverage expansions, such as an employer mandate, health exchange, Medicaid expansions, as well as funding to community health centers are intended to increase access to care. Disparities-specific provisions in the ACA are directed at data collection and reporting on race, ethnicity, and language and cultural competency training for providers. Additionally, there is a focus on “ensuring [that] information provided to individuals enrolling in Medicaid or purchasing coverage through the exchange is culturally and linguistically appropriate” (The Henry J. Kaiser Family Foundation, 2010).

Another effort launched by the Office of Minority Health in 2010, the Culturally and Linguistically Appropriate Services (CLAS) Enhancement Initiative, is “revisiting the CLAS Standards in order to reflect the past decade’s advancements , expand their scope, and improve their clarity to ensure universal understanding and implementation” (Office of Minority Health, 2011). The enhanced CLAS standards are expected to target organizations beyond ‘health care organizations’ (as originally drafted in 2001) to include public health departments and other types of institutions. This expansion will likely clarify the responsibilities of public health departments, a key stakeholder in this study. The Office of Minority Health will release enhanced CLAS Standards in 2012.

It is important to note that many more policies and regulations with language access or disparities-related provisions exist and will continue to be passed at the federal, state, and local levels. As a result, language access will become a mainstream issue, and the stakeholders groups involved and impacted will continue to expand. A steep learning curve is expected as new players enter this field, and this study lends insight into current policies and practice, as well as key considerations for the future.

In a changing landscape, many language access policies will remain as unfunded mandates with enforcement challenges, and other policies are/will be tied to financial incentives. Regulatory and financing mechanisms will continue to shape language access program implementation. For instance, unfunded mandates will likely continue to represent a financial drain to many organizations (i.e., operational costs, risk of liability), and language access champions and allies will have to continue to push the agenda. Policies with monetary incentives may represent a financial gain (which can be in the millions) for some organizations, and this will also create pressure to deliver linguistically appropriate services. Regardless of financial support, resources are limited, and will not fully address access and quality of care issues faced by LEP and other populations. Further research is necessary to examine the unintentional consequences of language access-related policy and implementation incentives. Are financial incentives a strong enough lever to ensure equitable care and services? Is this approach feasible and sustainable? What does it do to a field that has been markedly mission and values driven, as demonstrated by this study?

In conclusion, this study is timely, and contributes to health care and public health policy and program implementation in meaningful ways. It identifies strategies to increase organizational and community capacity in the provision of language assistance programs and services from the perspectives of administrators who lead this work 'from the trenches' of health care delivery organizations and public health departments. No other study presents their voices, highlighting the great strides that have been made over the years, as well as the challenges and opportunities for taking language access work to another level for greater collective awareness and support.

Health care and public health professionals have been charged with a formidable responsibility – to ensure the health of individuals and communities. This study presents a strong argument that language access is a critical part of the health equity equation and any efforts to eliminate racial, ethnic, and linguistic health care disparities.

At the same time, as professionals in these fields, we must recognize that language access is not the panacea for issues that are rooted inside and outside formal health care and public health delivery systems. Nonetheless, language access helps us connect with our diverse patients and communities. It is by asking questions and creating a dialogue that we can gain a true understanding of what makes some people healthy and others not, and arrive at truly responsive and transformative solutions.

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Appendix A.

Interview Guide

This interview is intended to be exploratory in nature; that is, it should flow fairly organically. This guide incorporates basic questions that will help me develop a better understanding of existing cultural and linguistic programs and services in various public health and health care settings. It is expected that there may be variations in organizational approaches; however, these questions identify some key areas based on my research and work experience.

Project Description: The purpose of this project is to collect information via interviews, from key stakeholders and personnel who are involved in the oversight and management, implementation, and research and evaluation of language assistance programs and services in public health and health care settings. This study aims to gather information about different organizational approaches in this work from individuals working in diverse settings. The information gather from these interviews will help me develop research questions and a research design for my future dissertation research.

Interviewee: _____

Organization: _____

Date: _____ Start/End time: _____

1. Can you describe your organization?

- The type of setting
 - Public, private? Health care or public health?
- Services rendered:
 - Clinical care? Prevention services? Research? Advocacy? Other?
- The population served

- Patient demographics—particularly interested in languages of patients, and their cultural backgrounds.
 - Geographic, service area
2. Can you describe how your organization addresses the cultural and linguistic needs of patients who are non-English speakers or limited English proficient?
- For example, what does your organization offer with regards to interpreter services, translations, and/or training programs for providers and staff?
 - What is your role in this work?
3. If applicable, what are some approaches employed in the following settings:
- Clinical settings?
 - Non-clinical settings?
 - Administrative offices?
 - Research?
 - Policy-related activities?
 - Advocacy?

4. What are the main factors or drivers for your organization to provide linguistic and cultural services?

5. What, if any, challenges does your organization face in making cultural and language services available to patients? Can you please describe some of these?

6. What, if any, are some of the strategies your organization uses to address and/or overcome these challenges?

7. To make these services available, does your organization work collaboratively with any of the following:
 - Other internal departments?

 - With other organizations in the community? Such as other health care organizations? Public health departments? Research agencies? Government?

8. If your organization works collaboratively, can you please describe the reasons why joint work was sought?

9. Is your organization involved in research and/or policy work related to improving access and care for non-English or limited English speaking patients at the:

- Local level (beyond your organization's immediate needs?), ie. With the county? City?
- Regional level
- Statewide level
- National level

If so, please describe and why or why not?

10. Are there any other individuals or organizations that you suggest I contact to get further insight into this work or area of research?

11. Is there anything else you would like to add or comment?

Thank you very much for your participation, time, and assistance.

Appendix B

Office of the Patient Advocate (OPA) reports the results from the Cultural Linguistic Access Survey, a component of the HMO Report Card, on their website.

The following examples show different ways consumers or end-users can search the site to learn about language assistance services in health plans across the state.

OPA Language Services Webpage

Language Services

To learn more about language assistance and services for non-English speaking members, you must first tell us the type of insurance you have.

Select one of the following types of insurance:

- ▶ **Group or Individual Plans**
A group HMO plan is health insurance that you get through your job. Your employer pays part or all of the cost of the plan. An individual HMO plan is health insurance that you buy yourself. You pay all of the cost of the plan.
- ▶ **Medicare**
Medicare is health insurance paid for by the federal government. It is for people who are 65 and older and for some people under 65 who have a disability.
- ▶ **Medi-Cal**
Medi-Cal is health insurance paid for by the state of California. It is for people with low incomes. In other states it is called Medicaid.
- ▶ **Healthy Families**
Healthy Families is low-cost health insurance for children and teens who do not qualify for Medi-Cal and who do not have other health insurance. Healthy Families covers health, dental, and vision care.
- ▶ **Healthy Kids**
Healthy Kids is health insurance for children and teens who do not qualify for Medi-Cal or Healthy Families and do not have other health insurance.

Source: (Office of the Patient Advocate, 2011a)

Below is an example of how consumers can examine language services availability in Chinese for Medi-Cal plans in Alameda County. Consumers can view whether the plan offers interpreter services and bilingual staff in Chinese (or another language); has translated written materials and web site information in Chinese (or another language); monitors language services complaints; offers staff and provider training; and has instituted language services operations and plan policies.

Medi-Cal Language Services Availability

[Language Services](#) ▶

For Medi-Cal

See specific language services that may be available to you and your family in your preferred language. You can also see other things HMOs do to improve access to services across all languages.

1. Choose a language:

Chinese

2. Pick a chart to view:

- ▶ [Interpreter Services and Bilingual Staff in Chinese](#)
- ▶ [Translated Written Materials and Web Site Information in Chinese](#)
- ▶ [Plan Monitors Language Services Complaints](#)
- ▶ [Plan Staff and Provider Training](#)
- ▶ [Language Services Operations and Plan Policies](#)

Chart(s) list plans in Alameda county. [Choose a different county](#)

Source: (Office of the Patient Advocate, 2011b)

In the next example, consumers can view data for plans offering Medi-Cal in Alameda County, and shows how Language Services Operations and Plan Policies have been operationalized to represent five key areas.

Medi-Cal Language Services Operations and Plan Policies

[Language Services](#) ▶ [For Medi-Cal](#) ▶

Language Services Operations and Plan Policies

<small>The services listed may not be available at all times to all members. Contact your HMO to request the services you need in your preferred language.</small>	Plan staff are made aware of written language services policies	Plan incorporates language services in quality improvement programs	Plan matches members to providers by language	Plan tracks when members request interpretation services	Plan reviews its quality data by language groups
Alameda Alliance for Health	✓	✓	✓	✓	✓
Anthem Blue Cross - HMO	✓	✓	✓	✓	✓
Kaiser Permanente - Northern California	✓	✓	✓	✓	

Source: (Office of the Patient Advocate, 2011c)