Five Steps to Improving Communications with LEP Populations

Quality health care demands clear communication. Communication problems are at the heart of many sentinel health care events—including unexpected deaths and catastrophic injuries—as well as the consequential legal liability and financial loss for health care providers (The Joint Commission, 2007b). Patients with limited English proficiency (LEP), low literacy, and those who are hearing impaired or have cognitive disabilities pose special communication challenges. Health care organizations and individuals need to develop a capacity to communicate effectively with diverse audiences. Linguistic competency is quickly becoming essential to maintaining quality of care standards and practices.

Fortunately, most health care organizations already have the seeds for developing cultural and linguistic competencies to care for today's diverse patients. These include human resources with diverse language backgrounds and quality improvement technologies; the formal structures and staff dedicated to assure that quality of care standards (either self- or industry-imposed) are met.

The recommendations in this tool offer broad national and global perspectives on language diversity and practical action steps that have emerged from our work with Hablamos Juntos demonstrations and focused research on translated materials. These recommendations and action steps are intended to build on existing core competencies by focusing a special lens on the communication needs of LEP patients. They suggest ways in which hospital and health plan administrators, physicians and other health care providers, and other government, insurance and industry professionals can develop linguistic competencies at the individual, organization and industry level.

Hablamos Juntos
We speak together.

The Five Steps to Improving Health Care Communications With LEP Populations:

Step 1. Embrace the Need for Change.
Accept the need for increased linguistic competency in your organization and beyond.

Step 2. Consider Your Own Population and Your Current Risks.
Become aware of the diversity of language needs and understand the consequences of poor communication.

Step 3. Assess the Availability and Quality of Your Non-English Written Materials.
Rate the strengths and weaknesses of your current stock of non-English health materials.

Step 4. Focus on Improving Your Translation Capabilities.
Learn more about the translation process and adopt standards and best practices.

Step 5 Encourage Investments in Communication Improvement.
Advocate for communication-related strategic investments by health providers, language professionals (interpreters/translators) and researchers.

The recommendations and practical steps in this tool are a work in progress, guided by our years of focused work to develop practical tools that address language barriers and the expertise of linguists, language researchers and practicing translators. They are not evidence-based guidelines. Rather, they represent a social-ecological approach to creating response capacity for a growing population unable to communicate in English. This approach assumes health communication takes place in many environmental subsystems within and outside of health organizations, and that cultural and linguistic competencies can take many forms and need to be developed at various levels within health care organizations as well as within the local, state or national health care industry.

We hope you find these recommendations useful in developing new competencies within your organization and that your work in this arena will help orient health care industry attention to the nation's diverse and multilingual society. Be sure to read the entire *Hablamos Juntos More Than Words Toolkit Series* for more guidance, tools and strategies to improve the quality of non-English materials.

Step 1. Embrace the need for change.

People often change in response to a perceived problem or temporary threat. Sometimes they make changes when they sense a new reality that offers both challenges and opportunities. The first type of change is reactive or defensive, while the latter is proactive and positive.

We believe you will be more likely to commit to the other steps in this guide, and ultimately succeed in improving communication with individuals who understand little or no English, if you truly believe that change is essential and act proactively rather than ignore the fact that the face of America has changed.

To begin with, we encourage you to consider the pervasive need for increased linguistic competency throughout the United States, not just in health care settings, but also in the education, business, entertainment and defense sectors. The trend that you are responding to in your organization (perhaps the reason you have read at least this far) is that you already feel the need to change your situation. But the need that you feel is only a part of a much larger movement currently underway in the country to improve language competencies. Although health care is surprisingly behind the curve in many aspects of language and communication (e.g., American Translators Association, the professional society that attests to translators' competencies offers testing in the domains of science, technology, medicine, law, business and finance, and is just now working to recognize health care), you are now part of the necessary and decades-long effort underway to develop national competencies to succeed in our increasingly multilingual society.

Next we believe that you should stimulate and participate in national, state and local discussions about the role of language and culture and encourage conscious and principled language planning. Ignoring the widespread implications of a quickly-growing multicultural and multilingual society is not in our collective, long-term best interest, nor is offering band-aid responses to this chronic need. Discussions about these issues can be difficult, but they must take place. When you do, consider that there is no such thing as a totally monolingual country. The idea that the U.S. is an exception, an island amid the increasingly blurred global linguistic lines, is a myth. But until now, the myth has largely delayed a proper response to the new reality. Politics, religion, immigration, culture, education, the economy and natural disasters have all played a role in creating multilingual societies, including our own (Crystal, 2005). These changes that are now so glaringly apparent in clinics and hospitals across the country are not likely to reverse course but will simply become more pronounced..

Language: The new must-have national competency

The challenge of communication in an increasingly multilingual and multicultural society goes well beyond health care. In 2004, leaders from government, industry, academia and language associations met for the first National Language Conference sponsored by the U.S. Department of Defense with the purpose of developing a *Call to Action for National Foreign Language Capabilities* (Call to Action, 2005). The report referred to the attack on September 11, 2001 as a "Sputnik moment," suggesting that the same bold action taken by Congress following the Soviet Union's 1957 launch of the Sputnik satellite is needed now with regard to foreign languages. Just as the National Defense Education Act created a generation of scientists, engineers and mathematicians who collectively worked to put a man on the moon and satellites circling the Earth to win the Cold War, the *Call to Action* envisions "a future in which the United States enhances its global leadership through increased proficiency in foreign languages and understanding of and respect for the cultures of the world" (Call to Action).

How do societies deal with populations who speak diverse languages? At a minimum, they can cope with attempts at interpreting and translation. This response, generally the approach taken in the U.S., is a reactive holding strategy with the idea things will return to normal. As the irreversible nature of this change takes hold, societies cope by supplementing the population's language skills, either encouraging everyone to learn a common language (lingua franca) in addition to their mother tongue or to learn as many languages as possible. In fact, speaking two or more languages is a way of life for three-quarters of the world's population

Finally, forward-looking societies tend to cope by planning, that is, by engaging in conscious, principled language planning and linguistic engineering. This involves creating policies about how languages and linguistic varieties are to be used, supporting existing foreign language programs, implementing new language teaching programs (e.g., bilingual programs, language immersion), developing coherent standards for language use and maintenance, and defining the role of the media and purpose-driven policies that guide public health communication in a multilingual society.

"A broad debate is going on now in all sectors of society. Start listening and learning. Participate when you can to inject the health care perspectives that until recently have been lacking. Only by being part of the larger dialogue will you begin to fully embrace and become a champion of the need for increased linguistic competency in your organization and ultimately the nation."

> **Health care organizations need to keep pace with local demographic changes in order to develop necessary competencies to provide high-quality care for patients with ever greater cultural and language diversity.**

Step 2. Consider your own population and your current risks.

The face of the U.S. has changed and in all likelihood your population base has also changed too. In 1950, there were nine white people under age 40 for every person of color. By 2000, the ratio was 1.5 white people for each person of color (United States Census Bureau, 2000). Moreover, the U.S. Census Bureau calculates that by 2042, U.S. residents who identify themselves as Hispanic, black, Asian, American Indian, Native Hawaiian and Pacific Islander will together outnumber non-Hispanic whites (Bernstein & Edwards, 2008). The United States today has broader language diversity than the whole of Europe. Fifty-two million Americans speak a language other than English at home, and 23 million (12.5% of the total population) report having limited English proficiency (LEP) (United States Census Bureau, 2005).

These changing demographics reflect the broader economic and political changes occurring worldwide. Specifically, the declines of Communism, open borders and open trade have all led to large-scale immigration and migration in most developed countries. The effects of these global changes are impacting local communities. Health care organizations need to keep pace with local demographic changes in order to develop the necessary competencies to provide high-quality care for patients with ever greater cultural and language diversity. In this step we suggest five action steps that you can undertake to learn more about the language communities you serve and to identify the dangers inherent in not responding to the language needs of these communities.

ACTION STEP 2.1: Conduct an internal assessment to determine the languages spoken by patients served and the services they seek. Use formal (e.g., needs assessments, chart review, health plan statistics) or informal (e.g., staff interviews/surveys) approaches. Be sure to search not only for the number of patients who speak a language other than English but also for those who are hearing impaired or unable to read and write. This assessment is also an early opportunity to see how your organization is currently responding to patients who prefer to receive information in languages other than English and to identify gaps that prevent you from gathering and/or creating solutions.

ACTION STEP 2.2: Conduct an external assessment to analyze the language needs of the community you serve and identify future or changing demand for non-English materials. Learning about demographic and workforce changes in the larger community can help you identify the response capacity your organization may need to develop to meet the language and communication needs of your community. It can also help to determine whether your patient population reflects the overall community you serve. External data sources on your local and regional demographics and language preferences may include U.S. Census data, county or state health departments, newspaper stories, regional business forums and hospital quality groups.

ACTION STEP 2.3: **Adopt practices and create systems to routinely collect language data.** Require collection of patients' preferred language on reporting tools and make this information known during the course of care. Develop a mechanism to train staff to remain alert to language barriers. For example, consider requiring notation of the language preference of patients on adverse reporting forms or including a standard question about the need for interpreters on consent forms or other similar commonly used forms. Promote patient safety by reviewing these reports to identify trends and set priorities. Also see Collecting Race, Ethnicity, and Language Data: A How-To Guide, a Web-based toolkit developed by Health Research and Educational Trust (HRET) with recommended approaches for the collection of race, ethnicity and primary language information (HRET, 2008).

ACTION STEP 2.4: **Designate overall leadership responsibility for raising awareness of the linguistic needs of the organization.** Formulate executive leadership responsibility to promote a general understanding of the diverse communication needs of patients in your organization, collect and disseminate the findings of your assessments and pave the way for building response capability. These champions can be armed with your internal and external data to paint a demographic and linguistic picture of your population, with examples of associated risks of poor communication. This heightened awareness allows your colleagues to develop their own sense of the need for improvement, especially when they understand the link between communication failures and poor patient safety and quality of care

ACTION STEP 2.5: **Proactively identify and address potential dangers for your LEP patients.** Engage clinical leaders by bringing attention to the potential negative health implications of poor communication. Communication failures between patients and their health care providers have been associated with adverse events and poor quality health care, such as medication or medical errors, which in turn has been associated with severe clinical consequences, even death (Cohen, Rivara, Marcus, McPhillips, & Davis, 2005; Divi, Koss, Schmaltz, & Loeb, 2007; Mitka, 2007). While it is widely acknowledged that communication barriers increase the risk of adverse events and poor quality of care for LEP patients, many providers and administrators fail to recognize the danger under their own roof. Reporting the level of risk within your own organization will make the issue a reality and help mobilize support for needed improvements. Work with your organization's quality assessment and safety programs to obtain estimates on the scope of errors and adverse events due to poor communication. In many cases, only anecdotal evidence of communication failures will be available, but even a few well-documented instances of language-related difficulties will help others start thinking more locally (and more seriously) about this global problem.

How do you eat an elephant? One bite at a time.

Effective communication with diverse populations requires, foremost, knowing your community and actively planning communication strategies to accommodate language and cultural differences. The information-gathering suggested in these action steps will help you map out the current language needs of your patients, as well as your organization's ability to respond to those needs step by step--and bite by bite.

Step 3. Assess the availability and quality of your non-English written materials.

Non-English materials are an important resource for providing health care information that is essential for ensuring safe and high-quality health care for LEP patients. In fact, they are required for meeting legal and regulatory requirements and accreditation standards. Many federal and state laws mandate that vital documents be made available to patients in their language, and certain health care quality and standards-setting organizations also require health care providers to meet the language needs of patients for accreditation purposes. For example, hospitals are now required by the Joint Commission to collect information on the language and communication needs of patients (The Joint Commission, 2007a, p.26). Similarly, Medicare and Medicaid programs require health care providers to provide language services to ensure access for LEP patients (H. R. 7152, Civil Rights Act of 1964, 1964). Thus, having vital documents (e.g., consent forms, financial policies, conditions of admission, notices of interpreter availability, descriptions of program benefits/participation requirements, safety notices, patient rights) available in the languages commonly spoken in your community is a baseline quality standard in meeting the health needs of LEP patients. In this step, we suggest four action steps that you can take to assess your current stock of non-English written materials—not just their availability but also whether these match the language and information needs of your patients, their usage, origins and translation quality.

ACTION STEP 3.1: Inventory, by language, all non-English materials available in your organization. Begin by taking an inventory of non-English materials currently available. Approach the task not only to compile an index of translated forms and brochures but also as a tool to learn how non-English materials are acquired and to evaluate your strengths and weaknesses.

A complete inventory should include English originals or source text and record of:

1) The title in both languages, *text type* (e.g., consent form, patient education, administrative, treatment instructions, medication use, marketing) and length or word count;

2) The topic and communicative purpose of the materials;

3) How the text is used (by whom/where within the organization);

4) The identity of the translator or translator vendor;

5) The champion or sponsor promoting the text's development;

6) When it was created (date) and;

7) How translation quality was assured.

> "Text Type is a term used in linguistics to describe how a text is organized, the writing style or intent (e.g., to inform, to persuade, to describe). See Translation Brief of the More Than Words Toolkit for more information."

Use the results to develop a repository and plan ways in which to make these resources widely known and available. If the usage information referred to in the third point is hard to gather, do the best you can to catalog your current inventory and develop new tools to learn how existing non-English materials are being used and where new materials in different languages may be needed. Also, assess how well these materials satisfy the communication needs of both those who distribute these materials and the patients to whom they are given.

ACTION STEP 3.2: Ask yourself: "How are we currently creating these materials?" Based on your experience in constructing the inventory, try to sketch the range of current practices for obtaining or developing non-English materials. Learn how needs are determined and priorities established, how translation projects are managed and who is involved, and about the internal review and approval processes are used. Begin the process of identifying strengths (such as identifying staff with experience in overseeing translation) and weaknesses in these current processes. Use these results to develop or update practices and promote transition to **Step 4 – Focus on Improving Your Translation Capabilities.**

ACTION STEP 3.3: Assess the quality of translated texts with the *Translation Quality Assessment (TQA) Tool*. The mere existence of a translated brochure on a given topic does not guarantee that the information needs of your patients will be met. Poor quality non-English health materials are common and primarily the result of under-developed competencies among translators and requesters. Unlike other developed countries, training for translators is virtually nonexistent in the United States. Those responsible for requesting translations often have little understanding of the translation process or how to develop meaningful translation instructions (going beyond asking for a translation in a specific language by a specified date). Translators then take on projects with insufficient guidance. Without agreed upon specifications for each translation product, measures of quality are subjective.

When health materials are released for distribution, a key safeguard to assuring quality of content involves the health professionals who dispense them; for non-English materials these professionals usually lack the foreign language skills needed to identify and remove any poorly-translated materials from circulation. It is not surprising, therefore, that poor-quality translations are pervasive, with examples found on the Websites of such reputable institutions such as the U.S. Centers for Disease Control and Prevention, Medline Plus En Español and many others.

The search for quality: What do we really mean?

Too often, requesters and poorly-skilled translators approach translation projects focusing only on the words, replacing the English words with equivalent target language words, with overriding emphasis on remaining faithful to the English original. However, translated text that retains the English language structure often inhibits comprehension for the target reader. To detect translation quality problems, non-English materials need to be evaluated in terms of how well they achieve the intended purpose and communicative objective of the source text. In other words, the person evaluating the translated document needs to ask if it is faithful to the original content and meaning in a form that *anticipates and honors the information needs of an intended target language reader.* This is distinctly different from a focus on creating an equivalent text. The *Translation Quality Assessment (TQA) Tool*, part of the *More Than Words Toolkit Series*, uses this framework to evaluate translated text.

> **A formal review of non-English materials will, in most health care organizations, reveal a motley collection of brochures, documents and forms with little consistency, uncertain origins and uneven quality. The review will also undoubtedly reveal major gaps between what is available and what is needed. You should emerge from this review with a clear sense of what has been done to address LEP populations and where new efforts are needed most.**

To make matters even more difficult, current approaches to assessing the quality of translations have limited success. Research suggests the practice of back-translation – translating from the newly-created target language back to English is not an effective measure of quality. Although several published standards exist for the translation field, these tend to focus on process standards or guidelines (the steps taken to produce a translation) not how to evaluate the actual content or the finished product.

The *TQA Tool*, a part of the *More Than Words Toolkit Series*, was developed to offer health care organizations a reliable prototype tool to assess the quality of non-English materials. This Tool goes beyond assessing the translation process used to determining how well the text actually achieves the communicative purpose of an English original. Use it to determine how many of your organization's most important translated documents can be read by the target audience, retain meaning-for-meaning content and achieve the intended communicative purpose.

ACTION STEP 3.4: **Ask: "Does our inventory of materials match the communication needs of our patients?"** Then develop a list of high-priority needs as applicable. Based on your inventory and analysis of the non-English materials, and also on your previous assessment of your population's language needs (Steps 2.1 and 2.2), assess how well this information is meeting the communication needs of your LEP patients. Analyze the gap between non-English materials available and those likely to be needed by your patients. Focus especially on identifying vital documents and materials associated with services frequently used by LEP patients and determine whether they are available in the languages of your patients. Establish preliminary priorities for creating translated documents, and then prepare budgets and set timeline for filling in identified gaps.

Translation is about more than words

Health care is an information-rich and document-dependent environment. Written materials play many roles and take a variety of forms (e.g., marketing brochures, disease-specific or general educational materials, legal or consent forms, registration or administrative forms, patient and product surveys, general or individualized patient care instructions, information on medication use).

Some documents convey basic information in common terms, such as visiting hours and event announcements, while others are more complex, requiring terminology and concepts unique to health care settings. The structure and purpose of a text contributes to and has embedded communicative intent. For example, the form that a registration clerk gives a new mother to complete may have many of the same elements as a birth certificate, but the purpose and use of each text is definitively different. A similar situation could involve a fact sheet on risks and benefits of anesthesia and the consent form for administering anesthesia. The purpose and use a source text is designed to fulfill may be explicit to the creators of a text but are often not self-evident to its readers.

Trained translators bring advanced knowledge of languages and writing skills to resolve conflicts that arise between languages and culturally-dictated communication styles or traditions, but they often lack understanding of the purposes and uses of the original text. These distinctions are important to point out as part of a translation brief, also referred to as translation instructions.

The bottom line? Aside from translator skill, translation quality is dependent on the requesters who understand that source texts are more than the words on a page. An effective translation requires knowing the purpose and use of a text and instructions to guide the work of translators. It must also consider assumptions about the original intended audience and culturally based understanding embedded in the original source text – its form, structure and associated practices (*text type*). Requesters need to emphasize how cultural differences and expectations of the new target audience should be treated; these decisions should not be left to translators alone. Tools for developing this broader view of translation can be found in the *Hablamos Juntos More Than Words Toolkit Series*.

Translation Standards are important but they tend to focus on the process, not the product.

There are a number of published standards for the translation field. Two well-regarded international standard-setting organizations are the International Organization for Standardization (ISO) and ASTM International.

ISO is an international standard-setting body located in Geneva, Switzerland, composed of representatives of various national standards organizations. The ISO is defined as a non-governmental organization that acts as a consortium with strong links to government. It is able to set standards that often become law, either through treaties or national standards. ISO 9000, a family of standards that includes three (ISO 9001:2000, ISO 9000:2005 and ISO 9004:2000) provides guidelines for quality management processes such as record-keeping, checking for defects and process effectiveness that apply to the translation process.

ASTM International, formed in 1898 in the United States, claims to be the world's largest developer of standards. Originally known as the American Society for Testing and Materials, it is an international standards developing organization that publishes voluntary technical standards for materials, products, systems and services. F-2575 Standard Guide for Quality Assurance in Translation identifies factors relevant to the quality of language translation services and provides a framework for agreement on specifications for translation projects but does not provide specific metrics with which to assess the quality of a translation product.

Both are examples of process standards, not product standards. Certification to these processes does not guarantee compliance (and therefore the quality) of final products and services; rather, these standards establish business processes that should be applied.

Step 4. Focus on improving your capabilities to procure non-English materials.

Health care organizations need to improve their understanding of the translation process and approach translation projects as a shared responsibility, where the translator's work is guided by criteria agreed upon in advance (ASTM International F-2575-06, 2006). In this step, several recommendations are made for improving your organization's approaches to procure non-English materials. One key suggestion involves learning how to prepare a *Translation Brief*, which is simply a set of instructions that specify how the translated product will be used, by whom, in what setting, for what audience and the communicative objective(s) to be accomplished. Preparing a translation brief can also help identify how the underlying assumptions and meaning in an English source text should be treated in translation. Instructions are available in Tool 3 of the *Hablamos Juntos More Than Words Toolkit Series*.

Going through the exercise of preparing translation brief results in instructions that enable requesters and translators, to consider from the very start tensions or cultural nuances that may exist between English and the target language and to clarify how these differences are to be addressed. The objective is to place the requester in a decision-making role rather than relying on the translator to know what to do. The requester, familiar with the health care environment and the communicative purpose of an English original, can best provide context and purpose to guide language decisions that the translator must make; these instructions can then serve as criteria to assess how well the translation product met these requirements. Close examination of an English original also provides an opportunity to consider whether it is of good quality or effective with the original audience, well-matched to the target audience and if translation is the best solution for this particular communicative objective. Poorly-written English originals are likely to contribute to poor-quality translations

This step contains seven action steps for adopting standards and best practices encompassing language services broadly and translation and interpreter services specifically. In addition to adopting more methodical tools such as the *Translation Brief* described here and *TQA Tool* introduced in Step 3, this may involve developing systems and creating standards through glossaries and language convention guides. Developing strong linguistic competencies for translation can parallel developments toward competent interpreter services and creating other capacity to respond to the growing diversity in our communities

Health Literacy

Reader comprehension is an important quality factor for effective health materials. According to the Institute of Medicine (IOM), an estimated 80 million Americans have trouble understanding complex or unfamiliar health information because of limited health literacy skills (Institute of Medicine, 2004). Health literacy is defined as "the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health care decisions" (Institute of Medicine, p. 1). The IOM report also points out that health literacy goes beyond an individual's ability to read and depends on how health information is presented. English source materials are designed with a typical reader in mind and reflect assumptions about the degree of advanced knowledge the reader is likely to have. Even with translated materials LEP patients are challenged not only by literacy skills in their own language, but also by a limited exposure to general information about health or health care delivery systems available through mainstream news outlets (e.g., Readers Digest, daily health updates).

ACTION STEP 4.1: Centralize requests and formalize policies and practices for procuring and dispensing non-English materials. Most health care organizations lack formal systems for procuring non-English materials. Many of our demonstration health care organizations found numerous examples where resourceful and motivated champions (doctors, nurses, etc.) or dutiful administrators, lacking formal guidance, applied American ingenuity in acquiring non-English materials. The result was a wide range of trial-and-error approaches scattered throughout their organizations. Most had no formal processes for dealing with the endless need for non-English materials..

› **Procurement:** Formalizing policies and practices, developing an explicit system for informed decision-making and quality review activity can help improve how organizations respond to demands for non-English materials. Centralizing requests also offers an opportunity to build upon lessons learned, develop expertise for procuring non-English materials and standards for translating materials, and to learn about and advance organizational practices to improve communication with LEP patients.

› **Dispensing:** Non-English materials have two audiences: the LEP patients for whom they were designed and the health care professionals who dispense them. Practices adopted for non-English materials need to give attention to how they are made readily available to health care professionals and the challenges associated with dispensing foreign language materials. Imagine the implications in the context of a multilingual environment that keeps changing. Adopting certain conventions like requiring English titles or subtitles or assigning colors to text by language (e.g., blue for Korean, green for Vietnamese) to help differentiate languages must become part of your organization's central strategy. This line of thinking can lead to other innovations; for example, using electronic medical record systems able to dispense information in English may be programmed to produce this information in other languages. Electronic information systems are well suited for the complexity accompanying the use of non-English materials in many languages.

ACTION STEP 4.2: Develop in-house experts to manage translation projects and attend to the communication needs of patients. Consider developing the role of requester and specializing project management for translation projects to boost effectiveness of how non-English patient materials are procured. Ideally, the procurement of non-English materials should not be separated from other evaluation-decision processes to procure patient materials in English. Adopting continuous improvement processes for materials and tools available for all patients can help establish in-house expertise on the types of text available and their communicative purpose and uses. This background knowledge is ideal for developing translation briefs and managing translation projects.

> "Those who study cultures formally acquire cultural knowledge, although they may not speak the languages of those cultures with any degree of proficiency. Native speakers of those languages often learn English as a second language and acquire cultural knowledge growing up in an ethnic culture at home and can offer important insights but may not have any cultural expertise beyond their own lived experiences."

In working with a translation vendor, make clear the difference between their sphere of knowledge and yours – they know translation, but they do not know your environment and your intentions. In forming project teams for a particular source text, make clear the distinction among translation team members with subject or content knowledge, foreign language skills, cultural knowledge and project management. Subject or content experts are essential to retaining the accuracy of information in a text. These subject experts may be those who dispense non-English materials and gather insights through direct observations or interactions about information seeking behaviors of LEP patients. Team members with expert knowledge of various patient materials your organization uses should be employed. These various experts, playing different roles in your organization, can contribute to preparing instructions for a translation project and help to specify the requirements of a project or set quality criteria.

Understanding language proficiency and how cultural knowledge is acquired can inform decisions about which team members to include in a project. Foreign language skills are distinctly different from cultural knowledge; both are essential for evaluating the quality of translated texts. Those who study cultures formally acquire cultural knowledge, although they may not speak the languages of those cultures with any degree of proficiency. Native speakers of those languages often learn English as a second language and acquire cultural knowledge growing up in an ethnic culture at home and can offer insights but may not have any cultural expertise beyond their own lived experiences

Designate people to fill the role of requester and support their skill building, specifically to develop competencies in preparing translation briefs. Use these trained requesters as key liaisons to the translators or translation vendors and as overseers of translation quality using the *TQA Tool*. Over time, through the accumulation of experience, more informed make-or-buy decisions and better creation and/or selection of non-English materials will become possible. Trained in-house requesters can become the key contact for those needing to commission new translations or wishing to acquire already-developed non-English materials, helping to identify alternatives to written materials, or assessing the quality and usefulness of existing or prospective patient materials.

ACTION STEP 4.3: Construct a STOP sign on the road to translation. Requests for translation are usually well-founded reactions to a real need for improved patient communication, but a translated document is not always the best solution. One immediate benefit of creating the aforementioned requester or project manager and a centralized request system is the ability to analyze translation requests in terms of underlying needs and to consider alternatives. In some cases, even a perfect translation of the source English document may not be able to capture the full intent for a specific target audience and setting. The first question that needs to be answered in preparing a translation brief is. "Will a translation achieve the communicative goal with our target population?" There are many reasons a translation may not fill a communicative need. Alternatives such as mandatory use of a professional interpreter, tools that do not require literacy skills (e.g.,

> **Professional translators are first and foremost writers capable of producing text that reads well in a target language (Aparicio, A., & Durban, C., 2003).**

audio, video, tactile) or a combination of communication strategies may be more effective. Considering alternative communication strategies for LEP patients may also serve as a reminder to explore health literacy barriers that may exist for all patients.

ACTION STEP 4.4: Adopt the practice of developing *Translation Briefs* to define specifications for each text to be translated. As has been discussed, the translation brief is a set of instructions that accompanies an assignment to help the translator make language choices and translation decisions to achieve the desired communicative goal. Easy-to-follow instructions for developing a translation brief are included as a resource in the *More Than Words Toolkit Series.* Adopting the practice of preparing translation briefs establishes a formal mechanism for initiating each translation project, which creates an internal consistency in how projects are prepared as well as sets the expectation that translation projects are a partnership with translators. By examining the content of the source material in the context of serving two different audiences and defining the communicative goals with respect to the target audience, the translation brief provides specific guidance for how a translator should address any problem areas that result from audience, cultural or language differences. It is a step toward framing how a particular text will address a specific communicative need and departs from any previously vague instructions that merely create foreign language equivalents of an English original. Developing specific directions for the translator also generates the criteria by which expected product quality is defined. Organizations need to adopt the practice of developing project-specific instructions to accompany a translation request and support the translation brief training of requesters and project managers.

ACTION STEP 4:5: Select translators carefully and track their work.
Professional translators are first and foremost writers capable of producing texts that read well in a target language (Aparicio & Durbin, 2003). Numerous attempts have been made to establish definitive guidelines for translator qualifications (Rivera & Collum, 2006). Recommendations often include familiarity with both cultures, expertise in the subject area of the text and knowledge about the activity discussed. For example, guidelines adopted for translation of educational and psychological testing materials require translators with experience as test item writers with academic specialization in the subject area of the test (Stansfield, & Auchter, 2001). These projects are supervised by a translation manager who is also a test developer.

> › **Pick experienced translators:** In selecting translators, consider the project requirements and match these to the experience and background of the translators. To translate health texts, they should be fluent in English and the target language and have extensive experience translating health care information. Beyond experience with health and health care, translators should have command of the subject matter. ASTM International F-2575-06, 2006.) They should be familiar with terminology, sentence structures, formats and writing practices typical of health materials in the

Bilingual: *Yes*
**Competent interpreter
or translator:** *Maybe not*

Hiring bilinguals from local language communities as formal or informal interpreters or translators is common practice. Less common is the understanding that language skills, although a prerequisite, are not equivalent to interpreting or translation skills. Bilinguals actually have a wide range of language proficiencies even though most consider themselves to be completely fluent in both languages. In addition, language fluency in communication for daily living is not sufficient for the communication that takes place in health care settings. Further, interpreting and translating require different skills. These skills must be developed and are not necessarily interchangeable. Using interpreters as translators may not produce the best results (i.e., highly-developed speaking or interpreting skills may not necessarily translate into quality translation skills).

pair language in which they work. Some health texts may require translators with background or direct knowledge of the subject or the content of the translation. Texts with specialized health content place higher demand on subject knowledge. For example, in translation projects involving consent forms, the translation expert should be familiar with this type of text (*text type*), the purpose they serve in a health care organization, their medical-legal nature and have experience in medical and legal translations. In evaluating translator experience, make a distinction between expected subject knowledge, translation experience, skills that translators should possess and other related project requirements. Successful translation projects include selecting a translator with the appropriate experience and skill and providing them with the correct orientation or instructions.

› **Link translators to translation products:** It is very likely that your inventory of translated texts (Step 3.1) failed to identify the individual, agency or vendor that produced each translated text. This disconnect between translator and translation product perpetuates the use of poor translators and is particularly important when working with translation vendors who work as intermediaries for translators with wide variability in translation skill, experience and background. Ensuring that each translator's name is linked with each of his or her translations (in your inventory file, if not in the final piece dispensed to patients) can be instrumental in making future decisions and raises the stakes in terms of professional reputation and future assignments. This is why organizations should adopt the practice of identifying translators on all the non-English materials they produce. Test different ways of developing uniform standards for noting the translator of target language texts. Inform your translators of this practice and keep track of patient user and provider satisfaction with their products.

ACTION STEP 4.6: Develop tools to help your translator. Publication style guides and glossaries are common in academic and professional circles. Translation style guides are becoming standard practice for organizations working internationally, (e.g., World Bank, European Commission) and businesses with global reach (e.g., Microsoft, Google). Translation style guides advance consistency in writing and provide guidance on language use. Such manuals can specify writing style details such as punctuation, capitalization, spelling, word usage, grammatical conventions, and formatting issues. The translation style guide for the European Commission provides translators with key translating rules, including not only the basic grammar of every language but also the most common errors that can occur when translating from one specific language to another.

› **Create a style guide:** The absence of a translation style guide with a standardized glossary for working in the health care industry creates inconsistency in the translations of basic health terminology and concepts and contributes to disagreements over possible errors in translations. It also increases the comprehension difficulty for readers. Adopting standardized glossaries of commonly-used words or phrases can help avoid

these difficulties. Translation style guides can be simple one-page documents with general rules about tone and guidance for approaching proper names, products or functions that may not translate well (Google, n.d.), or more detailed documents that incorporate spelling rules, sample of common standard text, conventions for translating official names, recommended formats for numbers and measures and so on (European Commission, 2008; International Bank, 2004). Consistent and uniform translations of common health care system vocabulary can also make it easier for LEP populations to recognize and learn health care terms and concepts.

› **Adopt a list of conventions:** Aside from rapid advancements in medical science and technology, health care environments use vocabulary and concepts unique to the American health care system. Terms like *advanced directives, health plan, health maintenance organization* and *managed care* are difficult to understand even for many English speakers, so the comprehension difficulty only increases for populations speaking foreign languages when there is inconsistency in how these terms are translated. Promoting consistent translation of key health concepts and terms will help readers equate the convention to its English counterpart. Conventions, adopted nationally and developed for each target language, can eliminate translation debates and offer readers consistency, an important factor for improving recall and learning new vocabulary over time. Several projects designed to create glossaries and conventions have been undertaken independently by translation vendors as proprietary ventures. None, except perhaps one undertaken by the Kaiser Permanente National Linguistic & Cultural Program, has had national participation. Thus far, none has been made broadly available for adoption.

ACTION STEP 4.7: Set Performance Expectations. *You can't manage what you don't measure.* Fueled in part by the potential for improving the quality of health care services and outcomes, attention to performance measures and improvement initiatives have proliferated in recent decades. Within the health care system, interest in performance improvement has advanced with the lofty goals of improving quality, enhancing accountability and strengthening the science base of health care. Performance standards are rapidly evolving as criteria for objective competence assessment. Few areas need more attention in this regard than the performance expectations for communicating with LEP patients.

Although published data are lacking, estimates vary that anywhere from 44 to 60 percent of the bilinguals employed in hospitals, clinics and medical offices across the nation are heritage speakers. From those tested during the pilot, the *Hablamos Juntos* team found that the average health interpreter in the demonstrations was a U.S.-born woman between the ages of 31 and 40 who had a relatively short tenure as a health interpreter. Nearly three-quarters had worked as an interpreter for five years or less. More than half reported having received no interpreter training, and nearly half reported learning their native language at home, not in school. The pilot project also showed that those working as interpreters were interested in being tested and readily sought to know how well they were doing.

"You can't manage what you don't measure."

› **Train the whole workforce:** Make performance expectation clear to all employees, and pay special attention to those with direct patient responsibility, particularly those caring for LEP populations. Use existing methods and tools (e.g., employee orientation, training program offerings, practice guidelines) to ensure understanding of appropriate use of non-English materials and interpreters and to increase staff competencies for working with culturally- and linguistically-diverse patients. Use these training opportunities to promote understanding of how to use non-English materials and to discuss how to best use interpreters and other available language resources. Your practices for using bilingual staff to mediate communications with LEP patients should be made clear. Ideally, these practices have been formalized and the language and interpreting skills of bilingual employees verified. For more information about testing the language proficiency skills of employees, see the Language Testing Options 2008 Report published by *Hablamos Juntos* (Hablamos Juntos, 2002).

› **Hire trained interpreters:** The term *health interpreter* and *medical interpreter* are used interchangeably to describe any individual whose primary role is interpreting, but they are often used to include those who do so only intermittently or on an ad hoc basis. Hire trained interpreters, or invest in training them, and establish protocols to match interpreters to interpreting events. Health interpreting is a multifaceted process requiring a variety of skills and subject knowledge (e.g., anatomy, physiology, psycho-social, health care system, reimbursement) to ensure the intent and meaning of health discussions are interpreted as accurately and completely as possible. Training for interpreters in health care is evolving and although standards are not yet available colleges and universities as well as other non-accredited organizations offer instruction on the fundamentals of interpreting. More advanced training programs include practicum, field coaching and mentoring programs that enable skill development through direct on-the-job training. This type of guided practical experience is vital to developing interpreter proficiency and should be sought in hiring.

› **Assess the language proficiencies and interpreting skills of your interpreters.** In health care in particular, cumulative and consistent research findings point to a causal relationship between limited English proficiency and poor health outcomes. Recommendations point to the use of trained and tested interpreters as standard practice for overcoming language barriers between health care providers and their LEP patients (Smedley, Stith, & Nelson, 2003). As a result, concerns about interpreting competence have gained prominence and prompted demand for better tools to assess language proficiency specifically and interpreting competence more generally. Make sure your interpreters are assessed for language proficiency and

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Make sure your interpreters are assessed for language proficiency and interpreting skills.
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interpreting skills. The field of language proficiency testing has evolved rapidly over the past five years. Recent attempts to address interpreting competence elicited response from government and accrediting bodies which suggest advancements in assuring interpreter quality. Few tools available to assess language proficiency pay special attention to heritage speakers, yet many dual role interpreters are heritage speakers.

› **Define scopes of practice for dual role interpreters.** The term *dual role interpreter* is used to connote bilinguals employed in health care organizations who are required to serve as an interpreter as part of regularly-assigned duties. *Ad hoc interpreter* is used to distinguish those who interpret only intermittently, (e.g., family, friends or others recruited on the spot). Although trained interpreters with advanced language proficiencies are ideal, bilingual employees may supplement the professional interpreter if they are trained and assigned to interpret only within a defined scope of practice.

Assess the language skills of employees assigned to interpret for LEP patients to ensure they are trained for the responsibilities they are given. Use language assessment results to develop defined scopes of practice, for each employee, consistent with their language skills, interpreting proficiency and domain knowledge. Provide training to match the language support expected, to ensure understanding of the language support they may agree to provide and to learn how to deal with pressure situations beyond their scope. See Step 5.2 for other thoughts on the importance of professional training for interpreters and translators in health care settings.

> *"...a collective effort by industry, government, professional societies, foundations and private individuals will be needed to achieve seamless communication for all patients and—more specifically—to help prepare the health care workforces for the future."*

Step 5. Encourage investments in communication improvement

Hablamos Juntos has been in existence since 2001. Since its inception, we have had the privilege to learn about some of the extraordinary efforts being undertaken by health care organizations around the country to overcome language barriers and develop capacity to care for their changing patient populations. Incredible discoveries are taking place, one institution at a time. Often what is learned in one place is rediscovered and learned anew by neighboring health care organizations. The amount of creativity, ingenuity and extraordinary human and financial resources that are being invested is impressive, as is the fact that these efforts are not being harvested and disseminated across the broader health care system.

The recommendations made in Steps 1-4 are designed to create capacity within health care organizations by taking practical steps based on consensus findings and some early signs of potential model translation and interpreting programs. The scale of capacity development that is needed has compelled the publication of these final recommendations. Looking ahead, it is clear that sustained, in-depth and widespread efforts are needed to develop standards and training programs to cultivate the type of language professionals we need and to stimulate research to determine whether the investments we are making today are contributing to improved health and health care outcomes. Who will pay for these next steps?

Individual organizations and practices clearly do not have the resources to respond to the gamut of challenges presented by the linguistic diversity emerging in our cities and states today. Instead, a collective effort by industry, government, professional societies, foundations and private individuals will be needed to achieve seamless communication for all patients and to help prepare the health care workforce of the future. Federal and state governments, and especially their health-related departments, can play a major role in funding these efforts. Foundations such as the *Robert Wood Johnson Foundation* have already stepped up to the plate to fund pioneering work and research, and they should continue to disseminate lessons learned and support new initiatives aimed at creating and evaluating national strategies and approaches. Professional health and hospital associations and industry leaders also have a role in promoting advancements in this area.

Many health care organizations have already made investments and progress in developing the field of language services. In this step, we offer suggestions for health care industry leaders to build upon and describe ways to integrate these new competencies as standards in our health care organizations. We encourage the use of known technology like rapid cycle continuous improvement, rewards programs and collaborative learning to develop health care organizations' ability to care for LEP populations. Support for national pioneering efforts to professionalize and set standards for language professionals is also critical, as well as investments in research and development to strengthen our health care system's capacity to care for a multilingual society. These recommendations call for public and private trend-setting organizations to pick up and support further capacity building, including the adoption of national strategies for the nation's health care system.

The Business Case:

Improving communication with LEP patients should be a national endeavor

A flat world…

Harvard historian Oscar Handlin wrote in the opening of the 1951 Pulitzer Prize-winning book *The Uprooted*, "Once I thought to write a history of the immigrants in America. Then I discovered that the immigrants were American history." Today's headlines leave little doubt about the strategic needs of the nation, whether in trade, diplomacy or health care, for a globally-educated citizenry and workers who are aware of the role of language and culture in meeting the challenges of the 21st century. Emerging global markets and rapidly-growing immigrant populations, here and abroad, have increased the demand for professionals and businesses that are able to work with diverse populations. Some see this trend as an unwelcome cost to doing business. Others, however, as outlined in Thomas Friedman's book *The World is Flat*, believe investing in language services and developing a workforce able to work across cultures is a strategy for continued growth and prosperity.

…has reshaped U..S health care …

The need for effective multilingual communication within the U.S. health care system is different, but no less real or critical, than the need for business people and diplomats working in our increasingly global economy. Rapid societal changes taking place both domestically and globally leave health care organizations struggling to retool and find solutions on their own. These organizations are already innovating and paying for training programs to prepare their health care workforces to work with culturally- and linguistically-diverse patient populations.

… and requires a collective response to language challenges

But individual efforts, even when highly innovative, are not enough. In fact, isolated efforts often equate to poorly-spent health care dollars and an endless reinvention of the wheel. For example, because there are as yet no minimum qualifications for interpreting or translating health materials, many organizations throughout the U.S. have already spent valuable time fashioning impromptu training programs and unproven skill assessment methods to fill the void. This means that hundreds of highly-trained individuals have labored independently to create their own criteria for translator skills and proficiencies. What is needed here, as in so many other parts of the communication puzzle, is a more collaborative development and exchange of tools and skills to aid translation improvement. Each health care organization need not start from scratch or reinvent solutions and practices alone.

> " *Around the country health care organizations are creating and paying for training programs to prepare their workforce to work with culturally- and linguistically-diverse patient populations.* "

ACTION STEP 5.1: Support collaboration and exchange of innovation. National health associations play a key role in representing and supporting their constituency organizations to ensure delivery of safe, quality health care, every time. Government, industry and private foundations promote the advancement of health knowledge and best practices. Early responders to demographic changes in the community need the support of these key national organizations to improve on progress already made and to share lessons with others. Around the country, programs and initiatives that share progress in all manners abound, why not for growing language competencies in health care organizations? National efforts, using a variety of these strategies, are needed to disseminate lessons learned, promote replication and encourage advancements. Approaches can include funding of: **test sites** to use and evaluate newly-created tools or to incubate ideas; **validation sites** for developmental programs; **implementation sites** for rolling out well-documented best practices; and, **collaborative learning** are frequently used for benchmarking, information sharing and testing.

Confronted with mandates and accreditation requirements, health care organizations are already investing significant health care dollars in language services to overcome language barriers. But without the resources to track and report those thousands of disparate local investments, no collective sense of what has worked has emerged. These front-line health care organizations therefore continue reacting to the latest crisis based on their own local knowledge. What is needed is an initiative to document and share the development efforts and experiences of individual organizations. This will help reduce the cost of subsequent development efforts to address language barriers.

ACTION STEP 5.2: Support pioneering efforts to develop voluntary national practice standards for language professionals in health care. Around the country, health care organizations are creating and paying for training programs to prepare the health care workforce to work with culturally- and linguistically-diverse patient populations. On a separate track, supported by philanthropy, pioneering language professionals and their health care employers are voluntarily working to establish standards for interpreters. Each health care organization need not start from scratch or reinvent solutions and practices alone. Industry leaders can support these efforts by working to develop standards and sponsoring opportunities for members to learn about, collaborate and exchange information on development of cultural and linguistic competency within their organizations. Government and industry leaders can also help extend the value of those investments by supporting initiatives within clinics, hospitals and offices to 1) educate staff about the new standards for interpreters and translators; 2) provide guidance on the role bilingual workers can play (e.g., stressing the need for assessing language proficiency before relying on bilingual staff to mediate patient communications); and 3) encourage hiring practices (of employees and vendors) based on the new standards.

> *Prudent public health calls for investments by both academia and government-sponsored research agencies to improve our baseline understanding of the implications of the growing complexity of literacy, language and cultural differences with respect to health communication.*

› **Ensure the validity of new standards for the training and certification of language professionals – both interpreters and translators.** There is currently no common methodology or pedagogic principles for teaching translators or interpreters, even in environments where translation and interpreting experts are in charge of instruction. The need for teacher training and research-based methods of teaching translation is "particularly acute in the United States" (Colina, 2003, p.5). The same is true for interpreter training. However, as new training programs are developed, they must be subjected to rigorous validation testing to ensure that they are actually producing the desired result: a cadre of new translators and interpreters who are capable of bridging any communication gap that arises in health care settings. Government and industry leaders can work together to ensure language professional training programs address these weaknesses.

› **Support programs to create regional or national shared language services.** Many small health care organizations and practices, on their own, do not have the resources necessary to respond to the wide range of population diversity issues. Practical capacity building at the regional or even national level may help. To allow sharing of critical language resources across geographic, programmatic or financial barriers we encourage health care and government leaders to consider sponsorship of repositories, national libraries, interpreter banks and technology-based solutions. These resources must be available to achieve the necessary economies of scale as well as enable smaller health care organizations to gain access to interpreters and quality non-English materials.

ACTION STEP 5.3: Invest in research and development. Advances in medicine and the biosciences are resulting in a curative potential once unimaginable. New treatments such as genetically-engineered anticoagulants to prevent heart attacks and strokes are providing new hope for patients, but they are also increasing the complexity of health care decisions because of new risks and costs. Prudent public health calls for investments by both academia and government-sponsored research agencies to improve our baseline understanding of the implications of the growing complexity of health literacy, language and cultural differences involved in health care communication. Only by establishing the baseline of where we are now can we begin to fashion the tools needed to improve the situation. Note that the study of communication barriers for those unable to speak English may also improve our understanding of how English-speaking patients understand—or fail to comprehend—complex and technical medical information.

ACTION STEP 5.4: Build a collaborative research network to accelerate the development and dissemination of strategies for improving communication with LEP patients. Practically every special area of health research today has benefited from the creation of cross-university multidisciplinary research collaboration. The National Institutes of Health has created several multi-institution clinical research collaborations. A similar approach is now needed to advance the development of new strategies for

overcoming language-based health communications problems. Currently, the burden is on individual researchers or clinicians to address language barriers on his or her own. Even with a funding source, solo development of strategies can be limiting and result in narrowly-focused solutions that may not be applicable to the broader national context. A coordinated collaborative research effort would expedite development of solid solutions and allow for a more efficient use of resources.

› **Identify tools and practices that are practical and useful.** Building on the basic recommendations in this tool, researchers must also develop and test solutions for reversing the negative health outcomes associated with language gaps and low health literacy. These proposed tools and innovations must be tested in clinical settings, be cost-effective in design and produce measurable evidence of benefits. The research must be action-oriented with an emphasis on real-time solutions. It must also be participatory, involving LEP patients, and be multidisciplinary, to include a cross-section of experts in language, health education and health communication. Moreover, any new strategies aimed at improving communication with patients who speak little or no English must be practical and easily adaptable by nonacademic clinics, hospitals and other health care organizations around the U.S.

Language barriers in U.S. health care settings are unlikely to fade in the coming years. In fact, they may become even more prominent as the complexity of care increases and the overall health literacy of the nation decreases. Combined with an aging of the population, the potential for significant increases in the nation's overall clinical and economic health care burden appears very real. Facing such a future, an additional modest investment aimed at determining how to best overcome the most common communication barriers seems reasonable. The recommendations made here are intended to highlight priorities for research funding over the next decade.

This Guide was Produced by *Hablamos Juntos*

Since 2001, *Hablamos Juntos*, ("We Speak Together") a *Robert Wood Johnson Foundation*-funded national initiative, has been studying language barriers in health care for patients who speak or understand little or no English. In our years of work, the fundamental lesson we have learned is that communicating across languages and cultures involves more than words. It requires recognition that the meaning of ideas and words is conveyed and extracted through the cultural lens of the interlocutors and that these can be vastly different in cross-cultural communication. Attention to these differences is essential in effective communication, whether in writing through translation or spoken, through interpretation.

The *Hablamos Juntos More Than Words Toolkit Series* brings together lessons learned from demonstration projects, eight years of working with nationally-recognized health care leaders and language experts and original research on translation quality. It has been made possible through the contributions of many around the country, including language academicians, researchers, practicing interpreters and translators and health professionals dedicated to providing safe and quality health care to our diverse nation. Among those requiring special mention for the production of Tool 2 are Christopher Gearon, David Ellis and participants at the Translation Quality Assessment Roundtable held in Washington, DC, September 17, 2007.

For more information about *Hablamos Juntos* or to download the entire *More Than Words Toolkit Series,* visit www.HablamosJuntos.org.

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