

QUALITY HEALTH STRATEGIES

Moderator: Maria Triantis
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1:00 pm CT

Operator: Ladies and gentlemen thank you for standing by. Welcome to the Disparities National Coordinating Center Language Service and Healthcare conference call.

During the presentation all participants will be in a listen-only mode. We will be facilitating Q&A throughout this presentation. If you have a question please press the 1 followed by the 4 on your telephone.

If at any time during the conference you need to reach an operator please press Star Zero. As a reminder this conference is being recorded Tuesday, March 11, 2013.

I would now like to turn the conference over to Ms. (Laura Bendle). Please go ahead ma'am.

(Laura Bendle): Thank you (Jeff). Good afternoon everyone. As (Jeff) mentioned this is the DNCC's monthly COP call. Welcome and on behalf of our entire team we're happy that you can be with us today.

As (Jeff) mention the title is Language Services and Healthcare. And the called norms you probably have seen this quite often. We mention them on every call so I won't go over all of those.

But the important points are that we will be sending out the presentation, the transcript and the audio to all participants and they'll also be posted on CMS Pulse and all - our Healthcare Communities Web site.

Secondly we would appreciate you completed the evaluation which will populate automatically at the end of the call.

And lastly we will be taking questions and answers after each presenter. So feel free to queue up your questions in the chat room or queue up and the operator will open the lines when we announce that we will be taking questions and answers.

So our agenda for today is that we are pleased to have four speakers representing three organizations with expertise in language services and we want to thank them all for joining us today.

Our first speaker, Marcos Pesquera is Executive Director at the Center for Health Equity and Wellness at Adventist Healthcare in Maryland. And he'll be discussing language access services at Adventist.

Our second presenter is Oscar Lanza and he is the Manager of National Linguistic and Cultural Programs at Kaiser Permanente in California.

And Oscar will be sharing the qualified bilingual staff program at Kaiser.

And we also have Mercedes Blanco and Victoria Williams who are co-directors at The Center for Health Literacy Translation services at Maximus which is based in Virginia. But I believe Mercedes and Victoria are actually in Rhode Island today so they'll be sharing their expertise in translation services that hit the mark.

So collectively this expert panel of speakers will help us accomplish our goal for today which is sharing ways that healthcare organizations can address the communication needs of their limited English proficient patient.

So I'd like to take the opportunity to present our first speaker Marcos Pesquera. Marco it's all yours. And (Ava) is now going to pass the ball to you so you can advance your slides.

Marcos Pesquera: You forgot to tell me how do I advance the slides though.

(Laura Bendle): You...

Marcos Pesquera: So I press...

(Laura Bendle): Click on this - put your mouse on the screen and click and then you can advance by either hitting your space bar or up on the top right there is a little arrow that you can use to advance.

Marcos Pesquera: Excellent. Okay well good afternoon and again thank you to the Disparities National Coordinating for inviting me to speak today and all of you that joined for allowing me to torture you for a few minutes.

So basically one of the big premises that I like to start with is the issue of cultural competence and culturally competent care being used as a strategy to eliminate disparity.

I personally define cultural competence as diversity clinically applied because it's important that we utilize this diversity to also have a big impact which is the reason why we do the work that we do on the healthcare outcomes of our patients.

And language access is a critical component to providing culturally competent care to our patient populations. Cultural competent care is a strategy to eliminate disparity by basically connecting with our communities.

I come from a hospital side perspective. And we want to make sure we connect with our community at a deeper level so that they can understand treatment well, we can build trust with our populations, our communities, our patients, our individuals that will result in increased compliance and improved healthcare outcomes for them.

So that's basically the premise for such an emphasis on language access.

So a little bit of information on local data, okay there you go. Okay from here you will see for the state of Maryland that's -- where I am at -- the changes in the census from 1990 through 2000 to 2010 has been remarkable.

We saw about a 9% increase in population growth with most of it being in the Hispanic community. And Adventist Healthcare service areas in Maryland rank among the largest county increases in Maryland which we serve Montgomery County as well as Prince George's County and some part of Frederick.

As you can see here for 2010 for the increase in residents for the state you're going to see around different ethnic groups what are racial and ethnic group what are the percentage change in that.

Here you could also see that by county the actual number of growth. And it's important to use this information when we're talking to our leaders for the support of language access so they can understand hey not only are we feeling it but the numbers are telling us these are the patients that are coming through our doors.

In terms of when we talk about the foreign born population look at language is spoken other than English at home this is specifically when you look at Montgomery County where we're at 38.1% of our homes speak a language other than English at home.

Basically about 1/3 of these residents do not have a family member who speaks English well and is linguistically isolated which has caused them to face barriers when accessing care.

When you look at the percent of county residents speaking non-English languages by race and ethnicity again focus on Montgomery County numbers there which is primarily we are in Montgomery county and Prince George's but primarily in Montgomery.

And you will see that from the White population Black African-American but when you look at the Asian and Latino communities from the Asian community 85% of their folks do speak a language other than English.

It doesn't mean they're not fully bilingual but that their primary language is a different one and then the Latino community the same thing -- 90%.

So when you look at these numbers said okay while we definitely have to have an emphasis on this issue because we want to connect with our populations well.

Now with all the Affordable Care Act and readmission rates for emergency departments and hostelry readmissions et cetera, communication takes a totally different front and center stage if you will as it used to do more than in the past.

So some of the requirements that we see when you look at federal requirements the class standard is something that I'll briefly discuss in the next slide.

(Unintelligible) standards have been recently updated 2013 to help end health care disparities and improve quality at hospitals and other healthcare organizations. And I'll go through them and a little bit next couple slides.

At a state level The Maryland Health Improvement and Disparities Reduction Act was signed into law in 2012. And this law identifies standards for collecting data on race and ethnicity in healthcare in addition to language access and ways to track and reduce disparities.

It also requires hospitals to describe their efforts to track and reduce health care disparities, a very important piece of legislation that also gives some more strength to the efforts that we're doing.

Locally we also obviously we're a hospital system. We have - we're being - patient bodies are very important to us. And when you look at joint commission and the patient center communication standards that became effective on July 1 of 2012 state three main things and that's number that the hospitals will identify the patient's oral and written communication needs including the patient's preferred languages - language for discussing healthcare. So that has to be included now in all the electronic medical record platforms.

The second is that hospitals will communicate with the patient during the provision of care. Also treatment and services in the matter that meets the patient's oral and written communications needs.

So it's not good enough to just do it at registration but we have to look at the whole healthcare continuum from admission, everything that happens in-between as well as discharge and making sure that we're meeting those needs.

But we're also required to identify that we are utilizing different tools if the patient is not sort of an English speaker or limited English proficient.

And in the medical records both contain the patient's race and ethnicity in order to identify health care disparities so those are really important things.

And if you're not familiar with the joint commission patient centered what you do call it? It's a publication they came up about a year ago with all these different requirements that they utilize now for accreditation purposes. It's a great one to give you great direction on how to do this.

All right so looking at the class standards obviously 15, the first four are particularly looking at governance, leadership and workforce or diversity issues are folks trained in cultural competence?

Do we have a workforce that represents the communities that we're serving, that's particularly Standards 1 through 4.

In the Standard 5 through 8 particularly looks at communication and language assistance not only oral but also written. And we're - you're going to hear from a great example from our two next presenters.

But basically the principle here of the standards to provide effective equitable and understandable and respectable quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

And then the final set of standards 9 through 15 it talks a lot more about engagement, continuous improvement process within your organization, health IT and electronic medical records, the capabilities there.

Also the way that you let the community know what is it that you're doing around cultural competency or language access to make sure the community knows that they can have access to those resources at no charge to them and other things.

So basically the last standards are more about infrastructure and organizational support.

All right so looking at Standards 5 through 8 which is the communication and language assistance some of the things that we look at are translation of

consent form and health education materials which you're going to be hearing from a translator which is different from an interpreter again.

And she'll be able to give you more details on that. But we definitely right currently we have a contract with a translation company that takes care of these issues for us.

We also decided we think we have - we can go both ways. We can even have full-time interpreters which are - which we have a couple of them one in each one of our hospitals.

But we also have a program that we adopted from Kaiser Permanente called the Qualified Bilingual Staff program which you'll be hearing from Oscar in a little bit.

We decided to go that route primarily and the reason being we have many languages here in the county, over 140 languages that we actually would we look at our (unintelligible) bill that's what we interpret for.

So and we do have employees that represent those communities. And many of them are healthcare providers or work - obviously work in the healthcare setting.

We test them to make sure that their English as well as their language of service is appropriate and for interpreting in a medical setting and the training that comes through. And you'll hear a lot more about the QBF program later.

What I - what we - why we decide to do this is because it gives - we have currently about 150, 175 employees that are trained and qualified at each one of our hospitals, the two main hospitals.

So we have about 300 to 400 employees, 350 employees trained that are out there and that allows us to really be accessible everywhere and to have different languages as well.

In some languages the demand for them is minimal so it's good that we have some of these folks trained and qualified.

So one of the languages like for us Spanish, Vietnamese, Mandarin and others we - the demand is much higher. So we have about 100 and - 100 folks in each one of the hospitals that speaks particularly Spanish in our case which again can be deployed at any moment's notice.

And you'll hear more about some of the organizations of as Oscar will speak to that.

We also make sure through these standards we monitor language differences among staff and patient populations and we provide ways to promote effective communication whether it's face to face, telephone interpreting, sing language interpreting and, et cetera.

And these are my last slide here will tell you what we currently use which is qualified bilingual staff as the first one that we utilized. Again these are a dual role and I'm not going to get into the details with you. You'll have more on that.

Over the phone interpreters as well, we have the (Sericom) phone or we call it the blue phone in which we train our hospital staff regularly on how to access this, who to call to get the information. We have the blue phones all over the place so a very highly utilized system.

Granted we prefer face to face but for 24 seven days a week coverage this is great.

In person interpreters as well. There's clinical reasons many times that patients will need in person interpreters. That goes for language as well as, you know, spoken language as well as sign language.

It could be we have the Video Remote Interpreter, the VRI which is a great tool. And we can access it immediately. And some clinically appropriate some in person interpreter might be needed. And that's also a service that we provide. And we have contract with outside organizations that do that.

Say the translation services which we make sure that at a centrally we have located, you know, the hospitals will call us, let us know what different forms, consent and health indication discharge forms et cetera that need to be translated.

And then we have as I said, we have a contract with a translation company that takes care of that for us.

In addition to this I think it's kind of a big - it's a big overarching thing. We have to really make sure that our organization is an organization that is culturally competent that look at these issues not as site thing but it has to be well integrated into the fiber of who we are as a hospital system.

And in addition to this we do train - it is a requirement for all of our staff to be training cultural competence which have a Web-based training that we developed which include language access as part of that.

I think I gave you - hopefully that gave you a good overview of what we have done. Thank you for listening. If you have any questions I'll be happy to entertain those now.

(Laura Bendle): Thank you Marcos. We appreciate your presentation. (Jeff) if you could let folks know how they can queue up to ask questions?

Operator: Absolutely. Thank you. Ladies and gentlemen if you would like to register a question please press the 1 followed by the 4 on your telephone. You will hear a three-toned prompt to acknowledge your request.

If your question has been answered and you would like to withdraw your registration please press the 1 followed by the 3.

If you're using a speakerphone please lift your handset before entering your request.

(Laura Bendle): So Marco while we're waiting for any questions to come in we do have one in the chat room that we'd like to ask you.

And it's what are your views on utilizing a patient's family members for translation during a hospital stay or medical appointment?

Marcos Pesquera: Well obviously what there is absolutely no other option to communicate with that patient in an emergency if you will maybe. I really - that's really not good patient care. I'm going to give you a quick example.

Not long ago one of our presidents got a letter from a patient complaining of about some of our nursing staff that they were doing a pre-surgery counseling to a patient, a limited English proficient patient.

And they insisted, the family member insisted that she wanted to interpret for her aunt which she did. And the letter said I'm really upset because they told - they wanted me to tell my aunt all the different risks of the surgery including, you know, death and other things. And how rude, how - well the lady just went off. And well thank God that I was interpreter - interpreting because I never told my aunt any of these things.

Well what is that telling you right there? Basically thank God the aunt went through the surgery and she did okay but the patient really did not know the risks of the surgery that she was going to go under.

So no family members frankly it's way too emotional for us to number 1 be - not want to filter what we say. But number two just because I am from a, you know, from a Spanish speaking country doesn't make me a medical interpreter or trained to do so.

So yes my views on using family members is that is poor patient care and we should not use them.

(Laura Bendle): Thank you Marcos. (Jeff) so we have any calls amongst our questions in the queue?

Operator: It appears there are no questions.

(Laura Bendle): Marco we do have another question from the chat room. Is there a way to access the training you offer for cultural competency?

Marcos Pesquera: Right now it's Intranet so it's internal to Adventist Healthcare. But yes I'll, you know, we can - you guys have my email here. And you can just send me an email and I'll be happy to share that with you.

(Laura Bendle): And one last question from the chat room. Since there are so many Asian dialects do you have any recommendations for effectively communicating since the dialects may be unknown?

Marcos Pesquera: Well that's when we went - when we did our contracting for over the phone interpreting which again is not primary, by primary choice but nonetheless the number of languages that were offered there, particularly Asian language was quite large.

So just make sure that you, you know, you look at the language, the languages of your populations, look what the needs are and when you do this contracting with your phone interpreting folks that those languages are there and are covered. That has to be clearly stated.

You know, unfortunately some of those languages you're not even going to have a staff that will speak it but language usually has done well by us.

(Laura Bendle): Marcos again thank you so much. And one last request if you could pass the ball to Oscar and then we are going to then proceed with the presentation.

So I'd like to introduce Oscar Lanza from Kaiser Permanente. Oscar we're going to turn it over to you. Thank you.

Oscar Lanza: No thank you. First of all good morning everybody, for me still good morning. We live in Oakland, California 11'23 I understand that for most of you it's good afternoon.

So I'd really like to thank the people who organized this event and especially Marcos for convincing me to participate in this event.

I mean he told me about the importance of it. And we are very grateful that we are here to share one of the best practices that Kaiser Permanente uses to address the issue of providing language assistance services to our limited English proficient populations.

As you saw Marcos explaining there are several strategies that organizations use. And if you want to take something away from this today is the qualified bilingual staff program is a strategy. And it has to be unique to your organization.

You have to be able to understand what is the reality of the organization, what are the needs that your organization has and how you can make a program to qualify your bilingual staff fits into the strategic goals of that specific organization.

That is what the qualified bilingual staff programmer model does.

If you want to take something away from here today is do I have a bilingual force and if I do how to I qualify them because in the end it comes to the perennial, patient safety and quality of care. That's what it comes down to.

You're going to hear people talking about what is the return on investment. Guess what and wake up. There cannot be return on investment or return investment at least for me is priceless when we talk about patient safety and patient satisfaction.

I remember that I heard a presentation one time at Cisco in Silicon Valley. One of our safety net hospital partners CEO was speaking. And he said what is the return investment on technologies?

And then he said let me change the question and said what will be the impact if we were not to invest in technology and how that would put our organization behind?

So when we talk about language access we're talking about something that is bigger than dollars, is bigger than anything else.

So Kaiser Permanente is a very huge organization. I don't know how many of you are familiar with Kaiser but it's big.

We serve more than 9 million members and sometimes that numbered depending at the end of the year with new enrollment and whether enrollment overlaps with termination of healthcare sometimes that grows between 10 million to 11 million people in that transition period which is the last quarter of any given year.

So but traditionally we talk about these numbers that say yes we serve 9 million lives.

Kaiser Permanente was founded in 1945. And one of its core mission is to provide high quality affordable health care services to improve the health of our members and the communities in which we serve.

The qualified bilingual staff program meets that lofty goal that Kaiser Permanente has. We have 38 hospitals. You see 37 because this is the data of 2012.

We have more than 600 medical offices throughout the country. We have more than 17,000 physicians, close to 50,000 nurses and more than 170,000 employees.

We are in several states in the nation and you can see the distribution here. And I think that these slides are going to be made available to you.

As you can see we have a huge workforce which is very diverse. And it is representative of the membership that we serve.

So one of the things that we said back then was okay we use the telephonic interpretation as a strategy. We have in person interpreters. But what do we do with this huge workforce that is not only bicultural but it's only - is also bilingual?

And that's what the QBS program was born back in 2003. Unlike translation there is no other formal process to certify interpreters and bilingual staff.

I think that we are having that conversation right now, we're having that discussion right now and whether or not some people are certified in certain states that doesn't mean that the certification is transferable to another state.

So what is the responsibility of the organization? One is to create the program. Okay we need to be able to - and we'll see it later in a slide is to be able to identify our workforce and then how do we qualify it?

So the comprehensive QBS program as developed by Kaiser Permanente is to improve the quality of the existing and future workforce meaning that answer the question what do we do with our bilingual staff?

And then we create the opportunity for us to finally recognize employees for the linguistic and bicultural skills that they bring to the workplace.

And then lastly and I think that some people take this as being the most important one is how do we comply with federal and state regulations as it relates to the provision of cultural linguistic care appropriate services?

So those are the drivers for Kaiser Permanente. So the Qualified Bilingual Staff model in program is a nationally recognized program which received an award in 2006 as one of the best innovated practices in the nation.

The dissemination of the program has been institutionalized in Kaiser Permanente in Georgia, in Northern California and mid-Atlantic states Southern California, Colorado and Northwest.

The QBS faculty is dying for dissemination into Hawaii region for obvious reasons and we will be sending an invitation soon.

So at Kaiser Permanente through the program 14,000 employees have been assessed, trained and qualified. Look at the words assessed, trained, and qualified. I haven't spoken about certification because of the reasons that I mentioned before.

Because we are a nonprofit organization we have responsibilities with the community and the nation. Some people say okay it's our responsibility based only in the service area.

And what I say is this. The tax-exempt status was given to Kaiser Permanente by the entire country see, not by the service area.

So yes we have responsibilities in the service area but we have a bigger responsibility to look outside in nine states in which we have Kaiser Permanente facilities.

So we will support any kind of qualified bilingual staff efforts that any organization wants to do to replicate the program in many ways or in several ways.

So with that we have partnered with hospital systems health plan government agencies and academic institutions in the dissemination of the program.

We have partnered and I think that Marcos mention at the beginning that in the dissemination of the program we have partnered with various healthcare systems to disseminate the program to the train the trainer model.

See I'm going to be very careful not to mention other organizations as well because we have made agreements with them.

We're not going to brag about the QBS program or where it's implemented and how many organizations, not - the names of the organizations that have implemented the program.

But what I can tell you is is that more than 50 organizations are currently using the qualified bilingual staff assessment to assess the linguistic skills of their bilingual staff today.

The only reason why I mentioned Adventist is because Marcos is here. And with Marcos we are partners in so many ways that I would be remiss if I don't mentioned him as being the preeminent partner organization for Kaiser

Permanente as it relates to the dissemination of the Qualified Bilingual Staff program.

So what is the purpose of the program? It's in a strategy and it will be in a strategy for your organization to become the quality of service leader in several ways -- quality of service for your patient, for your employees and providers and in several other ways.

This slide is a little bit busy. And I don't want to go into detail into it. The picture is an allegory picture that was the first Qualified Bilingual Staff dissemination that we did in 2003 in Oakland, California.

But we're going to follow the journey with the bubbles above. Once you get the slides then you can look at them in detail. But obviously you need to have policies and procedures in place that apply to either new hire existing staff and to the workforce in general.

So most importantly for you as you designed as a strategy is identify your workforce. Do you have bilingual workforce? And if you do did you identify it yourself, somebody told you about them or did they self-identify?

Now that you understand that you have bilingual - a bilingual workforce now how do you tap into that precious resource that you have?

But then again you just not going to deploy them because my assumption is that you care about patient safety and that you care about quality of service and that you want to ensure that patients for the first time understand what is being said to them by your organization through your providers or to the people that they come in contact with.

So then there is the qualification process. I mean and what is the qualification process? Don't you have the responsibility to assess them, to ascertain what level of competency they have in the language that they say they speak?

Do you have a process in place to train them or would you like to train them? Then the other one is to enhance. Okay how'd you enhance their quality?

Is it through continuing education? It is through by creating training opportunities for them. And then you - knowing your organization you will understand the operational issues that will come associated with removing staff for educational purposes.

Now is this something that you're going to be responsible for the organization or should it be the responsibility of the employee to do it on his or her own? Those are the questions that you will need to answer.

In our world we try to provide the space for the employee to be trained but then we also look at their financial realities associated with that decision.

Then once we know who they are, once we have qualified them, once we have done everything that we can to improve on their medical terminology as an example or in their interpreting skills how do we mobilize them? How do we deploy them? How do we reallocate that resource?

How do we remove a bilingual staff from a provider who is also bilingual and allocate that bilingual staff to a provider who is monolingual English speaking? And what does that mean for the employee?

Are we going to have policies and procedures in place for the mobilization of this employee? What kind of incentives are we going to give to this

employee? And do we have a mechanism to track them to know where they are so that we can tap into them?

And then the last one -- and I think that this is something that most organizations go on that journey once they have a program in place -- is how do you monitor them so that you can provide on the spot feedback? Do you channel your bilingual staff? Are you going to be getting satisfaction surveys from either the providers or the patients?

I can tell you one thing once providers get used to quality interpretation services they can spot a bad interpretation see.

And the dream for you would be when a provider says to you, you know what, this employee I don't know but I don't want to - I don't want that employee to provide interpretation services for me because I don't think he has the communicative competency that I expect and that I will demand.

So that is the journey of the Qualified Bilingual Staff. Again this is going to be shared with you as you heard at the beginning of this conference call.

So what are the components of the program? Like any other program it has several components. It has the national faculty. Obviously it would not be possible without a national faculty. And they are located in several places in the country. And we tap into them to ensure that not only the viability of the program but to ensure that we had the most up to date information for the training.

We have a training curricula that is centralized because we need to be able to do something that is called version control so that when this, the content is updated the update benefits every organization that uses the content.

Then we have the facilitation facilitators training which is done by the national faculty to ensure consistency on the program.

On the next two slides we're going to be talking about the Level I and Level II trainings and what that entails and then we're going to jump into the QBS assessment.

This is something that based on the realities of your organization and the amount of people that you have and that you have identified as being bilingual staff you can choose to do the assessment at the beginning or at the end of the training.

Why at the beginning? If I have 300 people to train then it would be better for me to assess them first? Why? Because the assessment will tell me who is at the Level I and who is at the Level II.

The Level I only requires eight hours of training. The Level II requires 24 hours of trading. So those are logistics decisions or operational decisions that you will have to make.

At the end of the training and once they pass the assessment I will show you at the end that employees at Kaiser and the partner organizations receive a certificate of completion that will go into the employee's file.

Now we know that this employee has completed the training and that has passed the assessment and that the organization can demonstrate to regulatory auditors that indeed this patient has gone through that process and we have deemed it to be qualified to provide interpretation services within the scope of practice. We'll see that in a minute.

And then as I said before we have the responsibility to disseminate the program and to support organizations that want to adopt the program through consultation and technical assistance. So...

(Laura Bendle): Hi Oscar. Oscar this is Laura. I just want to give you a time check. Five minutes.

Oscar Lanza: No problem. Thank you.

(Laura Bendle): Thank you.

Oscar Lanza: I'll be done in two minutes, all right.

(Laura Bendle): (Unintelligible).

Oscar Lanza: Thank you so much. So what is the QBS Level I and what is the scope of practice?

In general terms a Level I is a person who is a receptionist who is a person in the environmental services of the organization.

A when patients come in contact with the systems with the building we expect them - we expect this QBS Level I to facilitate the transition meaning a way to communicate with the organization.

By that I mean appointment and directions. That is in broad terms what Level I does it means.

What is a level II? A Level II we had to tap onto something that they already have -- medical assistance, LBN, laboratory technicians. They already have medical terminology as a foundation.

And in the discharge of their duties we want these individuals to be able to provide some formative interpretations as they move patients into, rooming patients take the blood pressure, vitals and everything.

So what we don't want them to do is to perform side translation of consent forms. We know that that is a lengthy form or to be able to say no this is above my head, I'm not going to be able to do it. Let's call a professional interpreter.

Another situation is in the emergency room or an emotionally charged encounter in which what you have is an individual whose values and beliefs come in conflict with interpretations that is about to be provided.

If my religious belief will get in the way of me providing language assistance services for somebody who is going to terminate a pregnancy I need to remove myself from that equation.

And this one and this is the last one individuals complete the training what we give them is a certificate of completion that they probably take to their managers.

It is signed by the facilitators as you - as your organization will make determinations as to who is going to be signing these documents. and this will become part of the employee's record and they can take them to another facility.

What does it do for example -- and Marcos is an expert at this -- you can see Qualified Bilingual Staff who were trained at Adventist Healthcare System that went on to work at Kaiser Permanente and vice versa with their QBS certificate.

So therefore you as an organization no longer have to invest in their training. They were already trained by another organization in your service area.

And to us one is the best way to share a practice that will benefit not only your organization but it will ultimately benefit limited English proficient members. And with that I'm finished.

(Laura Bendle): Thank you Oscar. We appreciate that. (Jeff) could you just remind our participants how they can queue up to ask questions?

Operator: Certainly. Ladies and gentlemen as a reminder to register for a question press the 1, 4 now.

(Laura Bendle): So Oscar while we're waiting to see if there are any questions we do have a question here. How can healthcare practices and hospitals assess their need for interpretation services?

Oscar Lanza: Well I think I mean like any organization they need to look at the member demographics to see - and specifically looking at the language that the patients that come through that door speak.

I think that would be event of their medical electronic medical record. It's just a matter of running a report so that we can understand what are the patient's needs.

And then the other one is due in internal environmental scan to determine how many bilingual employees they have and in what languages.

And that once you make that determination I think they will need to engage HR to see I mean how are we going to engage them so that they can get assessed and then trained and then qualify and whether or not you're going to be able to give them an incentive.

Most organizations to provide an incentive and it varies from region to region from market to market.

(Laura Bendle): Great. Thank you. (Jeff) are there any questions in the queue?

Operator: It looks like there are no questions in the queue.

(Laura Bendle): So Oscar we have one other question. Do you have any data on the percentage of interpretation needs that are met by a qualified bilingual staff versus certified interpreters?

Oscar Lanza: I mean and again that is very difficult to ascertain unless you have especially for qualified bilingual staff. What we do is that we put - we look at the physicians panel and how many patients that speak a language that physician is responsible for as part of that panel.

And then what we do for interpreters for example not for Qualified Bilingual Staff because they're constantly providing interpretation services be it over the phone talking to patients or the physicians or to in an out of the clinic.

But for the professional healthcare interpreters what we have is that in this scheduling system in one region or two regions in particular we put them as a

resource. And we schedule an appointment with a physician as a joint appointment saying okay this physician is going to see a patient who speaks Spanish therefore we're going to make it into a joint employment with an interpreter who speaks Spanish, no different than when you have a joint deployment between a pediatrician and a cardiologist that are going to be seeing the patient at the same time.

So that way at the end of the year or at the end of the month you can run a report on how many interpretations have been provided. This is done through electronics.

(Laura Bendle): And one last questions. Are the employees incentivized to become qualified bilingual staff?

Oscar Lanza: Not to become but they are incentivized once we say that we want them to use their linguistic skills to help the organization meet the needs of the patients.

Their range is from 30 cents an hour to 150 an hour depending on the market and the availability of this precious resource.

But those are decisions that are made by the finance department in the organization and by human resources of the organization.

So once they are incentivized those who didn't say that they spoke a language immediately sign up for these programs.

Now the question is do you want to sign up everybody or do you have a responsibility to ascertain that they indeed are qualified to provide these services? Because in the end it's not about the individuals, it is about the organization.

And I think that we all have a responsibility to protect the brand and the good name and the reputation of the organizations that we work for.

(Laura Bendle): Oscar thank you so much. We really appreciate your participation today and we have one last request if you could pass the ball to Victoria so that we can have them begin their presentation.

So our next presenters are Victoria and Mercedes from Maximus joining us from Rhode Island and I'm going to turn it over to you ladies. Thank you.

Mercedes Blanco: Thank you and good afternoon. Thank you for being with us. I am Mercedes Blanco and I am here with my colleague Victoria Williams from the Center for Care Literacy at Maximus.

I want to thank the Disparities National Coordinating Center for your invitation. We talked today about translations that hit the mark.

Translations is writing that conveys the meaning effects in another language. It makes communication possible among people who read or write different languages and have different cultural barriers.

The translation should convey the content of the original document completely and accurately while communicating effectively the meaning of the word to the new audience whose language and culture is not the same.

Okay many immigrants come from country where the health care system is different. Some of them didn't even have healthcare. Some of them are well-educated and some of them may not have a very good education.

Some immigrants are doctors or engineers but the vast majority have something in common. They don't speak or read English very well.

Translation is necessary to communicate information to those who need it, wanted it and are entitled to it but who have difficulty reading and understanding the language of the original document.

For example information about health insurance plans and enrollment must be in the right language and at the right literacy level and must speak to the culture of the reader.

It was all over the news this week about the problem with enrollment that California has with Hispanic population.

This change insurance in California is called (Cobra) California. The government numbers have been much lower than expected.

They hired a publicity agency to introduce this change to future enrollees. The information done for Hispanic did not consider the culture of the audience. They did not write a telephone to call or an address to go to get informed they only put the Web site as a preference.

If they have known the audience they would have known that Hispanics have a different way to shop for insurance.

So the idea is translator might implement in signs into the nuances of both cultures, that of the author and that of the target population.

Preferably a translator will at some point submit among the people for who he or she is translating and therefore know the language and culture well.

If a translator doesn't know her audience she's apt to use the wrong word even if she uses the right language. For example there is a different word for bus. This is an example only.

Using different Spanish-speaking countries if a translator doesn't know the primary country of origin where he or she is translating for Spanish-speaking audience he may use the wrong word.

The translator has to do his homework. If he's translating something for New York whose first language is Spanish he has to know that the largest Hispanic population comes from Puerto Rico.

If you're translator doesn't do his homework you should let him know who is the target language and literacy level of your reader.

A good translator adapts the original document content to the audience adopting is making sure to consider culture and educational level and write it so the audience can easily understand the messages rather than simply translating word for word.

This is important because in his word may not have a precise translation in other languages and sentence structure is usually different too.

This adaptation I was talking about is a translation equivalent of writing in plain language. So how do you find a good translator?

Look for a translator who is a good writer in his or her native language and who is knowledgeable in the field you work in.

Remember that just because someone speaks English well or another language well and is well educated sorry, doesn't mean he or she will be a good writer who can adapt text to meet the audience's needs.

During the interview process asked the perspective translator to explain his or her approach to work -- translations, managing a project and troubleshooting.

Ask him to discuss adaptation and his experience with adapting content for different audiences. Can he write for your audience?

Ask him or her to give you samples of previously translation work. Check his or her social skills. Since you will work with this person very closely the last thing you want is a translator who doesn't accept changes or is not willing to discuss question of word choices for example.

And more importantly check their references. Speak to people who worked with him or her previously.

Now Victoria will talk about what to do once you found your translator.

Victoria Williams: Thank you Mercedes. Once you hire your perfect translator how do you monitor the work if you don't write in the language that your documents are translated into and how can you be sure your translator is doing a good job?

Well my best advice is to design a checklist of what you want in your translated documents and asked the translator to use it to self-evaluate his work.

The checklist should spell out your requirements. For example you expect grammatical text and accurate punctuation.

You want the text written for people with limited literacy skills, you want the examples and illustrations to speak to the culture of the audience.

In other words the illustration should be culturally relevant.

Here's a short checklist that shows what I mean. Putting together the checklist will help you clarify your expectations.

If you find that with your new translator you're getting more questions and complaints from your clients than expected you might want to send several samples of his translation along with the English originals to an independent translator to proofread and give feedback.

Send along your checklist too and as the proofreader to use it to evaluate the translations. Having another set of eyes to check that the translations might help you evaluate your translators work.

Also another way to find out if your translation is suitable for your audience is to do a formal or informal review with individuals who will be receiving your materials.

Sometimes you cannot afford the cost of a professional translator so you might decide to look for a volunteer to do the translation.

Again like Mercedes just said remember that just because a person speaks a language while it doesn't mean they write well or can translate well.

So look for a good writer in the language of translation, someone who writes grammatically with good spelling and punctuation and who could adapt the content if necessary.

You don't want to make the mistake of having a volunteer translator who doesn't have the skills or experience to translate.

Get samples from several prospective volunteers just as you would if you were paying for a translator. And try to choose the best person for the job and asked them to use the checklist too.

Now Mercedes will discuss other important readability elements on translation.

Mercedes Blanco: The sign is an important element of his ability. The visual invitation should be present in the translation just as in the source document.

One thing that compromise your translator document design is the fact that different languages require different amount of space to express the same idea.

Some languages are wordier than English. In order to avoid crowding in the page by forcing another language into the same space that English took plan for more space where the language calls for it.

In this example you can see that the Spanish translation is a little longer than the English original whereas the Russian is half as long again. Therefore while the translated document should mirror the original in most respects its format may have to be modified or altered to accommodate the space differences.

In summary to produce good translator translation that communicate clearly you should take the time to know your audience and make sure your translator does it too.

And if you require your translator to adapt translations instead of translated literally word for word.

Look for an experienced translator that you trust and can work well with and give him very specific guidelines for what you want. Then monitor his work.

Finally make sure the translated document will look just as - will look just as inviting in translation as it does in English even if there are many more words in it.

I hope we have given you some useful tips to improve your translation. If you are interested in learning more we'll be glad to send you a copy of our word translation manual. Just send me an email.

Now we'll be happy to answer any questions you might have.

(Laura Bendle): (Jeff) one last time if you could let folks know how they can queue up for questions?

Operator: No problem. Ladies and gentlemen once again as a reminder to register for a question press the 1, 4 on your phone now.

(Laura Bendle): So Mercedes and Victoria while we're waiting to see if any folks have any questions we have one here.

We have heard people working in healthcare rave about Google translations. What cautionary notes can you provide about perhaps not using that particular product?

Mercedes Blanco: Well there are two things to consider. Google translator or any other machine translation is that, it's a machine.

It doesn't think and they will give you a translation and they will translate the first word of a sentence. For example if a translator read a sentence he will know what word to use.

In the case of a - Google translate or any other machine the machine will pick the first word and it will translate with the first meaning.

And so sometimes the first meaning is not the right one. Besides when you need a translator you need a translator who is an expert in the matter you want to translate. And in this case the machine translation doesn't think and doesn't feel that this is the right or the wrong word.

I don't know if I answered your question.

(Laura Bendle): I believe you did. Thank you very much. And we do have another question in the chat room.

If your audience is a mix of Mexican and Central American audience members how do you specify the appropriate language dialect?

Mercedes Blanco: This is a very good question. And we have dealt with this in the past.

In many occasions the language is - the streamlined language for Spanish is the same. But in many cases you will find that different words as an example of boss that you see there in different languages they say it in another way.

So what we have done in the past is when we know that there are some words that are different from one country to another we write the first one and we put in parentheses one or two that would lead the reader to understand that we are translating also for the Mexicans and also for the Puerto Ricans.

Did I answer your question?

(Laura Bendle): I believe you did. (Jeff) are there any folks queued up with any questions?

Operator: It looks like there are no questions.

(Laura Bendle): We do have another question in the chat room Mercedes and Victoria. And the person says while I agree the machine-based translations have flaws one benefit is that they allow a Web site to be easily translated and that, you know that's a process that is time-consuming and expensive.

If you want to do it manually for an entire Web site any thoughts about the best middle ground?

Mercedes Blanco: Well there is no middle ground when we talk about translations by a translator and a machine. It's very dangerous. In this case it's very dangerous to use a machine translation to do a Web site because the translator has to use to be very cautious.

He has to check what he or she said in the previous stage or in the previous chapter and do the translation consistently.

Consistency is one of the most important things that we can give in a Web site. The Web sites sometimes are not easy to follow. And if you translate one word in one way in one chapter and the next one is another way obviously our readers will be very confused.

They machine translators doesn't understand about consistency so they will translate in the way that the machine can in that moment.

(Laura Bendle): Thank you very much. (Jeff) one last check for questions in the queue?

Operator: It looks like there are no questions in the queue at this time.

(Laura Bendle): We just have a couple quick announcements from the DNCC but I want to first thank our presenters very much for joining us today. I think a couple of them have to jump off the call at this point.

But I just want to do some announcements from the Disparities National Coordinating Center. Victoria if you could pass the ball back to (Ava) we appreciate it.

Victoria Williams:Okay.

(Laura Bendle): Wonderful. Thank you very much.

So we just want to remind folks if you want to stay up to date on what's happening at the DNCC please join our listserv. You can also download all of the presentation slides from healthcare communities.

Also very important we wanted to let you know about our virtual conference. That's going to take place on April 8 from 12:00 until 4:00 PM Eastern Time.

Registration is now open so we invite all QIOs to join as well as their stakeholders and their providers. And if you can do it together press in a conference room that would be wonderful.

We are limited in the number of participants that we can have so if you can do it jointly we really would appreciate it.

Just to give you an idea of the agenda get out your magnifying glasses to see that but we figure once you get the presentation you can take a closer look.

But we're really excited. Our keynote speaker is Jeffrey Brenner from the Camden Coalition. And you can take the opportunity we send out the presentation to look at the other speakers. But we're really excited about the event and we hope that you can join us.

Also take a look at CMS Pulse. We have all of our presentations out there as well in addition to all of our resources and tools that we have disseminated you can download the most recent versions from CMS Pulse.

So again I just want to thank all of our presenters so much for joining us today and for all of you for participating in the call. And thank you very much for joining us. Have a good afternoon.

Operator: Ladies and gentlemen that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your line.

END