**Language Access in Kansas Healthcare**
**A Policy Brief for KDHE and Kansas Legislators**[1]

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## I. Executive summary

*In this policy brief, we recommend legislation that obliges healthcare institutions to create public language access plans and require individuals who provide interpreting services to obtain professional training. We also recommend that steps be taken to better understand how language access is currently provided in Kansas, disseminate information about language access to healthcare facilities, and improve professional development opportunities for healthcare interpreters.*

As Kansas becomes more linguistically diverse, studies show that language access services are necessary to maintain the highest possible level of health in our communities. Based on research that centers the experiences of patients and their families, healthcare providers, and healthcare administrators, this policy brief focuses on the need for more qualified interpreters in Kansas health systems and for health information dissemination in languages other than English.

The research team held stakeholder meetings in which participants shared their experiences related to language access in healthcare settings. Spanish-speaking patients reported inconsistent access to qualified interpreters with dangerous results like preventable conditions becoming life-threatening and the deterioration of trust between patients and providers. Lack of trust is known to decrease the likelihood that patients will follow a provider's care plan. Healthcare providers echoed the obstacles to developing trust when a qualified interpreter was not present and argued that institutions must invest more money in the provision of language access services. The administrators raised concerns that the processes for funding interpreting services in Kansas made it impossible for them to improve the quality of the services they offer.

Because the stakeholder meetings took place during the COVID-19 pandemic, Spanish-speaking patients and their families also expressed that information about the virus is not available to them in their language. Their central concerns were how they would pay for treatment if they became ill and afford basic expenses if they were not able to work for an extended period of time.

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Recommendations

The research team offers recommendations in five areas:

1. **Research:** Information is needed to understand how federally funded healthcare institutions inform patients about interpretation services, how they provide those services, and how institutions manage service fees. This research will provide recommendations for improving the current system and for creating a database of institutions that provide qualified interpretation services.
2. **Information Dissemination:** The Kansas Department of Health and the Environment should create a campaign to disseminate information to healthcare institutions about language access and develop methods for supporting institutions in offering services and training providers to use them.
3. **Professional Development Programming:** Educators should incorporate language access into health professions curricula and local organizations in Wichita and western Kansas should become licensed to provide forty-hour certificate programs for current and aspiring interpreters.
4. **Language Access Planning:** Healthcare institutions should create and make public step-by-step plans that describe how language access needs will be assessed and language assistance will be provided. Legislators could propose a ballot initiative to require that healthcare institutions create these plans and make them public.
5. **Legislation:** Kansas legislators should propose legislation that obliges healthcare institutions to require the interpreters on their staff and those with with whom they contract to complete a forty-hour healthcare interpreter training program.

## II. Introduction

Providing language access services in healthcare contexts for individuals who need them is an important component of creating a healthcare system that offers every individual the care they need to attain their highest possible level of health and maintain a healthy community. As the linguistic diversity within the United States increases, language access has been identified as a significant component of creating an equitable healthcare system.[6]

U.S. Census data from 2009-2013 indicate that nearly 300,000 Kansas residents speak a language other than English at home. The majority of these residents speak Spanish (almost 200,000), followed by Vietnamese, Chinese languages, Arabic, and about 150 others.[7] While the need for qualified healthcare interpreters in the state of Kansas increases due to the growing linguistic diversity in the state, the number of certified interpreters remains low, and Spanish-speaking individuals who need language assistance report not receiving interpreting services in a variety of types of healthcare encounters. The Certification Commission for Healthcare Interpreters lists 36 registered Certified Healthcare Interpreters™ in Kansas (for all languages), while the National Board of Certification for Medical Interpreters lists only eight Certified Medical Interpreters (out of 2,789 in the United States). Hiring interpreters that have completed the rigorous testing process required by either of these two credentialing agencies is considered

[6] Fernandez, A., Schillinger, D., Warton, E. M., Alder, N., Moffet, H., Schenker, Y., . . . Karter, A. (2011). Language barries, physician-patient language concordance, and glycemic control among insured Latinos with diabetes: The diabetes study of northern California (DISTANCE). *Journal of General Internal Medicine*.

[7] https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html

the "gold standard." The first step in the process to become an interpreter is the completion of a forty-hour English-language training in best practices, ethical issues, and medical terms, and this forty-hour course is considered the entry point into the interpreting profession.

Most healthcare facilities in the state are legally required to provide *qualified* interpreters to their patients with 'limited English proficiency,' as per a 2016 rule in section 1557 of the Affordable Care Act. The clarification that interpreters must be qualified implies that simply being bilingual is not sufficient; they must possess a demonstrable qualification of their adherence to ethical principles, fluency and comprehension in English and an additional language, and ability to use the necessary vocabulary effectively, accurately, and impartially.[8]

As part of a community engagement project funded by the Patient-Centered Outcomes Research Institute (Federal Award #88488-TOSU), a team of scholars from Wichita State University facilitated a series of stakeholder meetings in Wichita and via Zoom in the spring of 2020 to discuss healthcare for Spanish speakers in the state. During our meetings and subsequent outreach, Spanish-speaking patients, providers, interpreters, administrators, and community liaisons from across Kansas expressed diverse perspectives on the current state of language access here.

## III. Satisfaction with services

All of the groups of stakeholders—patients and their families, healthcare providers, and healthcare administrators—reported weaknesses at different points in the system that lead to inconsistent provision of language access services and ultimately inequitable healthcare for Spanish-speakers. Their perspectives indicate a need for improvements in language access provision at all levels of the healthcare system.

*Perspectives from patients and patients' family members*

Spanish-speaking patients and patients' family members reported that they did not receive language access services in sensitive situations, such as before an emergency operation or when a child was experiencing debilitating pain. Patients treated in Kansas who participated in our meetings expressed surprise upon learning from members of our team that they had a right to professional interpreting services and should never have to bring a family member with them to serve as an interpreter. They also noted that at times interpreting services were provided inconsistently, depending on the type of healthcare interaction in question.

**Veronica Mireles, Spanish-speaking Parent of Patient**

Veronica Mireles took her teenage son to the emergency room at a major hospital in Wichita, KS when he was experiencing severe abdominal pain. They were not provided with an interpreter, and her son's doctor sent him home, suggesting that he may be suffering from symptoms of a sexually transmitted disease. A few days later when the pain became unbearable, they returned to the emergency room and were seen by a different physician, this time with an interpreter. Veronica's son had appendicitis, and because of the delay in treatment, his appendix had ruptured. This preventable emergency led to a prolonged hospital stay for Veronica's son, an exorbitant medical bill, missed days of school, and a loss of family income.

[8] https://theculturalink.com/2016/05/19/your-guide-to-aca-section-1557/

Veronica Mireles' story shows that many aspects of an individual's life are affected by communication errors caused by insufficient or inadequate interpreting services.

In addition to concerns about poor outcomes due to lack of language services, some of the patients who participated in our meetings reported that the quality of interpreting services was inconsistent. For example, some patients had experienced interpretations of their interactions with healthcare providers that seemed to be incomplete or inaccurate, suggesting that the interpreters who served them may not have been qualified healthcare interpreters. Unlike many states, the state of Kansas does not require healthcare institutions to provide certified interpreters and does not even require interpreters to have completed a specific number of hours of training. The burden of ensuring the use of qualified interpreters is placed on the healthcare institutions. In turn, these institutions frequently contract out interpreting work to private companies and the responsibility for ensuring the interpreters are qualified shifts to those private companies.

When the quality of healthcare interpretation is consistently low, patients feel less comfort with professional interpreters. Further, the observable lack of information about the code of ethics for healthcare interpreters, may lead patients to mistrust professional interpreters in Kansas. Another issue related to trust that emerged in our conversations with patients in Kansas was that providers do not meet patients' expectations for interpersonal communication, leading to a lack of rapport and an obstacle to developing trust. This concern was exacerbated by the use of remote interpreters, who felt to some patients like machines. This lack of trust in professional interpreters and healthcare providers is one reason why patients choose to bring family members with them to interpret at their healthcare appointments.

In our meetings, bilingual adult children of Spanish-speaking patients shared concerns about having interpreted for their parents without any professional training.

**Elizabeth Macias, Patient's Daughter**:
"A lot of terms, we do not understand. I can remember being his age or little, and ... I am the oldest, so I had to be the first one to ever interpret. And my mom has been in and out the hospital all her life. So, when I entered the picture, it was like, you go to school. They are putting me through school so that I am, you know, the translator on the spot. But I remember sometimes hearing terms like, crazy terms and I would just be like... 'uhm..se dice, se dice...' and I would just stand there, and nobody would help. I remember the doctor staring at me and just waiting. And I would be just like 'ugh! Se dice....' I just didn't know how to translate it. But I can completely relate to that. And I always wished that... only because I know my set of skills are like basic level to what I know, but I would have wished that there was somebody there to explain it to my mom way better than any way that I could have ever explained to her. Only because then she understands it more so if she needs to be worried then she will be worried, and I am not here struggling or shy. Because I have another sister and she was always too shy. So, I always would think that if I am never there, then she is never going to help out. Or if somebody is not there except me, if they don't provide my mom with somebody, nobody is going to be able to translate for my mom. And that's why my mom has a strong personality. Because a lot of times she has to fend for herself not knowing the language. So, that is really scary."

Our stakeholders' experiences demonstrate that the pressure on child and family language brokers is enormous and safety issues arise when they are not prepared to interpret in healthcare

settings. Stakeholders like Elizabeth Macias recognize that healthcare interpretation requires professional training that they do not have and express a desire for professionals to accompany their family members in medical settings.

In addition to signaling a lack of quality and availability of professional interpreting services, patients and community liaisons in Kansas raised concerns about the availability of health information in Spanish. Because our Kansas stakeholder meetings took place during the COVID-19 pandemic, discussions on health information primarily focused on information about COVID-19 and the unique work and lifestyle choices that individuals must make during the pandemic. In our meetings, patients raised questions about the availability of virus-related information and about how the healthcare system works, particularly with respect to health insurance and other aspects of paying for health care. These patients suggested that a system of educating patients on this type of information would be fruitful.

*Perspectives from healthcare providers*

The healthcare providers who participated in our stakeholder meetings reported that when they worked at hospitals in Kansas, they used any available resources, including family members, office staff, or even Google Translate, to interpret the information for patients when interpreters were not available. They expressed that they were particularly concerned about using family members as interpreters when addressing sensitive topics, such as STDs, and family members were likely to be uncomfortable interpreting such questions.

Echoing the patients' experiences, providers also expressed critical concern about patients' trust in interpreters and providers. Providers explained that Spanish-speaking patients were more likely to trust providers who spoke to them in Spanish. While risky miscommunication may arise when providers who are not linguistically and culturally prepared attempts to communicate in a patients' language, the presence of a qualified interpreter will minimize misunderstandings and may improve rapport and trust between patients and providers. The providers on our team emphasized that patients are more likely to adhere to the plan of care if they trust their provider.

One nurse who participated in our stakeholder meetings said that she learned from hearing the experiences of the patients' team members and that it changed the way she looked at communication with her Spanish-speaking patients.

**Tammi Alonso, Nurse**

"I don't want any of my patients to ever walk out and say, 'I have no idea what she was doing, and she made me miserable and…,' so I am more careful now about what am I saying. I'll ask my patients if they speak English, and I didn't used to ask them because I want to explain it myself instead of having somebody as a picture on your phone. I think we need to really make sure that people understand and repeat back, kind of like that nursing thing where they have to repeat it…You know, I mean, I think that's kind of changed what I do because I'm—I don't want any of my patients to come and say 'I had a hysterectomy and I had no idea how I got there' or you know 'somebody did this and I didn't know what they were doing' or you know just starting an IV if people can't say what you're doing, you know. I think that just being more aware of that situation is a huge thing. Being aware that not everybody speaks my language especially in my clinic where our population is like 75% Spanish-speaking."

This nurse's perspective highlights the importance of teaching the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards and highlighting patients' experiences in nursing education and professional development. In addition, the providers concluded that there is a need to include more healthcare providers in stakeholder engagement activities with Spanish-speaking patients.

The providers on our team argued that healthcare institutions need to invest more money in providing interpreters and bilingual healthcare providers and health professions programs should require their students to study Spanish. They also argued that Spanish language study should be incorporated at all levels of education in the United States.

*Perspectives from administrators*

Our conversations with providers, administrators, and spokespeople for healthcare institutions in Kansas suggest that there may be insufficient awareness within the healthcare system of the legal obligation to provide quality language services to individuals with limited English proficiency and the process for funding such services. Organizations that accept federally administrated funds for payment of services (including from Medicare, Medicaid, Indian Health Services, or for active or retired military members) are required to provide interpreters through their accreditation process. Kansas's large community hospitals are accredited by the Joint Commission, whose accrediting process includes criteria related to the CLAS standards in health and healthcare. While some privately funded hospitals and donation-based clinics may not accept federally administrated funds for payment of services and thus may not have a regulatory obligation to provide qualified interpreters, most healthcare institutions do have a regulatory obligation to meet federal standards and are expected to be able to demonstrate their provision of culturally and linguistically appropriate services in the accreditation process.

If an organization is operationalizing accreditation criteria guided by the CLAS Standards, they must make patients aware of the availability of services at no charge. However, based on observations at clinics and patients' lack of awareness of the availability of services, it seems that healthcare institutions in Kansas are not doing enough to make LEP patients aware of these processes. Although the use of ad hoc interpreters, including child language brokers, can lead to an increased possibility for clinically significant errors and cause an undue emotional burden for the ad hoc interpreter, the practice is widespread in Kansas; an administrator at one safety net clinic in Wichita shared that the clinic commonly allows the use of ad hoc interpreters in lieu of telephone interpreters because it is the preference of the patients. However, patients are not necessarily made aware of the dangers of using untrained interpreters and the potential problematic dynamics of using an interpreter from the patient's own family.

In Kansas, some administrators have argued that Title XI and the federal legislation that supports it constitute an "unfunded mandate," in which providers are required to provide a service that they are unable to pay for. Although Medicaid is used to directly reimburse providers for interpreting services in Kansas, the system of paying for interpreting services in the state has changed. Currently, managed care organizations (MCOs), such as Sunflower Health Plan, that contract with Kancare, pay for interpreting services. For 95% of Kansas Medicaid beneficiaries, interpreter services are paid for by the MCOs, and there is currently no available data on how much Kansas MCOs have paid for those services. For the remaining 5% of the Medicaid population, the provider is referred to the state's contractor for translation/interpreter services.

When we spoke with Don King, CEO of Via Christi hospitals, he explained that there are many different ways to reimburse healthcare services, that reimbursement rates are inconsistent,

and that healthcare institutions try to avoid choosing the level of care they provide based on the patient's type of insurance or health plan. With these considerations in mind, the level of services an institution can provide for all patients must be lowered to account for those whose reimbursement rate is lower. In Wichita hospitals, this leads to strategies such as contracting out interpreting companies who then contract interpreters, rather than offering in-house interpreters. Administrators and providers who view the CLAS standards as an unfunded mandate may not feel that they can afford to provide the highest possible interpreting services for their patients; this situation can be worse for administrators who are unaware of the effects of inadequate language access services on their patients' health outcomes.

## IV. Recommendations

*Research*

To improve the quality of language access services for speakers of languages other than English in Kansas, research is needed to determine how healthcare institutions that accept federally administered funds for payment of services inform their patients of the availability of interpreting services, and how they provide interpreting services for different types of healthcare encounters. In addition, there is a need to increase understanding about individual institutions' management of the fees for interpreting services. In Kansas, statewide investigation of language access services provision would generate useful background information to inform the process of improving language access services across the state. This investigation is especially significant at the present time because Kansas recently shifted to a new system of paying for interpreting services and there is a need to understand the effectiveness of the new system in insuring language access. The study should gather information on which Kansas MCOs actively hire and pay for interpreters, how often this occurs and where it occurs. The investigation should also consider how patients request interpreter services, whether they are required to request the services in advance, and to what extent the MCOs are involved in determining how language access services are provided. This information will support decisions about what kinds of systems intervention may be needed. The investigation could also support the creation and distribution of a resource that lists providers who offer qualified interpreter services so that patients can take this feature into consideration when choosing where to go for healthcare. After gathering information on existing services and procedures, we recommend a multi-faceted approach to information dissemination, professional development, systems intervention, and accountability.

*Information Dissemination*

In addition to these investigations, we recommend that the Kansas Department of Health and the Environment (KDHE) develop: (a) a campaign of information dissemination to healthcare agencies across the state, (b) a method of supporting healthcare agencies in the process of disseminating health information to speakers of languages other than English, (c) a system of accountability to ensure that healthcare institutions are providing culturally and linguistically appropriate services, (d) a plan to support training for healthcare providers to care for culturally diverse patients and patients who speak languages other than English, and (e) an accessible system for patients to file complaints. KDHE should begin by disseminating updated recommendations to healthcare institutions about the implementation of CLAS standards. This information should include recommendations on the display of information about the availability of interpreting services, training of personnel, determining when and what modality of

interpreting services are appropriate in a given healthcare encounter, and ensuring that interpreters are qualified. Next, KDHE should provide recommendations and resources for the dissemination of local health information to speakers of languages other than English. In addition to providing templates for information on specific health topics to healthcare agencies and grant funding for some agencies to develop informational campaigns, KDHE should also support Kansas news agencies in disseminating state health information by immediately translating all press releases into Spanish and other languages and providing grant funding for a media campaign focused on Latino health. Finally, KDHE should develop a system that goes beyond the accreditation process for verifying whether state healthcare institutions are providing quality language access services. We recommend a revision of the responsibilities and resources provided to each institution's ADA Coordinator and Civil Rights Coordinator.

*Professional Development Programming*

In addition to strengthening the institutional systems for providing language access, professional development of interpreters and providers can further improve healthcare for speakers of languages other than English. We recommend broadening the incorporation of language access and cultural sensitivity into health professions curricula at educational institutions across the state of Kansas. In addition, there is a dearth of professional training programs for healthcare interpreters in Kansas and such programs need to be developed, particularly in the areas of Wichita and western Kansas. Instead of sending aspiring interpreters to other cities to complete their initial forty-hour training, Wichita should develop its own training program and could potentially draw interpreters from other parts of the Midwest.

*Language Access Planning*

After initiating the basic processes described above, we suggest the development and implementation of language access plans in Kansas hospitals that accept federal funding for services. A language access plan includes: a needs assessment, a description of the types of services a healthcare institution will provide, a description of how the institution will inform patients about the availability of services, a description of how the organization will train staff on its policies and procedures for providing language access services, and an evaluation plan.[9]

*Legislation*

Finally, our primary legislative recommendation is to propose legislation requiring that health interpreters obtain forty hours of training through a program such as Bridging the Gap or the Community Interpreter before offering services. In order to make this feasible, we recommend providing low-cost local interpreter training for Kansas interpreters and further implementation of video remote interpreting through a company with high certification standards such as MARTTI. Video remote interpreting services can be used when a trained professional interpreter is not available on-site and cannot be sent in a timely manner. After obtaining information about the new system of paying for interpreting services through MCOs, additional legislative recommendations may emerge in that area.

Improving healthcare interpreting services in Kansas is a necessary step toward equitable healthcare for all Kansans.

[9] Centers for Medicare & Medicaid Services. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf