LANGUAGE ACCESS POLICY

PLANNING & IMPLEMENTATION GUIDE

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Jeffery Hale – Saint Brigid's

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NOTE TO THE READER

*In this document, the term «**healthcare**» is used to refer to the provision of both medical and psychosocial services in the health sector.*

*In Quebec, French is the official majority language in the workplace. References in this document to minority community **Limited French-Proficient (LFP)** populations include, but are not limited to, English-speaking persons who prefer to receive their healthcare services in English. It should be noted that the English-speaking minority population in Quebec benefits from legislative guarantees to this effect and that designated establishments have a specific regional mandate to provide all of their services in both the English and French languages.*

This implementation guide was developed to serve primarily as a guide for the provision of bilingual services (French and English) within an establishment officially designated to provide all of its services in both languages. However, the theoretical framework, language access principles, and practical tools may be useful in guiding the development and implementation of language access policies and procedures for other minority language communities.

INTRODUCTION

Jeffery Hale – Saint Brigid's (JHSB) is a public, bilingual institution under participatory governance dedicated to providing safe, compassionate and high quality care. Among the strategic objectives of the organisation are *the promotion of linguistic duality and openness to cultural diversity.*[1]

Recognizing that language access is an integral component of the delivery of high quality and safe health services, JHSB has developed a number of policies, procedures and tools in the area of linguistic access. The organisation is currently seeking to consolidate and develop these initiatives within the framework of a comprehensive language access policy.

This report provides a theoretical model and reference to practical tools to inform organisational efforts in the development of a language access policy and the implementation and continuous improvement of a language access plan.

The objectives of this report are to:

- Conduct a review of the literature in the area of language access policies
- Analyze and summarize the most relevant information
- Present a theoretical model and practical information to assist Jeffery Hale – Saint Brigid's in the development of a language access implementation plan which reflect their designation as a bilingual health service provider
- Prepare a report synthesizing relevant information, including bibliographic references and links to website resources and tools

1 http://www.jhsb.ca/assets/official docs/strategic_plan.pdf

1 LEGISLATIVE CONTEXT

The Law on Health and Social Services (LSSSS) specifies the right of English-speaking persons to receive services in their language:

« Toute personne d'expression anglaise a le droit de recevoir en langue anglaise des services de santé et des services sociaux, compte tenu de l'organisation et des ressources humaines, matérielles et financières des établissements qui dispensent ces services et dans la mesure où l'on prévoit un programme d'accès à l'article 348 ». (L.R.Q., c. S-4.2, a. 15) [2].

The Quebec context is distinctive within Canada in that it includes both legislative measures for protection of the French majority language as well as measures designed to guarantee access of the English-speaking minority linguistic community to health and social services in the English language. [3]

Programs for access to health and social services in the English-language

Following the adoption of Bill 10 on February 9th, 2015, a law modifying the organisation and governance of the provincial health network, Regional Health and Social service Agencies were abolished and the number of establishments in the health network was decreased from 182 to 34.[4] As of April 1st 2015, with a few exceptions, health and social services come under the governance of a single public establishment in most regions, either one of the 13 Integrated Health and Social Service Centers or one of the 9 Integrated University Health and Social Services Centers. The Integrated Health and Social Service Centers are the result of mergers of health agencies and public establishments in each region of the province and will be responsible for the majority of health and social services within their territorial service network. However, programs for access to health and social services in the English language will be maintained in each region as will the status of establishments recognized under article 29.1 of the French Language Charter. [5]

Access programs in each region serve as the mechanism whereby the legislative guarantee of access to health and social services for the English-speaking population is rendered operational

Each Integrated Health and Social Services Center is responsible for implementing an access plan specifying the manner, the services and the public establishments in their integrated network that have an obligation to deliver health and social services in both the French and English languages, taking into account the human, material and financial resources of the establishments concerned. The Integrated Health and Social Service Centers must now also take into account linguistic requirements for the recruitment or assignment of personnel required to provide such services.

Designated establishment

A designated establishment is one recognized by l'Office québécois de la langue française (OQLF) as having a significant English-speaking client population, and which has subsequently been designated by health and social services authorities and the Ministry of Health and Social services, thus requiring that all of its services be made accessible in both the French and English languages.

Indicated service / program

An indicated establishment is one that has at least one department or one service program identified in the access program to provide services in both French and English. An indicated establishment does not require recognition by the OQLF.

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2 **GOUVERNEMENT DU QUÉBEC** (2006). *Loi sur les services de santé et les services sociaux : L.R.Q.,* chapitre S-4.2, Éditeur officiel du Québec, art. 15. www.msss.gouv.qc.ca

3 **Tremblay S and Prata G.** *Study on linguistically and culturally adapted health services: a Pan-Canadian portrait. Société Santé et Mieux-être en français of New Brunswick* (SSMEFNB. April, 2012.

4 L.Q. 2015, c. 1 (RLRQ, c. O-7.2) (« Loi 10 »).

5 http://www.msss.gouv.qc.ca/reseau/reorganisation/portrait

2 THEORETICAL FRAMEWORK: LINGUISTIC ACCESS POLICY

The diagram below illustrates the cyclical process components which are an integral part of a policy for language access.[6]

The following sections of this document present each of the 7 components of this model

6 Model adapted from **U.S. Department of Justice** *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs*. Federal Coordination and Compliance Section. Civil Rights Division. Department of Justice, Washington, DC. May 2011

2.1 ORGANISATIONAL POLICY STATEMENT: OBJECTIVES

Difficulties in navigating the healthcare system are exacerbated for English-speaking and other Limited French-Proficient clients (LFP). Accurate communication is necessary to ensure the correct exchange of information, allow clients to provide informed consent for treatment and to avoid breaches of client-provider confidentiality. The literature provides many examples of how the lack of language services negatively affects access to, and the quality, of health care. Failure to provide language services can lead to serious medical errors and liability.[7]

The objectives of a language access policy are to support the organisation in conforming to legal requirements for informed consent and confidentiality, to provide high quality and safe care, to assist clients in discussing and understanding their health condition, treatment options and expected outcomes and to support healthcare providers in accessing language assistance services when required.

Increasing attention to quality improvement and medical error reduction initiatives cannot overlook the critical element of effective communication between healthcare providers and their clients in ensuring successful health outcomes. In a study and literature review conducted by l'Institut national de santé publique du Québec (INSPQ) on language adaptation in health care, poor communication with minority language clients was reported in the literature to lead to longer, less frequent visits to medical clinics, more visits to the emergency room, fewer follow ups, greater dissatisfaction with services received, more frequent hospitalization and more medical tests, thus increasing the cost of care. [8]

Beyond legal requirements, health providers have a responsibility to offer understandable care to clients. Language barriers may also compromise the ethical character of professional care. *"Three ways that ethical care is compromised are through:*
a) failure to provide care to the same standard as received by other patients;
b) failure to protect patients' confidentiality; and
c) failure to adequately ensure patients' informed consent to treatment". [9]

Effective communication is also essential to empowering clients to become active drivers of their own health.[10] Generally, policies are necessary to provide support to staff in their offer of services to the LFP population. Policies pertaining to bilingual staff are a key component of an active offer of services because they: [11]

- clarify the mission and vision of the organisation;
- ensure the availability of resources required to offer linguistically appropriate and competent services;
- facilitate evaluation of the outcomes of services provided to individuals and families; *and*
- institutionalize the concept of linguistic competence within the organisation.

7 **Bowen, Sarah.** *Language Barriers in Access to Health Care.* Health Canada, 2001. www.hc-sc.gc.ca/hcs-sss/alt formats/hpb-dgps/pdf/pubs/2001-lang-acces/2001-lang-acces-eng.pdf

8 **Ouimet, A.M, Trempe N., Vissandjée B., et Bourdon J-F.** *Language Adaptation in Health Care and Health Services: Issues and Strategies.* INSPQ. January 2013.

9 **Bowen, Sarah.** *Language Barriers in Access to Health Care.* Health Canada. November, 2001, p.79.

10 **Winnipeg Regional Health Authority.** *Regional Interpreter Services - Language Access Policy.* July, 2013. http://www.wrha.mb.ca/about/policy/files/10.40.210.pdf

11 **Nouveau-Brunswick :** Politique et lignes directrices langue de service http://www2.gnb.ca/content/gnb/fr/ministeres/ressources_humaines/notre_sujet/politiques_lignes_directrices/langue_service.html

2.2 ORGANISATIONAL SELF-ASSESSMENT

The self-assessment assists the organisation in assessing their current situation and their progress in providing language assistance services to English-speaking and other Limited French-Proficient (LFP) clients.

The self-assessment approximates the elements that are part of effective language access policy directives and implementation plans and provides a starting point for an organisation to identify action priorities and areas for improvement.

Sample self-assessment tools which can readily be adapted for self-assessment in a healthcare organisation are available at: http://www.hablamosjuntos.org/resourcecenter/pdf/00103122004.pdf and http://azdhs.gov/hsd/health-disparities/documents/publications-data/language-access-report.pdf

The self-assessment should include **feedback from the community** and provide information in the following areas: [12-13]

- Understanding how LFP individuals interact with the organisation;
- Identifying and assessing the current and evolving language service needs of LFP communities;
- Evaluating bilingual, translation and interpretation resources available to help LFP individuals in accessing the organisation's programs, services, information or other operations;
- Assessing the availability and effectiveness of staff training on policies and procedures;
- Assessing the effectiveness with which the organisation provides notice of language assistance services to the LFP population; and
- Monitoring, evaluating and updating of the language access policy directives, plans, and procedures.

In identifying and assessing the current and evolving language service needs of English-speaking communities, useful information can be collected from both internal organisation-specific data collection as well as from external data sources. (Ex. CHSSN[14] baseline data reports, CHSSN community profiles, CROP surveys, demographic profiles available on public establishment sites, MSSS and Health Canada websites, surveys and focus groups with clients, families, CHSSN community networks and partnership tables, etc).

12 **U.S. Department of Justice.** *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs.* Federal Coordination and Compliance Section . Civil Rights Division . May 2011

13 **U.S. Department of Justice,** *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* 67 FR 41464-65 (June 18, 2002). (hereinafter "2002 DOJ Guidance"), http://www.justice.gov/crt/about/cor/lep/DOJFinLEPFRJun182002.

14 The Community Health and Social Services Network is a provincial organisation whose mission is to improve access to English-language health and social services in the province of Quebec. It is a network of 64 organisations and institutions.

2.3 IMPLEMENTATION PLAN[15]

The language access implementation plan is a management document that outlines how the organisation will meet organisational language access policy objectives and standards. The plan defines tasks, sets deadlines and priorities and assigns responsibilities.

Management Coordination

A manager should be identified to be responsible for devising the implementation plan, ensuring that the organisation adheres to its language policy plan and directives and for planning procedures aimed at providing meaningful access to English and French-speaking clients as well as to limited French-speaking (LFS) clients from diverse linguistic communities.

A sample position description for a Language Access Coordinator is provided in Appendix B

Content of the Implementation Plan

The organisational plan for providing meaningful linguistic access will address organisational planning for the next three steps in the framework and include a definition of the activities to be accomplished and assignment of responsibilities for:

- the development of language access procedures;
- the offer of services : oral and written Language Assistance Services (LAS);
- staff and community awareness : communication to clients and health care staff and partners of language assistance services;
- staff support and training : including awareness of language access policies and procedures;
- for establishments designated to provide all services in both English and French:
  - assessment of employee English language proficiency
  - assessment of English-language proficiency requirements at each point of contact
- determination of deadlines and priorities;
- ongoing monitoring and continuous quality improvement of oral and written language assistance services; and
- allocation of the resources necessary to maintain compliance with language access service standards.

15 **U.S. Department of Justice.** *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs.* Federal Coordination and Compliance Section. Civil Rights Division. May 2011

2.4 LINGUISTICALLY APPROPRIATE SERVICES (LAS)

2.4.1 Selecting Language Access Modalities

The Language Assistance methods chosen will depend upon a variety of factors such as percentage of the client population with Limited French Proficiency (LFP), languages most frequently spoken by the LFP population, technical infrastructure available (videoconferencing, access to a regional interpretation bank, etc), nature of the services being provided (technical, psychosocial), ability to recruit staff from minority linguistic communities, and so on.

An effective and cost efficient mechanism for the provision of English-language access in designated organisations where a significant portion of the patient population is English-speaking may be the recruitment of bilingual personnel. In various studies conducted in the U.S., both providers and patients reported that bilingual staff and clinicians were the optimal choice for communicating with LEP patients.[16-17]

The hiring of bilingual staff is a common practice in Quebec and can be an effective means to provide access to the English-language minority linguistic population when a designated establishment serves significant numbers of English-speaking clients, thus providing staff opportunities to maintain language competency.

In non-designated establishments, the organisation may also decide to adopt a practice of concentrating LFP population demand, thereby creating the conditions allowing for sufficient client population and the assignment of bilingual providers to serve the LFP population. For example, a weekly clinic could be organised to serve LFP clients of a particular language group, thus allowing the organisation to assign a service provider able to provide services in the language of that client group. Another example is when an establishment provides primary level health services to community schools , some of which are English-language institutions. A cost-effective manner in which to provide linguistically adapted services may be to adjust work assignments in order to assign one bilingual service provider to serve these schools.

Health care establishments have multiple options for providing language assistance. There is no single best manner in which health establishments can provide language assistance services to all LFP linguistic communities. "*It is generally agreed that the best communication is achieved where health care providers and patients speak the same language. There are a number of different approaches to increasing the number of language-congruent encounters, ranging from promoting English and French language training for new arrivals to Canada, to increasing the number of providers who speak minority languages. There will, however, always be a need for language interpretation services for some patients*". [18]

2.4.2 Bilingual Staff

Sufficient numbers of bilingual staff are necessary to avoid increased workload stemming from requests for interpretation from colleagues. Organisations must understand the communication encounters of bilingual staff and recognize the implications of confusing two-way communication with three-way communication. Two definitions of bilingual staff have been developed to reflect different language encounters.[19]

Two-way communication: *Staff that communicate in the majority language and another language at a level appropriate to their occupation and function.*

Three-way communication: *Staff that communicate in the majority language and another language between two or more parties to facilitate simple communication in their non-occupational role.*

16 **Downing, Bruce T., Ph.D., and Cynthia E. Roat, MPH.** *Models For The Provision Of Language Access In Health Care Settings.* Hablamos Juntos and The Robert Wood Johnson Foundation. (January2002).

17 **Paras, Melinda.** *Straight Talk: Model Hospital Policies and Procedures on Language Access*. California Health Care Safety Net Institute (2005).

18 **Bowen, Sarah.** *Language Barriers in Access to Health Care*. Health Canada, 2001. Santé Canada, 2001. P V

19 **Center for Culture, Ethnicity & Health.** *Bilingual Staff Research Project Report*. Melbourne, Australia. 2008. www.ceh.org.au/resources

These bilingual dual-role staff interpreters[20] are individuals whose primary job function in the healthcare organization is something other than interpretation—they could be physicians, nurses, therapists, social workers, billing clerks, receptionists, or orderlies. Every organisation needs to assess levels of risk for the different types of communication encounters conducted across the organisation[21] and then ensure that **the organisational language assistance policy provides guidance as to how and when bilingual staff can be used in situations requiring interpretation.**

'Hiring bilingual health professionals is one way to adapt services that has certain benefits in terms of optimizing linguistic communication between patients and health professionals. However, it is important to assess the second language proficiency of professionals who use a second language as part of their practice. The literature indicates that some tend to overestimate their proficiency in another language' (Ouimet et al.., INSPQ, 2013. P. IV)

When an organization decides to use a bilingual staff person to serve a dual role, one being to interpret, it is important to consider the following: [22]

- Proficiency and training: interpretation requires more skills than proficiency in two languages. Untrained interpreters may make errors in interpretation that could result in misunderstanding and miscommunication.
- How will workflow and productivity be affected if this person is pulled away from his or her normal duties to interpret?
- Are financial or other types of incentives offered to bilingual staff employees who interpret?
- Is interpreting listed in the job description for the bilingual employee?
- Will employee job satisfaction be adversely affected? and
- Will the frequency of use of the time of bilingual professionals to interpret for colleagues result in an increase in costs due to decreased productivity as professionals interrupt their work to interpret for colleagues (versus the use of contractual / dedicated interpreters)?

Interpreter competency requires more than self-identification as bilingual.

While a language services policy may recognize bilingual staff as part of language services in an organisation, it is important to keep in mind that Quebec has no provincial standards for interpreter training and there are no nationally accepted standards regarding qualifications and assessment measures for bilingual staff. Establishments should adopt procedures to confirm the competency of bilingual staff as well as external interpreters.

The organisational language assistance policy should provide guidance as to how and when bilingual staff can be used in situations requiring interpretation. Every organisation needs to assess levels of risk for the different types of communication encounters conducted across the organisation and then decide when and how to use bilingual staff. [23]

The Kaiser Permanente Qualified Bilingual Staff (QBS) Model and Program[24] in the United States is one example of a best practice model using bilingual staff and providers to provide quality care for limited-English proficient (LEP) clients.

Facing increasing language service demand as well as the need to comply with federal, state and local language access standards, the QBS program was designed to ensure qualified linguistic services and culturally competent care at every point of contact. Aside from providing safe and high quality care to LEP clients, Kaiser Permanente also recognized the cost-effectiveness of identifying and qualifying their own internal workforce to serve a broad spectrum of patient population and to address the unique staff-client encounters along the entire care pathway which require different levels of linguistic competency.

Through assessment of levels of linguistic competency and training, eligible staff builds the skills and the capacity necessary to fill critical interpretation needs. The QBS assessment enables the quantification and qualification of the linguistic proficiency of trained staff members, from administrative assistants to clinicians, which allows

20 **Office of Minority Health.** *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations.* September, 2005

21 **Bowen, Sarah.** *Language Barriers in Access to Health Care.* Health Canada, 2001. Santé Canada, 2001.

22 **Office of Minority Health.** *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations.* September, 2005

23 **Bowen, Sarah.** *Language Barriers in Access to Health Care.* Health Canada, 2001. Santé Canada, 2001.

24 http://kpqbs.org/training/hci.html

a broad identification of workforce linguistic capacity at the individual level. The organisation also creates opportunities to recognize and reward bilingual staff providing language assistance services and has a continuous quality improvement process to ensure satisfaction and patient safety.

In Quebec, a best practice example in the use of bilingual staff can be found at Jeffery Hale – Saint Brigid's (JHSB)[25]. The organisation developed tools to assist them in creating an inventory of positions in the organisation according to degree of English-language competency required as well as to assess English- language competency levels of staff who are occupying or who will occupy these positions. This has allowed the establishment to be less reliant upon external evaluation services and to evolve towards a model of self-sufficiency - the assessment tools developed belong to the establishment and JHSB staff has been trained to carry out the evaluations. Aside from ensuring a high quality of linguistically adapted services, benefits have included the facilitation of internal staff assignments, clarification of requirements for job postings, improved staff and organisational capacity, and increased awareness among staff of the importance of having an adequate level of linguistic competency according to the circumstances of the interaction when communicating with English-speaking clients.

2.4.3 Language Assistance Services

Language access services are also commonly referred to as language assistance services (LAS) and linguistically appropriate services. Effective communication with LFP individuals requires that the organisation have language assistance services in place. Participatory, collaborative relationships must be established with the English-speaking and other LFP communities served by the organisation to engage these communities in designing and implementing the organisation's language assistance services.

Language Assistance Services (LAS) include interpretation (oral) and translation (written) services. LAS can also involve provisions that enhance communication, such as assistive technology, tools for low literacy, signage and symbols for wayfinding.[26]

A. ORAL LANGUAGE ASSISTANCE SERVICES

This may come in the form of;

- "in-language" communication (a demonstrably qualified **bilingual staff member** communicating directly in an LFP person's language as described in the preceding section of this report, or
- interpretation.

Professional Interpretation

An **interpreter** renders a message spoken in one language into one or more other languages. Interpretation can take place in-person, through a telephonic interpreter, or via internet or video interpreting. An interpreter must be competent and have knowledge in both languages of the relevant terms or concepts particular to the program or activity and the dialect and terminology used by the LFP individual. Depending upon the circumstances, interpreters may provide:

- **Simultaneous interpretation** of proceedings so that an LFP person understands what is happening in a proceeding – the interpreted message is delivered nearly instantaneously after the original as is typically seen within conference settings
- **Consecutive mode interpretation** in an interview or conversation with an LFP person. Consecutive interpreting involves the conversion of a speaker or signer's message into another language after the speaker or signer pauses, in a specific social context. In this form of interpreting which is typically used in healthcare settings, the interpreter may interrupt the speaker and ask him/her to repeat, clarify or rephrase so as to ensure accuracy and completeness in the delivery of the message.

[25] **Jeffrey-Hale St. Brigid's** : *Systématisation du Processus de Formation Linguistique (Anglais Langue Seconde).* Rapport déposé à l'Agence de la Santé et des Services Sociaux de la Capitale-Nationale. 28 décembre 2012

[26] **Virginia Department of Behavioural Health and Developmental Services**. *Language Access Services Plan Template.* https://www.dbhds.virginia.gov/OHRDM-CLC.htm

"Although the use of a professional medical interpreter may lengthen the time of a visit, use of bilingual physicians and professional medical interpreters may decrease costs because of more appropriate resource utilization. Similarly, although implementing LAS may add costs in the short term, it may lead to reduced costs over time because of increased use of primary care and preventive services." [27] (O.M.H., 2005. p.4.)

Ad Hoc Interpretation

Types of interpretation errors may include, but are not limited to: [28]

- omission—the interpreter does not interpret a word or phrase said by the clinician or client;
- false fluency—the interpreter uses an incorrect word or phrase that does not exist in the targeted language;
- substitution—the interpreter replaces a word or phrase for a different word or phrase said by the clinician or client;
- editorialization—the interpreter provides his or her personal views; and
- addition—the interpreter adds information not said by clinician or client.

"Reliance on family members, or untrained interpreters recruited on an ad hoc basis (the most common responses to language barriers in Canada today) poses too many risks to be acceptable" [29]

If an English-speaking or other LFP client insists on using an ad hoc interpreter, family member or friend to interpret, the organization should record in the medical file that interpretation services were offered and that the risks of not using a qualified interpreter were explained to the client. [30]

27 **Office of Minority Health**. *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. September, 2005

28 **G. Flores and others**, "*Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters,*" Pediatrics 111, no. 1 (2003): 6–14.

29 **Bowen, Sarah**. *Language Barriers in Access to Health Care*. Health Canada, 2001. Santé Canada, 2001. P.vii

30 **Office of Minority Health**. *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. September, 2005

The Table below lists the different modalities available to provide linguistically appropriate services and summarizes some of the advantages and limitations of each approach.

Different Modalities for Provision of Linguistically Appropriate Services to Minority Language Communities [31 32 33 34]		
Modality	**Advantages**	**Limitations**
Trained external medical Interpreter (person-to-person)	Interpretation available in a variety of languages High quality if using trained interpreter Preferred for encounters that rely on nonverbal communi-ni-cation and for language populations less in demand Avoids issues of confidentiality Long-term cost benefits resulting from more appropriate internal resource utilisation	Scheduling required. Limited access to interpretation services for English-speaking clients. Services in regional interpreter banks are largely available for languages other than English. Interpreter may be unfamiliar with organisational policies and procedures Variable quality of interpretation - no mandatory provincial certification or training standards currently exist for public agencies providing access to banks of interpreters Staff training is required in working with interpreters Additional short-tem costs for establishments: interpreter travel costs and fees, increase in length of client visit.
Trained bilingual health care practitioner (a two-way client-provider interaction) (Two-way communication: Staff that communicate in French and another language at a level appropriate to their occupation and function.)	Preferred for encounters that rely on nonverbal communication. Health provider is familiar with organisational policies and procedures. High quality of interpretation if provider trained and second language proficiency is assessed Bilingual staff can fill simple communication gaps promptly. In two-way communication without third party involvement. This is particularly important when confidentiality is a factor. No increase in short-term costs due to interpretation and resulting increased length of client visits. Long-term cost benefits resulting from more appropriate resource utilisation and organisational efficiency.	Recruitment and retention of bilingual staff presents challenges Assessment of second language proficiency is required. Staff may overestimate their second language proficiency. Ability to conduct a conversation in a language is not a proficiency indicator for translating medical content or providing healthcare services in this language Costs for staff training, assessment of language competency
Trained bilingual staff - In three-way communication Staff communicate in French and another language (ex English) when called to interpret between two or more parties to facilitate simple communication in their non-occupational role.	Availability low to moderate	Loss of productivity (therefore increased costs) when staff are used to interpret for colleagues. Staff workload must be adjusted to allow for their role in interpretation Should be used in situations where there are minimal levels of risk. Communication may become complex and exceed staff member's capabilities, requiring a professional interpreter.
Telephone Interpretation	High level of availability, no travel costs High quality of interpretation when trained interpreters are used Avoids confidentiality issues Cost effective for less frequently encountered languages	Not recommended for encounters that rely on nonverbal communication (ex mental health interventions, explaining a diagnosis with serious outcomes, etc) Additional costs for establishment Requires access to private space and appropriate telephonic equipment
Ad hoc interpreter (family member, friend,..)	Availability moderate to high No additional costs for establishment	Quality of interpretation – high risk of interpretation errors Family or friend may withhold vital information or edit client statements to protect them (ex, family violence, substance abuse, mental illness, etc) Ethical considerations – confidentiality, professionalism of interpretation encounter.

31 **Centre for Culture, Ethnicity and Health**. *Bilingual staff research report*. Melbourne, Victoria, Australia (2008) www.ceh.org.au/resources

32 **Bowen, Sarah.** *Language Barriers in Access to Health Care*. Health Canada, 2001.

33 **Ouimet, A.M, Trempe N., Vissandjée B., et Bourdon J-F.** *Language Adaptation in Health Care and Health Services: Issues and Strategies*. INSPQ. January 2013.

34 **Office of Minority Health.** *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. September, 2005

B. WRITTEN LANGUAGE ASSISTANCE SERVICES

A sample list of Vital Forms which should be made available in other languages can be found in Appendix C

Translation is the replacement of written text from one language into another. A translator also must be qualified and trained. The organisation should identify and translate vital documents to ensure LFP individuals have meaningful access to important written information. Vital written documents include, but are not limited to, consent and complaint forms; pharmaceutical instructions, intake and application forms with the potential for important consequences; written notices of rights; signs; and notices advising LFP individuals of free language assistance services.[35] [36]

Regarding signage within the organisation - increased immigration from around the world has dramatically enlarged the population with limited French proficiency. Some hospitals and health care management companies have developed approaches to assessing wayfinding systems. These testing projects, promoted by organizations like the Center for Healthcare Design, have measured the positive effects of efficient and comprehensive wayfinding systems on the bottom line through decreasing staff time used in directing visitors and greater visitor satisfaction.

Universal symbols are more easily noticed and comprehended compared to multilingual word signs[37] and are more readily integrated within Quebec regulatory guidelines pertaining to signage in the majority language.

35 **U.S. Department of Justice.** *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs*. Federal Coordination and Compliance Section. Civil Rights Division . May 2011

36 **Office of Minority Health.** *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. September, 2005

37 **Berger, Craig.** *Universal Symbols In Health Care Workbook, Best Practices for Sign Systems*. Hablamos Juntos and Society for Environmental Graphic Design funded the Robert Wood Johnson Foundation - (December 2005). http://hablamosjuntos.org/resources/pdf/Best_PracticesFinal-Dec15.pdf

2.5 LANGUAGE ASSISTANCE PROCEDURES

Language assistance procedures are detailed explanations that specify the steps to be followed to provide language assistance services, gather data, and deliver services to LFP individuals. Procedures can be set forth in handbooks, intranet sites, desk references, and reminders at counters.

A comprehensive sample of model procedures is provided in Straight Talk: Model Hospital Policies and Procedures on Language Access http://www.safetynetinstitute.org/wp-content/OldMedia/Site/StraightTalkFinal.pdf

Language access procedures should explain the following: [38]

- How staff are to respond to telephone calls from LFP individuals.
- How staff are to track, and record language preference information.
- How staff inform LFP individuals about available language assistance services.
- How staff will identify the language needs of LFP individuals.
- How staff are to respond to correspondence (letters and email) from LFP individuals.
- How staff will procure in-person interpreter services.
- How staff will access telephone or video interpreter services.
- How to use bilingual staff for LFP services (ex. two-way or three way communication) and which staff members are authorized to provide in-language service.
- How to obtain translations of documents.
- How staff will process language access complaints.

[38] **Office of Minority Health.** *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. September, 2005

2.6 STAFF & COMMUNITY AWARENESS / OFFER OF SERVICES

The organisation should develop initiatives to promote awareness within the organisation of the importance of provider-client communication, the effects of language barriers and the appropriate use of interpretation services.

STAFF AWARENESS

Staff and managers should receive training on language assistance policies and procedures, including how to access language assistance services, work with interpreters, request document translations, and track the use of language assistance services.

Bilingual staff members who communicate "in-language" to LFP individuals, or who serve as interpreters or translators, should be assessed and receive regular training on proper interpreting and translation techniques, ethics, specialized terminology, and other topics as needed.

COMMUNITY OUTREACH & DISSEMINATION OF LAS INFORMATION

The organisation should conduct effective outreach, including: [39]

- providing information to the public and to LFP communities regarding the language assistance services available free of charge;
- providing information in English and in the appropriate other languages using, for example, signage, websites, translated documents, telephone tree options, kiosks, and community-focused outreach;
- coordinating with other agencies and stakeholders to ensure consistent identification of LFP status, primary language, and similar information; and
- exchanging promising practices and challenges with governmental agencies, public and community partners.

ACTIVE OFFER OF SERVICES [40]

An active offer of services implies that the organisation's offer of service in the English language be visible, audible and accessible all along the continuum of care. In an active offer of services model, the responsibility does not rest with the client to request if English-language services are available. The population served is made aware of the availability of services, of their right to receive health and social services in the English language and of the procedures in place to have access to these services.

The organisation should undertake measures to increase awareness of its offer of English-language services both in the community and within the organisation itself. Management leadership is critical in creating the conditions for organisational and staff engagement towards an active offer of services in both the French and English languages.

Action can be taken by healthcare organisations to actively inform the population of the possibility of receiving services in English while ensuring the respect of provincial legislation regarding signage and other measures designed to promote protection of the official French language. For example, bilingual staff can be identified with a symbol on their identification badge, appropriate signage placed in key areas of the establishment, and information provided in community newspapers and in CHSSN community network bulletins.

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39 **U.S. Department of Justice.** *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs*. Federal Coordination and Compliance Section . Civil Rights Division . May 2011

40 **Consortium National de Formation en Santé** (CNFS) http://www.offreactive.com/wp-content/uploads/2012/10/enjeux-et-defis-de-loffre-active-2013-04-29.pdf

2.7 OUTCOME ASSESSMENT / CONTINUOUS QUALITY IMPROVEMENT [41]

The following assessment measures can be used to create a record of language assistance services (LAS) to help inform programs as to whether there should be changes to the quantity or type of language assistance services:

- Conducting customer satisfaction surveys of LFP clients based on their actual experience of accessing the organisation's programs or services.
- Surveying staff on how often they use language assistance services, if they believe there should be changes in the way services are provided or in the external providers used, and if they believe that the language assistance services in place are meeting the needs of the LFP communities in the organisation's service area.
- Observing and evaluating the organisation's interactions with LFP individuals.
- Soliciting feedback from community-based organizations and other stakeholders about the organisation's effectiveness and performance in ensuring meaningful access for LFP individuals.
- Keeping current on community demographics and needs by engaging schools, community organisations, and other local resources.
- Considering new resources including funding, collaborations with other health and social service establishments, emerging technology, and other mechanisms for improving access for LFP individuals.
- Monitoring the organisation's response rate to complaints or suggestions by LFP individuals, community members, and employees regarding language assistance services provided.

The monitoring and review of current policies and the types of language assistance services provided should occur on an annual basis. Quality improvement processes should include audits of the timeliness of the provision of interpreter services and the charting of client primary language and provision of interpreter services in medical chart reviews.

Other elements which should be included in this annual review are:

- the requirements for training and certification of healthcare interpreters ;
- the designation of required bilingual positions;
- the quality of data collection on LFP clients and primary language determination; and
- the accuracy of the tracking of primary language in data collection.

The results of the Annual Review of Language Access Needs should be presented to the organisation's governing Board.

41 **Paras, Melinda.** *Straight Talk: Model Hospital Policies and Procedures on Language Access*. California Health Care Safety Net Institute (2005). http://www.safetynetinstitute.org/wp-content/OldMedia/Site/StraightTalkFinal.pdf

3 CONCLUSION

Initiatives aimed at ensuring language access are critical to enabling linguistic communities living in a minority language situation to not only access health services but also to actively participate in health promotion and prevention activities. A major challenge to the sustainability of a Canadian health system focused on hospital care will be the ability to evolve towards innovative models for chronic disease management which promote self-determination and community empowerment, particularly for the adoption of healthy lifestyles and for the well-being of citizens.

As depicted in the diagram below, access to a significant offer of health services within a minority French (or English) language context is a reflection of a hierarchical approach where each step serves as a foundation for the following step[42].

The minority English-speaking population in Quebec benefits from a legislative framework for the provision of health and social services in the English language as well as systemic approaches to the offer of services including access plans and designation of establishments. Provincial initiatives including language training for health professionals also exist to support professionals in developing linguistic competencies and community health and social services networks in each region of the province support community engagement and initiatives to improve access to English-language health and social services.

This report was prepared for JHSB as an establishment with a provincially sanctioned designated status to provide all of its services in both English and French. Given that JHSB has a significant proportion of clients who prefer receiving their services in English, they have adopted a bilingual staff provider model to serve both the French and the English-speaking communities.

It is hoped that the information and resources cited in this report will serve as a framework for other health establishments in Quebec to develop and structure their language assistance policies and implementation plans for the English-speaking community and other LFP minority language populations.

42 **Tremblay S and Prata G.** *Study on linguistically and culturally adapted health services: a Pan-Canadian portrait*. Société Santé et Mieux-être en français of New Brunswick (SSMEFNB). April, 2012.

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Winnipeg Regional Health Authority. *Regional Interpreter Services - Language Access Policy.* July, 2013. http://www.wrha.mb.ca/about/policy/files/10.40.210.pdf

APPENDIX A:
SAMPLE TOOLS AND RESOURCES

RESOURCE / WEB LINK	DESCRIPTION
LANGUAGE ACCESS MODELS	
A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations. September, 2005 http://www.omhrc.gov/templates/content.spx-?ID=4375&lvl=2&lvlID=107	Based on the OMH recommended National CLAS Standards. Provides practical suggestions and links to tools and resources for implementing Culturally and Linguistically Appropriate Services (CLAS).
Selected "Best and Promising Practices" – Cultural Competency http://www.ausl.re.it/phocadownload/HPH_CHANNEL_207/best-and-promising-practices-culturalcompetency-by-bob.best%20and%20promising%20practices%20-%20culturalcompetency%20by%20bob%20like.pdf	Consists of a list of web links to resources and tools including a section for linguistic competency
Models For The Provision Of Language Access In Health Care Settings	Describes approaches to avoid the linguistic incompatibility between health care providers and their patients.
WRITTEN LANGUAGE ASSISTANCE	
MultiLingual-Health-Education.net http://www.multilingual-health-education.net/faq.asp	A non-profit alliance of Canadian health agencies that provides translated materials for public use. More than 40 topics covered in English, French, Farsi, Hindi, Punjabi, Korean, Spanish, Chinese, Japanese, Vietnamese, Darshan, Italian, and Tagalog).
Universal Symbols In Health Care Workbook, Best Practices for Sign Systems.	Presents universal symbols as an effective design tool to assist visitors with LEP as well as limited literacy navigate health facilities and enable access.
ORGANISATIONAL SELF ASSESSMENT	
Cultural and Linguistic Competence Policy Assessment . http://www.clcpa.info/documents/CLCPA.pdf	Provides an organisational assessment questionnaire which captures data in its seven subscales including: Knowledge of Diverse Communities, Organizational Philosophy, and Personal Involvement in Diverse Communities, Resources & Linkages, Human Resources, Clinical Practice and Engagement of Diverse Communities.
Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance.	Presents a tool to assist in assessing current other-than-English language services capabilities and planning for the provision of language assistance to Limited English proficient (LEP) clients
Language Access Assessment among the Community Health Centers in Arizona. October 2012. http://azdhs.gov/hsd/health-disparities/documents/publications-data/language-access-report.pdf	Provides a sample survey questionnaire for health care providers to evaluate their healthcare organisation's LAS.
MODEL POLICIES & PROCEDURES	
Straight Talk: Model Hospital Policies and Procedures on Language Access. http://www.safetynetinstitute.org/wp-content/OldMedia/Site/Straight-TalkFinal.pdf	Provides a series of model procedures corresponding to policy statements
Winnipeg Regional Health Authority (WHRA) http://www.wrha.mb.ca/about/policy/files/10.40.210.pdf	Language access and interpreter services policy applicable to all sites and facilities governed by the WHRA including hospitals
Centre for Culture Ethnicity & Health (CEH) – Australia http://www.ceh.org.au/resources/publications#LSinfosheets	Series of information sheets covering many aspects of language services with the objective of enhancing language services planning and practice for staff working with people with limited English proficiency.
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. http://www.jointcommission.org/assets/1/6/ARoadmapforHospitals-finalversion727.pdf	Contains many Web sites, toolkits, articles, and other information to inform the development of practices that best meet diverse patient needs, support quality and safety, and aid in compliance with U.S. Joint Commission accreditation standards.
BILINGUAL STAFF MODELS	
Kaiser Permanente *Qualified Bilingual Staff (QBS) Model & Program.* http://kpqbs.org/training/hci.html	A best practice model designed to capitalize on ex¬isting workforce diversity and ensure qualified linguistic services and culturally competent care at every point of contact
ACTIVE OFFER OF SERVICES	
Consortium National de Formation en Santé (CNFS) http://www.offreactive.com/wp-content/uploads/2012/10/enjeux-et-defis-de-loffre-active-2013-04-29.pdf	Provides a toolkit on an Active Offer of Services including a section on the issues and challenges.

APPENDIX B:
LANGUAGE ACCESS COORDINATOR - SAMPLE POSITION DESCRIPTION [43]

Some agencies have found it helpful to appoint a language access coordinator and other responsible personnel. These individuals are responsible for devising and ensuring that the agency adheres to its language access policy directives, plan and procedures to provide meaningful access to LEP persons. The language access coordinator should be or report to a high-ranking official within the agency since high level support is essential to successful implementation. The coordinator is responsible for language assistance services and may delegate duties but should retain responsibility for oversight, performance, and implementation of the language access plan. Agencies with multiple offices and divisions may find that each component or field office should designate an individual as a local language access coordinator.

The language access plan should set forth the name and contact information of the responsible official(s). The language access coordinator should consider creating a working group of key stakeholders to assist in creating and implementing language access procedures for the agency. The language access coordinator may also oversee personnel and performance of employee and non-employee interpreters and translators, including:

- Identifying qualified interpreters and translators to be included in an interpreter database;
- Creating interpreter, translator, and bilingual staff qualifications and ethical standards;
- Outlining measures to ensure quality control of interpreters and translators;
- Training and testing bilingual individuals including staff who provide language assistance services;
- Assigning qualified interpreters, translators and bilingual employees to perform language assistance functions;
- Maintaining a regularly updated list of all competent bilingual employees, contract interpreters, and contract translators that includes their availability, non-English language(s) spoken, and contact information;
- Changing hiring and personnel practices to increase staff language capacity (e.g., providing pay incentives for bilingual employees);
- Developing a procurement strategy for contract language assistance services providers;
- Searching for funding and other resources to support interpretation and translation; technological and other infrastructural support, and staffing;
- Providing input in budgetary and procurement matters related to implementation of the language access policy, plan, and procedures; and
- Coordinating procurement for interpreter and translator compensation for services rendered

[43] **U.S. Department of Justice**. *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs*. Federal Coordination and Compliance Section . Civil Rights Division . May 2011

APPENDIX C:
SAMPLE LIST OF VITAL FORMS TO MAKE AVAILABLE IN OTHER LANGUAGES [44] [45]

Your organization may want to consider which forms to make available in other languages based on importance or frequency of use. As your organization decides which documents should be made available in languages other than English, it may be beneficial to ask LFP patients which materials they think would be most helpful. Also, your organization may talk with community-based organizations in the area that work with LFP populations when deciding what materials to make available.

Regular assessment of LFP population needs may be helpful in determining on a continual basis which documents should be made available.

Vital documents should include but not be limited to, documents that contain information for accessing hospital services.

The following types of documents are examples of Vital Documents:

- Consent forms;
- Advance Directives;
- Patient rights;
- Notices advising LFP persons of free language assistance and how to access them;
- Complaint forms;
- Intake forms with potential for important health consequences;
- Notices advising LFP persons of free language assistance, or applications to participate in a program or activity or to receive services;
- Pharmaceutical instructions and interactions;
- Discharge instructions;
- Preparation instructions for procedures and diagnostic tests; and
- Contact information for the organization.

44 **HHS Office of Minority Health.(OMH) :** *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. September, 2005
http://www.omhrc.gov/templates/content.aspx?ID=4375&lvl=2&lvlID=107

45 **California Health Care Safety Net Institute** *Straight Talk: Model Hospital Policies and Procedures on Language Access*. (2005).
http://www.safetynetinstitute.org/wp-content/OldMedia/Site/StraightTalkFinal.pdf

APPENDIX D:
SAMPLE CLINICAL ENCOUNTERS REQUIRING HEALTHCARE INTERPRETATION

Types of non-bilingual interpreter errors may include, but are not limited to: [46]

- Omission—interpreter does not interpret a word or phrase said by the clinician or patient
- False fluency—interpreter uses an incorrect word or phrase that does not exist in the targeted language
- Substitution—interpreter replaces a word or phrase for a different word or phrase said by the clinician or patient
- Editorialization—interpreter provides his or her personal views
- Addition—interpreter adds information not said by clinician or patient

The following types of encounters and procedures which are performed by providers who do not speak the primary language spoken by the patient/surrogate decision-maker, and which require the use of healthcare interpreter services, include, but are not limited to: [47]

- Providing clinic and emergency medical services;
- Obtaining medical histories;
- Explaining any diagnosis and plan for medical treatment;
- Discussing any mental health issues or concerns;
- Explaining any change in regimen or condition;
- Explaining any medical procedures, tests or surgical interventions;
- Explaining patient rights and responsibilities;
- Obtaining informed consent;
- Providing medication instructions and explanation of potential side effects;
- Explaining discharge plans;
- Discussing issues at patient and family care conferences and/or health education sessions;
- Discussing Advanced Directives;
- Discussing end of life decisions;
- Discussing patient participation in research studies and evaluation activities; and
- Discussing legal or financial matters.

46 **G. Flores and others,** "*Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters,*" Pediatrics 111, no. 1 (2003): 6–14.

47 **Paras, Melinda.** *Straight Talk: Model Hospital Policies and Procedures on Language Access*. California Health Care Safety Net Institute(2005). http://www.safetynetinstitute.org/wpcontent/OldMedia/Site/StraightTalkFinal.pdf

APPENDIX E:
THE NATIONAL CLAS STANDARDS[48]

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

Principal Standard

1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

[48] **Office of Minority Health**
http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

LANGUAGE ACCESS POLICY

PLANNING & IMPLEMENTATION GUIDE

MARCH 2015