Meeting Summary – Long
May 28, 2008 Meeting
Medical Leadership Council on Cultural Proficiency

The 35 medical and health care organizations comprising the Medical Leadership Council on Cultural Proficiency (MLC) met in San Francisco on May 28, 2008. An on-site introduction to San Francisco General Hospital's Video Medical Interpreting (VMI) capabilities was a highlight of the meeting.

Convened by The California Endowment since 2002, the MLC member organizations in the early years learned about the need for interpreters, translators and cultural proficiency in health care. Representatives of medical societies, county medical associations, and health plans and health systems attending the twice-yearly meetings have spent the months between meetings investigating ways to provide and fund these services. These days, most are working to guarantee language access, cultural proficiency and workforce diversity in health care statewide.

A Picture and 1,000 Words:
Videoconference Medical Interpretation – San Francisco General Hospital's State-of-the-Art Services

Hospital presenters: Gene O'Connell, CEO; Alice Chen, MD, MPH, Medical Director, General Medicine Clinic; Alicia Fernandez, MD, Associate Professor, University of California, San Francisco; David Minh Dao, Supervisor, Interpreter Services Department; Bruce Occena, VMI Coordinator

San Francisco General Hospital (SFGH) is a public teaching hospital where approximately 20 percent of patients do not speak English. Through presentations, and then clinic and interpreter services department tours, MLC members observed first-hand how SFGH provides VMI and other language access services in outpatient settings.

The Interpreter Services Department receives between 80,000 and 90,000 requests for interpreters each year. About half of these are handled using VMI. The hospital employs 34 staff interpreters who provide VMI, in-person, and telephone interpreting in 22 languages on-site; 11 on-call interpreters who provide interpretation in an additional 9 languages; two outside agencies that provide telephone interpreting in 170 languages; and an outside agency that provides American Sign Language interpreting. SFGH strives to use staff interpreters whenever possible.

The department, housed in two office locations, provides interpreter services throughout the clinics and the hospital 16 hours a day, 7 days a week.

VMI is the preferred method for providing interpreter services in outpatient clinics, though in-person and telephone interpreting are also provided when a physician or other provider requests them because the specifics of a patient visit make one of these methods

a better choice. (VMI is not used for inpatient services. Speakerphones are a better option because of hospital wiring challenges.)

Video interpreting is provided using a video monitor on a rolling cart, which can easily be moved to different exam rooms and is operated using just two buttons – 'on' and 'off.' SFGH uses 25 of these monitors for doctors/patients in the outpatient clinics. During consecutive interpreting, the interpreter appears on the monitor as a third party in the exam room. A live image of the interpreter fills the screen and a small live image of the patient and physician appears in a box at the top corner of the screen so they can see what the interpreter is seeing. For the interpreter the images are reversed, with the physician's and patient's images filling the screen and the interpreter's own image appearing in the small corner box. As in most videoconferencing set-ups, the camera can be temporarily blocked in case the physician-patient encounter requires temporary visual privacy.

SFGH has realized tremendous efficiencies using VMI, an effort that began in pilot projects in 2003. In earlier days, in-person interpreters usually were able to handle at best two requests an hour and the wait time for a patient and physician to meet with an interpreter was an average of 40 minutes. Today, using VMI, four to five requests can be met per hour and the average wait time is just 20 seconds. Because this allows for more effective use of the interpreter staff, the wait time for in-person services has also been decreased to nine minutes.

Telephone interpreting also is state-of-the-art, provided via speakerphones and, in areas with no wiring for phones, cordless speakerphones on rolling carts which facilitates clear, volume-controlled communication among a patient, physician and interpreter. SFGH uses four of these set-ups.

Physicians and patients alike rate VMI and SFGH's overall interpreter services highly.

First the Theory, then the Reality:
Ensuring Interpreter Services Are Integrated into Medical Practice

Demonstrating that the capacity to provide interpreter services works only as well as the medical staff trained to use these services, Alicia Fernandez, MD presented the published results of a study at SFGH showing that hospitalized patients who do not speak English are less likely to have documentation of informed consent in their medical charts.

The study compared the charts of 74 Mandarin/Cantonese/Chinese- and Spanish-speaking LEP patients who received a thoracentesis, paracentesis, or lumbar puncture with 74 English-speaking patients who underwent the same procedures, on the same date, on the same hospital service.
Researchers found that the charts of English-speaking patients were more likely than those of LEP patients to contain full documentation of informed consent (53% vs. 28%), and were more likely to contain a signed consent form (85% vs. 70%). These differences could result from several factors. Researchers believe, however, that the low rates of

documented interpreter use (fewer than one-third of LEP patients had documentation of interpreter services in the process of informed consent), combined with fewer signed consent forms, is due to an under use of interpreters, resulting in inadequate or absent informed consent.

This under use occurred despite legal requirements for informed consent and the legal standard of a signed consent form. This is in addition to federal and state laws that require providers to use interpreters and SFGH policy that requires documentation of interpreter use. In response, hospital CEO Gene O'Connell championed the results as an example of valuable quality improvement information and a good assessment of disparities.

SFGH has since developed a new consent form that: (1) can be understood by patients with lower-level reading skills; (2) prompts physicians to call interpreters and assess patients' comprehension; and (3) is printed in English, Spanish, Russian, Chinese, Vietnamese, and Tagalog. In addition, a new qualitative study is under way to examine medical residents' decision-making on interpreter use.

Heroes of the Safety Net:
The Role of Solo and Small Group Practice Physicians in Serving Underserved and Diverse Patient Populations

Funded by The California Endowment, the California Medical Association Foundation (CMA-F) has undertaken projects aimed at improving care for diverse populations. Elissa Maas, MPH, CMA-F's Vice President for Programs, outlined three recent efforts. In one, the CMA-F served as the lead organization for a National Center for Quality Assurance (NCQA) pilot project to understand and address barriers to care for minority patients in small primary care practices, and to provide demonstration grants to solo and small group practices to improve care for these same patients. Lessons learned included: Quality improvement takes longer than a year to achieve; smaller practices have fewer resources to devote to a change process, making it difficult to address information technology and quality improvement at the same time; and effective physician-staff communication is essential for success.

Another project examined ways physicians in 42 solo and small practices in Santa Clara County were providing language access. Findings included: Wide variations exist between physicians' own assessment of how well they can accommodate patients with limited English proficiency (LEP) and how confident they were that they communicated with LEP patients effectively; quality of care issues arose more frequently with LEP patients; and few physicians used trained interpreters.

Resulting recommendations include: Exploring ways medical school curricula can include training about multilingual and multicultural medical practice; publicizing health plan compliance plans in response to Department of Managed Health Care and other

language access regulations; and supporting increased opportunities for health care interpreter training.

The third project looked for ways to support the sustainability of primary care ethnic physician solo and small practices to ensure safety net patients' access to care. The study focused on the Bay Area, Los Angeles County, the Central Valley, and San Diego County and included focus groups with over 200 physicians, discussions with over 80 health care consumers, 40 physician office site visits, and a literature review. Resulting recommendations included: Increasing awareness about the role played by this segment of physicians; increasing Medi-Cal and other payments for these physicians; strengthening office infrastructure and medical office staff performance; and developing partnerships at the community level to bring these primary care physicians together with other safety net providers to improve access to care.

'The Color of Medicine in California:
An Analysis of the California Medical Board Survey

Kevin Grumbach, MD, reported on a study of the ethnicity and language diversity of physicians in the state. Using data from the Medical Board of California, this is the first comprehensive study of its kind. Assisted by colleagues at University of California-San Francisco Grumbach compared physician demographics with those of the state overall, examined the choice of medical specialty by ethnicity, the choice of practice location, languages spoken, and more.

His findings include: The under-representation of Latinos and African Americans in California medicine is "dire"; the state has few physicians of Samoan, Cambodian, Hmong and Laotian ethnicity and these groups should be more actively recruited; minority physicians are much more likely to serve in Medically Underserved Areas, Health Professional Shortage Areas, and minority and low-income communities; minority physicians are much more likely to work in primary care; few non-Asian physicians speak Asian languages, though California physicians speak several languages in addition to English; and more.

His recommendations include: Investing in the educational pipeline to prepare minority and disadvantaged students for medical and health professions careers; promoting diversity as a key element in expanding medical education in the state; insisting that health professions schools develop a culture that promotes diversity, including recruiting and retaining underrepresented minorities; increasing incentives for physicians to work in underserved areas; and collecting and analyzing more data on California physicians as part of the relicensure process.

The California Statewide Office of Health Planning and Development funded this project.

Show us the Money:
Leveraging Federal Funds for Language Access in the Medi-Cal Program

The California Healthcare Interpreting Association (CHIA) reported on the work of the 19-member Medi-Cal Language Access Services Task Force that has been meeting since December 2006. The group's final report will be released in July 2008, according to CHIA Executive Director Don Schinske. Convened to recommend ways to draw down federal matching funds to help pay for language access for the state's 2.5 million LEP Medi-Cal beneficiaries, the group included advocacy organizations, ethnic health organizations, representatives of counties stakeholders, medical associations, and others. Their recommendations include: Creating a hybrid broker/direct provider billing model in fee-for-service; paying for services performed by interpreters trained in accredited programs; convening a quality assurance board; and starting with a multi-county pilot project.

Elizabeth Nguyen, CHIA Board of Directors Chair, reported on the planned first meeting of the National Coalition on Health Care Interpreter Certification, which was to take place in late May in Chicago. The group, comprised of a broad range of stakeholder organizations, plans to eventually develop a national certification.

Looking Forward:
Next MLC Meeting in LA

The Medical Leadership Council's next meeting is set for November 12 at The California Endowment headquarters in Los Angeles.

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The speakers' presentation slides are posted at www.MedicalLeadership.org, also home to the searchable database of county-specific language access resources in California.