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# Interpreter Services in Massachusetts Acute Care Hospitals



Deval L. Patrick, Governor

Timothy P. Murray, Lieutenant Governor

JudyAnn Bigby, MD, Secretary of Health & Human Services

John Auerbach, Commissioner, Department of Public Health

Office of Health Equity

Georgia M. Simpson May, Director

James Destine, Report Author and  
Coordinator Hospital Interpreter Services

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# Executive Summary

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Massachusetts' increasing foreign-born population continues to be linguistically diverse. More than 20% of the Commonwealth's residents 5 years of age and older spoke a language other than English at home; of this population, 44% spoke English less than "very well" <sup>(1)</sup>. The Massachusetts foreign-born population accounts for 14% of the state's population - an increase of 18% from the 2000 Census <sup>(1)</sup>. Since it is critically important for providers and LEP patients to communicate seamlessly in the clinical setting, Massachusetts legislature mandates that its hospitals provide 24 hour per day, 7 day per week interpreter services at no cost to all limited English proficient (LEP) patients who seek emergency care or treatment.

Massachusetts has been at the forefront of ensuring language access. While most other states have little overall capacity, Massachusetts hospitals had one of the highest concentration rates of interpreters <sup>(2)</sup>. Since 1989, most hospitals applying for permission from the Department of Public Health to transfer ownership or expand services are assessed for their language access capacity and submit plans for provision of interpreter services as part of the Determination of Need program (DoN).

In addition, the International Medical Interpreters Association (IMIA) (formerly the Massachusetts Medical Interpreters Association) was not only the first medical interpreter association in the country, but also the first to develop ethical and practice standards for the emerging profession of medical interpreters <sup>(3)</sup>.

This first Annual Progress Report from the Office of Health Equity of the Massachusetts Department of Public Health (MDPH) focuses on the provision of interpreter services in Massachusetts 72 acute care hospitals.

## Key Findings

1. MA acute care hospitals provide a significant number of interpretation sessions annually
  - 1,202,031 completed interpretation sessions by 2,256 trained interpreters during FFY 2007; 80% were conducted face-to-face and 20% telephonically; 15% were conducted in Emergency Departments
  - 11,047 of the 13,559 sessions (81%) conducted in the Emergency Department in the Maturing Suburb occurred at Cape Cod Hospital. This is likely due to the influx of LEP workers during the summer season.
2. MA hospitals encounter tremendous language diversity within their settings
  - Over 100 languages spoken in MA
  - The ten most frequently encountered languages are Spanish, Portuguese, Russian, Chinese, Haitian Creole, Cape Verdean, Vietnamese, Arabic, American Sign Language, and Albanian which account for 94% of all interpretation sessions.
3. Spanish accounts for 43% of the interpretation sessions completed
4. When we compare the top ten languages of this report to that of the FLNE\* report we find similarities, however when compared to the Census there are significant differences.

## Conclusion and Recommendations

The growing influx of LEP populations continues to present challenges for hospitals in meeting the demands for services in multiple languages. In spite of the challenges hospitals face they are committed to ensuring accessibility to meaningful communication for all individuals seeking medical treatment regardless of language, place, or time. These efforts have led to changes in organizational structure and the ability to measure quantitative outcomes which is just one component in the provision of optimal interpretation services in clinical settings.

Going forward, the Massachusetts Department of Public Health must develop a multi-faceted strategy to measure the quantitative outcomes and work to improve the quality of language services at all Massachusetts hospitals.

*\*(FLNE is a bi-annual publication of MDPH with language data collected by the Massachusetts Department of Education for students whose primary language is not English)*

# Introduction

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The number of Massachusetts residents who are Limited English Proficient (LEP) increased 31.6% between 1990 and 2000 <sup>(4)</sup>. The trend continues in the 2005 American Community Survey. Massachusetts' foreign-born population accounts for 14.4% of the state's population - an increase from the 2000 Census (12.2%) <sup>(1)</sup>. In addition, slightly more than 20% of the Commonwealth's residents aged 5 years and above spoke a language other than English at home <sup>(1)</sup>. Of the population aged 5 years and older who spoke a language other than English at home, 44% spoke English less than "very well" <sup>(1)</sup>. Moreover, Massachusetts' increasing foreign-born population continues to be linguistically diverse.

This diversity represents great cultural opportunities for the state and its foreign-born residents. However, for limited English proficient (LEP) and non-English speakers, the amount of effort involved in communicating in English can become life-threatening in clinical settings, as the following example shows.

*A Spanish-speaking 18-year-old had stumbled into his girlfriend's home, told her that he was "intoxicado" and collapsed. When the girlfriend and her mother repeated the term, the non-Spanish-speaking paramedics took it to mean "intoxicated;" the intended meaning was "nauseated". After more than 36 hours in the hospital being worked up for a drug overdose, the comatose patient was reevaluated and given a diagnosis of intracerebellar hematoma with brain-stem compression and a subdural hematoma secondary to a ruptured artery. The hospital subsequently paid a \$71 million malpractice settlement<sup>(5)</sup>.*

This episode demonstrates how the misinterpretation of a single word can impair discussions of symptoms, resulting in misdiagnoses and poor treatment decisions, which lead to patient's delayed care and preventable medical malpractice; it can also be more costly than having language access. It also corroborates The National Health Net Law's remark, "When communication is compromised by language barriers, the quality of care is also compromised" <sup>(6)</sup>. Patients who need, but do not receive interpreter services, have more negative overall perceptions of their health care experience, including the medical professionals they encounter, making them much less likely to seek proper medical attention and care in the future <sup>(7)</sup>. Therefore, for federal and state regulators, addressing the challenges in meeting the language needs of the linguistically isolated population is imperative, especially in clinical settings since the language used in exam rooms is crucial to attaining the best health care outcomes.

This report from the Massachusetts Department of Public Health (MDPH) Office of Health Equity focuses on the provision of interpreter services in Massachusetts' acute care hospitals. The report will summarize briefly the legislative and legal foundations

for language access, describe how MDPH seeks to ensure language access and assure the quality of interpretation, and present findings based on the annual data reported by all Massachusetts acute care hospitals during Federal Fiscal Year 2007 (October 1, 2006 – September 30, 2007) and provide recommendations for moving forward.

# Federal Foundation for Language Access

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## **Title VI of the 1964 Civil Rights Act**

Title VI of the 1964 Civil Rights Act stipulates that “No person in the United States shall, on the ground of race, color, and or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance” <sup>(8)</sup>. In 1974, in *Lau v Nichols*, the U.S. Supreme Court interpreted Title VI to include discrimination based on language as being equivalent to discrimination based on national origin <sup>(9)</sup>. In addition to the major underpinning provided by Title VI, a number of state and federal laws require clients/patients to be served in their preferred language. Among them are the Substance Abuse and Mental Health Service Administration (SAMHSA), Food Stamp legislation, and The Emergency Medical Treatment and Labor Act.

## **Executive Order 13166 and the Limited English Proficiency Policy Guidance**

The Executive Order (EO) 13166, "Improving Access to Services for Persons with Limited English Proficiency" of 2000 required federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them <sup>(10)</sup>. It is expected that agency plans will provide for such meaningful access consistent with, and without unduly burdening, the fundamental mission of the agency. This EO also requires that federal agencies work to ensure that recipients of federal financial assistance provide meaningful access to their LEP applicants and beneficiaries.

To assist federal agencies in carrying out these responsibilities, the U.S. Department of Justice (DOJ) issued a Policy Guidance Document, "Enforcement of Title VI of the Civil Rights Act of 1964 - National Origin Discrimination against Persons with Limited English Proficiency" (LEP Guidance) <sup>(11)</sup>. This LEP Guidance established compliance standards that recipients of federal financial assistance must follow to ensure that programs and activities normally provided in English are accessible to LEP persons and thus, do not discriminate on the basis of national origin in violation of Title VI's prohibition against national origin discrimination <sup>(12)</sup>.

In August 2000, EO 13166 mandated that all federal agencies submitted guidance consistent with DOJ's materials to clarify Title VI responsibilities relative to access for clients/patients who are LEP <sup>(12)</sup>. In 2002, the Department of Health and Human

Services (DHHS) revised its guidance and assigned responsibility for providing technical assistance to the Office of Civil Rights—the entity responsible for conducting compliance reviews and investigating and resolving Title VI complaints. The LEP guidance identifies criteria to be considered when designing language access services. These criteria provided a basis for analysis and are known as the **four factor analysis**:

1. The number or proportion of LEP persons eligible to be served by the program or likely to be encountered,
2. The frequency of contact persons who are LEP might have with the program,
3. The nature and importance of service provided, and
4. The resources available to the grantee/recipient and costs.

Although the DOJ guidance does recognize that institutions' ability to meet expectations will vary depending on the budget or lack of other resources, it advises that "institutions should ensure that their resource limitations are well-substantiated before using this factor as a reason to limit language assistance."

# Massachusetts State Law and Regulations

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## **Determination of Need (DoN):**

Massachusetts has been at the forefront of ensuring language access. A 1995 study found that Massachusetts hospitals had one of the highest concentration rates of interpreter services while most other states had little overall capacity <sup>(2)</sup>. The International Medical Interpreters Association (IMIA) (formerly the Massachusetts Medical Interpreters Association) was not only the first medical interpreter association in the country, but also the first to develop ethical and practice standards for the emerging profession of medical interpreters <sup>(3)</sup>. In addition, since 1989, most hospitals applying for permission from the Department of Public Health to transfer ownership or expand services are assessed for their language access capacity and submit plans for provision of interpreter services as part of the Determination of Need program (DoN).

## **Emergency Room Interpreters Law (ERIL):**

In 2000, the Massachusetts Legislature enacted Chapter 66 of the Acts of 2000, known as the Emergency Room Interpreters Law (ERIL) <sup>(13)</sup>. ERIL states that “every acute care hospital...shall provide competent interpreter services in connection with all emergency room services provided to every non-English speaker who is a patient or who seeks appropriate emergency care or treatment.” A “competent interpreter” is defined as “a person who is fluent in English and in the language of a non-English speaker; who is trained and proficient in the skill and ethics of interpreting; and, who is knowledgeable about the specialized terms and concepts that need to be interpreted for the purposes of receiving emergency care or treatment.” A “non-English speaker” is defined as “a person who cannot speak or understand, or has difficulty with speaking or understanding, the English language because the speaker primarily or only uses a spoken language other than English.”

## **Regulations:**

The DPH convened an expert panel to develop the enabling regulations. These were issued in July 2001 concurrent with the guidance document “Best Practice Recommendations for Hospital Based Interpreter Services” <sup>(14)</sup>. The regulations

outlined the essential structure and components for meeting both the spirit and letter of the law. Thus, all Massachusetts acute care hospitals must:

- Identify a coordinator for interpreter services.
- Have policies and procedures in place for the provision of interpreter services and update as needed.
- Conduct an annual language needs assessment.
- Have a quality assurance in process for interpreter services.
- Post notices of the availability of interpreter services at no cost at key points of entry.
- Have 24/7 access to interpreters.
- Refrain from using families and friends as interpreters and prohibit the use of minors.
- Assure the quality of interpretation services and offer ongoing training to interpreters.
- Collect the language in which patients prefer to discuss their health related concerns.
- Ensure the translation of vital documents.

MDPH produced and made available signage to post at key points of entry for all hospitals. To view the Best Practice Recommendations for Hospital Based Interpreter Services (see Appendix A).

# Findings

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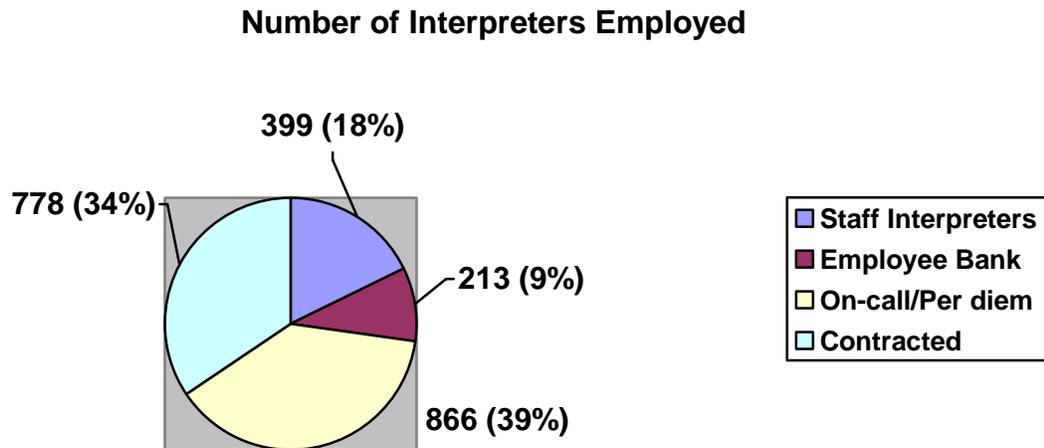
## **MA Hospitals Use Four Models for the Provision of Language Access**

Massachusetts mandates that all of its hospitals to provide 24 hour per day, 7 day per week, interpreter services at no cost for all LEP patients. To meet this challenge, hospitals employ a variety of models in their language service delivery:

- **Staff Interpreters:** Individuals hired as full-time or part-time regular employees whose primary duty is to provide clinical interpretation for healthcare providers and patients during clinical encounters.
- **On-call/Per Diem:** Independent interpreters hired on an on-call basis when needed to provide face-to-face or telephonic interpretation for unanticipated or scheduled appointments.
- **Contracted Interpreters:** Individuals or outside interpreter service agency/vendor whose duty defined in a contract with the hired organization is to provide face-to-face or telephonic interpretation.
- **Employee Bank:** A list of medically trained bilingual employees whose primary job are not medical/clinical interpretation but may be called upon to interpret.

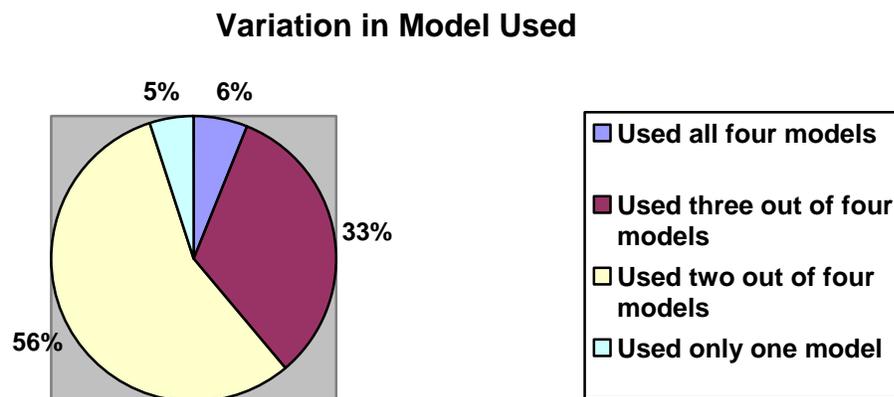
MA acute care hospitals employ a total of 2,256 trained interpreters to provide interpretation services. Of these, 399 are staff interpreters; 213 serve in an employee bank/volunteer; 866 are on-call/per diem; and 778 are contracted. In addition to the above, all 72 acute care hospitals contracted with at least one telephonic vendor to provide interpreter services.

**Figure 1**



The hospital's type, size, regional location, and community type play an important role in determining which model seems most appropriate to use exclusively, as alternatives, or as complementary parts of a system. During the period covered in this report, most hospitals used a combination of models to provide interpretation services. No two hospitals are exactly alike in the model or variation of models used to provide interpreter services.

**Figure 2**



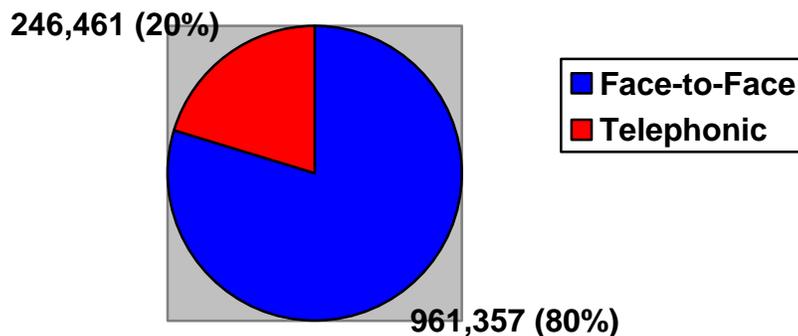
### Number of Completed Interpretation Sessions and Provision Method

Interpreter services can be provided in three ways: Face-to-Face, Telephonic, or Video Relay. Face-to-face and telephonic interpretations were identified as the two primary methods of services. A small number of hospitals provided interpretation sessions via video relay. Due to the small number of video sessions reported, we have focused our report on face-to-face and telephonic methods.

#### Interpretation Sessions Statewide:

Acute care hospitals reported a total of 1,202,031 completed interpretation sessions during the FY 2007. Eighty percent (80%) of the completed sessions were conducted face-to-face and 20% telephonically.

**Figure 3: Mode of Providing Language Access**



#### Interpretation Sessions by EOHHS Region:

The Executive Office of Health and Human Services (EOHHS) divides the Commonwealth of Massachusetts into six regions (see Appendix C). These regions are used by the Department of Public Health for statistical, care coordination and administrative purposes. The regions - Western, Central, Northeast, Metro West, Boston and Southeast - are based on geographical groupings of cities and towns (see map below). The 72 acute care hospitals covered in this report are located within these regions as shown on Table 1.

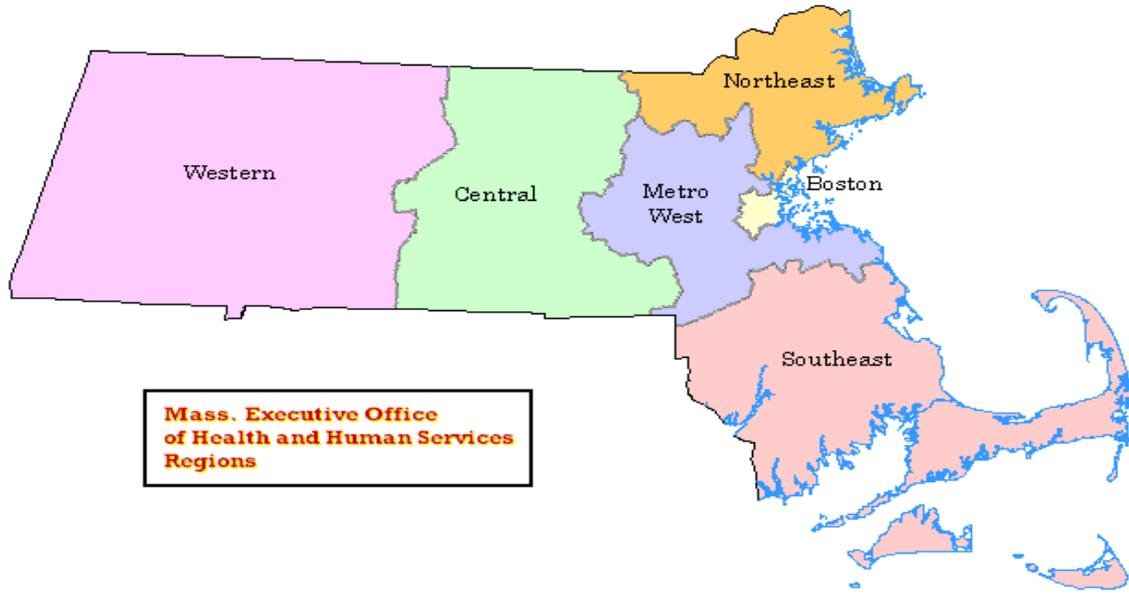
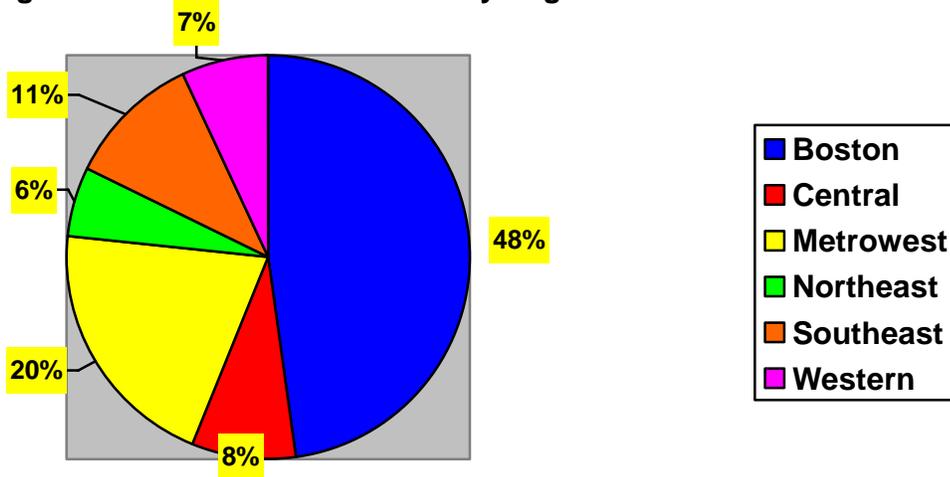


Figure 4 shows significant variation in the number of completed interpretation sessions from region to region. Of the 1,202,031 completed sessions, 48% occurred in the Boston region; followed by Metrowest at 20%; Southeast at 11 %; Central at 8%; West at 7%; and Northeast at 5%.

**Figure 4: Interpretation Sessions by Region**



Regardless of this differential, the methods of interpretation sessions did not vary drastically by region. Face-to-face interpretation remains the most common method for all regions, the Boston region reported higher telephonic sessions at 28%; that is 40% higher than the state average and 14 times higher than the Western and Southeast regions. This may be due to the 100+ languages spoken in the Boston region (see Table 1 below).

**Table 1: Number of Interpretation Sessions and Provision Method**

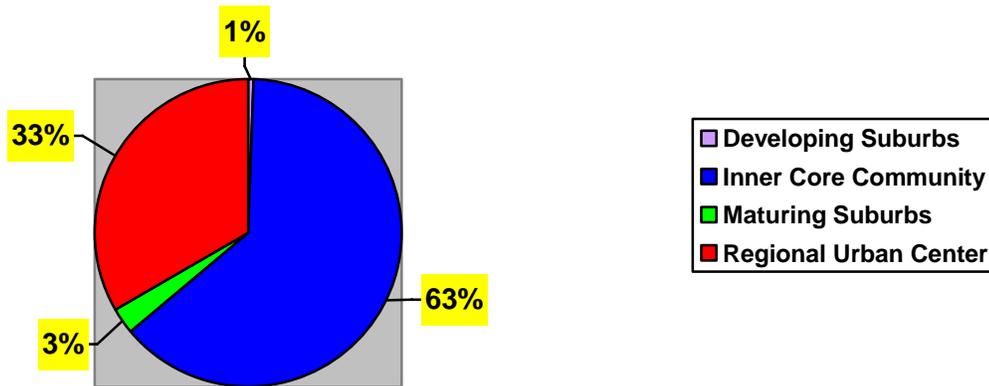
Region	# of Hospitals	Total # of Sessions	Face-to-Face		Telephonic	
			Number	Percent	Number	Percent
<b>Western</b>	10	83,507	81,651	98%	1,856	2%
<b>Central</b>	12	100,648	91,106	90%	9,542	10%
<b>Northeast</b>	12	66,978	57,526	86%	9,452	14%
<b>Metrowest</b>	16	245,956	191,375	78%	54,581	22%
<b>Southeast</b>	13	130,278	127,559	98%	2,719	2%
<b>Boston</b>	9	576,531	414,809	72%	161,722	28%

Interpretation Sessions by MAPC Community Type:

In order to support planning, analysis, and policy development, the Metropolitan Area Planning Council (MAPC) has identified five basic community types across the state: Inner Core, Regional Urban centers, Maturing Suburbs, Developing suburbs, Rural Towns. The criteria used to define Community Types can be used to understand how demographic, economic, land use, energy, and transportation trends affect the Commonwealth's diverse communities. The Classification system is summarized in Appendix D. The 72 acute care hospitals are seated within four of the five community types defined by the (MAPC, exclusive of the Rural Towns-there are no acute care hospitals located in the Rural Towns).

The variation in the numbers of completed interpretation sessions by community types is even greater than what was seen by region. Sixty-three percent (63%) of all interpretation sessions took place in the Inner Core Communities. When combined with the Regional Urban Center hospitals they account for 96% of all the interpretation sessions. The developing and maturing suburbs account for 4% (see Figure 5).

**Figure 5: Interpretation Sessions by Community Type**



Regardless of this differential the trend of using face-to-face interpretation for LEP patients continues to be the preferred method by community type. However, in the Inner Core Communities telephonic sessions average 40% higher than the statewide average; 9 times higher than the Maturing Suburbs; 4.5 times higher than the Regional Urban Centers; and 1.5 times higher than the Developing Suburbs (see Table 2).

**Table 2: Interpretation Sessions by Community Type**

	Number of Hospitals	Number of Sessions	Total Face-to-Face		Total Telephonic	
Inner Core Community	15	762,152	548,683	72%	213,469	28%
Regional Urban Center	38	400,501	375,192	94%	25,309	6%
Maturing Suburb	9	34,326	33,250	97%	1,076	3%
Developing Suburb	10	5,052	4,167	82%	885	18%

Face-to-face interpretation is the most common method for many reasons. It aids significantly in establishing the patient-provider relationship, is valuable when dealing with specific types of information, such as visual materials, or with certain patients, such as children and those who are hard of hearing. However, the frequency of usage of one method over another does not necessarily translate into superiority and quality of service. For instance, telephonic interpreter services are also invaluable in many areas, including dealing with languages of lesser diffusion, situations where an interpreter is needed quickly, and in small communities where the patient's privacy or modesty is critical. Meeting the needs of patients and clinicians without delay provides yet another and at times crucial benefit. According to the IMIA Medical Interpreter's Guide to Telephone Interpreting, "Quality in all modalities of interpreting depends on the training and skills of interpreters."

## Emergency Department Interpretation Sessions Statewide, By EOHHS Region, and MAPC-Community Type

Interpreter services in Massachusetts hospitals were mostly administered through the use of ad hoc interpreters, friends, relatives, and even children prior to the enactment of the ERIL. Use of trained interpreters was inconsistent. As a consequence quality care was often compromised. Since the enactment of ERIL, the field has advanced and it is commonly accepted that the use of untrained interpreters, family, friends and children has detrimental and even fatal effects for LEP patients.

A total of 177,788 interpretation sessions were completed in Emergency Departments during FY 2007. This represents 15% of the total number of interpretation sessions statewide.

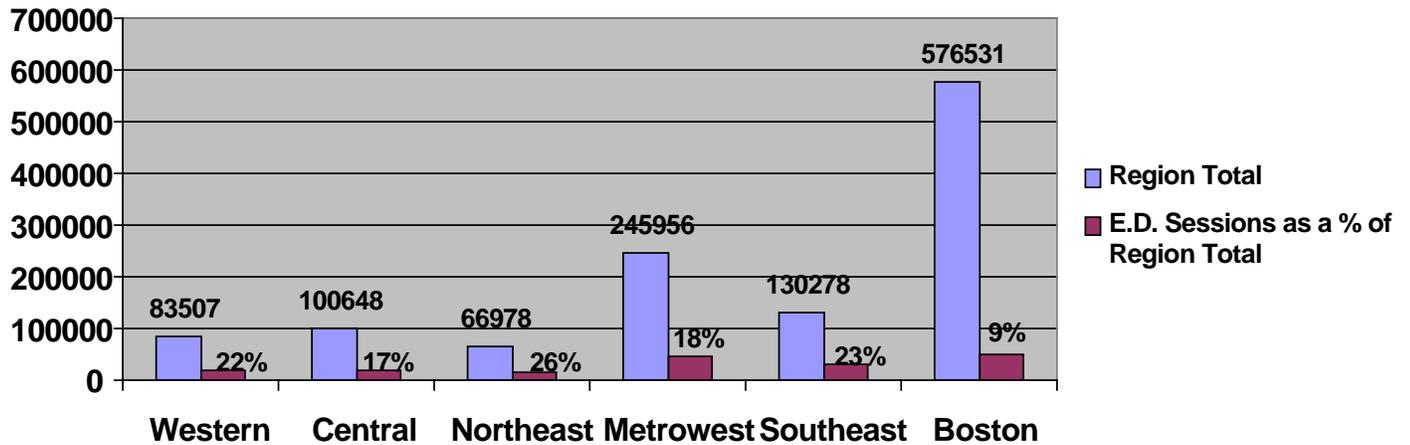
### Emergency Department Interpretation Sessions by EOHHS Region:

Of the 177,788 sessions, 18,028 were conducted in the Western Region, 17,447 in the Central Region, 17,166 in the Northeast Region, 45,123 in the Metrowest, 29,898 in the Southeast, and 50,106 in the Greater Boston Region (see Table 3).

<b>TABLE 3: Emergency Department (E.D.) Interpretation Sessions by Region</b>	
<b>Western</b>	18,028
<b>Central</b>	17,447
<b>Northeast</b>	17,166
<b>Metrowest</b>	45,123
<b>Southeast</b>	29,898
<b>Boston</b>	50,106

Table 3 shows the Boston region having the highest number of interpretation sessions in the Emergency Department and the Northeast region having the lowest. However, the lowest proportion of interpretation sessions conducted in an Emergency Department occurred in the Boston region, and highest in the Northeast (see Figure 6).

Figure 6: Emergency Dept Region Sessions as a Percentage of Total Region Sessions



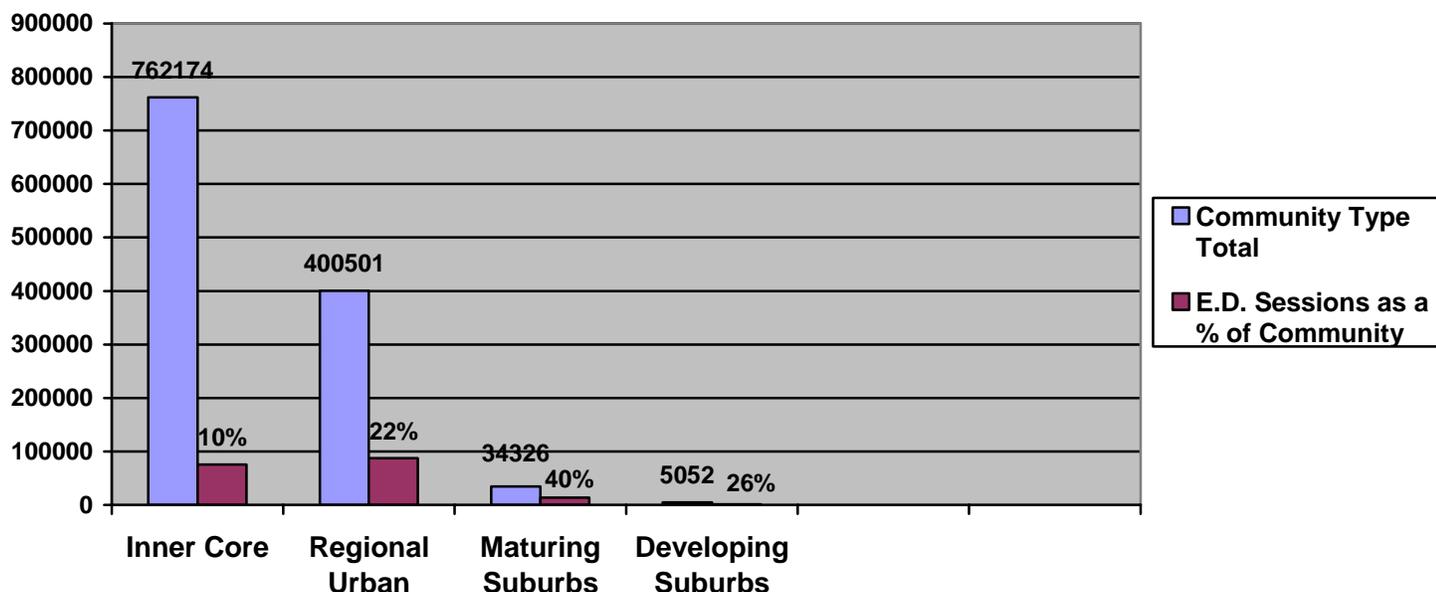
### Emergency Department Interpretation Sessions by MAPC-Community Types

Of the 177, 788 Emergency Department sessions completed by community type 75,258 were conducted in the Inner-core Community, 87,625 in the Regional Urban Center, 13,559 in the Maturing Suburb, and 1,336 in the Developing Suburb. It is worth noting that 11,047 of the 13,559 sessions (81%) conducted in the Maturing Suburb occurred at Cape Cod Hospital. The hospital reports that this is likely due to the influx of LEP workers during the summer season (see Table 4).

<b>TABLE 4: Community Type</b>	<b>Total Emergency Dept Interpretation Sessions</b>
<b>Inner Core Community</b>	75,258
<b>Regional Urban Center</b>	87,625
<b>Maturing Suburb</b>	13,559
<b>Developing Suburb</b>	1,336

Table 4 shows the Inner Core Community having the highest number of interpretation sessions in the Emergency Department (E.D.) and the Maturing Suburb having one of the lowest. However, the lowest proportion of interpretation sessions conducted in an Emergency Department occurred in the Inner Core Community, and highest in the Maturing Suburb (see Figure 7).

**Figure 7: Emergency Dept Community Type Sessions as a % of Total Community Type Sessions**



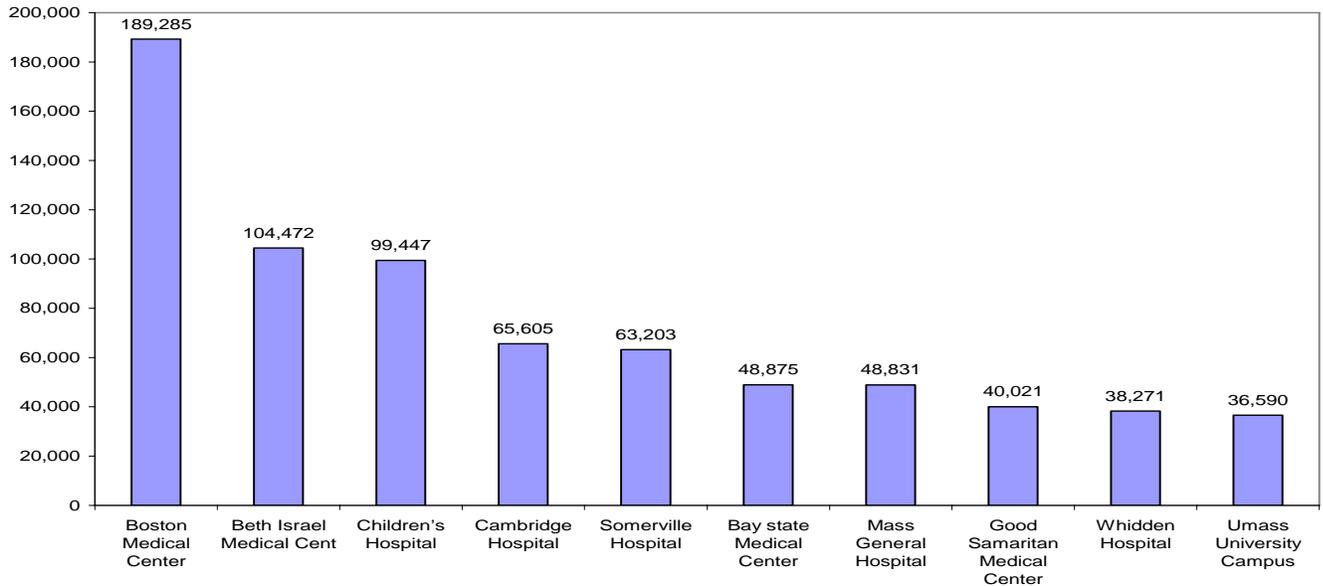
Prior to our analysis, the expectation was that the Boston region and Inner Core Communities would have experienced higher rates because of greater E.D. utilization, but they actually had the lowest rates. This unexpected outcome could be due to either a decrease in over-utilization of Emergency Department services or a significant unmet provision of E.D. interpreter services. Additional research would be required to determine the cause of this unexpected outcome; however, a recent study found that no interpreter was used in 46% of E.D. cases involving LEP patients <sup>(5)</sup>

### **Top Ten Hospitals with the Highest Number of Interpretation Sessions**

These ten hospitals account for 66% of the total number of interpretation sessions statewide, while the remaining 62 hospitals account for 34%. The ten hospitals with the highest number of interpretation sessions are not situated in a particular region or community type, nor are they relegated to a specific hospital size or type. They are found in all regions: four in the Greater Boston Region, three in Metrowest and one in each of the remaining three regions—West, Central, and Southeast. However, by community type seven of the top ten hospitals are located in Inner Core Communities and three in Regional Urban Centers; none are located in Maturing or Developing Suburbs.

**Figure 8**

**Top Ten Hospitals with the Highest Number of Interpretation Sessions**



**Top Ten Languages Most Frequently Encountered**

MDPH requires hospitals to monitor the languages for which they are providing interpreter services in order to improve communication with diverse populations. Hospitals should continually collect information on the languages spoken by the populations they serve.

The top ten languages in Table 5 account for 94% of all interpretation sessions. Spanish alone accounts for 43% of the interpretation sessions completed in the state – these numbers suggest that Spanish speakers are numerous and perhaps increasing in the Commonwealth. The other nine languages account for 51%. This finding should serve as a guide to acute care hospitals when conducting language needs assessments for their service area.

**TABLE 5: Top Ten Languages Most Frequently Encountered in Hospitals**

LANGUAGE	TOTAL	PERCENT	CUMULATIVE %
Spanish	512,221	43%	43%
Portuguese	260,510	22%	65%
Russian	82,663	7%	72%
Chinese	69,761	6%	78%
Haitian Creole	56,770	5%	83%
Cape Verdean	50,652	4%	87%
Vietnamese	45,069	4%	91%
Arabic	16,224	1%	92%
American Sign Language (ASL)	11,403	1%	93%
Albanian	9,593	1%	94%

To further substantiate the recommendations to our findings, we consulted two other programs that report on top ten languages, U.S. Census report\* and the First Language is Not English report (FLNE) report\*\*. In Massachusetts, these are often referenced when developing programs or when determining the language needs of a population.

<b>TABLE 6: Top Ten Spoken Languages in Massachusetts by Census</b>	<b>Top Ten Most Frequently Encountered by ACH</b>	<b>Top Ten Languages FLNE</b>
Spanish	Spanish	Spanish
Portuguese	Portuguese	Portuguese
French	Russian	Chinese
Italian	Chinese	Haitian Creole
Chinese	Haitian Creole	Vietnamese
French Creole	Cape Verdean	Khmer
Russian	Vietnamese	Cape Verdean
Vietnamese	Arabic	Russian
Greek	American Sign Language (ASL)	Arabic
Polish	Albanian	Korean

\*U.S. Census Report: [http://www.fairus.org/site/PageNavigator/facts/state\\_data\\_MA](http://www.fairus.org/site/PageNavigator/facts/state_data_MA)

\*\*FLNE - a bi-annual publication of MDPH with language data collected by the Massachusetts Department of Education for students whose primary language is not English.

The comparison revealed that the top ten languages in Table 5 as reported by hospitals were more consistent with the FLNE than that of the Census data. This highlights the fact that the data reported in the Acute Care Hospital Interpreter Services Report and the FLNE report represent direct demands for language services by a region or community. Census data reflects languages spoken in a region or community; they do not necessarily reflect language needs of populations within a region or community.

In summary, the data from the hospital report combined with FLNE data may be more appropriate not only for hospitals, but for all health service providers when developing programs, translating materials and creating signage for limited English proficient populations.

Table 7 below, contains information on the top three ranking languages of interpreter sessions at each acute care hospital during the period covered in this report. These languages should serve as a guide for respective hospitals when considering employment of medical interpreters.

**Table 7: Top Three Ranking Languages of Interpretation Sessions at the 72 Acute Care Hospitals**

<b>Facility</b>	<b>Language Rank 1</b>	<b>Language Rank 2</b>	<b>Language Rank 3</b>
<b>Addison Gilbert Hospital</b>	Portuguese	Spanish	Italian
<b>Athol Memorial Hospital</b>	Spanish	Urdu	–
<b>Bay State Medical Center</b>	Spanish	Russian	Vietnamese
<b>Berkshire Medical Center</b>	Spanish	Portuguese	Russian
<b>Beth Israel Deaconess Boston</b>	Spanish	Russian	Chinese
<b>Beth Israel- Needham</b>	Portuguese	Russian	ASL
<b>Beverly Hospital</b>	Spanish	ASL	Portuguese
<b>Boston Medical Center</b>	Spanish	Haitian Creole	Cape Verdean
<b>Brigham &amp; Women’s Hospital</b>	Spanish	Russian	Portuguese
<b>Brockton Hospital</b>	Cape Verdean	Portuguese	Spanish
<b>Burbank Hospital</b>	Spanish	Portuguese	Hmong
<b>Cambridge Hospital</b>	Portuguese	Spanish	Haitian Creole
<b>Cape Cod Hospital</b>	Portuguese	Spanish	ASL
<b>Carney Hospital</b>	Vietnamese	Haitian Creole	Spanish
<b>Charlton Memorial Hospital</b>	Portuguese	Spanish	Khmer/Cambodian
<b>Children’s Hospital</b>	Spanish	Portuguese	Chinese
<b>Clinton Hospital</b>	Spanish	Portuguese	Korean
<b>Cooley Dickinson Hosp</b>	Spanish	ASL	Khmer/Cambodian
<b>Emerson Hospital</b>	Spanish	Portuguese	Chinese
<b>Fairview Hospital</b>	Spanish	Portuguese	Hindi
<b>Falmouth Hospital</b>	Portuguese	ASL	Spanish
<b>Faulkner Hospital</b>	Spanish	Russian	Greek
<b>Franklin Medical Center</b>	Spanish	Russian	Romanian
<b>Good Samaritan Medical Center</b>	Portuguese	Cape Verdean	Spanish

ASL = American Sign Language

<b>TABLE 7 cont': Facility</b>	<b>Language Rank 1</b>	<b>Language Rank 2</b>	<b>Language Rank 3</b>
<b>Harrington Memorial Hospital</b>	Spanish	Chinese	Greek
<b>Heywood Hospital</b>	Spanish	ASL	Portuguese
<b>Holy Family Hospital</b>	Spanish	ASL	Portuguese
<b>Holyoke Hospital</b>	Spanish	ASL	Polish
<b>Hubbard Regional Hospital</b>	Spanish	Portuguese	–
<b>Jordan Hospital</b>	Portuguese	Spanish	Laotian
<b>Lahey clinic- Burlington</b>	Spanish	Portuguese	Chinese
<b>Lahey Clinic- North Shore</b>	Spanish	Portuguese	ASL
<b>Lawrence General Hospital</b>	Spanish	Vietnamese	Portuguese
<b>Lawrence Memorial Hospital</b>	Spanish	Chinese	Portuguese
<b>Leominster Hospital</b>	Spanish	Portuguese	Vietnamese
<b>Lowell General Hospital</b>	Khmer/Cambodian	Spanish	Portuguese
<b>Marlborough Hospital</b>	Portuguese	Spanish	Chinese
<b>Martha's Vineyard Hospital</b>	Portuguese	Romanian	Spanish
<b>Mary Lane Hospital</b>	Polish	ASL	–
<b>Massachusetts General Hospital</b>	Spanish	Portuguese	Chinese
<b>Melrose-Wakefield Hospital</b>	Spanish	Chinese	Portuguese
<b>Mercy Medical Center</b>	Spanish	Russian	Portuguese
<b>Merrimack Valley Hospital</b>	Spanish	Portuguese	Arabic
<b>Metro West Framingham</b>	Portuguese	Spanish	ASL
<b>Metro West LM Campus</b>	Spanish	Portuguese	Vietnamese
<b>Milford-Whitinsville Hospital</b>	Portuguese	Spanish	Arabic
<b>Milton Hospital</b>	Haitian Creole	Vietnamese	Spanish
<b>Morton Hospital</b>	Portuguese	Spanish	Cape Verdean

ASL =American Sign Language

<b>TABLE 7 cont': Facility</b>	<b>Language Rank 1</b>	<b>Language Rank 2</b>	<b>Language Rank 3</b>
<b>Mt. Auburn Hospital</b>	Spanish	Portuguese	Armenian
<b>Nantucket Cottage</b>	Spanish	Portuguese	Thai
<b>Nashoba Valley Medical Center</b>	Spanish	Hmong	Portuguese
<b>Newton-Wesley Hospital</b>	Spanish	Russian	Chinese
<b>Noble Hospital</b>	Russian	Spanish	Ukrainian
<b>Norwood Hospital</b>	Portuguese	Russian	Spanish
<b>Quincy Medical Center</b>	–	–	–
<b>Salem/North Shore Children</b>	Spanish	Portuguese	Russian
<b>Somerville Hospital</b>	Portuguese	Spanish	Haitian Creole
<b>South Shore Hospital</b>	Portuguese	ASL	Spanish
<b>St. Anne's Hospital</b>	Portuguese	Spanish	Cape Verdean
<b>St. Elizabeth's Medical Center</b>	Russian	Portuguese	Spanish
<b>St. Luke's Hospital</b>	Spanish	Portuguese	Cape Verdean
<b>St. Memorial Medical Center</b>	Spanish	Portuguese	Khmer/Cambodian
<b>St. Vincent Hospital</b>	Spanish	Vietnamese	Polish
<b>Sturdy Memorial</b>	Spanish	Khmer/Cambodian	Arabic
<b>Tobey Hospital</b>	Spanish	Portuguese	–
<b>Tufts-New England Medical</b>	Chinese	Spanish	Russian
<b>UMass Memorial Medical</b>	Spanish	Portuguese	Vietnamese
<b>UMass University Campus</b>	Spanish	Portuguese	Vietnamese
<b>Union Hospital</b>	Spanish	Russian	Khmer/Cambodian
<b>Whidden Memorial Hospital</b>	Portuguese	Spanish	Vietnamese
<b>Winchester Hospital</b>	Spanish	Portuguese	Chinese
<b>Wing Memorial Hospital</b>	ASL	Polish	Portuguese

# Conclusion and Recommendations

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The growing influx of LEP populations continues to present challenges for hospitals in meeting the demands for services in multiple languages. In spite of the challenges hospitals face they are committed to ensuring accessibility to meaningful communication for all individuals seeking medical treatment regardless of language, place, or time.

Acute care hospitals report annually to MDPH on the provision of interpreter services. Together they reported a high volume (1,202,031) of interpretation sessions conducted by 2,256 trained interpreters. With MDPH guidance, MA hospitals have developed unique organizational structures to accommodate interpreter service departments. Specific accomplishments within these departments include a designated coordinator, written policies and procedures, an annual language needs assessment with respect to their service area, tracking of interpretation sessions, completed sessions, and contractual agreements with supplementary language service providers. These are all advancements made in the area of interpreter services.

The ability to measure organizational structure and quantitative outcome is just one component in the effort for optimal interpretation service in clinical settings. All 72 hospitals require interpreters at hire to have a certificate of training and many require an on-site medical terminology test and or an oral test. Medical Interpretation trainings are being conducted without any regulatory oversight. These trainings are done primarily by independent companies and hospitals. The Commonwealth of Massachusetts lacks the regulatory mandate to ensure competent training, which can impact the effectiveness and quality of services.

Going forward, the Massachusetts Department of Public Health must develop a multi-faceted strategy to measure the quantitative outcomes and work to improve the quality of language services at all Massachusetts hospitals. The following recommendations can further advance industry standards:

## **MDPH:**

- Develop a monitoring system to ascertain the qualification, capacity, and competence of companies and hospitals that train medical interpreters.
- Standardize testing at hospitals for language proficiency prior to hiring an interpreter.
- Standardize the definition of interpretation sessions. Currently, each hospital defines the interpretation session per encounter or patient.

**Hospitals:**

- Establish data tracking mechanisms to capture requests for interpretation services as well as cancelled or completed sessions.
- Establish quality improvement measures to capture wait time between a request and the provision of service.

Adoption of these recommendations will:

- Improve quality of care for LEP patients
- Ensure competency of all interpreters across the state
- Provide consistency with data reporting for future assessment
- Increase service utilization
- Reduce delays in care
- Reduced costs
- Increase provider and patient satisfaction

The establishment of these recommendations will improve the quality of medical interpreter services, create opportunities to move towards a more appropriate and efficient system in the provision of language services in Massachusetts.

# Massachusetts Department of Public Health Methodology

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The collaboration between the Office of Health Equity (OHE) and the Determination of Need program has become the key component in MDPH's efforts to ensure the provision of competent interpreter services in hospitals. These efforts developed over time and built upon the efforts of the former offices of Multicultural Health and Refugee and Immigrant Health. The process is as follows: when a hospital applies for permission to undertake a change of ownership, capital improvements or addition of new technologies/equipment, the DoN office sends a copy of the application to the Office of Health Equity. OHE conducts a site visit to review the interpreter services system and places conditions on the application to improve language access.

A progress report on language access is required of all Massachusetts hospitals, including public, specialty, rehabilitation, and acute care since FY 2004 to assess progress on language access. The report was initially a qualitative survey. In FY 2005 it was converted to a "check all that apply" format. Finally, in FY 2007, the report was administered to all hospitals for reporting on the period from October 1, 2006 – September 30, 2007. A copy of the report is included in Appendix B.

Massachusetts 72 acute care hospitals submitted their annual progress reports to the Office of Health Equity covering the period of October 1, 2006 – September 30, 2007. We identify and define the models used to provide interpreter services, including variation in quality as well as articulate the implications of their usage. Next, we provide data on the number of interpretation sessions conducted statewide, by region and by community type. We also present data on the percentage of interpretation sessions conducted in hospital emergency departments; identify the hospitals with the highest numbers of interpreting sessions; and list and rank the languages that hospitals encountered most frequently. Lastly, we provide recommendations to further enhance the quality of language services.

## References

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3. See <http://www.imiaweb.org/about/default.asp>
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11. 67 Fed. Reg. 41455 (June 18, 2002).
12. [www.LEP.gov](http://www.LEP.gov)
13. Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services"
14. MDPH Regulations on Chapter 66 of the Acts of 2000

**Appendices:** To view the Appendices, please go to the following sites:

- A. Best Practice Recommendations for Hospital-based Interpreter Services:  
[http://www.mass.gov/Eeohhs2/docs/dph/health\\_equity/best\\_practices.pdf](http://www.mass.gov/Eeohhs2/docs/dph/health_equity/best_practices.pdf)
- B. Hospital Annual Progress Report (FFY 2007)  
[http://www.mass.gov/Eeohhs2/docs/dph/health\\_equity](http://www.mass.gov/Eeohhs2/docs/dph/health_equity)
- C. EOHHS Regional Map  
[http://www.mass.gov/mgis/reg\\_eohhs.htm](http://www.mass.gov/mgis/reg_eohhs.htm)
- D. Metropolitan Area Planning Council, 2008; *Massachusetts Community Types: A classification system developed by the Metropolitan Area Planning Council*.  
[http://www.mapc.org/data\\_gis/data\\_center/data\\_center\\_publications.html](http://www.mapc.org/data_gis/data_center/data_center_publications.html) or from [treardon@mapc.org](mailto:treardon@mapc.org)

Massachusetts Acute Care Hospital Interpreter Services  
2008 Report

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