QUALITATIVE CASE STUDY

Responding to the Language Challenge: Kaiser Permanente's Approach

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Abstract

Objective: To inform current debates on improving health care quality for patients with limited English proficiency by identifying the drivers and processes for one large health care delivery system's implementation of particular models, key success factors, and remaining challenges for the field.

Study Design: A qualitative case study of the Kaiser Permanente (KP) San Francisco Medical Center's approach to developing linguistic access services and subsequent organizationwide initiatives.

Methods: We conducted semistructured interviews with eight current and former clinical and administrative leaders from the KP San Francisco Medical Center and national headquarters. Interviews were analyzed for key themes.

Results: KP San Francisco Medical Center developed linguistic and cultural services in response to a confluence of external and internal factors, including changing demographics, care quality challenges, and patient and clinician satisfaction issues. Early strategies included development of language-specific care modules focused on Chinese- and Spanish-speaking members while meeting broader linguistic access and cultural-competency needs through a centralized Multicultural Services Center. Additional approaches across KP regions have focused on improving interpreter services, optimizing use of bilingual staff, and creating a translation infrastructure to improve quality and reduce redundancy in written translation efforts.

Conclusions: KP's experiences developing linguistic and cultural care and services since the 1990s provide lessons about decision-making processes and approaches that may guide other health systems, insurers, and policy makers striving to improve care quality and safety for patients with limited English proficiency.

Background

An essential determinant of health care access, quality, and safety is effective communication between patients and clinicians. Increasing numbers of people with limited English proficiency (LEP) in the US make linguistic access and the provision of linguistically and culturally competent health care a common challenge. In 2000, 18% of the US population reported speaking a language other than English at home, and nearly half of those reported some trouble speaking English.[1] Language barriers in health care are associated with decreases in quality of care, safety, and patient and clinician satisfaction;[2–8] contribute to health care disparities, even among people with insurance;[9] and challenge the health care delivery system in every type of clinical setting.

Federal and state regulations and standards oblige clinicians and insurers to provide language services so that patients with LEP have meaningful access.[10,11] Highly criticized as an unfunded mandate, the guidelines and emerging patchwork of legislation have left health care organizations, insurers, and clinicians scrambling to meet regulatory requirements and clinical needs while controlling costs.

Little is known about how health systems make decisions to respond to the language challenge. Although growing numbers of institutions report using professional interpreters,[12] other approaches to improving quality of care for patients with LEP remain opaque. In this context, health care organizations and policy makers can learn from the experiences of a large care provider. Kaiser Permanente (KP) is the nation's largest nonprofit health plan and nongovernmental integrated health care delivery system, caring for 8.7 million members in eight geographic regions. With more than six million members in California, where 1 in 5 people speak English less than "very well,"[1] KP must

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navigate the challenge of delivering care to large segments of the LEP population. Although its prepaid, integrated model differs from much of health care in the US, its experiences can nonetheless inform other organizations struggling to meet the needs of linguistically diverse patient populations. Specifically, this article addresses why and how KP decided to proceed with particular models and programs, what the key success factors are, what challenges remain, and what the implications for the field are.

Methods

We conducted a qualitative case study of the development of linguistic access services at KP's San Francisco Medical Center beginning in the mid-1990s, plus an analysis of other programs implemented more broadly. Data gathering consisted of individual, semistructured interviews with eight current and former clinical and administrative leaders from KP's San Francisco Medical Center and national offices. Institutional review board approval was obtained. One investigator (KM) conducted all interviews using a standardized interview tool and audiotaped and transcribed notes from interviews. All investigators reviewed the notes for key themes and developed this summary of findings.

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Results

Linguistic Access in San Francisco

In the mid-1990s, KP's San Francisco Medical Center faced several challenges in the care of patients with LEP.

Drivers for Change

San Francisco, CA, is a highly diverse city: 46% of residents speak a language other than English at home.[13] In the mid-1990s, San Francisco's Chinese population was growing, increasing from 12% of the city's population in 1980 to nearly 20% in 2000, (Steven Karet, personal communication, 2009)[a] more than one-third of whom did not speak English well or at all.[13] At the same time, Chinese membership trends at KP's San Francisco Medical Center were flat, meaning that market share for this population was declining.

Data from internal surveys and focus groups (as recalled by interviewees) revealed lower satisfaction with KP among Chinese-American members and nonmembers in San Francisco compared with other populations, and Chinese members with LEP reported communication challenges. KP clinicians expressed frustration about the lack of reliable and effective ways to bridge the language divide and about the implications for quality of care: interpreters were not consistently available; commercial telephone interpreter services were believed to be less than ideal; inadequate availability of bilingual support staff led bilingual clinicians to take on nonmedical tasks to assist patients, contributing to frustration and burnout; and bilingual employees were often asked to serve as interpreters without standard training or quality assurance.

Recognition of these issues arose at the same time that KP was focusing more intensely on clinical quality improvement across the organization. This enabled the San Francisco leadership to frame the linguistic access challenges as a quality and service challenge, helping provide momentum for change.

Considering Alternatives and Choosing an Approach

In the face of these drivers, several potential strategies were considered: 1) improving current language support services, 2) contracting with an external Chinese-speaking clinician network, 3) establishing a satellite clinic (or clinics) of Permanente Medical Group[b] physicians in the Chinese community, 4) hiring additional bilingual clinicians, and 5) consolidating bilingual physicians and staff into a specialized care module within the San Francisco Medical Center.

Several factors were important in choosing among strategies. Preferred strategies would respond to the priorities of the Chinese population, specifically the desire for easier access to services; would be relatively easy to implement and leverage existing strengths; and would enhance market penetration and facilitate longer-term solutions for this and other populations with LEP. On the basis of these priorities, medical-center leaders chose to pursue two strategies: a Multicultural Services Center was developed to strengthen broad language support and cultural-competency services throughout the medical center, and a general internal medicine Chinese module consisting of physicians, other practitioners, and support staff who were bilingual in Chinese and English and trained in cultural-competency issues was established in late 1996.

Although several approaches would have increased access to services, the Chinese module was particularly appealing because it leveraged existing resources and involved few new costs: Most of the bilingual clinicians and staff were already employed at the medical center and could be reorganized into one care setting. The decision to create the Chinese module, however, was not based on a formal business case. In part, interviewees believed that this was because the model had good face validity and

because the need to address linguistic access and cultural-competency issues was so glaring that people were willing to make decisions on the basis of pragmatism.

Another important consideration was the explicit recognition that patient care goes beyond the interaction between patient and physician in the examination room. When patients speak English well, their ability to navigate additional touch points (such as checking in, being roomed [assigned to an examination room], or scheduling appointments) is taken for granted. For patients with LEP, each interaction can determine the success of the clinical experience. By concentrating bilingual staff and physicians, the Chinese module not only improved the overall patient experience but also relieved bilingual physicians of the frustration associated with the nonclinical tasks that had previously fallen to them.

The Chinese module, in conjunction with activities of the Multicultural Services Center and outreach to employer groups in the Chinese community, contributed to an increase in annualized membership growth among Chinese-surname members from 1.7% in 1995 to 5.9% in 1997 (Dennis Lum, MPH, personal communication, 2007).[c] Interviewees recalled that satisfaction data for the Chinese population and clinicians and quality of care improved with the implementation of these new strategies.

Expanding the Reach

Soon after the Chinese module was established, local leaders planned the formation of a similar module for the Spanish-speaking population. Some drivers were similar—opportunities for membership growth and service improvement among a quickly growing population—yet creating a Spanish module presented other challenges, including the need to hire additional Spanish-speaking physicians and nurses who could navigate linguistic and cultural challenges associated with a diverse Spanish-speaking population. Once the Spanish module was in place, both modules added multidisciplinary bilingual staff as part of a broader redesign of adult primary care, including a health educator, diabetes case manager, complex chronic conditions case manager, medical behavioral specialist (psychiatric social worker), and physical therapist, expanding their ability to provide more comprehensive care within the modules.

Impact on Patients

To assess the impact of the new modules on patients, KP administered surveys and conducted focus groups in 2002 among Chinese- and Spanish-speaking patients at the San Francisco Medical Center. In the surveys, module members' ratings of their care experience was typically slightly higher than those of members not receiving care in the modules, though both groups mostly received high ratings. One area where the surveys revealed significant differences was that patients who received care in the modules were more likely to report that their physician provided enough information about the patient's condition and treatment. Module members were also significantly more likely to say they would renew their KP membership, and that they would recommend KP to others who speak their language. Focus groups revealed more about what that care experience meant to patients. As one Chinese-speaking member of the module said, "For an English-speaker, the module is better. For a non-English-speaker, the module is vital" (Kathryn Cirksena, PhD, personal communication, 2007).[d]

Overcoming the Barriers

Establishing the language modules was not without challenges. Although clinical champions were some of the most important driving forces, some clinicians resisted the idea out of concern that dealing with more patients with LEP would increase their workload if not matched by an increase in bilingual support staff, that the module would decrease the diversity of their patient population, or that a separate module amounted to "special treatment" or might appear discriminatory. In addition, the medical center needed to partner with local union groups to consider the impact of language skills on job placement and pay. Ultimately, these concerns were addressed and plans for the modules proceeded, but they highlight some of the barriers and challenges that can arise. The modules did not meet resistance from patients, who could opt in or out of the modules depending on their linguistic needs and physician preferences.

Providing Care Outside the Modules

The Chinese and Spanish modules addressed some core care delivery needs for the two largest populations with LEP in San Francisco, but because they addressed only adult primary care for these two large groups, additional action was needed for other medical specialties, care settings, and languages. The San Francisco Medical Center's Multicultural Services Center provided a foundation of services to meet LEP members' needs systematically, from the initial point of contact to the clinical encounter and follow-up care. This included internal and vendor-based interpreter services, document translation, signage, publications, phone hotlines, a Chinese interpreter call center, and

training for staff and clinicians on cultural-competency issues and the importance and availability of language services. Performance metrics included patient satisfaction, costs and use of internal and outsourced services, efficiencies in scheduling, and demand for services. Challenges have included perceptions of the services as ancillary, clinician and patient resistance regarding use of interpreters, and building capacity for services in other languages beyond Chinese and Spanish.

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Diffusing Linguistic and Cultural Competence

In the years since the Chinese and Spanish modules were established in San Francisco, other KP facilities across the US have grouped physicians and staff with special expertise to serve members with LEP and other distinct needs. In addition, three other strategies to improve care quality by addressing cultural and linguistic needs are being broadly adopted across the organization.

Increasing the Availability of Qualified Interpreters

KP's unmet need for formally trained health care interpreters, related training programs, and performance standards—and the implications for quality and safety—led the organization to design a health care interpreter training curriculum in 1996. In collaboration with City College of San Francisco, this curriculum was successfully expanded into the formal 15-unit Health Care Interpreter Certificate Program, whose goal is to develop a large pool of linguistically and culturally competent interpreters and other staff in health care settings.[14,15] The program has been disseminated to 15 additional geographic areas, and more than 1000 students with specialties in 13 languages have graduated from the certificate program at partnering colleges.

Leveraging Bilingual Staff

With demand for interpretation skills outpacing supply of on-site qualified interpreters, KP has turned to its own diverse workforce for a solution—while recognizing that ethnic diversity does not ensure linguistic and cultural competency.[14] The Qualified Bilingual Staff (QBS) program aims to capitalize on existing workforce diversity, provide professional development opportunities for staff, and ensure qualified linguistic services and culturally competent care at every point of contact in a cost-effective manner. QBS uses a standardized approach to identify workforce capacity, assess levels of linguistic competency, enhance linguistic and cultural capabilities, mobilize QBS within the care system, and monitor to ensure continuous quality improvement and patient safety.

Currently, the model targets the languages most prevalent in KP's service areas, including Spanish, Chinese, Vietnamese, Tagalog, Russian, Hmong, Punjabi, and American Sign Language. The organization has designated nearly 10,000 QBS employees (who receive a pay differential based on level of linguistic proficiency) and certified more than 100 QBS trainers across several geographic regions. This model has also been disseminated to external health systems. In addition, KP has expanded QBS to include assessment of physicians' linguistic and cultural proficiency, with more than 800 physicians assessed to date.

Improving Efficiency and Quality of Translation Services

Translation of written materials—such as patient education, consent forms, and insurance documents—is critical to linguistic access and presents additional challenges. Like many other large organizations, KP has historically dealt with translation on a local, ad hoc basis, resulting in problems with accuracy, cultural appropriateness, and redundancy. An internal survey of clinicians and staff revealed several challenges, including lack of knowledge on how to access translated materials, lack of budgets for translation, lack of organizational structure to share and access materials, questionable quality of translated information, significant delays in completing translations, and limited availability of materials even in the most common languages.[16]

Faced with these challenges, the organization is testing changes to improve quality and efficiency through a virtual translation environment. This platform uses translations management technology—embedded with evidence-based quality-assurance processes—to enhance efficiency and ensure quality in translations. This standardized quality translation infrastructure aims to avoid redundancy, maximize economies of scale, and ensure consistency. By testing how centralizing services affects quality, costs, work flow, and turnaround time for translations, the organization is gaining experience to build a longer-term translation infrastructure.

Discussion

Critical Success Factors

According to our interviews, three factors enabled innovations at the San Francisco Medical Center and across the organization:

- First, the confluence of external

and internal forces, such as changing demographics, declining market share, and increasing focus on quality, service, and safety, were critical to motivating improvement in linguistic access in San Francisco. These factors created a "policy window"—an opportunity to respond to specific needs with innovative changes.

- Second, in San Francisco the shared vision of local leaders opened doors and aligned stakeholders, and a diverse group of strong operational champions motivated and carried out the work. Their partnership addressed early hurdles and ensured that services progressed from concept to reality. Local and national improvement efforts were also enabled by KP's strong infrastructure for systematic diversity efforts, centered in the National Diversity office and mandated by the National Diversity Agenda, both of which provide a strategic platform for the work.
- Third, characteristics and incentives specific to KP's structure supported these innovations. As a prepaid care delivery system, the organization uses global budgets (not billing and reimbursement), enabling a degree of financial flexibility. As an integrated, multispecialty group practice, it encompasses the entire continuum of care, from primary care and specialty physician offices to hospitals (in some regions), pharmacies, and beyond. This provides the potential to set up consistent services in different points of the delivery system. Integration also enables sharing best practices and using common approaches, systems, and measures.

Challenges and Implications

The interviews and literature review revealed a number of linguistic access challenges for the health care field. These highlight potential areas where policy intervention—by government, accrediting bodies, employers, insurers, and health care delivery organizations—might accelerate progress.

The lack of funding streams or billing mechanisms for most linguistic access services is perhaps the biggest barrier to provision of these services by fee-for-service health care organizations. KP's prepaid, integrated structure creates more flexibility and incentives to provide these services where needed, though even in this model, competing priorities abound.

An integrated health care system such as KP benefits from the ability to make changes to multiple touch points where people receive care and interact with the system. In contrast, physician practices or hospitals that are not part of a larger system may be challenged by their lack of influence over other parts of the care-delivery continuum—where even if they improve linguistic access and cultural competency in their own care setting, they cannot ensure that their patients will receive similar services in other health care encounters, potentially undermining gains in satisfaction, efficiency, and quality.

Consistency of services and spread of best practices can also be impeded by "silos" of work, especially in large organizations. Efforts to improve care for patients with LEP could gain more traction by connecting to other major organizational initiatives in quality, patient safety, and service/care experience that may otherwise overlook linguistic access issues.[17] In addition, linguistic services are likely to have more impact if they are logistically easy to access and integrated into routine work processes[17-19] and if physicians understand the quality rationale and are involved in the development and implementation of services.[17]

Finally, health care organizations are challenged by the sheer volume and complexity of issues related to linguistic access—including the need for standards for assessment, training, and certification of interpreters and dual-role bilingual staff;[17,20] best practices for using interpreters versus bilingual staff; high-quality, cost-effective document translation; strategies for engaging clinicians so that they use language services; needs across the care continuum; and metrics to assess quality of services, patient satisfaction, and outcomes.

These success factors and challenges reveal important implications and options for accelerating progress:

- *Provide leadership.* Progress in linguistic access requires leaders' attention to the problem and commitment to identifying solutions. Increasing regulation alone is likely not enough to compel meaningful and sustained action. Organizational leaders—at micro and macro levels—and a diversity infrastructure are key drivers of progress and sustainability.
- *View regulation as a catalyst.* Linguistic access regulations or accreditation standards have had a mostly positive impact and provided motivation to address some existing problems. However, lack of enforcement or clear definitions of how these services should be integrated into the totality of patient care, from making appointments to dispensing medications, reduces their impact.
- *Understand the population.* Health insurers and care-delivery organizations, potentially in part-

nership with employers and other payers, can take a greater role in understanding the linguistic preferences and capabilities of their populations. The routine collection of data on preferred primary language, as well as data on race and ethnicity, can help inform linguistically and culturally responsive approaches.

- *Create incentives for linguistic access*. A key obstacle for proliferation of linguistic access services is the lack of payment streams. These services are essential to delivering high-quality and efficient care, and policy makers, employers, and other payers could work with insurers and care providers to identify realistic opportunities to establish incentives and drivers.
- *Increase the pool of qualified providers*. Inadequate numbers of and standards for qualified interpreters or bilingual/bicultural clinicians and staff impede progress. Establishing such standards and creating policies to increase their numbers (including creating incentives or requirements for linguistic access services) will help ensure high-quality and reliably available linguistic access services.
- *Integrate linguistic services into clinical care*. KP's Chinese and Spanish modules represent only one way of integrating linguistic services into routine clinical care. Health care organizations can make less-intensive changes to work flow and scheduling to improve linguistic access for patients.
- *Establish standards and metrics*. Performance measures for linguistic access have often been limited to volume of interpreter encounters and languages spoken. More meaningful metrics that evaluate the proportion of patients with LEP receiving linguistic access services and the quality and impact of those services are needed.[18] In addition, establishing standards for appropriate use of services would help guide health care organizations in developing programs and allocating resources.

As the diversity of the US population continues to grow, the challenges of effectively providing high-quality clinical care will likewise increase. The fragmented nature of US health care will likely result in a myriad of approaches to the language challenge. KP's experience developing linguistic access programs in San Francisco and across its regions provides a snapshot into one organization's decision-making process and approach, and its lessons can be applied more broadly across the health care system. ❖

[a] Director of Administration, ASIAN, Inc; San Francisco, CA.
[b] Permanente medical groups are partnerships or professional corporations of physicians. The full responsibility for providing and arranging the medical care necessary to satisfy each health plan's contracts with groups and individuals is assumed by a Permanente Medical Group. KP physicians are devoted full time to serving only KP members. Medical Group physicians provide patient-care services through a group capitation arrangement with Kaiser Foundation Health Plan. Individual physicians are compensated on a salary basis.
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References

1. Shin HB, Bruno R. Language use and English-speaking ability: 2000 [monograph on the Internet]. Washington, DC: US Census Bureau; 2003 Oct [cited 2009 May 13]. Available from: www.census.gov/prod/2003pubs/c2kbr-29.pdf.
2. Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. Int J Qual Health Care 2007 Apr;19(2):60–7.
3. Fernandez A, Schillinger D, Grumbach K, et al. Physician language ability and cultural competence. An exploratory study of communication with Spanish-speaking patients. J Gen Intern Med 2004 Feb;19(2):167–74.
4. Jacobs E, Chen AH, Karliner LS, Agger-Gupta N, Mutha S. The need for more research on language barriers in health care: a proposed research agenda. Milbank Q 2006;84(1):111–33.
5. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res 2007 Apr;42(2):727–54.
6. Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? J Gen Intern Med 1999 Jul;14(7):409–17.
7. Sarver J, Baker DW. Effect of language barriers on follow-up appointments after an emergency department visit. J Gen Intern Med 2000 Apr;15(4):256–64.
8. Wilson E, Chen AH, Grumbach K, Wang F, Fernandez A. Effects of limited English proficiency and physician language on health care comprehension. J Gen Intern Med 2005 Sep;20(9):800–6.
9. Fiscella K, Franks P, Doescher MP, Saver BG. Disparities in health care by race, ethnicity, and language among the insured: findings from a national sample. Med Care 2002 Jan;40(1):52–9.
10. Youdelman MK. The medical tongue: US laws and policies on language access. Health Aff (Millwood) 2008 Mar–Apr;27(2):424–33.
11. Chen AH, Youdelman MK, Brooks J. The legal framework for language access in healthcare settings: Title VI

and beyond. J Gen Intern Med 2007 Nov;22 Suppl 2:362–7.
12. Lee KC, Winickoff JP, Kim MK, et al. Resident physicians' use of professional and nonprofessional interpreters: a national survey. JAMA 2006 Sep 6;296(9):1050–3.
13. MLA language map data center [interactive database on the Internet]. New York: Modern Language Association; updated 2008 Dec 5 [cited 2009 May 13]. Available from: www.mla.org/map_data.
14. Tang G. Commentary on Chrisman NJ. Extending cultural competence through systems change: academic, hospital, and community partnerships. J Transcult Nurs 2007;18(1 suppl) 79S-83S.
15. Making the business case for culturally and linguistically appropriate services in health care: Health Care Interpreter Certificate Program, Kaiser Permanente [monograph on the Internet]. Washington, DC: Alliance of Community Health Plans Foundation; 2007 May 1 [cited 2009 May 13]. Available from: www.achp.org/library/download.asp?id=7042.
16. Tang G, Lanza O, Rodriguez FM, Chang A. Quality translations: a matter of patient safety, service quality, and cost-effectiveness. Perm J 2006 Fall;10(3):79–82.
17. Wu S, Ridgely MS, Escarce JJ, Morales LS. Language access services for Latinos with limited English proficiency: lessons learned from Hablamos Juntos. J Gen Intern Med 2007 Nov;22 Suppl 2:350–5.
18. Regenstein M. Measuring and improving the quality of hospital language services: insights from the Speaking Together collaborative. J Gen Intern Med 2007 Nov;22 Suppl 2:356–9.
19. Schyve PM. Language differences as a barrier to quality and safety in health care: the Joint Commission perspective. J Gen Intern Med 2007 Nov;22 Suppl 2:360–1.
20. Moreno MR, Otero-Sabogal R, Newman J. Assessing dual-role staff-interpreter linguistic competency in an integrated healthcare system. J Gen Intern Med .2007 Nov;22 Suppl 2:331-5.

Close to the Ground

Language is not an abstract construction of the learned, or of dictionary makers, but is something arising out of the work, needs, ties, joys, affections, tastes, of long generations of humanity, and has its bases broad and low, close to the ground.

— Noah Webster, 1758 – 1843, American lexicographer