

Language and Interpreters Skills Assessment – L&ISA Pilot Project

Health care organizations are urged to provide interpreter services to those who speak little or no English to assure equal access to health care services.¹ According to the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care*, issued by the Institute of Medicine, professional interpreter services should be the standard where language differences pose barriers to care.² This landmark report provides compelling evidence that disparities in medical care and health outcomes exist for minority populations in a number of health conditions and services. Looking for expedient and practical solutions, doctors, hospitals and other health organizations turn to heritage communities for help. Nearly half of the persons tested in the pilot project say they are heritage speakers; persons who learned their native language at home, not in school. Thus, one of the challenges of providing health care interpreter services is assuring competencies of interpreters.

Most health organizations struggle to determine whether their interpreter workforce is sufficiently skilled because tools to assess language proficiency or interpreting skills in health care currently do not exist. No valid or standardized tests exist to measure language ability in a health context. To fill this void, health providers across the country use a variety of locally devised ways to assess interpreters whom they hire or rely on informal measures such as the opinion of their staff or a trusted heritage community member. Because there is no standard language proficiency test for the health care setting, some providers use language proficiency tests that have been developed for business or academic settings. More recently several commercial products have been developed to fill this need, but none are empirically designed nor have they been tested.

Hablamos Juntos demonstrations participated in a pilot project to test four computer-administered assessment tools that measure Spanish language proficiency at the intermediate and advanced/superior levels and interpreting skills in a health care context. A set of tasks are performed for the language proficiency tests and video taped vignettes are used for the interpreter skills tests. The tools were created by Dr. Claudia Angelelli with the help of a team of experts to provide:

- ✓ Bilingual health care practitioners, bilingual staff and medical interpreters a means through which they can demonstrate their skills to their employers and community
- ✓ Health care employers empirically developed tools to assess the bilingual and interpretation services provided to their patients
- ✓ Training programs an objective means to evaluate potential students and assess their progress upon completion of the training

Computer based administration replaced cassette recorders, eliminated test booklets and simplified test administration to enable broad distribution of the tools while maintaining test security.

Pilot Project Description

Each Hablamos Juntos demonstration site identified a project administrator to oversee test administration in the region and two raters to score local test results. The National Program Office (NPO) reviewed the qualifications and approved candidates for these positions. Thirty-seven test centers were established in ten states. Test center computers are registered with a central server and test results are automatically sent to the central server when a test is completed.

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Instruction manuals were prepared to guide implementation. One manual provided instructions for downloading the software and registering the test center computers. Another provided instructions for establishing test centers. Guidelines were provided for recruiting, screening, scheduling, registering and administering the four tests. Sample applications, consent forms and scripts for administering each test were included.

Demonstration sites participated in de-bugging the program and provided suggestions for software improvements. The de-bugging process also helped to develop and refine test administration procedures for computer administration.

User Experience

Each grantee developed localized marketing materials for the region where testing is taking place to attract test candidates. Test center staff members provide an orientation to the testing process and how the software program works. Test takers are told that they are participating in a pilot project; that the tools (administered through a computer-based audio-visual software program) are new and are asked to complete a User Profile at the start of each test to collect demographic and background data. The need for confidentiality about the specific test content is stressed and test takers are asked to sign a confidentiality statement to ensure security.

Scoring

Trained raters score each test twice. Raters attended a two-day workshop to learn about test administration and scoring and received a manual with scoring guidelines and a rubric to score the four different tests on-line. Scoring is completed on a scoring rubric embedded with audio files. Raters access test results, click on the scoring rubric to listen to test results, score the test and submit scoring results via the Internet. The identity of the test taker is not made available to the raters.

Local raters are able to access local test results from a central server. National Program Office raters score tests from all test centers across the country. Dual scoring enables the program to evaluate the quality and consistency of ratings by individual raters. National level scores will also enable the development of benchmarks for ranking individual results.

Skills Measured

Candidates are asked to complete one language proficiency test (Intermediate or Advanced/Superior) and the Interpreter Readiness Pre-Test at the first visit. The Interpreter Readiness Final Test is scheduled for a subsequent date. Each test measures a set of skills at different levels. Listening and reading comprehension, literacy in Spanish and speaking are tested with the intermediate language proficiency tool. The advanced proficiency test measures speaking at different registers or ways of speaking as well as the four skills listed above but at more advanced levels. Both Interpreter Readiness tools test attention to detail and sequences, social and cultural appropriateness, general language ability, and terminology. In addition, the pre-test measures speaking and the post-test includes a test on ability to sight-translate a consent form. The table shows skills measured by each of the four tests.

Exam Title	Language Proficiency		Interpreter Readiness	
	Intermediate	Advanced	Pre	Final
Attention to details and sequences			x	x
Cultural/ Social appropriateness			x	x
General language ability - Final				x
Listening comprehension	x	x		
Spanish literacy	x	x		
Reading comprehension - general	x	x		
Speaking	x	x	x	
Speaking + Register		x		x
Terminology			x	x
General language ability - Pre Test			x	
Reading comprehension - Consent Forms				x

Individualized Self Improvement Plans

Since this is a national pilot evaluating a newly developed tool, test results in the form of numeric scores were not provided initially. Instead, the National Program Office gave test takers an Individualized Improvement Plan for each assessment test taken. The improvement plans were individualized based on the results of the assessment. This document identifies strengths and weaknesses and provides suggestions to improve current skills. Individual results cannot be released without written consent.

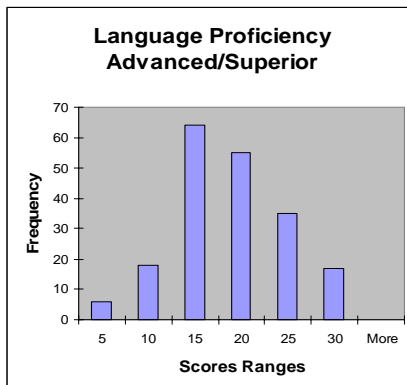
Pilot Results

The typical participant, based on the highest percentages in the categories reviewed, was a woman between the age of 31 and 40 from the United States. Her primary language was Spanish and she was educated only in the United States for up to 12 years. If working with a type of health agency and she was employed by a hospital. A third of the participants were asked to interpret as a child.

The candidates tested confirm that a large number, 44% of interpreters are heritage speakers, receiving no formal education in their native language. This has significant implications for language proficiency in their native language, particularly reading and writing skills. The distribution of participants in the category of years of school completed in the United States was relatively uniform: 23% of the participants completed up to 12 years of school in the US; 22% completed 2 years of college; 13% had 4 years of college, and 16% had 5 or more years of college education in the US. Seventeen percent of the participants had no years of education in the US.

Summary of all test takers

- A total of 882 tests were administered.
- 80% of all participants were female
- Most participants were between the ages of 21 and 50, with 30% between the ages of 31 to 40.
- Participants were born in 22 different countries. 44% of the participants were born in the United States. The next most common country of birth was Mexico with 18% of the participants. None of the remaining 20 countries had a frequency higher than 5%.
- For 60% of the participants, Spanish was their primary language. English was for 37%
- 44% of the participants had no schooling outside the United States. Of those who did, most had schooling up to 12 years.
- 28% of the participants were employed by a hospital, which was the highest percentage among the employers listed. 36% claimed some other, non-listed employer.

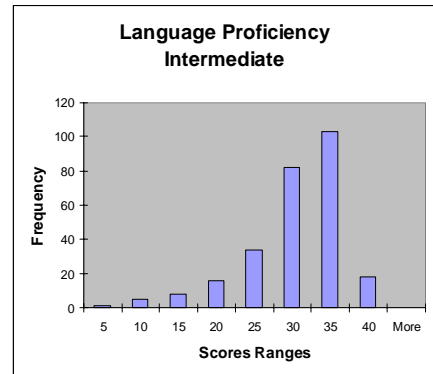


Language Proficiency Assessments

A total of 195 tests Advanced and 267 Intermediate test were administered during the pilot. Participants scored the lowest using the advanced Language Proficiency tool, scoring on average 53%. Participants scored 50% or below in three of the five skill sets tested by this tool, Listening comprehension, speaking, and Speaking + Register which is a skill not tested by the intermediate tool. For the advanced language proficiency test, the scores were within a range of 5 to 30 inclusive out of a possible 30. The distribution resembled a bell curve with the majority of the scores falling within the 15 to 20 range, inclusive. The peak frequency of 64 was at a score of 15.

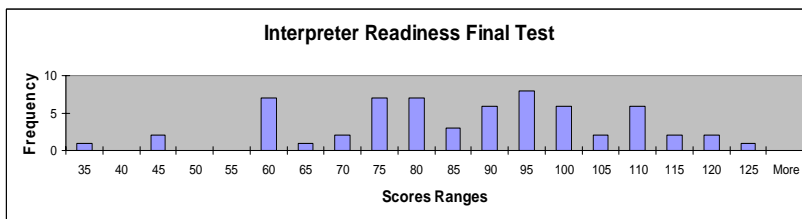
Fewer participants taking the advanced test were born in the United States (33% compared to 44%); slightly more (67% compared to 60%) considered Spanish their primary language and fewer (28% compared to 44%) had no schooling outside the United States

Participants scored the highest using the intermediate Language Proficiency tool, scoring on average 70%. Participants had among the highest relative scores within the skill set tested by this tool, scoring above 70% in Listening Comprehension, Spanish Literacy, and Reading Comprehension-General. For the intermediate language proficiency test, the scores were within a range of 5 to 40 inclusive out of a possible 40. The trend showed a general increase in frequency over the score range of 5 to 35 inclusive, with the peak frequency of 103 at the score of 35.



Interpreter Readiness Assessments

The pilot included two tests to assess interpreter readiness, the Pre-test which was designed to assess readiness and the Final test which was developed to assess interpreter skills after the completion of a training program. A total of 357 Interpreter Readiness Pre-test and 63 Final tests were administered. The typical participant that took the Interpreter Readiness Final test, based on the highest percentages in the categories reviewed, was a woman between the age of 21 and 30 born in the United States. Her primary language was Spanish and she was educated only in the United States for up to 2 years of college. If working with a type of health agency, she was employed by a hospital.

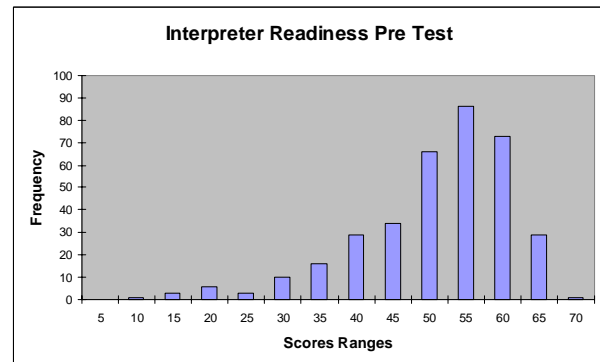


Participants scored on average nearly 7% lower on the Interpreter Readiness Final test as compared to the Interpreter Readiness Pre test. For each common skill tested by both these tools, participants scored lower on the final Interpreter Readiness test

than the pre Interpreter Readiness test. For example, the average pre test scores in Attention to details and sequences, Cultural/Social appropriateness, and Terminology were 66%, 63%, and 63% respectively whereas in the final test, the scores in the same categories were 62%, 57%, and 58% respectively.

For the Interpreter Readiness final tests, the scores were within a range of 35 to 125 inclusive out of a possible 140. There was a random distribution of scores with frequencies of 6 or higher at 7 different scores. The highest frequency was 8 which corresponded to a score of 95. Slightly fewer participants taking the advanced test were born in the United States (40% compared to 44%) and more had no schooling outside the United States (48% compared to 44%). Heritage speakers acquire native language ability, learning Spanish in the home.

For the Interpreter Readiness pre test, the scores were within a range of 10 to 70 inclusive out of a possible 72. The scores generally aligned with a bell curve, with the highest number of scores in the 50 to 60 range, inclusive. The highest frequency was 86 which corresponded to a score of 55.



For a single category, participants scored the highest in Reading comprehension-consent forms which is tested by the Interpreter Readiness final test. Scores were on average 80% in this category.

The turnover rate for interpreters is high and most receive little to no training for the job. Forty percent of the participants tested for interpreter readiness reported having one year or less in health care experience and near

three-fourths (74%) reported having worked 5 years or less as a health care interpreter. Over half of participants tested (56%) had not received training to work as an interpreter; 21% received less than 40 hours of training. Only 13 or 3% of the sample reported more than 100 hours of interpreter training. Combined these result illustrate the importance of testing and training interpreters.

Test Development

The tests used for this project were developed by Claudia Angelelli, Ph.D. Dr. Angelelli worked with a panel of experts including Dr. Guadalupe Valdes, Stanford University (Heritage speakers, Bilingualism and Testing), Dr. Edward Haertel, Stanford University (Design of Measurement Instruments; Item Analysis; Statistics), Dr. Mary Ann Lyman-Haeger, San Diego State University (Language Testing; Testing and Technology), Prof. Christian Degueudre, Monterey Institute of International Studies (Translation and Interpreting) and Dr. Jean Turner (Language Testing, Applied Linguistics) to design the Spanish language proficiency and pre and post interpreter readiness assessment tools used in the L&ISA program. Three tools were developed for Connecting Worlds with funding by The California Endowment. The fourth tool developed for Hablamos Juntos, uses the same design to assess for high, medium, low competency at the intermediate Spanish level.

¹ Perkins J. (2003) Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities. Available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=22093> (8/29/2005 10:28 PM); and Presidential Executive Order 13166 (2000) "Improving Access to Services for Persons with Limited English Proficiency." Federal Register 65, No. 159:50121. Available at <http://www.dol.gov/oasam/regs/statutes/Eo13166.htm> (8/29/2005 10:31 PM)

² Institute of Medicine (2003) Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Editors, Smedley, B. D, Stith, A. Y. and A. R. Nelson, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, National Academy Press, Washington, D.C. p. 192