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Improving Access for Latino Immigrants: Evaluation of Language Training Adapted to the Needs of Health Professionals

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The number of Latinos in North Carolina grew by almost 400% between 1990 and 2000. The rapid change in demographics in this state and other southeastern states has caught healthcare providers unprepared. Lack of ability to communicate with Latino patients may result in errors in diagnosis or reduced compliance with recommended treatments. The Culturally and Linguistically Appropriate Services (CLAS) Standards, published in 2001, mandate culturally and linguistically appropriate services for persons with limited English proficiency. This paper describes an innovative strategy to promote Spanish and culture-learning skills of healthcare providers and presents results of the evaluation conducted to determine its impact on access to quality care. The evaluation used a 360° case study design, at 1-year follow-up. Use of Spanish language health-related materials is key to the training's success. The authors make recommendations for replication of the integrated language and culture-training model in other new settlement areas, especially those in the southeast of the United States.

KEY WORDS: Spanish language training for health professionals; access to healthcare for Latino immigrants; health professions training; evaluation.

INTRODUCTION

The number of Latinos in North Carolina grew by 394% between 1990 and 2000, the fastest rate of growth in the nation (1, 2). North Carolina is not alone in becoming a new settlement area for Latino immigrants. Arkansas, Georgia, Tennessee, South Carolina, Alabama, and Kentucky are also listed among the states reporting the greatest rates of increase from 1990 to 2000 (2).

In North Carolina, 93 of 100 counties recorded greater than 100% increases in the number of Latino residents (2). Estimates suggest that 65% of the new immigrants are coming from Mexico, but substantial numbers of immigrants are arriving also from Honduras, Guatemala, and Colombia. As a result, births to mothers of Latino origin increased more than sevenfold, from 1752 in 1990 to 12,544 in 2000 (1). Many Latino men are employed in high-risk occupations, such as construction, factory work and agriculture, resulting in accidents and the need for emergency care (3). Recent analysis of the Behavioral Risk Factor Surveillance Study (BRFSS) indicates that deaths due to motor vehicle injuries to Latinos are 50% higher than other population groups (4). Limited English proficiency in this population is a factor in poor provider–patient communication, resulting in errors in diagnosis, or misunderstandings regarding prescribed medications and missed appointments (5).

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The year 2000 census estimates the Latino population in North Carolina to be 302,000. Nationally, Latinos are now the largest minority group, representing 12.5% of the population (6). Projections are, that by 2050, one out of every four Americans will be Latino (7).

Healthcare Antecedents

The rapid change in demographic characteristics of the population has caught healthcare providers unprepared. Few doctors and nurses speak Spanish. Until recently, in North Carolina and much of the southeast, interpreters were needed only occasionally. In 1998, at the outset of the Spanish Language and Culture Learning Initiative, a need assessment was conducted to assess the magnitude of the perceived need for health Spanish language training. A short survey instrument was mailed to hospitals, health departments, and community health agencies across North Carolina. Responses revealed just how unprepared agencies were to meet the needs of the new immigrants (8). One hundred twelve responses from health agencies in two-thirds of North Carolina's counties sketched a bleak picture of state level preparedness: three quarters of respondents had little or no Spanish training; only 9% reported being able to speak at a high intermediate or advanced level; 8% of the respondents, most of them interpreters, were native speakers. Further, only 13% had a Spanish-speaking receptionist; 29% had bilingual voice mail; 28% had all of their written consent forms in Spanish; and only 8% had all of their agency signs posted in Spanish and English.

Were this same assessment to be conducted today, the situation would be improved. Still, many clinical and administrative providers acknowledged understanding little of preferred Latino cultural beliefs and practices. Providers have difficulty assessing when Latino patients are experiencing pain or describing cultural or medical symptoms and knowing whether care prescribed is culturally acceptable (9–11). Lack of ability to communicate with Latino patients or family members may result in errors in diagnosis, misunderstanding of the nature of the problem, or reduced compliance with recommended treatments—all of which compromise the quality of healthcare services (5).

In the year 2000, an Executive Order was issued requiring federally assisted programs to improve access to services for persons with limited English skill. This federal requirement has increased recognition of the problem (12). In 2001, the Culturally and Linguistically Appropriate Services (CLAS) standards were published (13). These standards mandate provision of services for persons with Limited English Proficiency (LEP) under the rubric of Title VI of the Civil Rights Act and recommend a broad array of changes in an agency's strategic focus, human resources practices, and assessments of community needs. As a result, each local entity is required to assess the language needs of the population to be served and to develop a training plan for its own staff (14). Issuance of the CLAS standards has increased the pressure on agencies to hire bilingual interpreters—a temporary solution—and to train health professionals to be conversant in Spanish as well.

Preparing physicians, nurses, and related providers in health Spanish language and related culture learning is imperative in new settlement areas to provide access to quality healthcare services for the immigrant Latino population. In the pages that follow, the authors describe the Language and Cultural Learning Initiative, focusing on the innovative health Spanish language immersion training, and its 1-year follow-up evaluation. The authors also mention briefly the additional offerings of the Initiative.

Description of Program

The goal of the Language and Cultural Learning Initiative is to improve access through the provision of language and cultural training for health professionals appropriate to the healthcare needs of Latino immigrant populations. The Initiative was implemented through the North Carolina AHEC (Area Health Education Center), which provides a statewide infrastructure for training and continuing education of health professionals that has been developed and refined over the past two decades.

The Health Spanish Immersion Workshop is the cornerstone, and the most intensive training model, of the Spanish Language and Culture Learning Program. Other components of the Initiative include sequenced workshops (i.e., three 2-day-long workshops offered in consecutive months) at sites across the state; a 12-week course, with weekly evening meetings taught on the University campus or at a local health agency; an interpreter-training program, and a web-based resource center

(http://www.ncimmigranthealth.org/). Recently, as a result of these offerings, requests have come from across the state for novice level workshops that address the needs of specialized health learners, i.e., dental health and mental health providers. Each offering is designed to promote Spanish functional fluency through strengthening communication skills; the presentation of health vocabulary and practical grammar; and deliberate linking of language and cultural awareness training intended to improve access and promote quality care for Latino immigrants.

Clinical and administrative health and human services professionals who work in community health centers, health departments, hospitals, and other health or human services agencies are invited to enroll in training courses and workshops. The program has been generously supported by grants from The Duke Endowment's Immigrant Health Initiative and matching funds (NC-AHEC Program Proposal 2001; 1998).

Description of the Immersion Workshop

The Immersion Workshop is designed for intermediate learners, those who have a working knowledge of the language, but need a structured opportunity to practice speaking and listening and polish rusty skills. Applicants to the program were screened in a telephone interview to establish intermediate fluency in Spanish (i.e., both beginners and fluent speakers were screened out). Spanish language instructors, with experience in teaching Spanish for healthcare professionals conducted the screenings. The primary emphasis of the Immersion Workshop is on speaking and living the language and learning health-related cultural preferences of recent Latino immigrants. The early Immersion Workshops were 4 weeks in length; feedback from participants regarding the difficulty of finding replacements during a full month's absence resulted in the redesign of a 2-week Immersion. The first workshop, because the concept was so new, was supported fully by grant funds; a $500 fee was assessed for subsequent workshops (instruction, room, and board); the remainder of the program was supported with grant funds; participants had a range of support from their agencies—from use of annual or sick leave to full support during their workshop attendance.

The health Spanish instruction used principles of communicative language common to Berlitz; however, substantial modifications were made to integrate a health and medical care vocabulary and focus. The approach stresses listening and speaking of the language—the emphasis was placed on the need to facilitate immediate workplace communication. Grammar is taught, but is secondary to the emphasis on communication. Conversations that participants typically hear with their clients are modeled and practiced. A recently published book on Spanish for health care professionals was used as the key workshop text (15). The lead instructor, a recently retired physician, is a native of Colombia, South America.

The Berlitz method was chosen for two key reasons. First, the Fundor chose not to support international language training even at one of the well-known sites in Mexico or Guatemala, so we were limited to a US-based program. Second, in North Carolina, language learning programs are not common as they may be in New York or the southwest; Berlitz has a good reputation and they were willing to work with us to develop a healthcare focus appropriate to the learning needs of healthcare professionals.

Description of the Participants

Thirty-six health professionals participated in one of two month long immersion workshops; 45 additional health professionals have attended a 2-week immersion workshop. These professionals have a range of professional training, including health education, medicine (emergency medicine, family medicine, and pediatrics), maternal and child health, nursing (academic and community settings), nutrition, physical therapy, psychology, social work, and vocational rehabilitation. These same individuals were employed in health departments, community health centers, hospitals, university settings, and social services from across the state of North Carolina.

At the beginning of the workshop, participants' Spanish-speaking skills ranged from low to high intermediate. Some had previously traveled to Spanish-speaking countries for short-term immersion experiences. On the basis of self-reports of skill level, participants were placed into groups at one of three intermediate levels; the boundaries were flexible; the working assumption was that participants would do the best language learning if they were placed in a group where each felt a balance of comfort and challenge. The remainder of this paper presents the evaluation method and the results,

focusing in particular on the 360° case study, because of its innovative approach and greater depth.

Each week, participants arrived on Sunday evening and remained through Friday afternoon. Saturday and Sunday were spent with families. Participants also commit to speaking Spanish for the duration of the workshop. During daily language training, new vocabulary and grammatical structures were introduced through structured conversations. Participants were asked to discuss situations in which they encountered a Latino patient and a cultural situation that was different or difficult to understand. Common examples of perceived problems are social compliance (sometimes misread as "not telling the truth") and strong reliance on family members in a health emergency (i.e., not accepting a physician's recommendation without first calling home, even to Mexico, to consult with family members or a family doctor there about the decision).

Professionals with specialized expertise, such as mental health, alcohol abuse, or working with interpreters, were invited for informal evening seminars; Latino movies in English or Spanish with English subtitles were shown one night each week; a Latino band was even invited for the closing day. Discussions of the appropriateness of wording and reading levels of selected health education resources and games (Spanish language concentration; "Survival" adapted to a board game) rounded out already full days.

We also suggested that participants continue to cultivate their language skills after the workshop by continuing to watch Spanish language movies, eating at Mexican restaurants often enough to get to know the servers, going to Spanish language church services, or shopping at a local *tienda* (small grocery store).

METHODS

At the conclusion of each month-long Immersion Workshop, an outcome evaluation was conducted using two different paper and pencil instruments. In addition, an impact evaluation at 12-month follow-up was conducted with a subsample of participants to assess the more enduring outcomes of having participated in the Immersion Workshop.

The first end-of-workshop questionnaire asked participants to rate the value of workshop activities (conversation sessions, vocabulary building, grammar lessons, culture sessions, e.g., movies in Spanish, presentations by Latino professionals). Mean scores were between 7 and 9 on a 10-point scale. The second end-of-workshop instrument asked about professional and personal "costs" of participation in the immersion experience; that is, who covered for the participant at work during a 2-week absence and who at home helped with child care, cooking, or homework while a parent was away. All participants completed these instruments. At work, three-quarters of the participants had coworkers who covered for them; one-fifth of the participants had to work on weekends to compensate the lost weekday time. Only one agency hired a short-term person to fill in during the month. At home, a participant's husband or wife was most likely to do "double-duty," though occasionally a mother or mother-in-law offered an extra set of hands. Additional personal costs mentioned by participants included out-of-pocket expenses for extended childcare and transportation to children's after-school activities.

The 1-year follow-up evaluation was designed to assess whether participant attendance at the immersion workshop translated into continued efforts to improve Spanish language skill and use and, increased cultural sensitivity in health care settings. A 360° case study evaluation was chosen for the evaluation model because of the design's ability to integrate multiple perspectives relative to an employee (or, in this case, a participant's) performance (16, 17). The model has its foundations in human resources personnel development and utilizes a set of interviews that allow evaluation of employee performance from the perspectives of the employee, a coworker, and the employee's supervisor. Direct observation can be used, as well. The model was chosen because it seemed to offer the maximum opportunity to see how well the participant/employee had put the lessons of the immersion workshop into practice.

Six participants from the first and four from the second workshop were selected systematically for inclusion in the case study interviews. In total, given the requirement for interviews with coworkers and supervisors, a total of 30 semistructured interviews were conducted. Inclusion criteria included participants' profession, gender, type of health care agency, and location (both rural and urban). These criteria were chosen so as to develop a set of cases that reflected a range of perspectives across health care professions and tiers of care.

The interview addressed the following three topics: changes in the participant's skill level; changes in access to quality care resulting from the participant's

increased skill; and perceived need for changes in agency relationships with the Latino community. An observation of the participant's interaction with a Latino patient or family member was also done; the observation was designed primarily as a check on participant self-report.

After participants meeting the criteria were selected, a letter was sent to each explaining the study and asking for participation. On the date chosen for the interviews, a pair of interviewers (two of the four authors) visited the agency to conduct the interviews (only one participant selected declined the request). Each interview lasted 30–45 minutes; interviews were recorded and later transcribed.

RESULTS

Participants selected for the case study interviews included physicians or physician assistants ($n = 6$), nurses ($n = 2$), a nutritionist ($n = 1$), and a social worker ($n = 1$); this roughly corresponds to the range of professions included in the Immersion Workshops. The case study participants work in a variety of health care settings, including academic medical centers, private practices and hospitals, and county health departments (Table I). Each of the interview participants speaks Spanish daily and works in an agency that serves a large number of Latino clients and patients.

In the presentation of the results, participant, coworker, and supervisor responses to each theme are grouped together, so as to more clearly reflect the 360° model. The key recurring themes were related to marked improvements in language skill and cultural competency (Table II). The participants provided a range of insights and examples about these themes, and emphasized each of them differently.

Table I. Healthcare Agency Settings of Evaluation Participants

University medical centers
Hospital emergency department
Internal medicine department
Satellite primary care practice
County health departments
Nutrition program
Pediatrics
Sexually transmitted disease (STD) program
Affiliated private physician practice
Private physician practice within a county health department
Community health centers
Newborn and pediatric care
Prenatal care
Family practice

Table II. Key Recurring Themes From Case Study Interviews

Improved language competence
Improved cultural competence
Improved quality of care for immigrant Latino patients
Changing relationship with interpreters
Continued learning after the Immersion Program
Challenges of meeting the multiple needs of the Latino population

Improved Spanish Language Skill

Participants were quite positive about the amount of improvement in language competency they experienced as a result of the Immersion Workshop. Comments about a) improved comprehension; b) increased confidence in speaking; c) improved grammar; and d) acquisition of a broader vocabulary were made repeatedly. Comments reflected participants' increased ability to grasp context; to listen to phrases rather than separate words; and to "circumlocute"—use indirect ways of asking questions when the standard vocabulary was unknown—in their conversations with Latino patients. This result was not surprising, given that improved language competence is the main goal of the Immersion experience; still, it is important that expectations were confirmed. Coworkers and supervisors also noticed skill improvement, though their comments reflect needs at an agency rather than individual perspective.

Improved Comprehension

The most frequent aspect of language competence that participants discussed was improved comprehension (initials have been changed to preserve confidentiality). Among their comments are the following:

> Comprehension is where I have improved the most. If I don't know what they are asking, I can't respond so this is really important (CK).

> Before [attending the Immersion Workshop] I was lost; I remember the first day I came back [to work]. I told my husband..."I understood what she said!" I was so excited...I could hardly believe it. There were two patients that day and I understood them both (WC).

Increased Confidence in Speaking Ability

Participants also voiced consensus with respect to their increased confidence when speaking Spanish. The teaching methodology of the Immersion Workshop, because it emphasized speaking and listening skill over grammar, was intended to promote participants' confidence to communicate in Spanish. This aspect is very important, especially for adult learners, who may be unwilling to take the risk of talking to their Latino patients in Spanish. Among their key responses are the following:

> The course. . .gave me the confidence that I could do it—you just have to do it (CJ).

> Before I couldn't even try; I'd get flustered; and then I couldn't hear what they were saying. I think that there is a big difference in what I can do now and before (WC).

> Being able to talk to the children more has been one of the nicest parts of my improved Spanish skills; before I had a difficult time understanding them and was nervous to engage with them (JK).

> I can speak 2000% more than before, but I still do not feel even close to being fluent. I can now understand what the interpreters are saying, so that I can be sure that they are saying what I want them to [say]. I also find that a lot of patients will now seek me out and want to speak Spanish with me (SP).

Observations of the participants confirmed their increased confidence in speaking. While not every word or grammar structure was used accurately, in most cases the context mediated the error. In one instance, the spouse of a Latina woman added that the nurse's Spanish had improved a lot since his wife had been coming for prenatal care. The nurse was an Immersion Workshop participant.

Coworkers commented on the new confidence held by workshop participants. Some also commented on how their coworker's improved skills eased their need to "be everywhere" in the agency to assist Spanish-speaking patients.

> Her confidence and Spanish have improved. Now, she can string sentences together better. She certainly talks on the phone better, and we do a lot of phone consults. . .explanation of tests, you know, things like that (Coworker of CK).

> He is doing great with his Spanish. His vocabulary has really improved. Before he used a lot of interpreting. Now, he will call her when he is through with a patient to double-check and make sure that the patient understood everything. He has always been right (Coworker of TD).

Supervisors saw the benefit of participation in the Immersion Workshop primarily in terms of the cost–benefit to the agency.

> Prior to her going, she was pretty good; afterwards, there is a noticeable growth in her vocabulary. With her knowledge base, she has been able to help other practitioners. She has taught some of the front line staff some simple phrases; they are simple but direct. I need them, too (Supervisor of CJ).

Improved Knowledge of Grammatical Structures

It is not surprising that improvements in grammar were also regarded as important, especially since these language learners were most likely to measure their own competence in terms of traditional academic standards, i.e., grammar. Participants often made reference to their ability to construct accurate verb tenses, use reflexive verbs correctly, and select direct or indirect pronouns at will.

> I can use different tenses now. I especially notice that my use of the past tense has improved (ST).

> I now use the past tense and present perfect very comfortably. I also understand when patients use verbs in the past tense, which I didn't before (JK).

Noteworthy from an observer's perspective was the frequency with which a participant, in a professional role, self-corrected grammar. The self-correction happened most frequently with verb tenses and with verbs that are often interchanged, such as "venir" and "ir."

Expanded Vocabulary

The fourth aspect of language competence that participants mentioned was vocabulary. The new acquisition of medical words and vocabulary related directly to their daily practice was a source of pride. This reflects the emphasis on health Spanish in the Immersion Workshop including the role-playing and case exercises based on work situations.

> My Spanish is infinitely better but it is [still] limited to health, pediatrics and billing (CJ).

> I am definitely the strongest with medical vocabulary & discussing medical issues (SP).

Others dwelt on their frustrations that they did not learn enough to be considered "fluent."

> Now, I am comfortable taking an uncomplicated medical history, giving explanations, directions and

> answering direct questions. Still, rapid Spanish is still difficult for me (KA).

> Everyone will always be frustrated. . .you want to be fluent. . .in one month. . .it is stupid. . .(HW)

These comments clearly suggest the need for continued opportunities to practice and refresh language training. Emphasizing that language learning is a lifelong process—so called "native fluency" is not something that is accomplished in 4 weeks, or even a year—helped to reduce frustrations due to unrealistic expectations.

Observers also identified the participants' use of new vocabulary, ancillary to assessment of the primary presenting problem. Examples include exploration of child care arrangements in a visit for an ear infection; talking with a spouse about U.S. laws regarding abuse and expectations for supportive care of his pregnant wife; and a "pep-talk" about Mexican "fútbol" with a hospitalized Latino youth.

Improved Cultural Proficiency

Training in cultural competency was offered through a variety of integrated and breakout presentations. These served to broaden the professional cultural expertise of participants, and also gave them a better understanding of the range of preferences within Latino culture as it affects healthcare decision-making and compliance.

Participants spoke about sharpening their understanding of the Latino culture, and resultant expectations of health care providers, an outcome of their participation in the Immersion Program.

> In the Immersion Workshop, we learned about Latino last names. Before, we would all be frustrated by the fact that we felt our patients were changing their names to hide their identities because they're illegal or something, but now we all understand how their last names work (SP).

One interviewee, who works in a STD clinic, commented that it is the ability to lead with empathy that establishes the quality of the relationship with the Latino client. She continued, saying that it was this quality of the relationship, rather than being able to ask any particular culturally sensitive question, that seemed to lead to the adoption of recommended behaviors.

> I would like for staff to understand the new wave of people coming into this country. Less conversation about "them" and "us" (WC).

Another participant, a nutritionist, told a funny story about herself having misunderstood the difference between "pound cake" and "pancake:"

> I do a better job assessing my Latino clients' diet than I used to. Now I know the names of lots of ingredients, what all was in the foods and dishes they describe, and can ask more probing questions. . .For example, I recently had a client who had gained a whole lot of weight in a short period of time. I was able to ask enough questions that we finally could determine that she was eating huge amounts of pound cake (which I first thought was "pancake") not knowing how fattening it was (JK)!

Another interviewee talked about having attended medical school in Los Angeles, thus having some experience with Latino issues. Still, he mentioned how different the situations of recent immigrants are from those of longer-term residents.

> The women are very isolated and don't have the support of male [extended] family members. A husband was abusing the wife and she asked me as the doctor to talk with the husband about the abuse. They don't want to break any rules. I often have to play the roles of doctor, priest, father and counselor. I can often successfully intervene with the Latinos (TD).

This same individual has also been effective in facilitating better community relationships, especially with small, local employers of Latino workers. He recalled on instance in which an employer would not give release time to a woman who thought she was going into labor.

> I used to have patients calling saying, I think the baby is coming and I can't get off. Now I don't receive calls like this. The poultry places are more responsive (TD).

One mother of a 7-year old son who had had a sore throat for 2 weeks told the observer that she appreciated the doctor's efforts to speak Spanish. She said that his warmth made her trust the services her son received, even though the speaker (participant) sometimes still needed to rely on an interpreter as a check on his own accuracy.

In addition, participants cited examples of having shared their cultural competencies with their coworkers.

> I have had a big role in requiring our nutritionists to get more information into their care plans in terms of diet, and have gotten our nutritionists to understand the diets of our Latino clients and what is in the foods that they consume. . . I think that our staff is becoming more culturally competent, especially

> with regard to foods/diet and family relationships (JK).

To promote agency-wide cultural proficiency, participants and others interviewed agreed that more than individual commitment was necessary.

> We need cultural competency training for staff. And, steps need to be taken to make the [agency] multi-cultural. Also, the Executive Director and the Medical Director need to convince the Board of these things, but the bottom line is dollars (CJ).

Coworkers and supervisors, in some cases, clearly recognized the value of participants' sharpened perspective. The supervisor of the physician presented above, himself an African American, commented:

> She has pushed some initiatives, especially related to resource availability. She has pushed to hire some bilingual staff when there are staff vacancies. In our client population we have Vietnamese, Pakistani, East European, Chinese, many different African groups as well as Latino populations. In my strategic plan for next year, I have put four $1000 scholarships—really a bonus—to be given to people who reach some type of proficiency. Its been a positive experience —"Dr. Jones"' participation; that's the reason that "Jenny" went the second year (Supervisor of CJ).

A coworker added:

> Everybody was already onboard with Spanish. [But], we now have clinic hours in the evening and patient education, consent procedures and general billing procedures [available] in Spanish (Coworker of CK).

In summary, the integrated approach of presenting language and culture learning used in the Immersion Workshop resulted not only in improved language skills but also better knowledge of Latino family structure, dietary preferences, and personal priorities that characterize many immigrant Latinos. Participants also realized through their Spanish language conversations with one another that neither Latino patients nor U.S. healthcare settings were all alike, and that individualizing models of care was important to providing quality services.

Improved Quality of Care for Immigrant Latino Patients

Interview participants reported that the improved language abilities and cultural competency that they gained during the Immersion Experience resulted in higher quality of care for the Latino patients that they serve. This higher quality of care is most noticeably reflected in the shorter waiting times that Latino patients experience as a result of the participant being able to handle more client interactions in Spanish independently. One of the participants, who works in a hospital emergency department noted:

> There has been an impact on the hospital with time saved so everyone receives better care and decreased length of stay (KA).

Another participant, who works in primary care and maternal health, commented on her increased ability to take phone calls from Latino patients. She feels that this decreases the amount of time that clients have to wait to discuss their concerns and allows efficient patient scheduling decisions.

> Patients get seen faster since I can do triage over the phone. It speeds up decision-making because I can take a call right away. Before, it would go on a chart and it would have to sit and wait until the only person with Spanish could take it. Now I, in addition to two other staff, am available to do it in Spanish (CK).

This same participant discussed the impact the Immersion Workshop had on her ability to assist her coworker with a portion of the Spanish-speaking patients. The result was a decrease in the pressure on her coworker and higher quality of care for patients.

> My coworker saw the value in the end of having my Spanish improve. She was resentful, at first, because she had to work harder when I was gone for a month.
>
> However, the time has paid off because the cases I always pushed on her, I now take. She is happy about it (CK).

Still, interviews with several coworkers suggested that despite general enthusiasm, there were pockets of resistance to this new way of providing services.

> There is still a lot of prejudice, especially among the residents. At times I try to step in and point it out. The hospital is trying to be more correct by having the interpreters and being more aware of the population (Coworker of KA).

One supervisor spoke of a new policy that had recently been put into place to establish a culturally appropriate posture agency-wide and share opportunities for training equally.

> The county required everyone to have 8 hours of cultural diversity training [per year]. " Winnie" was one of the organizers of the 4-hour training that we had

this morning on cultural competency (Supervisor of WC).

An important related topic was each participant's ability to reduce risks for Latino and other patients as a result of improved communication skills. Many participants found their language abilities were strong enough to ask probing questions in Spanish much more effectively than before the Immersion Workshop. For example,

> When we have walk-ins, I have to find out why they are here to see the doctor. Once there was a man talking about something different, and he said something that clued me in that he could be diabetic. Sure enough we did a blood test and he was (CK).

> I have more confidence because I know that I understand more. For example, there was a woman who had a child with measles. My boss, almost in a panic, said, "She can't be in here with that child. What are we going to do?" With confidence, I went to the woman and explained, "You have to leave [this waiting room] because your child has measles." Measles is a problem that we learned [about]. Knowing about it has been very useful (WN).

A coworker commented that in their emergency department, setting the reputation for good care had improved during the previous year. As an example she said:

> They have confidence in the hospital because they have had good experiences here. I have talked with some bilingual Hispanics and that is what they said. Before, people sent them home with instructions in English. Now, forms and instructions are in Spanish (Coworker of KA).

Changed Relationship With Interpreters

Participants found that their reliance on interpreters changed upon return from the Immersion Workshop. Participants felt less dependent on interpreters than before, especially for routine care and initial assessment of patient conditions.

> [Before the Immersion Workshop] I always gave my office manager the Spanish phone calls to make because she is bilingual. Now, I don't think about it at all. Now, I write letters and call people (CJ).

At the same time, however, each of the participants discussed their continued reliance on interpreters, especially when they were faced with a complicated diagnosis or situation.

> If it is a difficult psychiatric history or an abuse situation, I call an interpreter (KA).

> A woman wanted birth control pills and I knew when she started mentioning other things such as cramping and clots that there was something else she needed as well. I called the translator because I know it was deeper than just the surface level (TD).

> I call an interpreter for anything that is complicated, such as abdominal pain, a marital situation, an STD, or when I just don't understand what the patient wants (SP).

During the Immersion Workshop, participants discussed the role of interpreters. One aspect of these discussions centered on knowing when to seek an interpreter's assistance. Participants have each set boundaries for themselves given their estimation of their language competency.

A coworker noted that after returning from the Immersion Workshop, she applied her energies to developing a justification for hiring an interpreter.

> To justify an interpreter, "Catherine" took a highlighter and marked all of the Latino surnamed patients for several days at a time. We were all surprised, but we got the interpreter (Coworker of CK)!

Continued Spanish Language Learning

Participants have found different ways to continue refining their Spanish skills since completing the Immersion Workshop.

> I work on my Spanish each night and I make myself tapes, which I listen to in the car. I also do a language exchange with a doctor from Mexico who is learning medical English here. We tutor each other (HW).

> I learn new words at work and through music. I even try to talk to my English-speaking coworkers and family in Spanish. I also bought computer programs, but they are not all that helpful (JK).

> I listen to my Berlitz tapes everyday in the car and find myself picking up new things all the time. For example, I have started to understand the present perfect and the present progressive more lately, and am trying to use it. I also watch Univision often (SPS).

> I subscribe to Salud and Perspectiva [Spanish newsletters with articles on health topics] and I keep a medical notebook at work (CJ).

Although none of the participants who were interviewed had yet taken other formal Spanish language courses, the authors are aware that a number of

Immersion Workshop participants not selected for the evaluation have enrolled in subsequent Spanish courses, including other courses offered by the Initiative.

Coworkers also commented on the energizing influence that a staff member's participation and continued interest in "growing" Spanish had had on other employees' desire to learn Spanish.

> Everyone seems to be a lot more anxious to be more fluent. Nurses are interested and motivated. I even use my phrase book to say new things (Coworker of KA).

> The whole staff had not always been open to learning Spanish and about Latino culture.

> They have been somewhat resistant to the adjustments. "Dr. Phillips" has been a role model for everyone. . .since he took time off,. . .spent time away from his family. . .and made other sacrifices to improve his Spanish abilities. He sets an example of someone who is trying to break down barriers (Coworker of SP).

Challenges of Meeting Needs of the Growing Latino Population

The interviews suggest that all of the participants' agencies are facing challenges as they attempt to meet the needs of the fast-growing Latino population. Increased stress on the part of staff, the demand for more training related to CLAS, large caseloads, and the role that agency leadership, i.e., managers and budget staff, ought to play in alleviating these pressures were among the challenges discussed.

> With the Latino patient increase, there has been a lot of stress and strain on the staff; we are having to double-book; nurses are resentful and sometimes have said, "When your patients come in," so we are definitely having some growing pains (CJ).

> I've bombarded them with lots of things since I came from the Immersion Workshop. Our immediate supervisor is supportive. But there is still a lot of hesitancy here. We need more in-service training for staff (WC).

> The Latino population at the clinic is supposed to be 30% of the cases, but, honestly, I think it is higher than that. I often go for a whole day in the WIC (Women Infants and Children) Clinic and see only Spanish-speaking people (WN).

One participant, who works in the health department in a county with the highest rate of increase in Latino immigrants, also discussed the negative attitudes that people in the community, including some staff members, hold, partly as a result of these pressures.

> Our whole community is feeling very stressed by the pressures of such a rapidly growing Latino population. Health services and schools are completely overwhelmed, and the American kids are picking up negative attitudes toward the Latinos. The adults, who do not have a comfort level with the Latinos, teach them these attitudes (JK).

This stress can lead to some staff being resistant to learning Spanish and gaining a further understanding of Latino culture. Two examples of these attitudes from the interviews are

> Some of the nursing staff [should learn Spanish] but they are not receptive (CK).

> There is an attitude in our community and among some of our staff of "I've lived here all my life and never had to learn Spanish" (JK).

Still, two participants noted that their participation in the Immersion Workshop had motivated other staff to want to learn Spanish, signaling that participants can serve as models for staff that are interested in being able to better communicate with Latino patients.

> Four or five people have been inspired to take Spanish classes so I have set a good example (KA).

> I had another doctor here at the clinic do an immersion experience and convinced another doctor to travel to Venezuela (SP).

Interviewees also commented on how their Latino clients have helped them to build their language skills and how appreciative their clients are of their efforts to speak in Spanish.

> When clients come, especially the men, they help me a little bit, if I am having difficulty; they appreciate it so much when someone tries (WC).

> I have not encountered any communication problems with Latinos. They are very appreciative that I am trying (HW).

Finally, one participant described his successful efforts to organize short-term trips for health professionals to go to Honduras to work in a clinic. He commented on how these trips not only provide a rich cultural experience, but can also be an inspiration to really learn Spanish after their return.

> I just came back from my most recent trip to the clinic in Honduras. I put together a team of 12 people, 8 of whom are affiliated with [a large local hospital]. One of the people on the trip renewed her interest in polishing her Spanish (HW).

The urgent need for additional Spanish language and cultural competency training was addressed repeatedly. Participants and coworkers alike mentioned the needs of front desk staff.

> I would like to see our front desk and reception staff at least be able to understand what the question is when a Latino patient approaches them. The same is true when these staff answer the phone. I would like them to be able to at least know enough Spanish to know whom the call needs to be directed to (SP).

> Speaking realistically, I would like to have all of our reception staff be bilingual or at least to be friendly and willing to learn some Spanish. I would like to see an attitude change from them, more than anything (JK).

> Yes, [additional training] would help a lot. Since the Latino population is growing, it is important that everybody can at least communicate the basics. I think the administrative and front desk staff would benefit the most from the language training. They need to be able to at least understand what the client is here for (Coworker of ST).

The participants reported serving as important advocates for Latinos within their agencies. During the interviews, participants described ways in which they have worked to improve the care that Latinos receive. Some examples include:

> I highlighted all of the Spanish names from the appointment book and showed it to. . .the executive director. About 50% of the patient load was Latino. He then hired a translator up front (CK).

> I have written lots of memos that we need to be more user-friendly. I also pulled something off the Web about legal issues and sent it to my medical director that has to do with that [Title VI] (CJ).

> I have brought many issues forward, such as the problem with Medicaid reimbursable clients and the fact that, by law, we must have interpreters and signage. This has helped to increase the number of interpreters (JK).

Coworkers and supervisors commented on the efforts that a staff member had made since returning from the Immersion Workshop to strategically reposition the agency with respect to providing accessible services to the Latino population.

> "Dr. Phillips" has helped the community a lot. For example, he helped [the health departments] in Siler City to get a Duke Endowment Immigrant Health Initiative Grant to educate people about Emergency Department Services and the importance of having health insurance. Forms are also being translated (Coworker of SP).

> The big role that "Dr. Thomas" has is with regard to being able to say things correctly to her patients. The fact that she can speak Spanish has helped to attract more clients (Coworker of ST).

> Now the agency has obtained information on STDs in Spanish. It wasn't a priority before. Now she is advocating for information in Spanish. In a recent meeting, she noted that the posters that tell the client their information is confidential are only in English. We need something in Spanish that says the same thing (Coworker of WC).

> Now, we do not have to use the interpreter line anymore, so her Spanish saves us dollars (Coworker of CJ).

Finally, participants discussed the key role that division managers and agency leaders play in obtaining Spanish language and cultural competency training for staff.

> I am convinced that the key people who need to be targeted in our agencies regarding the importance of language training are the middle managers and budget people. They need to be convinced of the necessity of having staff that speak Spanish (JK).

> If management came down and said, "We want some people to go to this [Immersion Workshop]," it could be different. Some people would go. It all comes down to money. Someone upstairs needs to see the need and then they'll be creative (WC).

CONCLUSIONS

The Immersion Workshop provides a unique experience for health professionals with intermediate Spanish abilities to challenge themselves to a new level of functional fluency. The use of health-related concepts and vocabulary for teaching Spanish is key to its success according to feedback from participants, coworkers, and supervisors. Second, the emphasis on communicative language, i.e., speaking and listening, seems to have been an essential ingredient in promoting the confidence to speak with which participants returned to the work place.

Still, at the heart of the experience is an important assumption less easily stated. Health professionals are generally very well-educated people. They have been successful in traditional academic environments. They know how to study, how to take tests, and how to develop protocols for managing their clinical work. Health professionals tend to be very skilled, organized, and in control of their work environment. These are the attributes that ensure the

provision of high quality of care to each patient. At the same time, the attributes valued in the provision of clinical care are not necessarily the same ones that lead to successful second language acquisition (15, 18).

As a part of the Immersion Workshop program, facilitators spent a great deal of time helping participants "let go of" more traditional learning skills and, instead, develop a new set of abilities. This other set of learning skills is based on process; it is intuitive. It is not formulaic, nor does it lend itself to protocols or "recipes." For professionals who have learned to associate success with very particular detailed questioning and responding, the concept of letting language "wash over their ears" is not easy to accept as a proven learning method. Learning these new skills is not always easy. They are required to think in terms of context; to develop a new set of listening skills; to listen for the meaning of the whole conversation instead of listening for individual words.

We have learned from our experiences and the feedback of the health professionals who have been participants in these immersion experiences. There is more to be done. For our ongoing trainings and for those who may seek to create a similar model, we offer several suggestions:

- It is clear that a health-focused immersion experience can produce substantial gains in comprehension and speaking ability of intermediate level trained health professionals in relatively short periods of time.
- Language learning is intuitive and context based; it is not a task to be memorized.
- Support for individual learning styles enhances the confidence and skill of auditory and visual learners. While auditory learning is the cornerstone of the Berlitz method, flip charts, flash cards, and short written exercises have been integrated for learners who need visual stimuli.
- Integrating culture learning with language training has the advantage of facilitating an understanding of the preferred practices of different Latino cultures within the context of the language used by these populations.
- Graduates of an Immersion Workshop may serve as advocates for change in their agencies, promoting both individual and agency-based initiatives.
- Some participants need assistance in clearly stating the limits of their new skills to a supervisor on their return. Supervisors may have unrealistic expectations and need help in knowing what situations a participant can handle and when support of an interpreter is still appropriate.
- Participants have confirmed for us the overarching importance of identifying or developing language and cultural competency materials that focus directly on the learners' field of application, i.e., healthcare practice.
- Training health professionals in Spanish and related cultural competencies is essential to compliance with the CLAS mandates and to promoting strong relationships with the immigrant Latino community.

In summary, the intent of the Spanish and Culture Learning Initiative Immersion Workshop is to train participants to draw on life and work experiences to become more adept at discerning the nuances of language, while improving grammar and expanding vocabulary. In addition, the importance of developing lifelong habits for building language competence is stressed. Fluency in a second language cannot occur solely through classroom recitation, but instead grows through exposure to both verbal communication and cultural traditions. Learning a second language is life changing. The experience opens windows onto other peoples' lives and their communities in ways that are not possible without making a second language part of one's everyday life.

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