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ABSTRACT

CLAMs are "Culturally and Linguistically Appropriate Materials" designed for diverse populations to help them overcome language barriers to effective treatment. The demographic shift underway in the United States is making the country more linguistically diverse. Health plans need to accommodate this shift, because without information patients cannot understand and use services provided to them by their providers and cannot engage in self-care or self-management, highly cost-effective means of promoting patient health. All of the reasons why it is legally and financially imperative for health plans to provide CLAMS are discussed. After this case is made, the newsletter discusses the best and most effective ways to make CLAMS available, including a three-step recommendation for producing effective CLAMS: select good source materials; translate and pretest; and pilot test. The issue concludes with a discussion of the five elements that determine the likely effect of printed materials: attraction, comprehension, acceptability, self-efficacy, and persuasion. (Adjunct ERIC Clearinghouse for ESL Literacy Education) (KFT)

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All Health Plans Need *CLAMs*

Culturally and Linguistically Appropriate Materials

for diverse populations can overcome language barriers to effective treatment

By Sandra Smith, MPH, CHES, and Virginia Gonzales, EdD, MSW, MPH

U.S. residents speak at least 329 languages. In some U.S. cities, less than 60 percent of the population speaks English. About 32 million of us speak a language other than English at home. If a health plan's population is not diverse today, it soon will be. The Census Bureau estimates that by 2030, the Hispanic population will increase by 113 percent and the number of Asian Americans will grow 132 percent.

These demographic shifts have profound implications for managed care. Success in improving the health of ethnic populations will substantially influence the future health of America as a whole. Successful plans will develop the capacity to address language barriers and cultural differences.

According to the U.S. Department of Health and Human Services, non-English speakers face substantial communication barriers at almost every level of the health care system. Studies show that communication barriers have a negative impact on health, discourage use of preventive services, and increase costs of treatment through unnecessary testing, delayed diagnosis, extended treatment times, and misinterpreted instructions.

Without information that they can understand and use, patients cannot engage in self-care or self-management. In short, they cannot take responsibility for their health and be partners in treatment, as effective managed care requires.

In most cases, plans and providers have the means to overcome language barriers. Still, according to a report from the National Health Law Program, current practice in most communities reflects an assumption that it is the patients' obligation to make themselves understood. In most instances, this assumption is wrong as a matter of law. The assumption is also contrary to a health plan's mission, which is to proactively reach out to its entire member population.

Federal and state civil rights laws and Medicaid regulations require access to

linguistically appropriate care. These laws are the basis for accreditation standards that require plans and providers to position themselves for a multicultural future.

Health Plan Employer Data and Information Set (HEDIS) standards ask managed care organizations (MCOs) to report how many doctors and staff serving Medicaid patients speak a language other than English and the availability of out-of-plan interpreters for all members. HEDIS also asks for an inventory of all materials in languages other than English. JCAHO (the Joint Committee on Accreditation of Healthcare Organizations) requires hospitals to document that patients and families received and demonstrated understanding of linguistically appropriate explanations and instructions.

In addition, states are mandating information for Medicaid beneficiaries in their own languages. For example, Oregon requires CareOregon, a Medicaid MCO serving the Portland area, to provide health and benefit information in nine languages. And, Harborview Medical Center in Seattle provides interpreter services in 160 languages.

Liability exposure may motivate providers to press plans to help them overcome language barriers. Providers who fail to communicate effectively with patients who have English skills run the risk of malpractice claims arising from injuries suffered because of miscommunication. Providers also face potential claims that failure to ensure their understanding of the patient's complaints breaches professional standard of care. Failure to ensure that the patient understands treatment options, risks and benefits breaches informed consent requirements.

Overcoming Language Barriers

Health plans and their affiliated providers can overcome language barriers by developing CLAMS - Culturally and Linguistically Appropriate Materials. CLAMs are attractive, easy to read and understand, acceptable, and persuasive to the intended audience. They allow plan managers and providers to inform and educate members and patients and to comply with accreditation standards.

Plans and providers already rely on printed materials to convey information to English speakers, and translating those materials is a cost-effective way to communicate with diverse populations. Studies show that patients prefer printed materials they can hold in their hands.

Researchers at the University of Oregon conducted a series of focus groups with participants of various ages and cultural backgrounds during development of the Oregon Consumer Scorecard, which is intended to aid consumer decision-making regarding choice of health plans. A clear message from participants was that written information should always be available, even in the presence of multiple other media.

In a review of the literature on written patient information published in the *Journal of Advanced Nursing,* numerous studies are cited showing that print materials, particularly in combination with brief counseling, can increase recall, compliance, and behavior changes; and reduce consultations regarding common discomforts.

While they are not a total solution, CLAMs are the necessary foundation for a comprehensive communication effort, and an obvious starting place. Some patients will need assistance to fully comprehend printed health messages. Reviewing salient points in printed material with patients and

highlighting key messages makes materials more valuable for readers with low literacy skills.

Internet and Audio Resources

Health information in languages other than English is increasingly available on the Internet. Before sending patients to a site, it is essential to evaluate the source, review content for scientific accuracy and cultural relevancy, and text must be tested with the target population to ensure that it is well translated and understandable. Two examples of Spanish language health sites developed by and for Spanish speakers are www.graciasdoctor.com and www.salud.com.

Health information is also available on the radio through the Pan American Health Organization (PAHO), which produces a one-minute Spanish radio series called Salud Siempre. The daily programs feature experts speaking about the important health issues such as emerging infectious diseases, environmental health, and prevention of childhood diseases. The series debuted in February 1998 in the Miami area, and is now broadcast in the United States and Latin America by hundreds of independent stations, radio networks, and the Voice of America. The Office of Public Information at (202) 974-3497 has information on which radio stations broadcast the series.

No Quick Solution

Translating good health care information in translation is easier said than done. Cultural specialists warn of the dangers of literal translation, including diversity among native speakers and subtleties in language. They recommend developing new materials in the native language of target groups. This is rarely feasible, however, because few health professionals with the knowledge to develop content speak languages other than English and have the cultural background to tailor information for readers' perspectives. This makes it necessary to work closely with native speakers who may be unfamiliar with medical topics and terms, and to rely on specialized interpreters. The rigor, time and expense of developing quality English materials are multiplied for developing other-language materials and must be duplicated frequently to keep information current.

As a result, while many health plans now translate member service information and informed consent forms, translated materials are limited. Patient care instructions are rarely available in any language other than English, and the quality of available materials varies widely.

One apparent reason for the scarcity of translated materials is a shortage of quality materials in English. Patient education receives plenty of lip service, but little research funding and no reimbursement. Many providers rely on "freebies" offered by manufacturers in exchange for implied endorsement of their products. Consequently, materials are rarely tested and are often out-of-date.

Patient education materials produced by medical professionals are notorious for exceeding patients' literacy skills. While the average American reads at a seventh to eighth-grade level most materials for patients, including most information on the Internet, are written at a 10th grade level or higher. When healthy, about 5 percent of the population has the college-level literacy skills needed to understand a standard consent form. When they are ill enough to require medical procedures, even the highly literate have difficulty with unfamiliar topics and term -that includes almost all medical and insurance information.

Producing Effective CLAMS

To address the need for printed materials for diverse populations, researchers at the University of Washington Center for Health Education and Research developed a process for producing foreign language CLAMs from English materials. With funding from the federal Agency for Healthcare Policy and Research (now Agency for Healthcare Research and Quality), they demonstrated the validity of the process using prenatal health information and produced practical guidelines. The process involves three steps:

Step 1 Select good source materials: The research team selected source materials already rigorously reviewed for scientific accuracy and developed specifically for a socioeconomically and culturally diverse population with a wide range of literacy skills. The materials, *Beginnings: A Practical Guide Through Your Pregnancy* (third edition), have been accepted nationally by the medical community and managed care organizations since 1989. Readability ratings for the materials are fourth grade on the Fry and Flesch-Kincaid scales and 88.1 (easy) on the Flesch Reading Ease Index. Both college-educated women and those with less than ninth grade education in commercial and Medicaid populations reported extreme satisfaction with these materials.

Step 2 Translate and Pretest: The challenge to the research team was to produce translated materials acceptable and persuasive to Spanish speakers from various Hispanic cultures in the United States. "While we recognize differences among Spanish-speakers, it would be an administrative nightmare to store materials for each group, identify each patient's country of origin, and attempt to make the match," says Nancy Guenther, director of health education at CareOregon.

The researchers formed a partnership with a team of perinatal outreach workers in the Hartford (Conn) Health Department. These bilingual community health workers and their supervisors represent five Spanish speaking cultures present on the East Coast. Together they hammered out a translation acceptable in each of their cultures.

The community health workers pre-tested their translation with clients. Each asked several mothers to read sections of text and answer questions to verify their understanding, and each brought clients' suggestions back to the team. They revised their manuscript accordingly and sent it to the West Coast translation team who incorporated the Mexican perspective. A readability test was done to verify the text was on a third grade reading level. A professional translator then edited the text to fit the format.

Step 3 Pilot Test: Research demonstrated that pilot testing does not need to be complicated, expensive, or time consuming, but it needs to be done. It is a fairly simple step that can prevent alienating and confusing your audience and wasting a lot of resources.

Because the materials were pre-tested with East Coast Spanish speakers, and 70 percent of Hispanic babies born in the United States are of Mexican descent, the research team conducted pilot testing with West Coast residents, primarily from Mexico. Since the subject of the test materials was pregnancy, testers were Medicaid eligible currently or recently pregnant women with 6 to 12 years' education. All testing was conducted in Spanish.

The research team tested two methods to evaluate the fit between materials and readers. One method, the

Reader Verification and Revision Interview process, effectively uncovers troublesome content and format features and elicits readers' suggestions in a positive way. This is good news for health care professionals who are considering evaluating translated materials. One method - reader interviews- is sufficient to determine suitability.

Evaluating Translated Materials

Five elements determine the likely efficacy of printed materials: attraction, comprehension, acceptability, self-efficacy, and persuasion. The Reader Verification and Revision Interview process proved to be an effective means to assess each of these elements.

■Attraction: The learner must be attracted and carried into the message. By looking at the cover, learners need to understand the purpose of the material and see how it applies to them. In this project, all but two testers (94 percent) said they would pick up the material and read it. All testers accurately described the subject matter by looking at the cover.

■Acceptability: To avoid unfamiliar words and to discover which terms would convey the same meaning to speakers of various Spanish dialects, we asked participants what specific terms meant to them. While less than one-third correctly defined the term *self-care*, responses indicated that participants understood and embraced the concept. With this information, the editor decided to introduce the term on the first page and use it throughout the materials.

■Comprehension, self-efficacy and persuasion: Interviewers asked women to read a section summarizing key messages and then name healthy things to do during pregnancy. All successfully named several key healthful behaviors. When asked to name things not to do, 86 percent correctly named, on average, two or three of the key messages.

The researchers concluded that the test materials are suitable for 83 percent of women in a population of Medicaid eligible Spanish-speakers with an average nine years' education. Half of those with six to eight years' education and 80 percent of those with nine to 12 years found the materials easy to read and understand. About 18 percent did not have sufficient literacy skills in their native language to use materials written at a third grade level. These persons need materials that convey the key messages without words.

Testing and evaluation successfully produced CLAMs for Spanish speakers from existing English materials. In fact, the testing produced significant improvements in the translation and in the source materials.

This project showed that it is possible to provide the same high quality health information to readers in most segments of a diverse managed care population and that patients and members are key players in the process of adapting materials for their use.

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