Addressing Language Barriers in Health Care:

What's at Stake?

Hospitals and clinicians face a growing challenge as America becomes more multicultural and multilingual: how to provide high-quality care to more than 20 million people who speak or understand little English, if any.

One in six Americans speaks a language other than English at home—not only Spanish, but languages from across Asia, Africa and Europe as well.

"Communication between health care providers and patients is difficult, even when everyone speaks the same language. Add language barriers into the mix and it's almost inconceivable that you will have a really effective health care encounter," says Marsha Regenstein, PhD, a professor at The George Washington University School of Public Health and a nationally recognized expert on language barriers in health care. "When patients and health care providers are not able to communicate clearly and thoroughly with each other, the quality of care suffers."

Regenstein heads *Speaking Together: National Language Services Network,* a new project funded by the Robert Wood Johnson Foundation (RWJF) that aims to identify, test and assess strategies for hospitals to provide effective language services to patients with limited English proficiency (LEP).

The program is leading 10 selected hospitals through a 16-month "learning network" to test new ideas, quantify results and share lessons learned. Program successes will be shared nationwide, providing models of effective language services that hospitals can adapt to meet the needs of linguistically diverse patients.

"Hospitals are providing medical interpretation in a variety of ways, but they are doing so without federal guidance, uniform standards or agreed-upon systems for assessing the quality of the language services they provide to patients," says Pamela Dickson, MBA, deputy director for RWJF's health care group. "There is a clear link between the overall quality of care a patient receives and the quality of the medical interpretation they were provided—and that is why we want to better understand how hospitals can provide consistent, effective and timely interpretive services."

Measures of Success

Speaking Together has pilot-tested and is now recommending the use of several core measures for determining patient needs and evaluating how well the hospital is meeting those needs.

- **Identifying Patient Needs**
  Measure 1: What percentage of patients are screened for their preferred language?

- **Documenting Use of Qualified Language Service Providers**
  Measure 2: What percentage of limited English proficiency patients receive initial assessment and discharge instructions from trained medical interpreters or assessed bilingual providers?

- **Evaluating Timeliness and Efficiency**
  Measure 3: In what percentage of encounters do patients wait more than 15 minutes for an interpreter?
  Measures 4/5: How much of their time do interpreters spend providing medical interpretation in clinical settings? How much of their time do interpreters spend waiting to provide services?

Robert Wood Johnson Foundation

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Research Shows Value of Trained Medical Interpretation

Experts say the program comes at a good time. Recent research shows that providing trained medical interpreters has a positive impact on health care processes, on the use of preventive health services and on patient outcomes. Research is providing evidence that:

- Patients with language barriers have a higher risk of non-adherence to medications and are less likely to have a regular source of medical care. These patients are also more likely to leave the hospital against medical advice and miss follow-up appointments.

- Patients who need—but don't get—interpreters often report a poor understanding of their diagnosis and treatment.

- Family and friends serving as interpreters often misinterpret or omit doctors' questions, and omit important, but potentially embarrassing patient complaints. They often also fail to mention side effects and make errors that may have clinical consequences.

- Interpreter services increase the use of preventive services and reduce hospitalization rates for patients with certain conditions.

For hospitals, language barriers can also hinder efficiency in delivering care. One recent study found, for example, that treating patients with limited English proficiency required greater use of resources and longer emergency department visits compared to patients with English proficiency.

Language Barriers Contribute to Disparities in Care

Patients with limited English proficiency are also likely to suffer more than English speakers in the aftermath of medical errors or adverse events.

A report issued earlier this year by the Joint Commission on Accreditation of Healthcare Organizations found that half of LEP patients who reported adverse events experienced some degree of physical harm—compared to less than a third of English speakers. It also found that the rate at which LEP patients suffered permanent or severe harm or death was more than twice that of English-speaking patients.

Good Care Requires Effective Communication

Everyday experience is teaching hospitals that the quality of their medical care is closely linked to how well they meet the language needs of their patients—and language barriers are often complicated by cultural differences.

"There is critical information the doctor can easily miss. We find that many times, the interpreter provides cues to the provider," says Helena Santos-Martins, MD, medical director at East Cambridge Health Center, a facility of Cambridge Health Alliance in Massachusetts. "The questions the provider asks might not capture the nuances of the patient's particular culture, particularly differences related to traditional understanding about illness or adherence to follow-up care regime. Just telling a patient what he or she can or cannot eat takes on more complexity when there are language and cultural differences."

Cambridge Health Alliance—one of the 10 major acute care hospitals taking part in *Speaking Together*—has more than 50 interpreters on staff and uses an additional 100 on contract to provide in-person interpreter services in 54 languages.

"It often takes a trained medical interpreter to bridge the gap, to get the most accurate information, to clarify the patient's questions and to help doctors probe deeper into the patient's medical history," she says.

To respond to the needs of patients speaking a wide range of languages, Cambridge trains its entire staff how to work effectively with interpreters.

"We hold orientation for all of our new employees about the patient safety issues related to miscommunication, and we have a similar orientation with our physicians," says Loretta Saint-Louis, PhD, director of Multilingual Interpreting at the Cambridge Health Alliance.

"We've found many physicians who've worked for decades without an interpreter and have struggled to provide treatment with partial communication. Sometimes they've used charades to try to communicate; sometimes they've used family members," Saint-Louis says. "A doctor cannot really make a diagnosis without fully understanding the patient's complaint and history."

The Joint Commission recently recommended that hospitals "use well-trained medical interpreters for patients with low English proficiency" and train all staff to recognize and respond appropriately to patients with language needs.

However, less than one in four hospitals currently provides training for medical interpreters. Most hospital staff are not trained to work with interpreters and have little or no education in linguistic or cultural issues related to clinical care.

The federal government requires that all hospitals provide patients with interpreters if needed. But the government has not set formal standards for interpreter services, and does not require quality assessment of these services.

"Although there is no uniform standard, experts increasingly agree that language services are best provided by people who have been trained in these skills and whose abilities in this arena have been formally assessed," Regenstein says.

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Collaborating to Improve Interpreter Services

Speaking Together: National Languages Services Network is now developing models of high-quality language services and helping hospitals use measures to evaluate the performance of these services.

Speaking Together brings staff from participating hospitals together to share successful strategies for managing language service programs and for increasing their

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Getting It Right

We are working "to marry patient safety with the ability of patients to communicate with providers in the language of their choosing," says Warren Ferguson, MD, who coordinates the *Speaking Together* project at UMass Memorial Health Care in Worcester, Mass. "We are really moving towards having interpreters as essential members of the health care team and recognizing them as professionals critical to providing safe care."

UMass, a large, not-for-profit academic health system, uses a force of more than 35 interpreters who work in Albanian, American Sign Language, French, Portuguese, Russian, Spanish, Vietnamese, and less frequently in more than 50 other languages.

"If you consider that much of the information a doctor uses for diagnosis comes from taking a history, it's like operating with a rusty scalpel if you can't talk to them," Ferguson says.

Knowing whether patients are getting interpreters when needed depends on collecting information about the use and timeliness of language services. UMass spent considerable effort adjusting data systems to gather this information.

"Our hospital has different systems that do not talk to each other, so you have to figure out ways to link them, as well as create safeguards to make sure information is correct and up-to-date," says Lee Hargraves, PhD, a

professor at UMass Medical School. "We have systems for administrative data, for clinical data, for quality improvement. We had to merge these systems, so we can tell whether every individual patient gets what's needed."

With systems in place to assess performance of interpreter services, UMass is now implementing changes to improve care. Some are small and seem simple.

"When we see that a patient should receive care in another language, we're going to create a sign that will go above the patient's bed indicating the patient requires an interpreter," says Connie Camelo, director of interpreter services at UMass. "We indicate other instructions like skin precautions and other things that are utilized all the time for patient safety, so why shouldn't we do the same thing for language services?"

Camelo has also begun having interpreters make patient rounds once a day to check on the needs of patients with limited English proficiency. Another focus is testing strategies to improve the use of interpreters at discharge. "We'll be following emergency room use and readmission rates 30 days after discharge for LEP patients. These are two quality markers of whether patients are discharged with enough information. Then we'll compare the rates of LEP and English-speaking patients to see how we are doing."

effectiveness. For many participants, this collaborative learning model provides critical feedback and exposure to new ideas.

"It's a huge eye-opener," says Regenstein. "Many of these hospitals have built programs without the benefit of input from colleagues around the country. The collaborative helps them see that there are other ways of doing things, other ways of thinking about how you define quality for language services. Each hospital brings different expertise and experience to the table."

"It's a wonderful experience. I can't begin to tell you how excited we are, because we are working with nine other hospitals that have the same goal," says Irma Bustamante, manager of language and cultural services at Phoenix Children's Hospital. "In the collaborative, we all exchange ideas and have the support to develop new tools, especially for data collection."

"We've developed these performance measures so hospitals can get a sense of how well they are doing, and they can benchmark against themselves or they can benchmark against other hospitals," says Regenstein. "This is the first time that these performance measures have been developed and they have been developed especially for this collaborative, this quality improvement project."

Once data collection systems are firmly in place, participating hospitals will use performance measures to test how providing more effective language services can improve quality of care, with a specific focus on treating depression, diabetes and heart disease.

Lessons learned from the 16-month *Speaking Together* project will be made available to hospitals nationwide. The full set of performance measures with supporting documentation is currently available at **www.speakingtogether.org.**

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Collecting Data to Assess Language Service Programs

Speaking Together is also helping participating hospitals systematically collect data that can be used to evaluate how well language service programs meet patient needs and how efficiently they use interpreter services. *Speaking Together* has developed a set of standards for collecting this data that participating hospitals are now adapting for their own use. These measures look specifically at:

- The percentage of patients who are screened for language of preference.

- The percentage provided interpreters when assessed at admission and at discharge.

- The timeliness and efficiency of interpreter services.

Speaking Together: Participating Hospitals

- Bellevue Hospital Center
  New York, New York

- Cambridge Health Alliance
  Cambridge, Massachusetts

- Children's Hospital and Regional Medical Center
  Seattle, Washington

- Hennepin County Medical Center
  Minneapolis, Minnesota

- Phoenix Children's Hospital
  Phoenix, Arizona

- Regions Hospital
  St. Paul, Minnesota

- UMass Memorial Health Care
  Worcester, Massachusetts

- UC Davis Health System
  Sacramento, California

- University of Michigan Health System
  Ann Arbor, Michigan

- University of Rochester Medical Center
  Rochester, New York