

Do You Speak The Language?

Providing Linguistically Appropriate Care

A large part of a hospital's provision of culturally competent care means providing adequate language services for patients with limited English proficiency (LEP). To be truly culturally competent, hospitals must face the fact that roughly 23 million people living in the United States have LEP—and a good share of them will be coming through their doors.

"Diversity is here to stay," says linguistic consultant and interpreter trainer Linda Joyce. "Our nation is becoming more diverse, more spread out over the whole country. If hospitals are interested in safety and quality, language and culture need to be addressed in every department; it has to be part of hospitals' goals and strategy. It can't be an ancillary service; it must be a funded core service."

Hospital interpretation can be done several ways. On-site interpreters should be trained in medical terminology and also able to help patients with consent forms and other paperwork. Phone services are frequently used as a backup, and patient education brochures and universal signage can be helpful as well. For deaf patients, video can sometimes substitute for on-site interpreters.

According to the International Medical Interpreters Association (IMIA), the interpreter's primary task is the transformation of a message in a source language—the health care provider's language—into its equivalent in a target language, that being

the language of the patient. Based on IMIA's Medical Interpreting Standards of Practice, interpretation must go beyond language conversion and recognize the complexities of interpretation in the clinical interview. The IMIA states, "the medical encounter is a highly interactive process in which the provider uses language as a powerful tool to understand, evaluate and diagnose symptoms." The interpreter, therefore, cannot simply be a "black box converter," but must establish a therapeutic connection between provider and patient and must know how to engage both sides of the communication in accessing the nuances and hidden sociocultural assumptions embedded in each other's language, which could lead to dangerous consequences if left unexplored, the IMIA says.

"Language permeates all areas of the hospital," says IMIA president Izabel Arocha. "It serves all departments in the hospital and is not a separate service. Everything is affected by language access."

Started in 1986, the IMIA is the certifying body for medical interpreters with national and international members, promoting interpreter training and education as other interpretation schools have emerged. The association also defines standards of practice, educational requirements and quality for medical interpretation and serves as a clearinghouse for information on medical interpretation. It disseminates newsletters, reports and other information to hospital leadership, illustrating best prac-

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tices and making them aware of mandates for language services.

“Hospitals don’t have the knowledge they need for language services,” Arocha says. “Language services need to be accurate for patient safety ... there is liability for hospitals who do not have interpreters. Health outcomes are related to communication errors.”

The IMIA has worked with hospital associations to provide “Access Symposia” that teach health care leaders the importance of medical interpretation from the top down. “Sometimes someone in the hospital is dedicated to providing language services but is not empowered to promote access,” Arocha says. “Boards and leadership are not aware of this and need to be.”

On the Joint Commission’s Radar

The Joint Commission has grown increasingly concerned with language access as well. Sponsored by the Commonwealth Fund, the Commission is working to develop standards for culturally competent care, including language. It has a project going through January of next year based on work it has already done on cultural competence as well as the furtherance of good practices from the National Quality Forum (NQF). The NQF enforces reporting on issues of safe practices, self-reporting on adverse events and being culturally competent.

The project’s focus, steered by an expert advisory panel is twofold—to advance patient-centered care, focusing on respecting the needs and perceptions of each individual; and to provide culturally competent care, which takes into account race, language, religion and other differences in culture.

“In pursuing this project, we have concluded that there are a number of factors that may interfere with patient-centered care, including poor communication between patients, nurses and doctors, both in language differences and disabilities such as blindness or deafness,” explains Paul Schyve, M.D. senior vice president of the Joint Commission.

“Safe care is dependent on communication with the patient,” Schyve says. “Limited English proficiency patients are more likely to have something bad happen to them in the hospital and when it happens, the results are worse for them than other patients.” These results made the Joint Commission decide it should develop standards to help hospitals. An implementation guide will be provided with the standards.

“Leaders have a responsibility to foster communication in their [health care] systems and to provide resources to allow nurses and doctors to provide patient-centered care,” Schyve explains. “In both language and cultural issues, we don’t understand the degree to which we are not communicating—and how much we need interpreters.”

As the former director of language interpretive services at Grady Health System in Atlanta, Joyce has become a consultant on language access, conducts health care interpreter training and testing for medical interpreters and is an interpreter herself, fluent in Spanish and Portuguese. Her goals are broader than medical interpreter training and testing, however; she sees the need for more training and mentoring nationwide.

“I want to see interpreters accepted as equal members of the treatment team,” she says. “Communication is 80 percent of

treatment, and it must be accurate. We interpret meaning for meaning, taking in cultural considerations. The role of the interpreter is to be transparent so that the patient and provider talk to and look at each other, not at the interpreter.”

She is involved with seeking national certification for medical interpreters through the National Council on Interpreting in Health Care. The council has already produced ethics and best practices that Joyce says professional medical interpreters strive to follow.

The goal for interpreters after credentialing is compensation, Arocha says. “Hospitals are required to have language services but they are not funded. It’s treated as an administrative expense, but it’s a patient expense. Now it is paid out of pocket but we need to make it reimbursable.” She adds that medical interpretation “is actually quite cheap, about the cost of a blood test.”

The next course of action, Arocha says is to have hospitals join the IMIA in advocating for language services to the federal government. “If [hospitals] are mandated to provide language services, we need to be reimbursed. Now we have a huge need and no financial resources. It’s a capped service, but there is a great growth in demand.”

“Each hospital needs to evaluate the population it sees and find out how prepared it is to provide language services,” Schyve says. “There are a number of nationwide telephone services that can provide interpretation for any location if interpreters cannot be provided on staff.” He adds, “Patients also need to be informed of their right to have interpretive services.”

Language Line Services

One such national language organization is Language Line Services, which serves a variety of organizations in the United States and the United Kingdom, working in government, travel and other fields as well as providing medical interpreters. It also works with a variety of government teams to look at potential legislation and regulations that have an impact on health care interpretation.

The organization has a Language Line University in Monterey, Calif., that trains, tests and certifies interpreters in 30 languages. The top 10 languages requested for interpretation are, in order: Spanish, Mandarin, Russian, Vietnamese, Korean, Cantonese, Portuguese, Polish, French and Japanese.

“A patient should be able to walk into any hospital in the U.S., and if he doesn’t speak English, he must receive language assistance,” says Marty Conroy, manager of Public Health Initiatives for Language Line Services.

Hospitals tend to use existing bilingual staff before seeking on-site or telephone interpreters, Conroy says. Although Language Line does provide on-site interpreters and can train existing staff, the majority of its assistance comes through telephone interpretation. Handsets are installed in exam rooms with physicians on one handset and patients on the other, with an interpreter on the line between.

“It improves communication immeasurably between physicians and patients,” Conroy says. “It not only provides a better patient experience and outcomes, it protects hospitals from a risk management standpoint when the wrong diagnosis is avoided.” He

adds, “It is in the best interests of patients and hospitals to provide good language assistance, but they need cost-effective ways to do it. It’s optimal to have an on-site interpreter but not always the most cost-effective, especially for languages that are not needed that often.”

Small and rural hospitals are often best served by telephone language services as well, while video interpreting is best used for American Sign Language.

“Look at your return on investment,” Conroy advises. “For every dollar invested in [interpretation] you will see better patient

SNAPSHOT: GRADY HEALTH SYSTEM

Sandra Sanchez, director of multicultural affairs at Grady Health System in Atlanta, says that she and Linda Joyce, former director of language interpretive sources at Grady, investigated the Joint Commission’s recommendations as well as the Department of Health & Human Services Office of Minority Health’s Culturally and Linguistically Appropriate Services (CLAS) standards and recommendations and statistics from the Office of Civil Rights. They put together a presentation for Grady’s C-suite to make them aware of what the system needed to do to reduce adverse events related to language.

“The field has grown over the past 10 years,” Sanchez says. “The purpose of our presentation was to stress the importance of using qualified interpreters. We were seeing simple mistakes because of language and culture, and we wanted to do something.”

Grady’s CEO, Michael Young, says the presentation “brought everyone up to speed,” explaining what language services were needed and the resources needed to do it. “Leadership made it happen,” he says. “We have taken what is good and made it better ... and our board has asked us to continue to make it happen.”

“Health care leadership is absolutely critical,” Joyce says. “If it’s not there, you can forget it. Our front-line doctors [at Grady] were not using interpretive services unless they had to, acting on what residents told them. [Interpretive services] had to become integral—from the top down—for the entire hospital, every department, all leadership.” In the case of her CEO at Grady, Joyce says she and Sanchez had to demonstrate the cost and value of building language services into the Grady health system.

“The hospital was trying to cut costs, so we had to justify why getting interpretive staff and services was the right thing to do,” Sanchez explains. In making their argument, Sanchez and Joyce pointed out that Latina women in the area were going to competing hospitals to have their babies because Spanish interpreters were available at those hospitals. To capture that Medicaid reimbursement, Grady needed to start providing better interpretive services.

“Our Latino population has exploded, and we are comfortable with what we are providing, and they are coming to us,” Young says. He adds that one-third of new nurses hired have come from a multicultural background. “The best way to learn a culture is to be a culture,” Young says, and for this reason Grady’s human resources department was asked to actively seek diverse job candidates.

In addition to speaking to its board and C-suite executives, Sanchez says, “We talked to the patient safety officer, risk management, quality management, nurse managers and the chief of medical affairs and they started incorporating practices to have language and culture considered when interacting with patients.”

It was no small task at the 953-bed public hospital, which also has 10 neighborhood health centers and a rehabilitation center.

“Forty percent of our patients are uninsured; 40 percent are Medicaid; 10 percent are Medicare; and only 10 percent have insurance. So for us to apply this level of support tells you how important this is,” Young says.

Grady Memorial is a teaching as well as a safety-net hospital that receives a majority of the area’s uninsured and underserved. Sanchez estimates that roughly 12 percent of that population have limited English proficiency, and 90 percent of those speak Spanish, with Vietnamese, Mandarin and Amharic—an Ethiopian language—next in line. However, Sanchez estimates that there are over 100 languages for which Grady needs to provide interpretive services.

The Grady Health System uses language assistance agencies that provide interpretation for the less-common languages, and the hospital has a French and several Spanish interpreters on-site. Interpreters need to be proficient in medical terminology as well as language fluency.

“Sometimes patients nod their heads out of politeness, but they don’t understand,” Sanchez says. “Just one word can be the difference between life and death.”

She gives the example of a hospital in Washington state that admitted a Hispanic man who said he was “intoxicado.” The medical staff thought he was saying he was intoxicated and needed detox treatment, but instead, he was having a stroke.

When someone is already ill, “add language barriers and what kind of communication will you have?” Sanchez asks. “Gestures may not be clear. If you use a child to interpret, what medical terminology do they know? You increase the risk of a bad outcome.”

In putting together a professional interpretation program, Sanchez and Joyce had to find physician champions who understood that both physicians and patients benefit from interpretive services. “It’s a morale booster for all to bridge communication,” Joyce says. “[Using a professional interpreter] is better than using [a patient’s] child or a random staff member.”—L.L.

outcomes and reduced litigation. Any missed diagnosis or one adverse litigation would far outweigh the cost of providing language access. It's a risk management tool."

Case in Point

Harborview Medical Center in Seattle has understood that investment for many years. Harborview is a publically owned 368-bed hospital serving a population of LEP patients who collectively speak 80 different languages. Martine Pierre-Louis, manager of Interpretive Services and Community House Calls, says her department "puts mission into reality." She estimates her department had 100,000 patient encounters last year, covered by 47 on-staff medical interpreters, one-half of which are full-time employees, a quarter are half-time and a quarter are traveling interpreters. These staff members covered 65 percent of interpretive needs with the rest handled by a language agency.

"The needs of LEP patients are not considered as extra needs, they are considered as part of all their needs automatically," Pierre-Louis says. "They are part and parcel of how we do business as a hospital."

Language services start at registration, with preferred language entered into the patient's record. LEP patient information is sent to schedulers in the interpretive services department and an interpreter or telephone assistance from a nearby call center is dispatched to assist with patient-provider communication from their initial encounter until their discharge from the hospital.

The Community House Calls program is available to the six largest language groups served by Harborview (the top three are Spanish, Somali and Vietnamese). Patients also are referred to

appropriate interpreters who go to the patient's home as "cultural mediators," possibly with a physician, nurse or a pharmacologist, to find out why patients are not complying with recommended treatment.

As an example, a Somali patient was repeatedly seen in the ED with asthma attacks. Visiting his home, an interpreter and a nurse asked him: "How do you take your medication?" He had two asthma medications, one to prevent attacks and one to use when attacks happened. He had them mixed up and therefore saw no value in using them. Once the differences were explained, he complied. The nurse and interpreter also looked at his home to see what asthma triggers were in the environment.

"This is where compliance meets the reality of the patient's life," Pierre-Louis says. Harborview's leadership has offered "implicit and explicit" support of interpretive services all along, Pierre-Louis says. "Board members and all C-suite positions are strongly committed to follow our mission and if we're not providing language assistance, care is not equitable. [Interpretive services] are woven into the fabric of how things are done."

Schryve recommends that leaders go on "walk rounds" where they directly observe patient/provider interactions and ask about language proficiency. "If leaders ask the questions about language and culture, it becomes important," he says. "We're talking about something that will be effectively and systematically carried out only if the organization says, 'This is what we value in our culture.'" **T**

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