Meeting the Language Needs of Patients at CHCs

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Objectives

• Know evidence for meeting language preference as a quality and patient safety issue
• Cite the four key data fields critical to tracking language services
• Take home important best practice tips from CHCs in the collaborative
Modeled after Speaking Together

- 75 Hospitals applied
- 10 chosen
- 18 month quality improvement collaborative intervention
- 3 national meetings and monthly calls
- Monthly data reports
- Use rapid cycle change to improve quality
The evidence for quality and patient safety
Language and Health Care

  - Access to health care
  - Health status
  - Use of health services
  - Patient-physician communication
  - Satisfaction with care
  - Patient safety
Adverse Outcomes: LEP Patients

• Fewer primary care visits
  Mexican children whose parents spoke English 12 times more likely to have regular provider vs. those with parents who didn’t (regardless of insurance) (Takata, 1991)

• Fewer preventive services
  Fewer mammograms and pap smears in Mexican women who don’t speak English (Marks et al. Am J Psych Health 1987;77:1315)
Adverse Outcomes: LEP Patients

• Asthmatic children with LEP parents 3 times more likely to be intubated for their asthma than those with English proficient parents (LeSon & Gershwin. J Asthma 1995;32:285-294)

• Monolingual Spanish-speaking adults with asthma whose physicians speak English: 3 times more likely to miss 1 or more follow-up appointments (Manson. Med Care 1988;26:1119)
Health status and communication

LEP patients who need but don’t get interpreters more likely than LEP patients who used interpreters and EP patients to:

• Have poor or fair self-reported understanding of diagnosis and treatment plan
• Wish healthcare provider explained things better (Baker et al. JAMA 1996)
Communication

Hazards of using ad hoc interpreters (family members, friends, strangers pulled from waiting room, untrained staff):

- Patient less likely to be told about medication side effects (David & Rhee ’98)
- Interpretation errors more likely to have potential clinical consequences vs. those by professional interpreters (77% vs. 53%) (Flores et al. ’03)
- Family members misinterpret 23-52% of questions asked by physicians (Ebden et al. ‘88)
Satisfaction with Care

LEP patients who need but do not get interpreters have lowest satisfaction with care (Baker et al. ’98)

• Significantly lower scores than EP patients on 5 satisfaction items and LEP patients who had interpreters on 3 items

• Needing but not getting interpreter strongly associated with lower overall adjusted satisfaction scores
Satisfaction

- Ratings of perceived physician behaviors were significantly lower by LES patients
  - Explanations
  - Friendliness
  - Respect & courtesy
  - Poor perception of problem by physician
  - Show of concern
What are the safety issues?

- LEP patients more likely to experience adverse events of serious nature
- Untrained bilingual staff and physicians with “false fluency” more likely to err in communication
- LEP patients have worse patient experiences (satisfaction, perception of MD, adherence)
Joint Commission study on adverse events

- Study of six hospitals over seven months
- 49.1 vs 29.5% of adverse events with LEP patients resulted in physical harm
- 46.8 vs 24.4% of adverse events with LEP patients classified as moderate transient to death
- LEP adverse events more likely to be due to communication error (52.4% vs 35.9%)

Supporting LEP: Points of contact

- Reception Registration
- Appointment
- Triage
- Provider Visit
- Check Out
- Lab XRay Rx

- Signage?
- Language Assess?
- Data?
- Dual appointment with interpreter?
- Translated forms?
- Multilingual Providers?
- Access to qualified interpreters?
- Documentation
- Dual appointment with interpreter?
- Multilingual Staff?
- Access to interpreter?
- Telephonic available?
The Collaborative
Language Services Improvement Collaborative

- November 2008
- Community Health Center Needs Assessment

A survey of community health centers completed to understand efforts to deliver qualified language services to LEP patients.
Survey components

• **Elements of the survey included:**
  
  – capacity to collect language data at the time of registration
  
  – workflow processes in place to link an interpreter to a patient appointment
  
  – level of training of staff providing interpreter services
  
  – efforts to assess skills of bilingual staff and use of emerging technologies for interpretation.
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<th>Always</th>
<th>Most of time</th>
<th>Some of time</th>
<th>Never</th>
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<td>18(56)</td>
<td>11(40)</td>
<td>1(4)</td>
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<td>Interpreter scheduled?</td>
<td>6(19)</td>
<td>6(19)</td>
<td>16(50)</td>
<td>4(12)</td>
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<td>Bilingual staff used?</td>
<td>6(19)</td>
<td>10(33)</td>
<td>13(43)</td>
<td>1(4)</td>
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<td>Bilingual provider used</td>
<td>3(9)</td>
<td>8(25)</td>
<td>20(63)</td>
<td>1(4)</td>
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<tr>
<td>Provider assessed?</td>
<td>4(12)</td>
<td>1(4)</td>
<td>6(19)</td>
<td>21(66)</td>
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## Results, N=32 (%)

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<tr>
<th>Function</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Professional interpreter used?</td>
<td>21(66)</td>
<td>11(34)</td>
</tr>
<tr>
<td>Bilingual Staff tested?</td>
<td>20(63)</td>
<td>12(37)</td>
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<tr>
<td>Telephonic used?</td>
<td>20(63)</td>
<td>12(37)</td>
</tr>
<tr>
<td>Family/friend used?</td>
<td>17(53)</td>
<td>15(47)</td>
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Language Services Improvement Collaborative

• January 2009 - Develop RFR & distribute
• February 2009: Six CHCs Selected
• Develop intervention curriculum
Elements of the Intervention

- Three collaborative meetings
- Site visits
- Monthly conference calls
- Interpreter services course
- Monthly narrative and data reports
Language Services Improvement Collaborative

- AIM, Goals & Strategies developed
- March 2009: First conference
- Intervention Phase begins
- Rapid cycle PDSA cycles initiated to achieve aims, goals and strategies
Data Collection & Feedback
Language Service Collaborative 1 (LSC 1)

- Screening for preferred language
- The percent of patients who have been screened for their preferred spoken language
- Report monthly
LS1 Measure Calculation

Total number of patients with preferred language screened and recorded

__________________________________________________________

Total number of patients in the health center
LS2 Measure Calculation

Total number of patients receiving medical care from an assessed and trained interpreter or assessed bilingual provider

Total number of patients that prefer care in a language other than English
LSC 3 Measure Calculation

Total number of bilingual staff who have been assessed for language proficiency

________________________________________

Total number of staff members that pre-identified that they provide medical care in a language other than English
LSC 4 Measure Calculation

Total number of providers who have been assessed for language proficiency

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Total number of providers that pre-identified that they provide medical care in a language other than English
Bilingual Providers

- Recent survey of MA CHC physicians revealed that 75% are speaking another language with patients.
Language proficiency scales exist

• Interagency Language Roundtable scale
  Level 0: No communication ability
  Level 1: Ask and answer uncomplicated topics about familiar topics
  Level 2: Give straightforward instructions but may use awkward phrasing
  Level 3: Communicate effectively in most social and professional settings
  Level 4: Near-fluent and sensitive to cultural nuances but trouble with slang
  Level 5: Communicate like natives
The danger in the middle

• Confuse knowledge of technical vocabulary with fluency

• May indicate knowledge of “medical Spanish”

Short, intensive language training in “medical Spanish” may diminish use of interpreters

False fluency

• Analysis revealed that health care providers made 76% of false fluency errors
  – 58% of errors occurred while interpreters out of room or on phone
  – Remaining 42% of errors made by providers without correction by interpreters
  – Providers 11 times more likely to make false fluency errors when professional hospital interpreters used (RR, 11.4; 95% CI, 1.7-76.2)
Massachusetts Language Services Quality Improvement Collaborative

Provides Medical Care in Languages Other than English

UMASS MEDICAL SCHOOL | COMMONWEALTH MEDICINE
Languages of CHC Providers

- Spanish: 11
- Portuguese: 4
- Chinese: 4
- Vietnamese: 0
- Other (French, Haitian): 2
How would you rate your level of fluency in Spanish?

- Excellent: 0
- Very Good: 2
- Good: 1
- Fair: 6
- Poor: 1

UMASS MEDICAL SCHOOL | COMMONWEALTH MEDICINE
Who’s Responded?

“Other” includes 3 nurse practitioners, 2 infectious disease, 1 preventive medicine, 1 nutritionist, 1 CRNP, and 1 diabetes educator
Ann E. White
Director, Quality Assessment
Joseph M. Smith Community Health Center
JOSEPH M. SMITH CHC

- Primary site serving the Allston/Brighton area of Boston
- Other sites: Waltham
  - 2 Boston Schools
  - Vision Center
Health Center Demographics

• Percent of population that is LEP: 47%/65%
• Percent of population in community that is LEP: not clear
• Predominant languages:

Of the 65-70% non English speaking:
40% are Spanish, 13% Portuguese and 6% are Thai and Vietnamese
We applied to be in the collaborative because....

- Our Interest in bridging cultural gaps (Theme of Schwartz Rounds)

- Patient Satisfaction scores

- Patient population needs/Opportunity to improve our services
Aim Statement and Goals

- **Aim Statement**: By 2/10, the % of LEP pts who will have a medical visit at the Allston site, conducted in their preferred language by a certified interpreter will increase by 30%
  - **Goal #1**: establish an accurate baseline of data points (e.g. need, resources)
  - **Goal #2**: Establish an Interpreter training program
  - **Goal #3**: Establish a provider language proficiency training program
Massachusetts Language Services Quality Improvement Collaborative

Most important accomplishments

• Enthusiasm of the HC staff for the project
• Multifaceted approach to improvement (formal course, conversational class, software, etc.)
• Improvement in interpretive services
• Sustainability
Influencing our success:

- Support of Senior Leadership
- IT department = Service Department
- “Peripheral players” contribution
- Staff willingness to share language expertise
Pearls of advice for other CHCs with respect to language services

• Composition of the team and the perceived influence of the members
• Capitalize on opportunity to make a positive difference in care
• Appeal to desire to learn and improve skills
Lessons Learned

1. The assumptions about what we thought patients wanted
2. There IS a difference between interpreters and medically-certified interpreters
Obstacles and challenges

1. Funding for our plans and activities
2. Team members work schedules
3. Bilingual staff comfortable with their level of proficiency
Future plans going forward

- Build **Interpreter templates** to facilitate pt scheduling to insure certified interpreter for app’ts; and to allow certified staff to use skills
- **Language line** ease
- Changes in **human resource** practices
- Continue w/classes, software use, testing,
One last note

- Our sincere THANKS to the MA League and the UMASS group
- We learned from others, our interest was piqued in a number of ways, the staff was incredibly accommodating, we learned....
Massachusetts Language Services Quality Improvement Collaborative

Helena Santos-Martins, MD

Medical Director

East Cambridge Health Center

Cambridge Health Alliance

May 6, 2010
East Cambridge Health Center

Background

- Primary care clinic
- Multidisciplinary center
- Speaking Together site
- Language Services Collaborative work focused on:
  - Adult practice providers
    - 4 MDs and 2 NPs
    - FTE: 4.35
  - Office visits only
East Cambridge Health Center

Patient Demographics

• ECHC adult practice (CY09):
  – **14,702 visits** (Total practice: 30,016 visits)
  – **4,941 patients** (total practice: 8,560 pts)
    • 3,889 patients (79%) speak language other than English
    • 3,655 patients (74%) Portuguese-speaking

• Cambridge community (ACS, 2006-2008)
  – ~90,000 total residents aged 5 years and over
  – 31% speak language other than English
  – Main Languages: Portuguese, Spanish, Haitian-Creole
We applied to be in the collaborative because....

• During *Speaking Together (ST)*, ECHC served as a pilot site for several language service improvement initiatives.

• In ST, identified further areas for improvement:
  – Improving the accuracy of language of care information
  – Improving the response options for a tool in the electronic medical record that allows providers to document how patient language needs were met during each clinical encounter
  – Assessing bilingual providers’ language proficiency
East Cambridge Health Center Team

• Helena Santos-Martins, MD
  Medical Director / Team Leader

• Izabel Arocha
  Cultural and Linguistic Educator & Multilingual Manager

• Lisia Caldeira
  Operations Supervisor

• Susan Choi
  Research Associate

• Abbot Cooper
  IT Applications Analyst
**AIM**
By February 2010, the percentage of adult LEP patients’ medical visits at ECHC in which they receive language services in their preferred language of care from either bilingual providers assessed for proficiency in that language or trained interpreters will increase by 20%.

**GOALS**
- Achieve 90% accuracy rate for preferred language of care documentation for all adult patients served at ECHC.
- Increase by 25% (from February 2009) the percentage of adult patients’ visits at ECHC that will have documentation of how patients’ language needs were met through the use of the Quick Questions tool.
- 50% of bilingual providers at ECHC will complete a language proficiency assessment for the non-English language in which they provide care.
**GOAL #1:** Achieve 90% accuracy rate for preferred language of care documentation for all adult patients served at ECHC.

**BACKGROUND:**
- Accurate language of care data necessary to ensure patients receive interpreting services or care from a language-concordant provider
- Two weeklong rounds of data collection in Spring 2009 by providers at ECHC found 13-20% error rate in language of care.
  - Errors may be due to patient learning English, clerical mistakes, changes not being made to minors’ language of care when they come of age.
  - Therefore need to check this information at every visit

**ACCOMPLISHMENTS:**
- 100% of patients get screened for their language of care at every visit
- Developed workflow to correct language of care
- Provided training to staff on rationale for checking language of care and best practices
- Changed EMR screen visible to registration staff to reflect language of care, not primary language
**GOAL #2:** Increase by 25% (from February 2009) the percentage of adult patients’ visits at ECHC that will have documentation of how patients’ language needs were met through the use of the Quick Questions tool.

**BACKGROUND**
- Need to better understand what is happening during encounters when LEP patients don’t receive language services from qualified language service providers → Documentation by providers helps identify problems to target
- Extensive piloting since 2008, but need 100% completion among providers

**ACCOMPLISHMENTS**
- Engaged key stakeholders, including CHA senior leadership and champions in IT/Nursing Informatics
- Refined response options based on stakeholder feedback
- Made completion of this question mandatory by providers for all office encounters - implemented October 2009
Language Services Pearls of Advice

- **Collect accurate data.**
  - Provide clear rationale and training to those collecting data.
    - For example, target language of care accuracy by training staff to pay attention to potential errors in the patient’s chart, be proactive about confirming information from patients, and correct when necessary.
    - Create feedback loops in which you regularly share information about data quality to those collecting the information.
  - Refine tools for data collection.
    - Take the time to pilot tools extensively.
    - Incorporate feedback from users to make tools as user-friendly as possible. There’s always room for improvement!
    - Harness the power of the EMR if possible!

- **Use the data that you collect for quality improvement.**
  - For example, using the Quick Questions data, we have identified that large numbers of providers are meeting patient language needs. This has fueled our provider language proficiency efforts.
Language Services Pearls of Advice

- **Be inclusive when seeking input.**
  - Get input from all involved in patient care (phones/FD/MAs/providers/interpreters/leadership, etc.)
  - Convene a workgroup of individuals with diverse skills and from all relevant departments.
    - For initiatives involving EMR, be sure to engage IT leadership early!
  - Seek targeted feedback about potential barriers. For example, work with providers to identify ways to address obstacles to institutionalizing language testing.

- **Get buy-in from leadership when seeking systems change.**
  - Mandatory Quick Question completion was only made possible through support of IT leadership.
  - Compliance and patient safety rationales are useful in securing leader buy-in.
East Cambridge Health Center
Obstacles & Challenges

• Reporting and data collection:
  - Increasing completion of the Quick Questions tool (~50% of LEP visits at start of collaborative) without a mandatory requirement.
  - Lower percentages of LEP patients getting qualified language services than expected (~50% throughout collaborative)

• Assessing language proficiency of bilingual providers
  - Piloted and identified test for use → 2 tests passed (Spanish & Portuguese) out of 7 total to be taken
  - Key issues to address:
    • How to engage senior leadership on this issue?
    • How to engage and incentivize providers? Address lack of time
    • What level of proficiency should be considered “passing”?
    • What should happen for providers who do not pass?
    • In lieu of institutionalized provider language testing, are there other measures that could be put in place to ensure safe communication?
**East Cambridge Health Center**

**Future Plans**

- **Engage in outreach to providers to:**
  - Determine the kinds of support that would enable language proficiency assessment and language learning
  - Identify potential barriers to making use of interpreter services.

- **Use data from the “Quick Questions” tool to:**
  - Identify patterns of language service usage
  - Design future quality improvement initiatives

- **Work with registration staff more closely** to develop a process whereby corrections to language of care information are made more efficiently.
Lessons Learned

• If a job requires bilingual skills, test before hiring
• Be sure registration staff are asking the right questions
  – “What language do you prefer while receiving health care?”
• Integrate a question on how language services are met in your EMR
• Get staff trained who are providing interpretation
• Consider increasing telephonic access
• Ensure a provider champion is engaged
• Test provider fluency