

Identifying patients with Limited English Proficiency and improving interpreter services

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Abstract

Of those 65 million individuals who speak another language at home, about 40% reports speaking English “less than very well” (United State Census Bureau, 2016). Those that speak another language “less than very well” can have Limited English Proficiency (LEP). The Health Services and Resource Administration (2018) defined LEP as “individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English” (n.p.). There are challenges associated with providing care for those with LEP. Those with LEP face greater health disparities and are at increased risk for having poorer health outcomes and dissatisfaction towards care. It is important to identify those with LEP and interpreter services should be offered. This was a multi-focus project aimed to improve access to healthcare for those with limited English proficiency by providing interpreter services and improving its practice.

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Problem Description

As the United States' population is exponentially growing, more and more people are indicating that they speak a language other than English. There are about 21% or roughly 65 million individuals in the United States that speak a language other than English (United States Census Bureau, 2016a). Of those that speak another language, about 40% reports speaking English less than "very well" (United State Census Bureau, 2016a). In comparison, in Portland, Oregon, 19% or about 110,000 individuals speak a language other than English and of those that speak another language 44% reports speaking English less than "very well" (United State Census Bureau, 2016b). Those that speak English less than "very well" may have Limited English Proficiency (LEP) and this is defined as "individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English" (Health Resources and Services Administration (HRSA), 2018, n.p.).

Those with LEP are at risk for unmet healthcare needs, delays in delivery of appropriate care, failure to receive preventative services, and preventable hospitalizations (Office of Disease Prevention and Health Promotion (ODPHP), 2018b). In efforts to provide optimal care for those with LEP, many organizations have identified interpreter services (IS) to be an important intervention. Title VI of the Civil Rights Act mandates beneficiaries of federal financial assistance to take the appropriate steps in ensuring their programs, services, and activities are accessible to persons with LEP and that includes providing IS (HRSA, 2018). In 2013, the Office of Minority Health developed standards titled National Standards for Culturally and Linguistically Appropriate Services (CLAS). CLAS was used to provide plans and strategies to guide individuals and healthcare organizations to deliver culturally and linguistically appropriate care at no cost. (U.S. Department of Health and Human Services, n.d.). The Institute of Medicine (IOM) also put forth efforts to address language and communication by releasing a publication

titled *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* (Nerenz, McFadden, & Ulmer, 2009). Healthy People 2020 also identified having limited language as a barrier to health access (ODPHP, 2018a; ODPHP, 2018b). As the United States is becoming more diverse, it is important for providers and healthcare organizations to provide culturally and linguistically appropriate care to those with LEP.

Available Knowledge

A literature review was conducted to assess data on patients with LEP and how it affects health outcomes and the current overall practice surrounding IS. The database use was PubMed and CINAHL Plus. A search was conducted using the terms “limited English Proficiency,” “interpreters,” and “health outcomes.” The filters used limit publication dates 2008-2018 to ensure the most recent and relevant data. Also, “full text” and “human” filters were also applied. PubMed search yielded 43 articles. CINAHL Plus yielded 9 articles. All articles were reviewed and a total of 20 articles were selected to be reviewed in this paper.

Another search was conducted using Google Chrome for government websites and health organizations such as United States Census Bureau (American Fact Finder search engine used for current data on languages spoken at home), United States Department of Health and Human Services (Think Cultural Health and Health Services and Resources Administration), Institute of Medicine and Healthy People for prevalence data and background assessment.

Those with LEP tend to have poorer health outcomes, be less likely to receive preventative services, have decreased access to care, lower adherence to management, and higher ED utilization and hospitalization (Fernández et al., 2017; Kim, Kim, Paasche-Orlow, Rose, and Hanchate, 2017; Jenny, Anderson, Le, Escobar-Chaves, and Reyes-Gibby, 2013; Njeru et al., 2015; Njeru et al., 2017; Ohtani, Suzuki, Takeuchi, & Uchida, 2015). Those with

LEP should be offered IS. The use of an interpreter has been linked to an improvement in quality of care by increasing communication, increasing patient satisfaction, better symptom management, and decreases in readmission rates with decreasing expenditures (Karliner, Pérez-Stable & Gregorich, 2017; Lee et al., 2017; Lor, Xiong, Schwei, Bowers & Jacobs, 2016; Silva et al., 2016).

Accurately identifying those with LEP so that language assistance is provided is crucial. However, there is limited research on what is the best method of identifying those with LEP. Patients are often missed and IS is not offered (Boscolo-Hightower, Rafton, Tolman, Zhou, & Ebel, 2014). A study conducted by Karliner, Napoles-Springer, Schillinger, Bibbins-Domingo, & Pérez-Stable (2008), found that the English proficiency question asked by the U.S. Census Bureau had a high sensitivity for identifying those that may benefit from IS if patients answered any option less than “very well”. On the Census-LEP item that asked, “how well do you speak English?” Options were as follows: “not at all,” “not well,” “well,” or “very well”. Individuals who responded that they speak English less than “very well” was the most sensitive. Those responding “not at all,” “not well,” or “well” should have a follow-up question asking “In general, in what language do you prefer to receive your medical care?” This follow-up question will allow providers to capture more patients that are likely to benefit from language assistance. A more recent study by Okrainec, Miller, Holcroft, Boivin, & Greenaway (2014), found that perhaps adding a self-reported ability to communicate can capture more patients with LEP. The study not only asked for patient’s preference but also self-reported proficiency and self-reported ability to communicate. Asking for patient’s preference alone is not sufficient in identifying those with LEP. A study by Balakrishnan, Roper, Cossey, Roman, & Jeanmonod (2016) found that the triage nurses misidentified 27% (n=15) their Spanish speaking patients to be English

proficient [odds ratio 39 (CI 5.0–305), $p < 0.0001$]. Thus, accurately identifying those with LEP is important.

Those who have LEP need to be offered interpreter services (IS) to ensure that important health information is obtained in an accurate manner so that effective and safe decisions can be made; however, a study done in an Emergency Department (ED) shows that only approximately 20% of patients who need an interpreter are offered IS (Ryan, Abbato, Greer, Vayne-Bossert, & Good, 2017). Overall, multiple studies show that interpreter services are highly underutilized (López, Rodriguez, Huerta, Soukup, & Hicks, 2015; Silva et al., 2016; Zurca et al., 2017). A study by López et al. (2015), reported that 65.8% of their patients who needed IS did not have a documented interpreter visit; thus, it is unclear if this could have simply been undocumented, physicians could have spoken the patient's language, or physicians opted to use family members. Better documentation is needed to capture the true sense of utilization.

It is not appropriate to use ad hoc interpreters. A certified medical interpreter must be utilized. Ad hoc interpreters are often identified as family members, friends, or staff that speak the language but are not formally trained to provide IS (Flores, Abreu, Barone, Bachur, & Lin, 2012). Even with professional medical interpreters that are utilized during patient encounters, this does not guarantee that patients will receive accurate health information and this can negatively affect patient outcomes. Alterations can occur during translation. Alterations to translation include: deletion/omission of words, addition of words, change in meaning by replacing words or phrases, editorialization where interpreters provided their own views and even false fluency where interpreter use a word/phrase that not does exist in the language being interpreted (Flores et al., 2012; Jackson, Nguyen, Hu, Harris, & Terasaki, 2010). In a study conducted by Jackson et al. (2010), audio-recorded encounters from routine outpatient visits

between patient and providers with translation services were transcribed and translated. The study found that 31% of all utterances contained an alteration (Jackson et al., 2010). Utterance was defined as the “unit of spoken content given to the interpreter to interpret (Jackson et al., 2010). Another study by Flores et al. (2012) found that ad hoc interpreters had twice the alterations as professional medical interpreters.

There are many types of professional medical interpreters such as in-person, telephonic, or video-assisted. In-person interpreters can also be certified bilingual providers. Various research has shown that there might not be a difference in the types of professional medical interpreters used as long as the patient was provided with any interpreter services (Crossman, Wiener, Roosevelt, Bajaj, & Hampers, 2010; Lion et al., 2015). A systematic review comparing the different types of interpreters did not find one mode to be more superior (Joseph, Garruba, & Melder, 2018).

According to a qualitative interview study by Lor et al. (2016), quality of interpreters is based on three factors. The factors are interpreter’s ability to deliver literal interpretation, cultural interpretation, and emotional interpretation (Lor et al., 2016). Efforts to educate providers on the techniques of how to work with medical professional interpreters and how to use interpreters have shown positive result. In order to ensure patient satisfaction in IS, providers must have a heightened awareness for providing care for those with LEP. When culturally appropriate care is not met, it can lead to dissatisfaction among both providers and patients (Hernandez et al., 2014; Lor et al., 2016).

Rationale

The project was based on the Model for Improvement (MFI). The MFI consist of a rapid cycle process of Plan, Do, Study, Act (PDSA). The model asks the following questions: (1)

“What are we trying to accomplish?” (2) “How will we know that a change is an improvement?” (3) What changes can we make that will result in improvement?” (Agency for Healthcare Research and Quality, 2013). This model will allow for continuous assessment and reassessment so that new interventions can be implemented to improve the overall goal. Improving access of interpreter services can be done with a multi-system approach and utilizing MFI can allow for change as newer literature is published within the community.

Specific Aims

The aim of the project was to improve access to healthcare for those with limited English proficiency by providing interpreter services and improving its practice.

Design and Method

Setting

The clinic to implement this project is a unique clinic that is not only affiliated with an academic institution, it is also a Federally Qualified Health Center (FQHC) that serves patients of all backgrounds. The clinic serves those that are of low income, lower education level, and multi-lingual. The clinic’s mission is to serve patients and communities through excellence in clinical care, education, research, and leadership.

Barriers and Facilitators

Since the clinic is part of an academic institution, the clinic strives for quality of care. It fosters a learning environment that is open to change and improvement. The clinic has multiple quality improvement projects (QIPs) occurring simultaneously, which can be a facilitating factor and a barrier as projects are divided among providers and staff. Consequently, engagement can vary according to projects. The Health Literacy committee held a meeting at the clinic and its attendees voiced interest and expressed excitement in participating in a QIP that can improve the

care of those with LEP. Also, the clinic has recently changed their electronic health record system to a new system. The clinic will anticipate some stress from this occurrence which may cause a lack of participation in a new project. However, a new electronic health record system can also mean that there is room for improvement.

The project was expected to be generalizable to other clinics especially those that are FQHC clinics. FQHC clinics qualify for federal funding and are responsible for having an ongoing quality assurance program. FQHC clinics tend to care for underserved communities, a wide-spectrum of illnesses, racially and ethnically diverse populations (Hamso, & Iyer, 2018). Providers at FQHC clinics also practice with a higher awareness for cost-conscious care as their patients are uninsured or have financial concerns (Hamso, & Iyer, 2018). This particular clinic is in a unique position as stated before that not only is it an academic institution but also a FQHC. Thus, FQHC with an academic institution partnership can have the advantage of extra funding or strong community referral network.

Participants/Population

The project included providers, staff, administration, contracted interpreter services, and patients requiring interpreter services. The goal of increasing IS for individuals with LEP is a multi-level approach; thus, requires multiple aspect of the healthcare team to contribute to its success. To increase provider and staff participation, the project leader built rapport with the clinic by visiting the clinic and going from each work pod to introduce the project. Providers and staff were also given the opportunity to discuss their views on the project and what they hope they can gain from the intervention.

Proposed Implementation and Outcome Evaluation

Intervention

The proposed intervention is a project aim at increasing access to IS. This will be a multi-focus project that will ultimately contribute to the aim. The design will be a pretest and posttest design. The first step of the intervention is to review the institution and clinic's policy on interpreter services and care surrounding those with LEP. Next, a qualitative process will occur where the project leader will observe current clinic's practice on how those with LEP are identified. This can be done by observing and interviewing staff and providers. The patient care coordinator will also be followed and interviewed as they are the first to interact with patients and set up appointments. The contracted interpreter service will be contacted to learn their process of providing services once a request from the clinic is in place. Suggestions for improvement or a screening tool to identify those with LEP will be adapted from previously mentioned studies and implemented if one is not in place.

The next intervention is to increase patient knowledge on interpreter services. The clinic setting will also be observed for signs or ways for patients to recognize that they have the right to ask for an interpreter.

Next, the intervention will include an education component that will include current clinic policy as well as the current best practice surrounding the care for those with LEP. This will increase staff and provider awareness on the importance of providing quality care for those with LEP.

Measures/Outcomes

The primary outcome for this project was to increase access to IS. Increase in access to IS will be measured by obtaining baseline data on current number of those that identify to speak another language as well as the number of interpreter services used. Data will be extrapolated from the electronic health record (EHR). A run chart will be kept each month of intervention to

see if there are any changes. Chi-square test will test for statistical significance pre- and post-intervention.

After the project is completed, recommendations to leadership regarding current procedure can be given. A potential for a change in the way the current clinic practices is a possibility with continuous PDSA cycle. Ongoing assessment can be taken on by the current Health Literacy committee or a new committee can be developed to ensure further commitment and success. Failure of quality improvement project would be for the clinic to discontinue their focus on language barriers overall.

Ethical Considerations

There is no potential conflict of interest for this project. Ethical considerations for this project would be to ensure that any interview of staff and providers are de-identified. The second consideration would be to protect patient identity when extrapolating data from the EHR.

Implementation of Project

The project was implemented from January 2019 to March 2019. As indicated previously, this project was a multi-focus approach. The first step was to understand the workflow and role of the clinic, the role of the Language Service Department, and the role of the Registration Service Department. All three entities were separately interviewed in a semi-structured approach. The Registration Service Department was interviewed through phone interview and only one representative was available. The Language Service Department was interviewed in-person and two representatives was interviewed simultaneously. A total of 18 clinic staff and providers were interviewed; however, not all staff answered every question as some question did not apply to their role or they chose not to answer. The Registration Service Department was included because they collected patient address, social security number, phone

number, insurance information, and special requirements including patient's preferred language prior to the patient's first visit with the clinic. After the initial interview with the Registration Service Department, the department had asked to not be further involved in the project.

Appendix 1 outlined the sample questions. Appendix 2 outlined the response from the Registration Service Department. Appendix 3 outlined the response from the Language Service Department. Table 1-3 outlined the response from the staff and provider of the clinic.

When asked of the staff and providers whether there was a policy on providing IS for those with LEP, 78% (n=14) said no. Some of the comments were the following: "I have never seen a policy," "I know that (the) policy exist, but I've never looked," "the policy is hard to find." When staff and providers were asked, "How do you know if your patients need interpreter services?" 88% (n=15) indicated that they refer to the EPIC Banner. While 39% (n=7) state that they use personal experience to judge how the encounter is going and if the patient appears to not understand then they will get an interpreter. 28% (n=5) said the patient will be the one to ask for an interpreter and 11% (n=2) will look at the appointment note to see if an interpreter is needed. The interviewee from the Registration Service Department (appendix 2) also indicated that they identify LEP patients with the EPIC banner. This means that the Epic Banner is a tool that is highly used by staff and providers to help identify LEP patients.

When asked if staff and provider had a personal scripted screening tool to help identify patients who would need an interpreter, 88% (n=14) answered, "no." 23% (n=2) said, "yes." (To clarify, a scripted screening tool is a systematic way to ask the patient if they need an interpreter so that one can be provided). The two participants who said "yes" were providers who have had training in caring for LEP patients. One person stated, "I will ask, 'Do you speak another language or do you prefer medical interpretation?' It is well received, but sometimes patients still

refuse (interpreter services)." A statement from a staff who answered "no" stated, "I don't usually ask the patient because I'm not the first point of contact."

When asked if staff and providers have "ever perceived care was misdirected due to patient speaking another language?" 92% (n=12) said "yes" and 8% (n=1) said "no." Common theme was miscommunication and delay in care. A provider stated, a "patient misunderstood directions and stopped all medications." Someone else stated, "No interpreter was present (at the visit) and Spanglish was used." Another statement included, "I went into the room and patient did not have interpreter present. I observed the patient might have trouble understanding and so I asked if patient would like interpreter and they said yes. It was assumed the patient did not need interpreter."

When asked "how do you prefer to provider interpreter services to your patients", an overwhelmingly majority stated that they prefer face-to-face interpretation (92%; n=11) while only 1 person answered both in-person and telephonic. Reasons for why face-to-face was preferred included the following: more personable, better communication, phone is not efficient, there is the body language component, it is more trauma informed care (especially for refugees). A reason why telephonic was preferred was because for smaller communities there can have a limited number of interpreters. The patient may personally know the interpreter and so there are confidentiality issues.

21% (n=3) of clinic staff and providers have had training with interpreter use and 46 % (n=6) have had training in caring for those with LEP. Many of those who have had training were more likely to be providers than staff.

Table 2 outlined the barriers and facilitators of providing interpreter services. There were many that were identified. The top four barriers to providing interpreter services included the

following: limit number of languages available, face-to-face rarely available, limited appointment time allotted, various phone issues. The top 4 facilitators to providing interpreter services included the following: more face-to-face availability, more interpreters and/or more dialect available, training on how to interact with interpreters, streamline the process of scheduling interpreters.

A second part of the intervention was to provide staff education on interpreter services and LEP in hopes that it can improve the practice surrounding interpreter services and LEP patients. Based on the findings of the interviews, the University's policy, and current evidence, a best practice guideline PowerPoint presentation was created. For example, staff indicated that a barrier to providing services was not knowing the workflow and the need for the process of requesting an interpreter to be more streamline. The best practice guideline addressed this issue by reinforcing the current gaps and answering questions staff had. Accuracy was confirmed with the Language Service Department as they are the department that handle all requests. The best practice guideline PowerPoint presentation was presented during the clinic quality improvement committee meeting. The presentation was also presented another two times on a separate week so that those who could not attend the first time, could have a chance to attend the second time. The presentation was also voice recorded and sent to the patient care coordinator and the Language Service Department as they could not attend the presentation. The overall, response to the presentation was well received and the clinic had a positive response to the best practice guideline presentation.

A third component of the intervention was to increase patient knowledge on interpreter services by observing for signs or ways for patients to recognize that they have the right to ask for an interpreter. The clinic did have a notice displayed in the waiting area informing patients of

their rights to an interpreter; however, it was hung in a hallway with small fonts, not easily found by patients. This was mentioned to the clinic and the clinic's health literacy committee discussed this finding at their following meeting to make the clinic more patient friendly for LEP patients.

Outcomes

Originally, the project was a pre- and post-test intervention that aimed to measure baseline data on current number of those that identify to speak another language as well as the number of IS used. Data would have been extrapolated from the EHR. This was not possible. There currently is not a way to track which interpreter modality was used for each patient. There was a possibility of doing an individual chart review to see if providers chart whether an interpreter was used and via which method. However, due to the project being 3 months long, there was not enough time to request an Institutional Review Board approval and complete a chart review. Even if a chart review was completed, currently there is no uniform practice on charting whether an interpreter was use during the visit and via which modality was requested. The Language Service Department was able to electronically pull data on how many face-to-face interpreters was used by the clinic each month (Table 4); however, it did not include phone interpreters and so overall utilization could not be compared to indicate whether there was an increase in access of interpreter services. Also, there was no data on how many total patients needed interpreter each month. Patient's access healthcare different points of the year and the reason for access can vary. Thus, the total number of patients identified as LEP per month compared to how many accessed face-to-face and/or phone interpreters would have been valuable.

Table 5 report all the languages preference charted in EPIC for the clinic. It was hope that the data from this table can indicate whether there was an increase in identifying patients with

LEP. A pre- and post-test analysis was also not possible with this data as the data included “unknown” and “unidentified.” It is unclear if “unknown” was marked because the patient’s language preference was not available in EPIC or whether it was because it was not recorded. It is also unclear if “unidentified” was because the patient was not asked of their preferred language or if they did not want to provide one. If the category “unknown” and “unidentified” was added to alternative language other than English-speaking then there is a risk the chance of over-capturing patients who speak another language other than English. If the category “unknown” and “unidentified” was not included in the alternative language other than English-speaking, then there is a risk for under-capturing patients who speak another language other than English. As mentioned in previously, accurately identifying LEP is crucial so that IS can be provided (Karlner, Napoles-Springer, Schillinger, Bibbins-Domingo, & Pérez-Stable, 2008; Okrainec, Miller, Holcroft, Boivin, & Greenaway, 2014). It is known in literature that healthcare personnel tend to overestimate patient’s English proficiency (Balakrishnan et al., 2016). Table 5 indicate that the clinic’s LEP population is approximately 5-8% depending on if the “unknown” and “unidentified” group was included. The clinic is a FQHC that serves patients of all backgrounds. The clinic is also located right in the city of Portland; however, the reported LEP patients that served at the clinic is well below the reported national (21%) and city (19%) data. This raises the question of whether the LEP patients are under-captured (United State Census Bureau, 2016a; 2016b).

Although an end analysis could not be calculated, to indicate whether there truly was an improved access to healthcare for those with limited English proficiency. There was valuable information from the interviews with the clinic staff and providers. The information not only

help guide the best practice guideline, it helped identify gaps surrounding LEP patients at the clinic.

After investigating the roles of staff at the clinic, it was found that the new patient coordinator played an important role in initially identifying those with LEP and entering the information into EPIC. Figure 1 illustrates each time a new patient makes contact with the organization up until their first visit. Points of contact are important because they can be opportunities to identify LEP patients and offer interpreter services. A staff member stated, "I don't usually ask the patient (for their preferred language) because I'm not the first point of contact." This finding can stress the importance of the role of the person who originally is entering the patient's preferred language (the patient care coordinator) or it can highlight a gap in health care and patients are not being asked for their preferred language. Under-capturing patients with LEP can mean underutilization of interpreter services (Boscolo-Hightower, et al., 2014). Since many staff and providers indicate that the EPIC banner was the first place they check for patient's language preference (83%, n=15), it is important that it is captured correctly. Capturing patient's language preference is also important for future data collection and clinic research. A response from a staff member at the clinic indicates that there is a possibility of under-capturing, "I went into room and patient did not have interpreter present. I observed the patient might have trouble understanding and so I asked if patient would like interpreter and they said yes. It was assumed the patient did not need interpreter." A temporary screening tool was implemented with the new patient care coordinator at the clinic for 2 months during the time the project took place. The screening tool was adapted from Okrainec et al. (2014). The purpose was to see if this can help better identify patients with LEP, improve interpreter service practice and ultimately lead to an increase in IS utilization. The new patient care coordinator was asked to implement the screening

tool on all new patients and keep track of every time it was used and to make note of why it was not used. By the end of two weeks, it was found that the screening tool was not used on all patients as intended. As stated by the user, “I did not ask everyone. I didn’t want the patient to yell at me if they could speak English.” If the patient “sound” proficient, the screening tool was not used. Limitations to why the screening tool did not work was because there was a fear of asking patients if they spoke another language other than English. There appears to be a stigma around asking patients for their preferred language. Although research has shown that patient’s English proficiency were overestimated, upon literature review, there is no clear answer as to whether healthcare personal have their own bias and are not asking the patient’s preferred language or whether they have a fear of asking (Balakrishnan et al., 2016). The clinic staff and providers also report that they do not ask patients (88%, n=14) if they need an interpreter. It is unclear if this is because the banner is the number one tool used as reported or because there is a fear or asking?

The results of the questionnaire were shared with clinic staff and providers during the best practice guideline PowerPoint Presentation. Attendees expressed surprise to see that many staff and providers perceived that healthcare was misdirected within their own clinic. This led to an open discussion on how staff and providers can improve practice. At the end of the project, the best practice guideline presentation was made into a Word document and shared with the clinic for use. Figure 2 outlines the table of contents of the best practice guideline. A list of recommendations was also given to the Language Service Department and the clinic to help fill the gap in practice. A decision flowsheet (figure 3) on whether an in-person or telephonic visit was indicated was also created for the Language Service Department, whether it will be adapted is at the discretion of the department. Per literature, there is no superior modality; however, an

overwhelmingly majority of the clinic prefer to use face-to-face (92%, n=11). The Language Service Department stated that face-to-face interpretation was more-costly than phone interpreter. Staff have also mentioned that there was a limited number of interpreters available. A decision flowsheet may help aid in managing current resources.

Practice-related implications and recommendations

Although this project was not able to perform a pre- and post-test analysis to definitively observe whether there was an increase in access in interpreter services or an overall improvement in interpreter services, staff did respond well to the best practice guideline.

It is recommended that the clinic review the best practice guideline and reflect on their own practices and change the best practice guideline as new evidence surrounding the care of LEP emerges.

It is also recommended that the clinic and other clinics who wish to capture utilization of interpreter services adapt a “smartphrase” in EPIC so that all documentation of interpreter services can be recorded in an accurate manner. This way, future data can be extrapolated and research on the data can be analyzed. The “smartphrase” should include whether an interpreter was used, which modality, name of interpreter, and interpreter number.

There are questions on whether there is stigma surrounding the topic of asking for the patient’s language preference. Another study interviewing staff and providers sentiments regarding this topic can provide insight on this topic. A study recording how often patients are asked about their language preference or whether they need interpreter services can also provide some insight on if they patient is being asked about their preference.

Limitations

There were many limitations to this project. First the time to implement this project was only 3 months. If there was more time, then the project could have been modified to meet the aim of the project. The Model for Improvement was utilized for this project because it allowed for continuous assessment and reassessment so that new interventions can be implemented to improve the overall goal. Another limitation was that the best practice guideline was developed using the response from the clinic and staff; thus, what is presented and the way it was presented is specific to the clinic and cannot be generalized to other clinics. Another limitation was that the number of participating staff and providers were low. An email was sent out for recruitment but only 1 person replied. To get more participants, this co-investigator went to each pod and sought participants in between patient appointment times. Another limitation was that the Language Service Department indicated that they were going through internal changes. Thus, no major changes could be implemented without the approval of the department and a list of recommendations was given to the department post-intervention.

Summary and Next Steps

Overall, the data obtained from this project can be seen as valuable as it details insights from staff and providers. There is much room for improvement. If there is a better way to track interpreter service utilization and patient language preferences accurately, then a month to month analysis can be done and this will allow the clinic to track their progress. As mentioned before, this project is intended to allow for continuous assessment and reassessment so that new interventions can be implemented to improve the overall goal, which is to increase access to healthcare for those with LEP. Whether or not this project continues on depends on if there is a committee within the clinic that is able to carry on the project. There were some questions

surrounding stigma of asking for patient preference that was raised. It would be valuable to see future research on this topic.

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Appendix 1

Interview questions for each department/role:

1. Registration department staff of the organization:
 - a. Do you have a scripted screening tool to identify patients who may need interpreter services?
 - b. How do you know if your patient's need interpreter services?
 - c. Do you have a policy on providing interpreter services for those with LEP?
2. Staff and providers at clinic:
 - a. Do you have a policy on providing interpreter services for those with LEP?
 - b. Do you have a scripted screening tool to identify patients need interpreter?
 - c. How do you know if your patients need interpreter services?
 - d. How do you prefer to provide interpreter services to your patients?
 - e. What is the percentage of LEP (limited English Proficiency) patient volume of your panel? (low<10%, medium 10-30%, high >30%)
 - f. What do you consider your overall self-efficacy in caring for LEP patients? (high or low?)
 - g. Have you ever perceived care was misdirected due to patient speaking another language? (yes or no)
 - h. Have you had training in interpreter use? (yes or no?)
 - i. How is your interpreter experience? (low, moderate, or high)?
 - j. Do you have any training in caring for those with LEP? (yes or no?)
***Questions d-i adapted from Hernandez et al., 2014.
 - k. What barriers do you have to providing interpreter services?
 - l. What facilitating factors can you identify that improve interpreter services?
3. Staff from interpreter services department:
 - a. Do you have a policy on providing interpreter services for those with LEP?
 - b. How far in advance do providers have to request an in-person interpreter?
 - c. What barriers do you have to providing interpreter services?
 - d. What facilitating factors can you identify that improve interpreter services?
 - e. What kind of training do your interpreters have to go through?
 - f. Are there an annual competency review?

Staff and providers may be asked clarifying questions or questions that is not included in this list.

Appendix 2

The semi-structured interview was conducted with 1 person from the Registration Service Department over the phone. When asked, “Do you have a scripted screening tool to identify patients who may need interpreter services?” the staff state that, “we usually do not ask what the patient preferred language is because when the patient calls in to registration, they have been transferred in, and on top of the banner in EPIC they already have their preferred language.” The interviewee also state that they are not the first point of contact for patients at the clinic because the clinic will refer the patient to registration. The interviewee added that sometimes there can be a mismatch in the Epic banner where patient might need an interpreter. “Judging from the patient’s voice, I would ask if they need an interpreter or sometimes the patient will ask for an interpreter.”

Appendix 3

The semi-structured interview was conducted with 2 people simultaneously from the Language Service Department in person. The interviewees indicated that they recently updated the University's policy on providing care for those with LEP. One of their roles is to manage requests from various departments for face-to-face interpreter. They also preschedule phone-interpreters for rare languages. The interviewee indicate that they manage roughly 3000 requests for entire university monthly.

Barriers to providing interpreter services includes the following: short noticed requests, languages not available even if they had enough time schedule, and prescheduled phone interpreter is scheduled but providers are running late on appointment times. Facilitators to providing interpreter services includes the following: Requesting interpreter at least 2 weeks in advance, call the department if there is a canceled appointment so that resources are allocated elsewhere, do not copy forward notes that state "PTL FF" because this was made by the Language Service Department previously to let them know that interpreter was requested, clinics knowing when to use face-to-face interpreter and when to use phone interpreter, and send an email to department if a request is made less than 48 hours to ensure that they are aware of the request.

There are two servicers for interpretation services. One is the universities own interpreter; however, they mainly on the inpatient side and is not available for outpatient use. The second servicer is an outside vendor that works closely with the university. All interpreters are recognized with the Oregon Health Authority and must have national certifications and have continuing education hours per their board. The Language Service Department is indicating that they are going through internal changes and hope to implement new projects/policies that will

unify the practices surrounding language throughout the University. Any major changes in practices within the clinic, the department needs to be made aware.

Table 1.
Interview questions with staff at clinic

Questions	N	n	%
Role	18		
Medical Assistants		4	22%
Team Coordinators		3	17%
Pharmacist		1	6%
Front Desk		3	17%
Registered Nurse		1	6%
Providers		5	28%
Do the clinic have a policy on providing interpreter services for those with LEP?	18		
Yes		4	22%
No		14	78%
Do you have a scripted screening tool to identify patients need interpreter?	16		
Yes		2	13%
No		14	88%
How do you know if your patients need interpreter services? (can have multiple answers per person)	18		
Banner		15	83%
Personal experience		7	39%
Patient will indicate		5	28%
Appointment note will indicate		2	11%
How do you prefer to provide interpreter services to your patients? (can have multiple answers per person)	12		
Face-to-Face		11	92%
Telephonic		0	0%
Both, Depends on patient population/situation		1	8%
What is the percentage of LEP (limited English Proficiency) patient volume of your panel? (low<10%, medium 10-30%, high >30%)	5		
low <10%		3	60%
medium 10-30%		0	0%
high >30%		0	0%
No response/Unsure		2	40%
What do you consider your overall self-efficacy in caring for LEP patients? (high or low?)	13		
low		2	15%
high		7	54%
*moderate		4	31%
Have you ever perceived care was misdirected due to patient speaking another language? (yes or no)	13		
Yes		12	92%

No		1	8%
Have you had training in interpreter use? (yes or no?)	14		
Yes		3	21%
No		11	79%
How is your interpreter experience? (low, moderate, or high)?	8		
low		3	38%
moderate		5	63%
high		0	0%
Do you have any training in caring for those with LEP? (yes or no?)	13		
Yes		6	46%
No		8	62%
Notes: Total staff interviewed at Richmond =18 Some staff chose not to answer certain questions or the questions did not apply to their role. Question 3: OHSU clinics do not utilize remote video interpreters Question 4: Applies to providers only Question 5: Original answer included high or low; however, participants added their own response to include "moderate"			

Table 2.
Barriers and facilitators of providing interpreter services

	N	n	%
What barriers do you have to providing interpreter services?	18		
Limit number of languages available		4	22%
Face-to-face rarely available		4	22%
Limited appointment time		4	22%
Phone issues: too static, volume low, miss nonverbal cues, no human element (patient does not disclose as much), long waits that affect work flow/appointment time		3	17%
Message get lost in translation		2	11%
Unsure if interpreter is scheduled for appointment and coming to appoint.		2	11%
Quality of interpreters		2	11%
Interpreter late to appointments		2	11%
Using ad-hoc interpreters: family not interpreting correctly		2	11%
Not able to test to be bilingual provider because spoken language is not available.		1	6%
Patient Confidentiality		1	6%
Patients feel offended when we ask if they need interpreters		1	6%
Family schedule appointment for patient but does not mention they need interpreter.		1	6%
No barriers to providing interpreter services		1	6%
What facilitating factors can you identify that improve interpreter services?	18		
More face-to-face availability		6	33%

More interpreters and/or more dialects	4	22%
Training on how to interact with interpreters for staff	3	17%
Streamline the process on scheduling interpreters	3	17%
Improve telephone quality:	2	11%
Availability of Remote Video Interpreter	1	6%
More Epic training	1	6%
SBIRT/PH9 available in multiple languages	1	6%
Provide patient education on what interpreters can and cannot do	1	6%
In-house translators	1	6%
Identify more patients who speaks English but might benefit from interpreter in medical environment	1	6%
Improving patient confidence in interpreter use	1	6%
Interpreter is confident in their translation	1	6%
No facilitating factors to providing interpreter services	1	6%
*note: Both questions were free response with multiple responses		

Table 3.

Qualitative responses from staff

Do you have a policy on providing interpreter services for those with LEP?	"the policy is hard to find" "I know that policy exist but I've never looked" "I've never seen one"
Do you have a scripted screening tool to identify patients need interpreter?	"I don't usually ask the patient because I'm not the first point of contact" "I will ask 'Do you speak another language or do you prefer medical interpretation?' It is well received but sometimes patients still refuse (interpreter services)"
How do you know if your patient's need interpreter services?	"we will start the visit and if I see the patient having trouble understanding then I will get interpreter" "OCHIN use to have interpreter yes/no section in addition to language. Now it's only preferred language"
How do you prefer to provide interpreter services to your patients?	Why staff prefer face to face: personable, better communication, phone is not efficient, body language component, trauma informed care (esp. for refugees) Why staff prefer telephone: Smaller communities can have limited interpreters and so there are confidentiality issues, due to nature of role

<p>Have you ever perceived care was misdirected due to patient speaking another language?</p>	<p>Themes: miscommunication, delays in care "patient who request that daughter interpret but she was interpreting for two patients in different rooms. I felt visit was rushed because daughter needed to go to next room. "Patient misunderstood directions and stopped all medication" "No interpreter was present and Spanglish was used for visit" "I went into room and patient did not have interpreter present. I observed the patient might have trouble understanding and so I asked if patient would like interpreter and they said yes. It was assumed the patient did not need interpreter."</p>
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Table 4.
 Number of Face-to-Face Interpreter used by clinic per month

	November	December	Jan	Feb	March
American Sign Language (ASL)	18	7	3	10	
Arabic			2	4	
Chinese Cantonese		2	1	3	2
Karen		1	1	1	
Khmer					1
Lao (Laotian)					1
Mai Mai		1	1	1	
Mandarin		1			
Mien					
Russian	1		1	1	
Somali	1	1		1	
Spanish		1	4	7	3
Swahili		1			
Tactile Sign	2	2	2	1	
Tagalog					
Vietnamese	3	2	3	1	2
Grand Total	25	19	18	30	9

Note: *Data includes only face-to-face request in Epic. No data on phone interpreter	
*March data was only extrapolated up until the 24th of the month.	

Table 5.

Patient language preference at the clinic

Language	Dec	Jan	Feb	March
*Unspecified	144	155	160	167
Acholi	1	1	1	1
Albanian	8	9	9	9
Amharic	7	8	8	8
Arabic	28	29	30	30
Bengali	2	2	2	2
Bosnian	14	14	14	15
Burmese	15	14	14	15
Cantonese	123	122	127	129
Chuukese	4	4	4	4
Croatian	2	2	2	2
Czech	1	1	1	1
Dari	2	2	2	2
Egyptian	1	1	1	1
English	16035	16780	17009	17244
Farsi	17	18	18	18
French	5	5	5	5
French-Creole	1	1	1	1
Haitian Creole	1	1	1	1
Hindi	3	3	3	3
Hmong	3	3	3	3
Italian	1	1	1	1
Japanese	3	5	7	7
Karen	1	2	2	2
Kayah (Karenni)	1	1	1	1
Khmer	34	35	35	35
Kinyarwanda	3	3	3	3
Korean	9	9	9	9
Krahn (East)	1	1	1	1
Krio	1	1	1	1
Kurdish	1	1	1	1
Laotian	6	6	6	6
Mai-Mai	7	7	7	7
Mandarin	22	23	23	23
Mien	7	7	8	8

Nepali	1	1	1	1
Persian	1	1	1	1
Punjabi	1	0	0	0
Rohingya	3	3	3	3
Romanian	14	15	15	15
Russian	108	106	108	110
Samoan	2	2	2	2
Serbo-Croatian	4	4	4	4
Sign Language	33	35	35	36
Somali	34	35	35	35
Spanish	345	335	353	356
Swahili	4	4	4	4
Tactile to Sign	2	2	2	2
Tagalog	11	11	11	11
Taishanese	3	5	5	5
Thai	9	9	10	10
Tibetan	2	2	2	2
Tigrinya	9	9	9	9
Tonga	1	1	1	1
Ukrainian	5	7	8	8
Unknown	249	207	210	215
Urdu	1	1	1	1
Vietnamese	94	93	96	96
Zomi	7	9	9	10
Sum	17457	18174	18445	18703
English	16035	16780	17009	17244
Alt Language	1422	1394	1436	1459
% of alt language	8.15%	7.67%	7.79%	7.80%
Alt Language without "unspecified" are presumed English speaking	1278	1239	1276	1292
% Alt Language without "unspecified"	7.32%	6.82%	6.92%	6.91%
Alt Language without "unknown" and "unspecified" are presumed English Speaking	1029	1032	1066	1077
% Alt Language without "unknown" and "unspecified"	5.89%	5.68%	5.78%	5.76%

Figure 1.

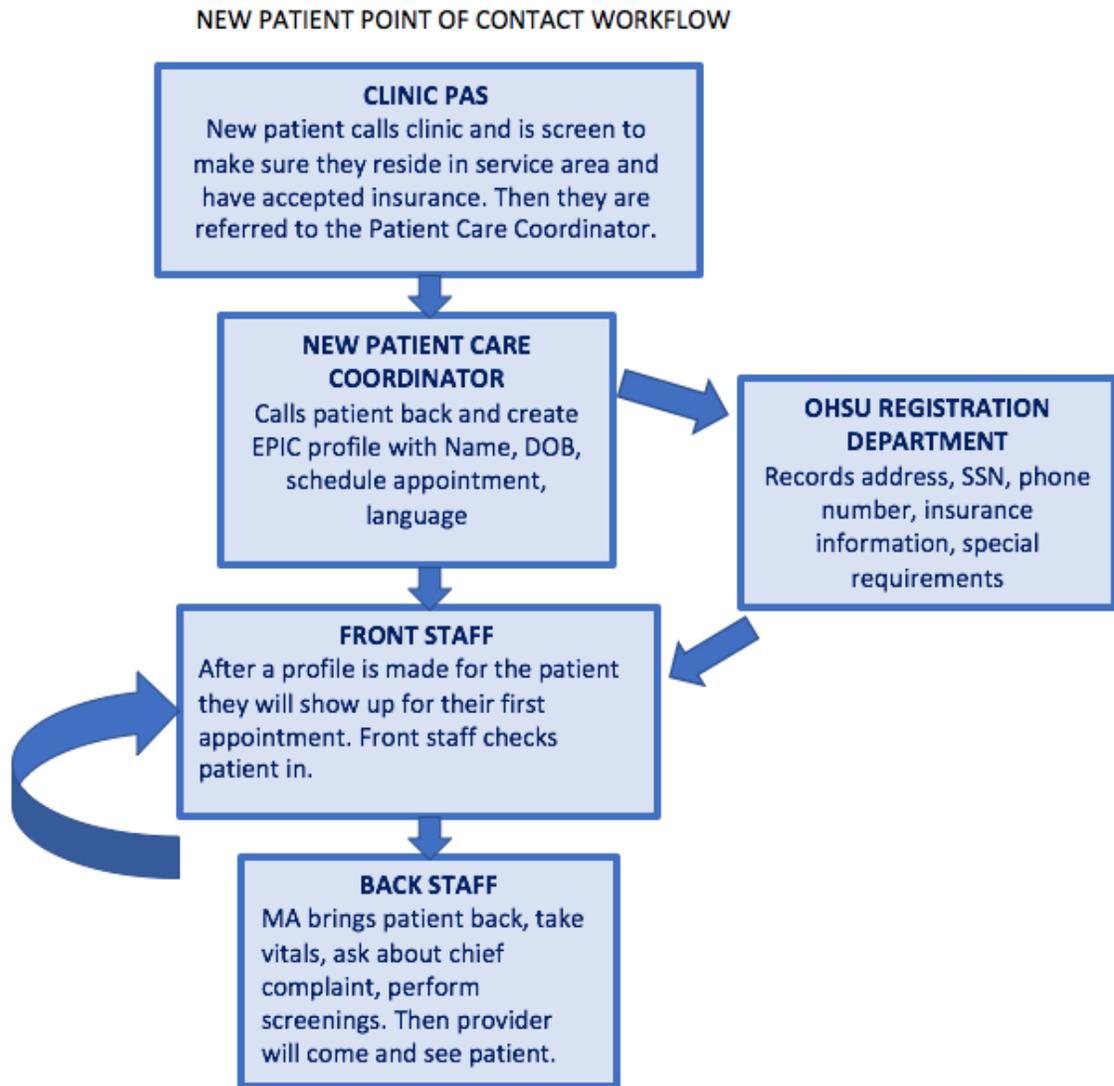


Figure 2.

Clinic Best Practice Guideline: Caring those with Limited English Proficiency

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Figure 3.

