

Talking With Patients

How Hospitals Use Bilingual Clinicians and Staff to Care for Patients with Language Needs

Issue Brief: Survey Findings

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It is an exciting time for language services. Improving access to language services in health care settings has become a focal point for health reform and disparities-focused legislation, in recognition of the increasing linguistic and cultural diversity of individuals across the nation. Bilingual staff and clinicians can serve as enormously valuable resources to hospitals and other health care organizations, offering a critical set of skills to interact with individuals who require care in a language other than English. Bilingual clinicians can serve a vital need for hospitals by providing high-quality health care, improving patient safety, and meeting organizational priorities to provide linguistically and culturally appropriate care for patients.

We spoke with human resources directors at 899 hospitals around the country to learn how hospitals are using physicians, nurses, and other staff and clinicians as resources for communicating with patients in languages other than English.¹ The majority of hospitals care for patients with language needs, with 74 percent of hospitals serving patients whose primary language is not English. Of these hospitals, nearly three-quarters reported seeing patients with limited English proficiency (LEP) on a daily or weekly basis.

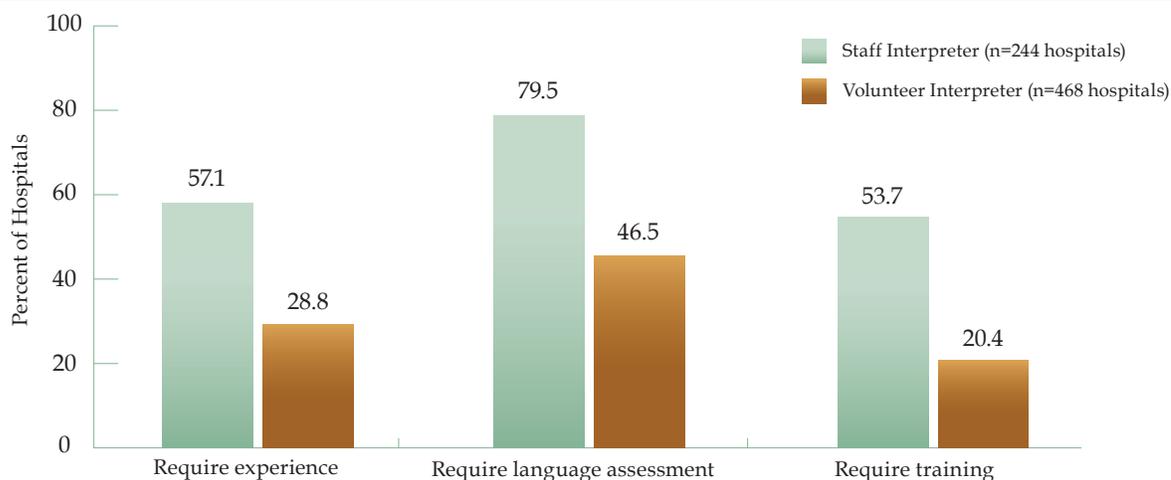
Quality of Bilingual Resources

Volunteers can provide high-quality and valuable resources for language services if they are appropriately trained and properly assessed for language fluency. However, our study shows that patients receiving interpreter services from volunteer interpreters are likely to be served by interpreters whose qualifications or language proficiency have not been verified by the hospital. Hospitals generally apply less rigorous assessment requirements for volunteer interpreters than staff interpreters, with fewer than half of hospitals requiring volunteer interpreters to have their language assessed (see Figure 1). Only one in four hospitals require volunteer interpreters to have experience or medical interpreter training. This often occurs even when volunteer interpreters serve in the same capacity as staff interpreters.

Hospitals appear to use volunteer interpreters differently than other volunteers in the hospital, and essentially deputize often untrained individuals to assume a critical place on the health care team. For example, volunteer interpreters are expected to provide essential information in critical communication with patients, such as taking a patient's medical history or providing discharge instructions. Half of the hospitals in the country use

Figure 1

Requirements for Staff and Volunteer Interpreters



Source: George Washington University, 2008; weighted data

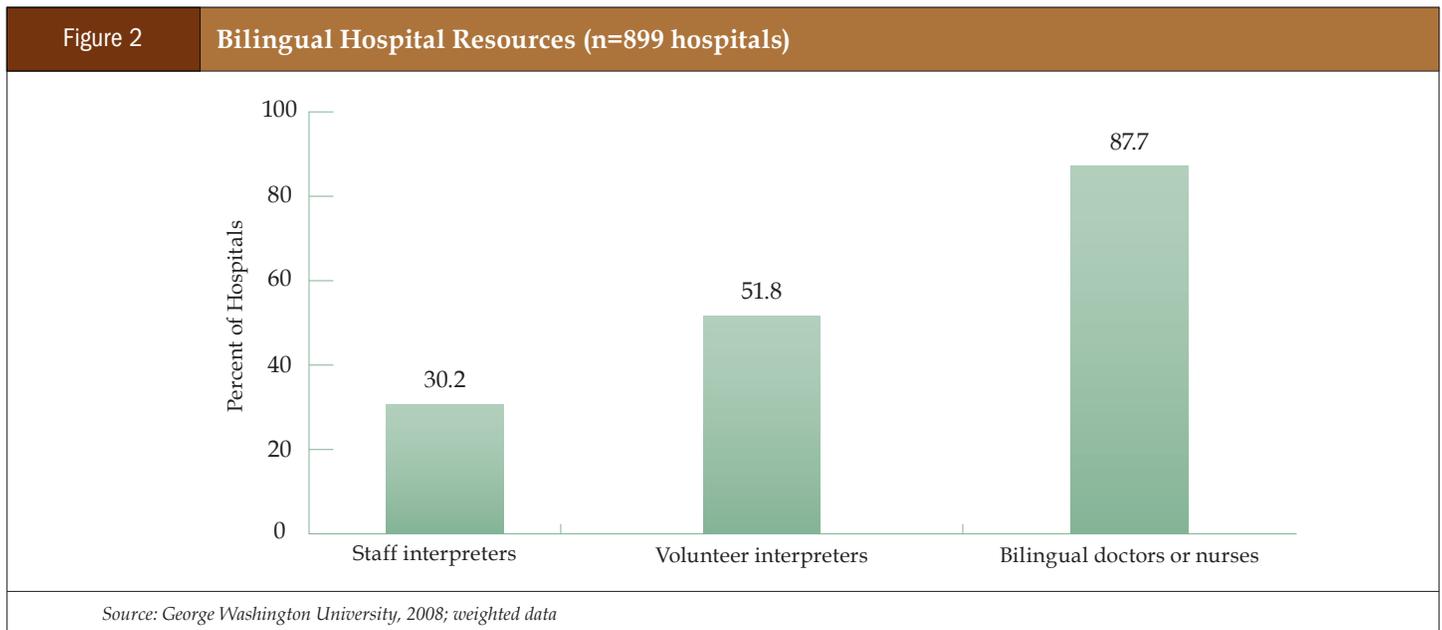
volunteer interpreters, while only three out of ten hospitals hire interpreters as staff (see Figure 2). The implications for safety and quality are enormous under this scenario, and emphasize the importance of ensuring the language proficiency and competency of volunteer interpreters.

Similar concerns are raised with the use of non-interpreter staff for communicating with patients in languages other than English. Effectively using the resources available through bilingual clinicians and staff can be challenging for hospitals. Too few hospitals have policies about how to use non-interpreter staff in communicating with patients; only 28 percent of hospitals have policies related to the use of bilingual doctors and nurses serving as interpreters (data not shown). Only 18 percent of hospitals with bilingual doctors or nurses offer any assessment of fluency; of these, half require the assessment for bilingual doctors and nurses (data not shown). Nearly 9 out of 10 hospitals have bilingual physicians and nurses but too few assess the language proficiency of these clinicians in languages other than English—creating a climate where errors and miscommunication can be commonplace.

Little information is known about the use of financial incentives related to language ability. We were surprised

to learn that 123 hospitals, or 15 percent of hospitals surveyed, have implemented incentive programs (data not shown), offering strategies for using bilingual staff and clinicians to care for LEP patients. We were particularly interested in the types of incentives hospitals offer and the amount that actually accrues to the employee for using their bilingual skills. Interestingly, most financial incentives were very low additions to an hourly rate or involved adding a relatively small percentage of salary for bilingual skills. For about three-quarters of the 123 hospitals offering incentives, incentives take the form of an add-on to base pay. The range of the incentive was very large, ranging from less than one dollar per hour to over 20 dollars per hour. Fifteen percent of hospitals with incentive programs provide a one-time payment for bilingual skills, ranging from 25 to 500 dollars.

Financial incentive programs appear to be complex to manage and track, yet some pioneers around the country manage to both assess the languages spoken by their physicians and nurses and reinforce these skills with incentives. More information should be developed to determine what type and amount of incentives would be most effective in encouraging bilingual clinicians and staff to participate in training for medical interpreting,



have their skills in secondary languages assessed, and serve in the capacity of dual-role interpreters to fill the resource needs of their hospitals.

Less than half of respondents (40 percent) reported having formal policies regarding the use of family, friends, or minors to provide language assistance. CLAS Standards² and NQF-endorsed practices³ recommend that minors, children, family members and friends not be used to provide interpreter services, except in life-threatening situations. Across the country, more hospitals must take steps to ensure that language services are available and appropriately delivered so that minors, children, family members and friends are not used to provide interpreter services.

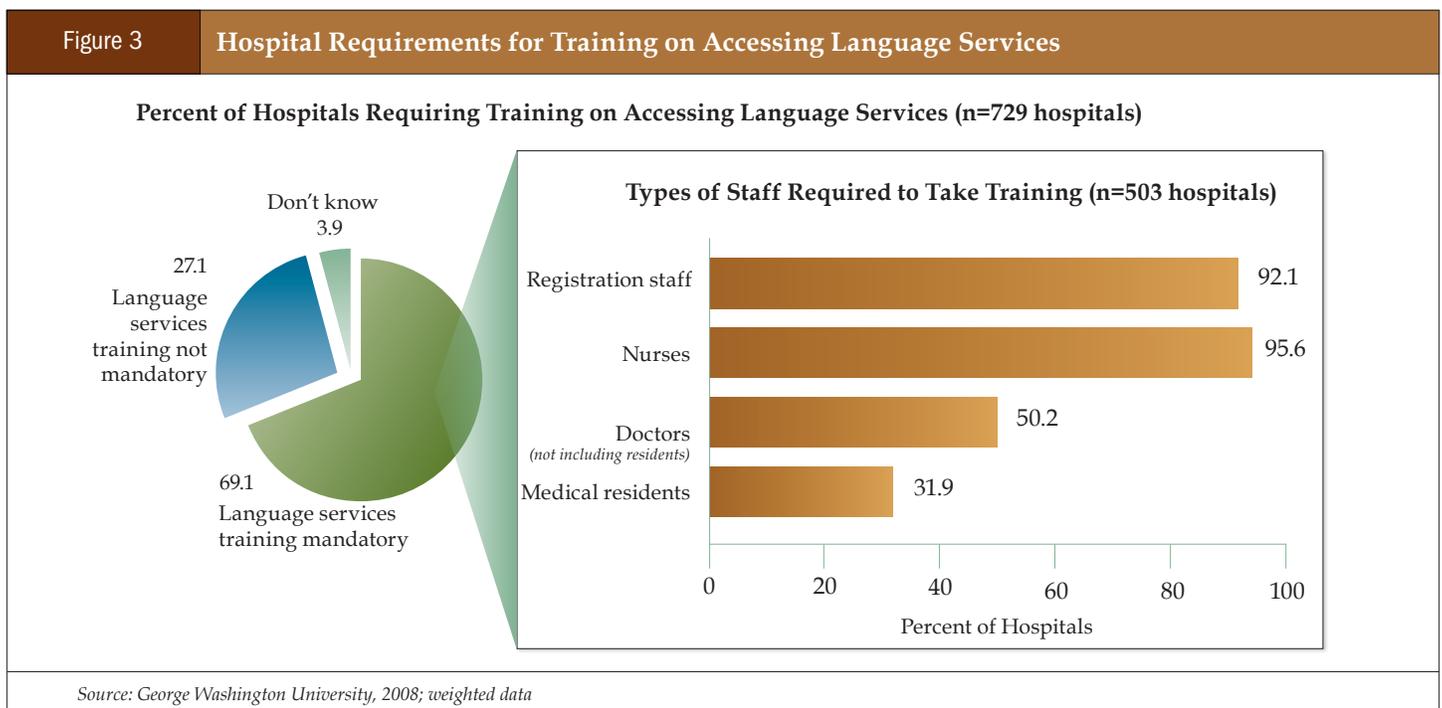
Training on Accessing Language Services

Hospitals need better training for physicians and medical residents about when and how to request interpreter services. The need for better training is emphasized by The Joint Commission’s *Hospitals, Language, and Culture* study, recommending that hospital staff undergo ongoing in-service training on how and when to access language services.⁴ Also, NQF-endorsed practices⁵ specifically recommend that clinicians receive training on how to work effectively with language services. More than 8 out of 10 hospitals offer training, but 27 percent of

these hospitals indicate that this training is optional (see Figure 3). Only half of the hospitals with training programs about how to access language services require this training for doctors, and only one-third require this training for medical residents. With so few hospitals requiring physicians or medical residents to take training on accessing language services, many clinical encounters with LEP patients may be conducted without the support of interpreter services.

Hospitals are more likely to require training on accessing language services for registration staff and nurses, with more than 9 out of 10 hospitals requiring nurses and registration staff to attend (see Figure 3), supporting anecdotal information that nurses are frequently the decision points for whether or not an interpreter is requested in a clinical encounter. Given their role and the frequency with which they are trained in accessing language services, registration staff and nurses need to be advocates for LEP patients to access language services, both at the system and policymaking level, as well as at the individual patient encounter level.

All states have much work to do to ensure that all patients with language needs are effectively communicating with clinicians and staff, but California appears to be several steps ahead in this process relative to the nation.



California hospitals are more likely to have organizational policies related to language services, have a diverse health care work force, have stringent requirements related to qualifications of interpreters and encourage appropriate use of language services through training and education (data not shown). Many California hospitals are engaged in innovative strategies designed to improve the quality of language services, such as assessing language proficiency of bilingual clinicians and offering incentives for secondary language skills. Other states can learn from California's challenges and successes to use bilingual clinicians and staff to care for patients with language needs.

Recommendations

We recommend the following strategies to strengthen hospital policies and programs designed to improve language services on behalf of patients with limited English proficiency:

- Hospitals should develop explicit policies or plans related to the provision of language services for patients with LEP.

- Bilingual clinicians and staff should be assessed for language proficiency if they provide direct services or care to patients with limited English.
- Volunteer interpreters should have their language proficiency assessed and be trained in medical interpreting.
- Hospitals should require that all staff, including clinical staff, receive education on the critical importance of language services to patient care and training on how to access language services.
- All hospitals should know who their patients and work force are and work to meet the language needs of all of their patients.
- Hospitals should take a proactive approach to learning more about the many ways that high-quality language services can be provided to their patients.

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Notes

¹ The survey sample represent nearly 20 percent of all non-federal, acute care hospitals in the U.S. Of the 899 respondents, we spoke with 159 hospitals located in California to develop a clear understanding about language services and use of bilingual clinicians and staff across the state. We also oversampled rural hospitals to provide to understand hospital practices and policies in this sector of the nation. The nationwide analysis was adjusted by ownership, teaching status, market, and geography (CA vs. not) to reflect the characteristics of the U.S. hospital industry.

² 65 FR 80865, December 22, 2000.

³ National Quality Forum. *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report*. Washington, DC: NQF; 2009

⁴ Wilson-Stronks A, Galvez, E. *Exploring cultural and linguistic services in the nation's hospitals: A report of findings*. Oakbrook Terrace: The Joint Commission; 2007.

⁵ National Quality Forum. *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report*. Washington, DC: NQF; 2009

