

Office guide to communicating with limited English proficient patients

Second edition



For more information:

- Visit www.ama-assn.org/go/healthdisparities
- Call the AMA Division of Medicine and Public Health at (312) 464-4526

About this guide:

This guide provides information and resources that physicians and health care staff can use to provide better care to patients with limited English proficiency (LEP). With the LEP population rising in both rural and urban areas of the United States, language gaps between physicians and patients are increasing. This guide offers detailed information on the ways LEP can affect patient care and effective strategies to address the language needs of patients in a culturally, linguistically and ethically appropriate manner.

FAQ

1 What does the term “LEP” mean?

“LEP” is the acronym for both “limited English proficiency” and “limited English proficient.” The U.S. Census Bureau’s operational definition for LEP is a patient’s self-assessed ability to speak English less than “very well.” Approximately 23 million individuals were identified in this category by the 2005 American Community Survey.

2 How do I know if I have LEP patients in my practice?

The best way to determine this is to ask the following question:

- “What is your preferred language?”
Individuals who speak English less than “very well” require some form of language assistance in the health care setting. However, because self-assessment is subjective, even patients who self-identify as English speakers may find health care encounters challenging. Patients may also require language assistance to understand unfamiliar medical concepts and terminology.

In the clinical encounter, if your patients: (1) ask very few questions or rarely initiate conversation; (2) simply nod or say “yes” in response to your questions or comments; or (3) give inappropriate or inconsistent answers to your questions, it can be useful to verify their understanding by asking them to explain back to you what you have discussed during the appointment. Some patients may have cultural reasons for nodding or saying yes, even when they do not agree.

3 How do language barriers affect quality of care and patient safety?

Individuals with LEP face a great risk for poor communication during health care encounters.

a) Patient-physician miscommunication

- May result in: delayed diagnoses, misunderstanding of care plan, medication errors, lack of follow-through by the patient, misuse of health services

b) Lack of trust and confidence in the physician

- May result in: low patient satisfaction, lack of patient willingness to ask questions, to follow prescribed treatment plans and/or to share information vital to making accurate diagnoses

When a patient and physician don't speak the same language, there is less opportunity for them to develop rapport or to share small talk, to obtain a comprehensive patient history, to learn clinically relevant information and to increase the emotional engagement in treatment.

4 What is the relationship between language assistance and cultural competency?

Language and culture are very closely linked. Culture is encoded in language through forms of expression, communication preferences and the way words are used (e.g., “The door is closed” versus “The door closed”). As a result, communicating with patients in a language they understand is imperative—but it is just one step in providing effective and respectful care.

Health care that is patient-centered and ethically appropriate should respect and respond to a patient's cultural background. Modesty, refusal to eat certain foods and observance of religious rituals are examples of cultural factors that must be taken into account during clinical encounters. Even when patients and physicians share the same language, they will rarely share the same cultural background.

The way in which patients interact with health care practitioners can also be influenced by culture. To effectively communicate—regardless of language or cultural differences—physicians must specifically ask patients about their needs and preferences. Providing patient-centered care means viewing patients as individuals with unique experiences, not simply as members of one ethnic group or another. While it is important to learn about culture-specific health care beliefs that may be common in your patient populations, it is equally important to understand the risks of stereotyping based on cultural assumptions.

Like other disciplines, cultural competency requires continuing education at the clinical level. It is important to:

- Develop an inquisitive attitude toward your patients' cultural backgrounds, especially as they might relate to health beliefs and clinical decision making
- Refine your skills for communicating across cultures
- Train your staff members to understand the ways social and cultural factors can affect patients' health beliefs and behaviors

- Empower patients to take active roles in medical encounters
- Strive to build trust with all your patients

On an organizational level, physicians should try to make sure that the diversity of their staff reflects the patients they are serving. Physicians should also strive to ensure that the larger systems in which they work have the ability to: assess community composition; gather community feedback; collect data on patient race, ethnicity and language preference; monitor patient satisfaction and other clinical performance measures according to demographic characteristics; and maintain culturally and linguistically appropriate education materials, signage, and health promotion and disease prevention interventions.¹

Visit these online resources for more information on providing health care in culturally diverse settings:

- Cross Cultural Health Care Program (www.xculture.org)
- National Center for Cultural Competence (<http://gucchd.georgetown.edu/nccc>)

5 What current and emerging strategies exist that can help physicians care for LEP patients?

The U.S. Department of Health and Human Services has issued guidance to help physicians gauge their obligation to provide language assistance for LEP patients, according to Title VI of the Civil Rights Act of 1964. When deciding how to provide this assistance, physicians should assess the following factors in their practice²:

- 1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the practice
- 2) The frequency with which the LEP individuals come in contact with the practice
- 3) The nature and importance of the program, activity or service provided by the practice to people's lives
- 4) The resources available to the practice and costs

¹ Information adapted from The Commonwealth Fund's cultural competency report series, released during the 2006 National Conference on Quality Health Care for Culturally Diverse Populations. Available at: www.commonwealthfund.org/topics/topics_show.htm?doc_id=421983

² Office for Civil Rights. Guidance to Federal Financial Assistance Recipients Regarding Title VI and the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. Available at: www.hhs.gov/ocr/lep/summaryguidance.html

Depending on their responses to these four factors, physicians may have multiple options for providing language assistance. Table 1 compares the different types of interpretation with the corresponding potential for their use in ambulatory settings. When referencing this table, it is important to keep in mind that the term “quality of interpretation” is a relative one—national standards for interpreter training are still being developed and there are no standardized methods for assessing interpreter competency. However, physicians should make a reasonable attempt to confirm the competency of interpreters.

Table 1

Type of interpreter	Average availability	Professionalism (knows ethics of interpretation)	Comfort to patient	Interpreting quality	Circumstances where interpreter type is appropriate*
Trained onsite interpreter	Varied	High	Moderate–high	High	All
Trained telephonic interpreter	High	Moderate–high	Moderate	High	All
Bilingual health care practitioner	Varied	Moderate–high	High	Moderate–high	All
Trained bilingual staff	Low–moderate	Moderate–high	Moderate	Moderate–high	Moderate–high risk circumstances (depends on level of training)
Untrained bilingual staff	Varied	Low	Low–moderate	Low	Low-risk circumstances **
Bilingual family member or friend	Moderate–high	Low	Varied	Low	Low-risk circumstances **

Adapted from: Hsieh E. Understanding medical interpreters: re-conceptualizing bilingual health communication. *Health Commun.* 2006; 20:177–186.

*Examples of possible use circumstances:

- Low: Nonmedical communications such as scheduling follow-up or making appointments for referrals; some low-risk medical encounters, such as medication refills, annual influenza vaccination, otitis media recheck
- Moderate: Routine follow-up for chronic disease, patient triage
- High: Consent discussions, diagnostic evaluations for new problems, end-of-life discussions

**Experts in medical communication consider this an option of last resort.

a) Trained onsite interpreter

Competency in medical interpretation requires more than fluency in a language or even knowledge of medical terms in that language. Trained medical interpreters are individuals who have received professional instruction in medical concepts and terminology, interpretation skills and process, communication skills, ethics, confidentiality and cultural issues.

While there is a national code of ethics and the *National Standards of Practice for Interpreters in Health Care*³, training standards are still in the process of being developed. No specific certification requirements currently exist for use by all training organizations.

Many health care organizations and some insurers will provide access to onsite medical interpreters. If you do not have access to these resources in your clinical setting, you can access community-based, trained medical interpreters through:

- Local language agencies
- Community colleges
- Social service programs such as legal aid, welfare assistance programs, immigration programs, migrant health clinics and English as a Second Language programs

Onsite interpreters are preferred for encounters that rely on nonverbal communication (e.g., facial expression, body language), such as when delivering bad news. They may also work best when obtaining informed consent. In these situations, it is important to ensure effective communication and nonverbal cues are appropriately considered to assess whether informed consent truly takes place.

b) Trained telephonic interpreter

Trained telephonic interpreters provide offsite multilingual interpretation to the patient and physician by telephone. Companies providing these services can furnish wireless remote headsets for use in areas not wired for telephones or dual-handset equipment that avoids the need to pass the telephone back and forth. (The speaker option available on many phones can also be used for this purpose, if it has good sound quality.) Telephonic interpretation usually works best when a specific telephone in the office is designated for interpretation or when one is placed in every examination room.

Trained telephonic interpreters are particularly useful for practices with a multilingual patient base, at which it would be difficult to have multiple onsite interpreters. They are most effective for administrative and routine encounters,

³ Published by the National Council on Interpreting in Health Care. Available at: www.ncihc.org/sop.php

when nonverbal communication plays a limited role. Some considerations when choosing telephonic interpreting are cost, miscommunication due to patient dialect and possible discomfort with the use of a telephonic versus an onsite interpreter.

The National Health Law Program (www.healthlaw.org) provides resources for researching interpretation services across the country, such as the *Language Services Resource Guide for Health Care Providers* (October 2006).⁴

c) **Bilingual health care practitioner**

Being bilingual or being a bilingual medical practitioner does not ensure competency in medical interpretation. Practitioners in this role should complete an interpreter training program to optimize their effectiveness and the quality of care they deliver.

d) **Trained bilingual staff**

If bilingual staff members are trained to serve as interpreters (as described earlier in section a), and have been tested to demonstrate competency, they can effectively fulfill the role of interpreter. However, because bilingual staff are also responsible for performing their primary roles, their availability for interpretation may be limited.

e) **Ad hoc interpreters (bilingual family members or friends, untrained bilingual staff)**

Experts in medical communication believe that family members, friends and untrained staff should only be used as a *last resort*, when none of the other preferred methods are available.

Research indicates that when family members, friends, strangers or other untrained individuals serve as interpreters (known collectively as ad hoc interpreters), significantly more interpretation errors of clinical consequence occur. Studies also show that the use of ad hoc interpreters is associated with a high risk of interpretation errors, omissions, distortions and redundancy. Ad hoc interpreters are unlikely to have adequate training in medical terminology and confidentiality, and sometimes may have priorities that conflict with patients and may inhibit or preclude essential discussions on sensitive issues such as domestic violence, substance abuse, psychiatric illness and sexually transmitted diseases.

If you must work with an ad hoc interpreter, there are some tips you can follow to make sure information is being exchanged accurately⁵:

- Introduce yourself to the patient, then the interpreter. Gauge the interpreter's level of English skills and professional training. Remind the interpreter to interpret everything accurately and completely. Direct the interpreter to avoid paraphrasing or answering for the patient, and to let you know if you should repeat yourself, explain something or slow down.
- If needed, introduce the interpreter to the patient and explain the interpreter's role.
- In general, position the interpreter next to and a bit behind the patient. Sign language interpreters should be positioned next to the interpreter, so the patient can see the interpreter's hands.⁶
- If you are concerned that the interpreter has not interpreted everything, ask him or her to do so.
- If the interpreter and the patient get into a conversation that is not interpreted for you, interrupt and ask the interpreter to let you know everything that is being said.
- Interact frequently with the patient. Use the teach-back method ("Please tell me everything I just told you"). Speak simply and pause between sentences. Remember to speak to the patient, not the interpreter.

f) **Emerging technologies**

- *Videoconferencing Medical Interpreting*
This emerging technology can provide the patient and physician with a real-time video image of the medical interpreter who, in turn, can see, hear and assess the body language of both the patient and the physician. More information on this technology can be found at the Health Access California Web site (www.health-access.org/providing/vmi.htm).
- *Voice activated software*
New technology is being developed to recognize and translate phrases from multiple languages into spoken English, and from English into multiple languages. Voice activated software, referred to as a "phraselator" or "speech-to-speech translation," is offered by a variety of companies and is most useful in urgent care situations. This technology, however, is still under development and has not been formally tested.

⁴ The AMA does not endorse any individual company for this purpose.

⁵ California Academy of Family Physicians. Working with untrained interpreters, on-site. *Addressing Language Access Issues in Your Practice, A Toolkit for Physicians and Their Staff Members*; 2005.

⁶ For more specific guidance, see the National Council on Interpreting in Health Care's "Guide to interpreter positioning in health care settings." (November 2003). Available at: <http://www.ncihc.org>

6 How should physician offices handle telephone calls to and from LEP patients?

- Determine how your staff is handling calls from LEP patients and develop procedures to help them respond to patient communication needs.
- If possible, telephone calls from LEP patients should be answered by bilingual office staff or onsite interpreters.
 - Possible alternatives include enabling staff members to activate three-way calling with a telephonic interpreter or to transfer calls to someone at the office who speaks the relevant language.
 - Otherwise, offices should refer to table 1 and make decisions based on the clinical scenario.
- Answering machine messages should be provided in more than one language (with prompts) if there are a significant number of LEP patients in the practice who speak one or more non-English languages.
 - In the case of a high volume of diverse LEP patients, telephones can be programmed to rollover directly to a phone line with telephonic interpretation services.
- If using an answering service, consider contracting with one whose language capacity mirrors that of your practice.

7 What can your office do to improve access to services for LEP patients?

- a) Develop policies and strategies to identify and address your patients' needs for language assistance for both commonly and rarely encountered languages.
- Create a written plan for coordinating interpretation services and monitoring quality. The plan should describe funding for the services, what modes of interpretation are provided and situations in which each mode may be used.
 - Identify available resources for trained medical interpretation services and the logistical details involved in their use (e.g., availability, cost, number and appropriateness of languages offered).
 - Assign responsibility to a particular work force member for arranging interpretation services when needed. Designate another staff member to take the lead in incorporating language assistance services into continuous quality improvement activities.

- b) Implement a system to track patient need for language assistance services.
- When an individual schedules an appointment, the work force member making the appointment determines whether an interpreter is needed and in what language.
 - An individual's charts, records or database entries include information on primary language and whether an interpreter is needed or requested.⁷
- c) Develop policies to govern the use of bilingual work force members as interpreters and service providers.
- Ensure that bilingual work force members who serve as interpreters are trained a minimum of 40 hours, have been tested and are regularly assessed on the level of services they may be called upon to perform.
 - Make sure that bilingual work force members who serve as interpreters know what duties they are expected and authorized to perform and the limits of these duties.
 - Before you use them on a regular basis, ask contracted interpreters to provide credentials or evidence of language proficiency and interpreter training.
- d) Train clinical and nonclinical staff members on how to work with interpreters.
- e) Inform LEP patients of their rights to interpretation and translation services.
- Provide patients with information in their primary language or post notices to let them know that interpreters are available and can be requested.
 - Conduct outreach into the community to ensure that patients are aware of your office's ability to communicate with them.
- f) Reserve blocks of time for LEP patients to schedule appointments and arrange for interpreters to be available during these times.
- g) Ensure all signs are understandable (e.g., multilingual or symbol-based).
- h) Provide vital documents and patient education materials in English and in the language of your patients (translated by certified translators). Even though your patients may not read English, someone at home may.

⁷ Refer to the Health Research and Educational Trust Disparities Toolkit; 2006. Available at: www.hretdisparities.org/hretdisparities_app/index.jsp

- The National Library of Medicine maintains a Spanish-language version of MedlinePlus, with links to patient education materials and health information also written in Spanish.
- Many physician associations have frequently requested information available in commonly spoken languages on the Internet free of charge. For example, the American Academy of Pediatrics Web site provides Spanish-language information explaining how the immunization and vaccination process works.

8 How can physician offices finance language assistance services?

Depending on the resources available in your community and your state's reimbursement policies, you may have multiple affordable options for obtaining language assistance services.

- Find out if the Medicaid or State Child Health Insurance Plan in your state pays for interpreter services. In a number of states, reimbursement for interpretation is authorized directly to the health care provider, who then pays the interpreter. Alternatively, the state contracts directly with interpreter organizations to provide interpretation.
- Negotiate for discounted rates with local hospitals that provide interpreter services.
- Develop collaborative contracts for use of a telephonic interpreter service with other physician practices in your region (e.g., use an existing independent practice association network).
- Contact community organizations in your area for possible volunteer interpreter services and offer them medical interpreter training in exchange for service commitment.

The following resources provide further information on strategies for financing language assistance services:

National Health Law Program (www.healthlaw.org)

- Language Services Action Kit: *Interpreter Services in Health Care Settings for People with Limited English Proficiency*
- “Providing Language Services in Small Health Care Provider Settings: Examples from the Field”

California Academy of Family Physicians (www.familydocs.org)

- *Addressing language access in your practice: A toolkit for physicians and their staff members*

The Office of Minority Health (www.omhrc.gov)

- A patient-centered guide to implementing language access services in healthcare organizations

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The Office for Civil Rights of the U.S. Department of Health and Human Services (HHS) issued Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency (LEP Guidance). See *68 Fed.Reg.47311 et seq.* The U.S. District Court for the Southern District of California has stated that the LEP Guidance does not create a mandatory rule or otherwise supplement an entity's existing nondiscriminatory obligations under Title VI of the Civil Rights Act of 1964. See *Colwell et al. v. U.S. Department of Health and Human Services*, 2005 U.S. Dist. Lexis 6556 (2005). The LEP Guidance is merely a statement of what HHS considers is required for compliance. In the AMA's view, serious questions can be raised regarding the positions taken in the LEP Guidance with respect to (1) the entities that are covered and (2) the affirmative steps such entities must take to ensure compliance.