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Speaking Together: National Language Services Network

An RWJF national program

Speaking Together: National Language Services Network, which ran from 2005 to 2010, was the first Robert Wood Johnson Foundation (RWJF) national program to improve the delivery of language services (interpretation and translation services) to patients with limited English proficiency using standardized performance improvement measures and a quality improvement framework. Ten hospitals developed and tested strategies to improve the quality and accessibility of their language services. The RWJF Board of Trustees authorized the program at up to $3 million.

CONTEXT

The United States is becoming increasingly multicultural and multilingual. One in six Americans speaks a language other than English at home. More than 20 million people across the country speak or understand little, if any, English.

The inability to communicate has particularly significant implications in the health care environment, where even communication between providers and patients who speak the same language can be difficult, according to Program Director Marsha Regenstein, Ph.D., an expert on language barriers in health care. "When patients and health care providers are not able to communicate clearly and thoroughly with each other, the quality of care suffers."

Warren Ferguson, M.D., associate professor and vice chairman of the Department of Family Medicine and Community Health at UMass Memorial Medical Center in Worcester, Mass., and project director of the Speaking Together site at the medical center, adds, "If you consider that much of the information a doctor uses for diagnosis comes from taking a history it's like operating with a rusty scalpel if you can't talk to them."

Research shows that:

- People with limited English proficiency are less likely to receive primary care and preventive services and less likely to receive the same quality of care as patients who are proficient in English. They have a higher risk of taking medications improperly and often have a poor understanding of their diagnosis and treatment.
- Family members, including children, and friends may be tapped to act as interpreters in the medical setting but may misinterpret doctors' questions or omit embarrassing, but important, patient complaints. Their errors may have clinical consequences.
- Treating patients with limited English proficiency is less efficient for hospitals and other health care providers, requiring a greater use of resources and time.

Federal law (Title VI of the Civil Rights Act) supports a patient's right to an interpreter, if requested, at no cost to the patient. However, the law offers no guidance on implementation and there are no national standards on what constitutes appropriate or adequate language services. Most health insurance plans do not provide reimbursement for language services.

RWJF's Interest in the Area

Access to quality health care for all Americans has long been a goal of RWJF. A core element of this strategy is to remove obstacles that impede an individual's ability to gain access to quality health care. A language barrier is one of these obstacles.

RWJF initially addressed its interest in language barriers by creating a national program called *Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care*, launched jointly with the Henry J. Kaiser Family Foundation in 1992. This program addressed nonfinancial barriers to health care access, recognizing that even when health care is available and affordable, language, culture, race and ethnicity can impede access and lead to poorer health outcomes.

Opening Doors allocated $5.5 million for 23 projects in rural and urban areas in 11 states to identify and reduce sociocultural barriers. Three of those projects involved trained language interpreters who facilitated communication between patients and providers. (See Program Results.)

Other RWJF-supported projects in the 1990s and early 2000s for people facing language and cultural barriers included:

- A survey by the People-to-People Health Foundation (1996–99) about the use of and barriers to health care services among undocumented Latino immigrants in El Paso and Houston, Texas (see Program Results on ID# 026618)

- A series of studies (1996–99) conducted by the University of California, Los Angeles, School of Public Health on the effects of immigrant and citizenship status on health insurance coverage and access to health care services (see Program Results on ID# 026855)
- A project at the University of Maryland at College Park (1998–2001) to improve access to care among Latino children. Researchers analyzed and compiled data from the 10 states with the largest populations of Latino children and convened an expert panel that developed policy recommendations designed to improve their health (see Program Results on ID# 037533)

In October 2001, RWJF launched *Hablamos Juntos: Improving Patient-Provider Communication for Latinos*, the first national effort to help health care organizations meet the challenge of providing language services and facility signage, primarily in Spanish.

Hablamos Juntos pioneered demonstration programs to provide high-quality language services in a multitude of health care environments. Key results from the program included the creation of a prototype health care interpreter training program and a computer-based program to assess interpreters' proficiency in Spanish and their readiness to interpret. *Hablamos Juntos* ran through June 2006. (See Program Results and a chapter in RWJF's 2010 *Anthology*.)

In 2003, the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, recommended the use of interpretation services to help reduce health care disparities. RWJF Assistant Vice President, Health Care Group, Pamela S. Dickson, M.B.A., said, "RWJF realized that health care organizations would have to be convinced that this was a mainstream issue, that disparities should be a quality of care mainstream issue."

THE PROGRAM

RWJF launched its national program, *Speaking Together: National Language Services Network*, in November 2005.

Speaking Together was the first national program to apply standardized performance-improvement measures and a quality-improvement framework to improve the delivery of language services to patients with limited English proficiency. "We created a very focused, language quality-improvement model that didn't exist anywhere," said Program Director Regenstein. "We were creating a very new way of thinking about language services and embedding it in what the hospital does."

Speaking Together had four goals:

- To improve communication between patients with limited English proficiency and their health care providers
- To partner with hospitals to develop models of high-quality language services
- To enable hospitals to develop measures of effectiveness and create performance benchmarks for language services
- To encourage grantee hospitals to share successful strategies for increasing effective language services within and across hospitals and health systems

The *Speaking Together* framework included three key components:

- Developing and using language services performance measures and clinical performance measures
- Implementing a 10-hospital collaborative learning network
- Disseminating findings and spreading learning through publications and presentations to outside groups

Management

National Program Office

The School of Public Health & Health Services at the George Washington University Medical Center in Washington served as the national program office for *Speaking Together*. It had also served as the national program office for Expecting Success: Excellence in Cardiac Care and Urgent Matters (see Program Results), which were models for this initiative.

Marsha Regenstein, Ph.D., professor, Department of Health Policy, was program director. Jenny Huang, MS, was deputy director from the beginning of the program until 2006 when Melissa Stegun, M.A., became deputy director until 2008. Catherine West, M.S., R.N., was the quality improvement specialist.

National Advisory Committee

A national advisory committee of seven language services experts and two advisers evaluated hospitals applying to participate in the collaborative learning network and recommended final candidates. Committee members participated in site visits and grantee meetings and provided guidance throughout the program. See Appendix 1 for a list of national advisory committee members.

Communications Assistance

Under a separate contract with RWJF, the Washington-based communications firm, GYMR, helped to distribute materials for the general public (including a report, video and issue briefs) and provided organizational support and materials for the grantee meetings. GYMR staff also offered communications advice during the program.

The Planning Phase

During the early part of the program, national program staff:

- Developed and tested language services measures
- Selected hospitals for the collaborative learning network
- Created a program website

Measuring Interpreter Services

Speaking Together focused on developing measures for spoken (or, for the deaf population, signed) interpreter services. Program staff adapted the Institute of Medicine's six dimensions of quality (safe, effective, patient-centered, timely, efficient and equitable) to guide the development process.

"There were no previous measures available," said Regenstein. "We spent a lot of time in prep work. We did a thorough literature review. We talked to dozens of people who were interested in the topic from a research, practice or quality perspective.

National program staff drafted a set of 10 language services measures, drawing on the extensive literature review, interviews with about three dozen language services experts across the country and a site visit to Boston Medical Center's language services department.

The feasibility of implementing these measures in hospital and outpatient settings was reviewed in three parts:

- Language services experts provided feedback during two conference calls with national program staff.
- A 17-member working group of medical directors, physician leaders and interpreter services directors representing 10 organizations assembled for a one-day meeting in September 2006. Among the organizations represented were San Francisco General Hospital, Memorial Healthcare System in south Florida and RWJF.
- With the list narrowed to five measures, Boston Medical Center and Children's Hospital of Philadelphia conducted week-long pilot tests of their feasibility and the usefulness of data reporting formats.

The process resulted in five standardized measures of language services performance:

- ST1: The percent of patients who have been screened for their preferred spoken language
- ST2: The percent of limited-English-proficiency patients who receive initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers assessed for language proficiency
- ST3: The percent of encounters in which the patient waits 15 minutes or less for an interpreter
- ST4: The percent of time interpreters spend providing medical interpretation in clinical encounters with patients, as a percent of their total work time
- ST5: The percent of encounters in which interpreters wait less than 10 minutes to provide services to provider and patient

Measuring Translation Services

Speaking Together focused specifically on spoken interpreter services, excluding written (translation) services. However, since the language services field lacked any standardized performance measures for translation, national program staff also drafted four process measures for translating written material. These were reviewed in two steps:

- A panel of medical directors, nursing leaders, interpreter services directors and translation services experts from acute hospitals, outpatient settings and community health centers evaluated the measures for quality, data-collection feasibility, clarity and accuracy of description.
- A separate panel of national experts in language and translation services evaluated the measures on the same criteria.

While the experts agreed that all four measures were important indicators of quality for patients with limited English proficiency, they expressed concern about the feasibility of collecting some of the data. Ultimately, they recommended the use of one additional translation-related screening measure:

- The percent of patients who have been screened for their preferred written language for health care information

National program staff did not field test this measure since it was similar to ST1, the measure addressing spoken language need. However, it is included with the five interpretation measures in the National Quality Measure Clearinghouse of the federal Agency for Healthcare Research and Quality (see Afterward).

Forming the Collaborative Learning Network

Speaking Together adapted the Collaborative Model for Achieving Breakthrough Improvement, developed by the Institute for Healthcare Improvement. That model is designed to help health care organizations close the gap between best care and usual care through short learning and action cycles designed to create incremental and rapid improvement. The framework allows organizations to learn from each other and from recognized experts in topic areas in which they want to make improvements.

Two other RWJF-funded hospital initiatives served as models for the collaborative approach used in *Speaking Together*:

- *Expecting Success: Excellence in Cardiac Care*, a 29-month collaborative to improve cardiac care for racial and ethnic minority populations in the United States
- *Urgent Matters*, an 18-month collaborative to improve patient flow and reduce emergency department crowding (see Program Results)

National program staff issued a call for proposals on March 15, 2006 to select the sites that would be part of the collaborative learning network. Eligible sites were:

- Nonfederal, general acute-care hospitals that served a substantial number of patients with limited English proficiency and had a minimum of 10,000 discharges annually
- Hospitals currently operating a language services program for non-English-speaking patients that included on-site professional interpreters

Hospitals selected for the collaborative learning network were to:

- Improve the quality and accessibility of language services for patients with limited English proficiency.
- Adopt effective use of language services and quality-of-care performance measures.
- Focus on quality improvement in at least one of three clinical care areas to demonstrate how these diseases may be affected by improvements in language services and communication:
  - Cardiovascular disease
  - Depression
  - Diabetes mellitus

Seventy-one hospitals submitted full applications and 10 sites, representing a diverse group of urban, rural, teaching and community hospitals, were selected following a multi-part review process. See Appendix 2 for key characteristics of hospital-based languages services at the 71 *Speaking Together* applicant hospitals.

RWJF publicly launched the collaborative learning network on December 13, 2006.

The grantees, who received grants of $60,000 each for 18 months were:

- Bellevue Hospital Center, New York
- Cambridge Health Alliance, Cambridge, Mass.
- Children's Hospital and Regional Medical Center, Seattle
- Hennepin County Medical Center, Minneapolis
- Phoenix Children's Hospital, Phoenix
- Regions Hospital, St. Paul, Minn.
- UC Davis Health System, Sacramento, Calif.
- UMass Memorial Medical Center, Worcester, Mass.
- University of Michigan Health System, Ann Arbor, Mich.
- University of Rochester Medical Center, Rochester, N.Y.[1]

In some of these hospitals, more than 40 different languages are spoken by patients.

"*Speaking Together* recruited hospitals that saw the measurement of language services as an integral aspect of care," said RWJF's Dickson. "They looked at this as a mainstream element of care."

Three grantees were chosen to receive 18-month grants of about $100,000 apiece for dissemination, both within their institutions and externally, the work they had done during *Speaking Together*. The grants began about four to five months after their $60,000 grants ended. The grantees were:

- Cambridge Health Alliance, Cambridge, Mass.
- Children's Hospital and Regional Medical Center, Seattle
- University of Michigan Health System, Ann Arbor, Mich.

Program Website Launch

National program staff designed a website during the initial phase of the program.

The public portion of the site informed interested visitors about program goals, and the performance measures and the progress of the collaborative learning network. The site

[1] See Appendix 3 for grantee details.

encouraged visitors to submit inquiries and to share their own language services innovations.

A password-protected area available to grantees only included sample data logs and other quality-improvement tools, and allowed grantees to share:

- Success stories
- Monthly reports of progress
- Rapid-cycle change, based on tests involving small samples that allow quick improvement to be made
- Language services and clinical performance measure data

In the first year after its December 2006 launch, the *Speaking Together* website had received over 191,000 hits, with an average of about 2,700 per day.

The Implementation Phase

National Program Office Activities

National program staff maintained a centralized repository for data generated by all hospitals participating in the collaborative learning network. They also provided technical assistance in the form of expert advice and training. For example:

- The office's quality improvement specialist made two site visits to each hospital.
- Topic experts participated in four meetings of all grantee hospitals, including two that hospital CEOs were required to attend, and in 13 monthly conference calls in which all of the hospitals participated.
- Reports to hospital CEOs outlined their progress and made recommendations for improvement.
- Program staff provided training in:
  - Building a hospital-wide language services improvement team
  - Collecting and analyzing data
  - Using the improvement model and rapid cycle change
  - Measuring performance using standardized performance measures
  - Achieving organizational buy-in
  - Spreading and sustaining change throughout the organization

- A Web-based project management system included standardized performance measures and an easy mechanism for posting site experiences and resources to facilitate improvement (i.e., literature, laws, regulations).

Program staff also participated in national conferences, such as the AcademyHealth Annual Research Meeting and the Quality Health Care for Culturally Diverse Populations meeting.

Overall Site Activities

Participating hospitals built on the five performance measures to test and implement in-person and telephone interpretation services in many different areas of the hospital (patient rooms, emergency department, outpatient department, etc.) and at all or most hours of the day and night.

Their strategies varied, depending on available resources, organizational needs and the particular challenges facing each hospital's language services program. Strategies to improve the quality of language services to patients with limited English proficiency included:

- Screening for preferred language:
  - Designate a place in the patient record for recording language needs
  - Create and revise a list of languages that registration and scheduling staff can easily use to select and record the patient's preferred language
  - Develop scripts for registration and scheduling staff to use when asking about language preference
- Providing interpretation from qualified language services providers in person or by telephone:
  - Program electronic systems to automatically notify the language services department when appointments requiring interpreters are scheduled
  - Assess bilingual providers for language proficiency
  - Place language next to patient's name on inpatient unit's white board
  - Include language services in planned care models and work flows
- Decreasing patient wait time:
  - Notify clinics in advance about which visits will be assisted with an in-person interpreter and which will be assisted by phone or other remote methods
  - Map out interpreter schedules based on peak service times, by language

  - Increase access to remote interpreting methods for infrequent languages, nights and weekends

- Increasing the proportion of time interpreters actually spend interpreting:
  - Use data related to the type of encounter (i.e., a routine appointment or one involving complex decision-making) and location to determine how much time the interpreter will need
  - Revise interpreter assignments to decrease travel time
  - Provide permanent interpreter assignments in high-volume languages at high-volume locations

- Reducing the time interpreters spend waiting to provide language services:
  - In clinics with a high volume of limited-English-proficiency patients speaking a particular language, schedule interpreters in blocks of time
  - Conduct daily morning huddles with clinical managers to review the day's schedule and interpreter needs
  - Remind patients a day in advance of their medical appointments

Hospitals reported monthly, through the *Speaking Together* website, on:

- Each of the five language services performance measures. Participating hospitals shared data, tracked their progress, and identified effective strategies and gaps in their efforts to improve language services.

- The impact of language services on clinical performance measures in at least one of three disease areas: cardiovascular disease, depression or diabetes. These reports included both inpatient and outpatient areas.

Brief descriptions of specific approaches used by the hospitals are included in the Key Site Activities, Results and Findings section. See also, Profile: Telephone Interpretation Services Can Serve Hospitals Well, to learn how hospitals used this service as part of their language services program and Profile: What Language Services Mean to Patients for a real-world look at their importance.

PROGRAM FINDINGS

Overall, participating hospitals improved on all but one of the five language services performance measures from the beginning to the end of the collaborative, and some hospitals made significant improvements on many measures. National program staff reported these findings in a report to RWJF:

- **Screening for preferred language (ST1) decreased from a median of 97 percent to 94 percent due to dedicated efforts to verify screening accuracy.** The two hospitals with the lowest initial performance, however, showed substantial improvement in screening, with one rising from 50 percent to 90 percent and the other from 59 percent to 83 percent over the course of the program.
- **The median percent of patients with language needs who were assisted by a qualified interpreter during their initial assessment or at discharge (ST2) increased from 35 percent to 64 percent.**
- **The median percent of patients waiting 15 minutes or less for interpreter services (ST3) increased from 94 percent to 95 percent.** At one hospital the change was from 66 percent to 93 percent.
- **The median time that interpreters spent interpreting as a percent of their total work time (ST4) increased from 39 percent to 43 percent.**
- **The median percentage of encounters in which interpreters waited 10 minutes or less for a provider or patient (ST5) increased from 90 percent at the start to 93 percent at the end.**

PROGRAM RESULTS

These results were reported to RWJF and described in interviews with program participants.

The Relationship Between Language Services and Health Care Quality

- ***Speaking Together*'s heavy emphasis on formal measurement and quality improvement made it possible to be rigorous in determining what works.** "*Speaking Together* resulted in a common interpretation of what constitutes quality in interpreter services. It defined the gold standard for in-person, phone and other interpreter services," said RWJF Senior Program Officer Debra J. Perez, Ph.D.

- ***Speaking Together* promoted a culture shift that strengthened patient care, according to RWJF, national program office staff and the staff at participating hospitals.** Among their comments:
  - "There is now an emphasis on being a qualified language services provider: having trained interpreters and qualified providers with language ability," said Program Director Regenstein.
  - "Hospitals said the program shifted their thinking about language services—that it is not about the interpreter but about the patient," said the program office's Quality Improvement Specialist West.
  - "At the end of the program the majority of the hospitals were talking about this in terms of patient safety, said West. "It shifted from an interpreter issue to a physician and nurse issue: how to provide safe care for patients."
  - "It made a point on the national stage and to providers that they shouldn't use children to interpret for their parents," said Perez. "This was tremendously important."
  - Said Regenstein, "We are most proud of the culture shift.… It was exciting to see the shift in thinking."

Sidney Van Dyke, manager of Interpreter Services at Regions Hospital in Saint Paul, Minn., offered an example of how a hospital nurse made that culture shift:

> During discharge the nurse would get everything ready and then call for an interpreter. Then she would go into the room and say to the family that she was waiting for the interpreter. The family would want to leave and a family member would try to interpret. This started the patient down the path to not understanding discharge instructions.
>
> The nurse had an "a-ha!" moment and realized that getting the interpreter had to be one of the items (like getting medications organized) done before going into the room. Then she would go into the room with the interpreter. This has resulted in a 100 percent compliance with having the interpreter there and a big difference in how well the discharge goes.

Benefits of the Learning Collaborative

- **The collaborative learning model offered critical feedback and exposed the sites to new ideas.** "Many of these hospitals have built programs without the benefit of input from colleagues around the country," said Program Director Regenstein. "The collaborative helps them see that there are other ways of doing things, other ways of thinking about how you define quality for language services. Each hospital brings different expertise and experience to the table."

Seven Factors for Success

- **Seven factors for successful efforts to improve language services emerged during the program, according to national program office staff and project directors:**
  - **Use measurement to track language services performance.** Data are key to tracking performance, engaging providers, driving change and directing organizational improvement efforts.
  - **Start small before spreading the use of language services measures to the rest of the organization.** Starting small allows for change and adjustment along the way and saves valuable resources. If a hospital can only work on one measure initially, focusing on ST2 (percent of patients receiving language services from qualified language services providers) will provide useful information about how well a hospital is meeting patients' spoken language needs.
  - **Place clinical providers at the forefront of improvement efforts.** Frontline providers are ultimately responsible for ensuring that their patients' language needs are met. Without clinical involvement, the hospital cannot get language services to patients when and where they are needed.
  - **Work with the quality improvement department to develop and oversee strategies for change.** Language services must be linked with quality improvement in order to effectively embed them into the organization.
  - **Engage senior and executive leadership in achieving high-quality language services in the organization.** Meaningful change in the delivery of language services cannot occur without strong leadership support.
  - **Develop a relationship with registration and scheduling departments as the first point of patient contact.** An effective language screening process at registration and scheduling creates efficiencies in language services delivery and helps ensure that patients receive the services they need.
  - **Seek support from information technology to link systems.** Recording and tracking performance can be burdensome without the right systems to support these processes. A hospital's information technology and quality improvement areas can help language services departments identify ways to link to registration, scheduling, and other key departments and systems.

Communications

Disseminating program findings and knowledge was a key component of *Speaking Together*. National program staff and participating hospitals developed multiple tools to spread tested strategies for change, including tools focused on:

- Developing language services measures, such as a list of principles for a high-quality program and an organizational framework for measurement

- Measuring quality language services, such as measures specifications and a data dictionary
- Data collection, communication and reporting, such as templates for reporting language preference and wait times
- Improving language services delivery, such as a video and user's guide and a measures implementation guide

See Appendix 4 for a detailed list of tools and resources produced by *Speaking Together* in each of these categories.

National program staff and staff from participating hospitals also developed resources to spread the lessons learned from *Speaking Together* beyond program participants (see the Bibliography). These include:

- A toolkit that guides hospitals on improving the quality and accessibility of language services. The toolkit is available on the RWJF website.
- Five journal articles (three from the national program office and two from grantee hospitals)
- Three issue briefs and four reports, including a final program report, In Any Language: Improving the Quality and Availability of Language Services, available on the RWJF website
- *Speaking Together for Better Care*, a 7-minute video on the *Speaking Together* program, available on the RWJF website.
- More than 30 presentations and webinars to outside associations and groups
- A publicly available *Speaking Together* website. While the website is no longer operational, the RWJF website contains many of the resources originally posted there.

See the Bibliography for details.

Program Director Regenstein also shared the knowledge and lessons of *Speaking Together* as a member of several panels and advisory groups, including:

- Expert advisory panel guiding the development of the Joint Commission hospital standards for culturally competent patient-centered care. Many recommendations from *Speaking Together* program staff are incorporated into the new standards (released in January 2010) that will affect every Joint Commission-accredited hospital.
- Expert panel advising the National Committee for Quality Assurance (NCQA) and Eli Lilly and Company in developing a comprehensive guide to improve culturally and linguistically competent health care

- Steering Committee for the National Quality Forum's Project to *Endorse a Cultural Competency Framework and Preferred Practices for Quality Measurement and Reporting*
- 2009 NCQA *Recognizing Innovation in Multicultural Health Care Award Program* Panel

KEY SITE ACTIVITIES. RESULTS AND FINDINGS

Language Services Performance Measures

Most participating hospitals addressed all five language services measures in their *Speaking Together* projects. Examples of project accomplishments targeted at each of these measures are described below.

ST1: The percent of patients who have been screened for their preferred spoken language

University of Michigan Health System. The University of Michigan Health System created scripts for registration staff to use, and at intake they began asking, "What language do you prefer to speak to your doctor or nurse?" This proved to be much more useful than asking for the patient's primary language, as had been done previously. Staff also changed the wording in the electronic medical record.

Not all patients had contact with registration, and three areas had not been capturing language data: labor and delivery, the emergency department, and the operating rooms. Project staff created a blank field on the daily inpatient report to help capture this information.

"It involved a lot of training as to why we were doing this and what it is," said Connie Standiford, M.D., clinical associate professor in the Department of Internal Medicine. "There was an ‘ah-ha' moment when people got why we were asking this, when they realized that the response may mean that they need to schedule an interpreter. When we found that 20 percent of the time we had collected inaccurate data, people were more willing to schedule an interpreter or to use phone interpretation."

Results

- **The proportion of patients screened for language at the University of Michigan Health System increased during the course of the project from 59 percent to 84 percent.**
- **"The interpreters started doing daily rounds to patients that preferred other than English," said Harris.** "A lot of patients didn't know that we had this service. A

mother of a child in the ICU started crying when she found out that we had a Spanish interpreter because she didn't know what was going on."

Phoenix Children's Hospital. At Phoenix Children's Hospital the goal was to increase the percentage of patients screened for their preferred language to 90 percent. Project staff revised the registration drop-down menu to include the 10 most common languages, trained registration staff on using a script to ask patients about their preferred language, and made it mandatory to complete the field on the form.

Results

- **Language was documented 100 percent of the time at the end of the project.** Registration staff quickly corrected occasional errors in preferred language if they were discovered during interpreter rounds.

ST2: The percent of limited-English-proficiency patients receiving initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers assessed for language proficiency

Children's Hospital and Regional Medical Center, Seattle. Project staff at Seattle Children's Hospital designed and implemented a hospital-wide electronic data reporting system that tracks interpretation for families with limited English proficiency. The system produces a report, by clinic focus area, of the need for interpreters and the ordering and scheduling of interpretation.

Results

- **The project created measurement tools that allow the hospital to track what percentage of patients are getting the service they need and to measure service delivery.** "One of the most critical results," said Beth Ebel, M.D., director of the Harborview Injury Prevention & Research Center at the University of Washington and Harborview Medical Center, "is having firmly grounded language services and language access as a core quality measure for patient care. This is really central to the hospital's commitment to provide the highest quality of care to everyone."

- **The availability of interpreter services helps nurses and families develop a relationship, according to Sarah Rafton, M.S.W., the Seattle project director.** "Without opening that door we can miss important clinical questions. The parent may leave without saying what is on their mind. We need communication during an inpatient stay. We need to develop trust.

  "As an example, there was a family whose child's surgical site was changing and the family noticed. They were able to tell the staff right away. Parents notice when things are changing—for example, if the medication doesn't look like the same medication their child has been getting."

Regions Hospital, Saint Paul, Minn. Project staff at Regions Hospital focused on improving the documented percentage of patients receiving language services from qualified interpreters at both admission and discharge. At the beginning of the project the six internal medicine and four behavioral health pilot units had no documentation at all of patients receiving these services.

Staff made several changes in order to improve performance on this measure. They:

- Developed and implemented a process to capture language data in the electronic medical record, such as when services were provided and by whom or by what method
- Worked closely with nurse managers to identify a nursing champion on each participating unit through formal meetings and weekly check-ins. Nurse managers and champions gathered information during "daily huddles" on their units
- Analyzed documentation and service-provision failures to target improvement efforts and education. Learning from this process drove system changes
- Communicated progress updates and key messages in hospital newsletters and presentations to management, the board quality committee and other key groups
- Recognized and rewarded the accomplishments of individuals and units with pizza parties, monthly reports from the CEO and patient services vice president (accompanied by chocolates), an "interpreter's day" breakfast and recognition of individual employees in daily huddles

Results

- **The documented percentage of patients receiving language services increased steadily from none to 70 percent in the first year and then fell to just below 60 percent.**
- **The number of patients with any documentation of how their language needs were met increased from 50 percent to nearly 100 percent during the project.**
- **The provider environment with regard to interpretation has changed, according to Manager of Interpreter Services Van Dyke.** "All involved are being more helpful. For example, a doctor came in to talk with a patient about a procedure and used the teenage grandchild to interpret. The nursing staff became aware of this and there was an appropriate and quick outcry saying this was ‘against our policy' and 'not right.' We have increased accountability across the board for all."

UMass Memorial Medical Center, Worcester, Mass. Project staff at UMass Memorial Medical Center wanted to increase by 20 percent the number of patients whose admission and discharge visits were conducted in their preferred language by a qualified bilingual provider or with the assistance of a hospital interpreter. To achieve this, staff:

- Developed a data-collection process to measure and report on the provision of interpretation to patients with limited English proficiency
- Involved hospital staff who determine whether a patient requires interpretation as well as staff who actually provide it
- Developed a process for evaluating, maintaining and improving the qualifications of language services staff
- Developed a process for evaluating the quality of telephone interpretation vendors
- Expanded access to telephone interpretation in the outpatient clinics, emergency department and an inpatient floor in order to provide "just-in-time" interpretation
- Changed the interpreter staffing practices to provide around-the-clock coverage rather than on-call coverage on evenings and weekends
- Identified the needs of interpreters in the inpatient setting

Results

- **Language services have had "a definite impact on quality improvement for patients," said Director of Interpreter Services Connie Camelo.** She reports that:
  - The entire interpreter staff is qualified.
  - Access to language services is now available around the clock, seven days a week.
  - The number of languages offered increased from 44 in 2006 to 90 in 2010.
  - The number of interpreters (full-time equivalents) increased 42 percent, from almost 25 to 35.
  - Use of telephone interpretation increased 900 percent.
- Many areas of hospital operations have been strengthened as a result of the initiative. "It became clear to the organization that language services is a critical component, a tool for the organization linked to clinical processes and outcomes, such as patient safety, and not just a way to comply with regulatory requirements," said Camelo. She also noted that:
  - The hospital has recognized that language services are critical for financial performance—by decreasing wait time for interpreters and offering more languages, providers can see more patients.

- Providing language services decreased patient length of stay and the rate of readmission within 30 days of discharge.
- Patients' experience and satisfaction with the institution improved.

- **Language services staff have become more involved in quality improvement and gained more understanding of its relevance to their job.** Camelo said, "This changed the culture of the department. It is no longer reactive. We make sure that gaps are addressed."
- **The project helped to "elevate the discussion" about language services among institutional leadership, according to Warren Ferguson, M.D., in the Department of Family Medicine and Community Health.** "Its influence was to start [our] thinking of interpreter services less as serving providers and more as raising the bar as a very significant quality issue in the organization."

Ferguson has written about his own experiences trying to communicate with his Spanish-speaking patients in an essay in *Health Affairs* in 2008 (available on the RWJF website).

ST3: The percent of encounters where the patient wait time for an interpreter is 15 minutes or less

Children's Hospital and Regional Medical Center, Seattle. At Seattle Children's Hospital, staff worked to overcome the perception that providing interpretation for families would be burdensome and inconvenient or delay care. Measuring interpreter response time helped dispel the myth that "it will take too long."

"The families think they will wait longer if they ask for an interpreter," said Ebel. "This is a doctor issue too. We help them appreciate that this is a free service. We have a standard of 15 minutes or less for an interpreter. If there is a delay, you can pick up a phone. It is really relaxing to families."

One strategy to speed access to interpreter services is to identify the need when an outpatient appointment is scheduled, so that an interpreter will be available. In inpatient settings, an online order entry for interpretation requests is integrated into other order processes and around-the-clock telephone interpretation is readily available for "check-in" conversations.

Results

- **For the most frequently requested languages, 94 percent of outpatient and inpatient interpretation was provided within 15 minutes of the request.**
- **In the emergency department, 89 percent of interpretation for the most frequent languages was provided with 15 minutes of the request.**

ST4: The percent of total work time interpreters spend providing medical interpretation in clinical encounters with patients

University of Michigan Health System. In order to improve the amount of time interpreters spend actually providing medical interpretation in facilities in the system, University of Michigan project staff:

- Defined work regions and assigned interpreters to specific regions so that driving and down time was reduced
- Introduced a new database with data for each interpreter and clinic area so staff can identify problems and take corrective action
- Developed guidelines on when interpreters should be present and when use of telephone interpreting is acceptable in the emergency department and labor and delivery area, where there tends to be a lot of interpreter down time

Results

- **The percentage of work time interpreters spent interpreting increased from 11 percent at the beginning of the project to 36 percent at the end.** Staff continue to work toward a goal of 60 percent.

ST5: The percent of encounters in which interpreters wait 10 or more minutes to provide interpreter services to provider and patient.

Most of the participating hospitals did not focus on this measure, so the results are slim.

University of Rochester Medical Center. Project staff at the University of Rochester Medical Center collaborated with support staff to notify the interpreter of provider delays, reorganized interpreter assignments to avoid delays and increased the use of telephone interpretation.

Results

- **Interpreter wait time of more than 10 minutes decreased from 10 percent at the start of the project to 7.5 percent at the end.**

Clinical Performance Measures

Grantees collected data on the impact of language services on two clinical measures of their choosing related to cardiovascular disease, depression or diabetes. Examples of measures used and related results by the end of the *Speaking Together* intervention period include:

Clinical Measure: Depression Screening

Staff at East Cambridge Health Center (part of Cambridge Health Alliance, Cambridge, Mass.) set a goal to screen all new patients and all patients coming in for a physical exam for depression, regardless of their language needs. They used a standard questionnaire for mental health screening translated into the highest volume languages spoken at the center. Staff trained providers, medical assistants and interpreters on how to administer the questionnaire.

Prior to this initiative, patients were not screened for depression during their medical visits.

At project end, 75 percent of patients with limited English proficiency (mostly Portuguese-speaking) were being screened, as were 71 percent of English-speaking patients. Staff continued to fine tune the process in order to reach the health center's 100 percent screening goal.

Clinical Measure: Readmission Within 30 days of Discharge for Patients With Congestive Heart Failure

With a goal of lowering readmission rates within 30 days of discharge for patients with limited English proficiency, staff at Whidden Hospital (also part of Cambridge Health Alliance) provided enhanced language services during discharge.

During daily interpreter rounds, interpreters asked patients and nurses about communication needs and provided information on reaching an interpreter. Dual handset speaker phones at each bedside facilitated phone interpretation for patients speaking languages not covered by staff interpreters.

During the project period, 8 percent of patients with limited English proficiency were readmitted, compared to 17 percent of English-speaking patients.

This result raised questions such as:

- Do patients with limited English proficiency who have interpreters discuss discharge instructions more than English-speaking patients without interpreters?
- To what extent is it helpful to have discharge instructions come through someone who understands the patient's cultural context?

Clinical Measure: Improve Hemoglobin A1c Testing for Diabetes Patients With Limited English Proficiency

Staff at University of Rochester Medical Center increased access to qualified language interpreters for patients with limited English proficiency who had diabetes. They also translated diabetes education materials into languages other than English.

At the start of the project, 9.1 percent of the patients met target blood glucose levels (hemoglobin A1c).

At project end 18.8 percent of patients were at the target hemoglobin A1c level.

Clinical Measure: Improve Documentation of Diabetes Self-Management Goals for Patients With Limited English Proficiency

Staff at University of Rochester Medical Center educated providers on self-management tools and strategies (including developing and documenting self-management goals) for their patients with diabetes who had limited English proficiency. Providers then reinforced the techniques and strategies with their patients.

At the start of the project none of the patients with diabetes had documented self-management goals.

By project end, 70 percent of patients had documented self-management goals.

RELATED WORK

To provide further insights into the provision of language services, RWJF made additional grants as part of *Speaking Together*:

- One grant to obtain patient feedback on ways to enhance language services offered by hospitals participating in *Speaking Together*
- Three grants to study the cost-effectiveness of language services programs

Patient Feedback on Language Services

Lake Research Partners conducted 19 focus groups with limited- and non-English-proficient patients who had received language services at one of the hospitals participating in *Speaking Together* (ID# 061224). Lake Research Partners is a national public opinion research firm with offices in Washington, New York and Berkeley, Calif.

Lake Research staff designed the focus groups to:

- Inform *Speaking Together* national program and grantee hospital staff about what was working well with language services and what could be improved
- Explore patients' ideas for improving language services

The focus groups took place from August 2007 to February 2008, about a year after the learning collaborative network had been formed.

Findings

Staff reported key findings from the focus groups in a report to RWJF entitled *Patients Give Feedback on Language Services at Ten Hospitals: Insights from 19 Focus Groups With Limited-English and Non-English-Proficient Patients:*

- **The majority of focus group participants reported positive experiences with language services.** They appreciated the services offered—"it shows they care about us," said one patient—and stated that the services greatly enhanced their experience.
- **Long waits were the biggest concern.** Waits for interpreters ranged from 20–30 minutes to several hours and were longest in emergency departments and on weekends. Waits were not a problem when there was a scheduled appointment with an interpreter.
- **The greatest communication barriers and longest waits occurred in hospital emergency departments and registration areas.** Staff might not have been sensitive to their needs and often they were not told of the availability of language services.
- **Interpreters seemed overbooked and rushed.** Problems included: appointments where interpreters did not interpret all of their questions, interpreters leaving in the middle of an appointment because they were late for their next one and interpreters telling them not to ask so many questions.
- **Interpreters were not always gender-matched according to patient preferences.** Female patients, in particular, felt uncomfortable with a male interpreter present during an exam.
- **There was not enough bilingual staff.** Spanish-speaking patients, especially, felt other hospital staff should speak their language, rather than relying only on interpreters.

Participants suggested a range of improvements to address communication barriers in hospitals:

- **Monitor interpreter waiting time, especially in areas such as emergency departments and registration.** Address problems with staggered interpreter hours, hiring more interpreters and using alternatives such as telephone or video interpretation
- **Schedule interpreters at the same time medical appointments are scheduled**
- **Increase interpreter training, especially encouraging them not to rush patients**
- **Increase training for registration staff, focusing on regular communication with patients about delays and waiting periods**
- **Match the gender of the interpreter to patient preference as a standard practice**

- **Promote language services inside and outside the hospital so limited- and non-English-proficient patients are aware that services are available**

Developing a Model for Assessing Cost-Effectiveness of Language Services

Researchers from the Institute for Community Health (a collaboration of the Cambridge Health Alliance, Mount Auburn Hospital and Partners Healthcare in the Boston area), developed and tested a model for estimating the cost-effectiveness of professional Interpreter services (ID# 055881.)

To identify clinical and administrative outcomes and their associated costs, researchers:

- Reviewed more than 30 research articles on interpreter services:
  - Evidence indicated that interpreters generally have a positive benefit on patients with limited English proficiency in terms of resource utilization, satisfaction, quality of care and quality of communication.
  - The literature lacked evidence of the costs associated with interpreter services and the effects of these services on clinical outcomes, especially for specific diseases, such as diabetes.
- Interviewed 18 patients with limited English proficiency who had diabetes, five primary care providers, five lab and front office staff and two leaders from the ambulatory and nursing departments. Interviews addressed the perceived benefits and challenges of using interpreter services, among them:
  - Benefits of interpretation include increased patient compliance with care, increased patient and clinician satisfaction and decreased use of the emergency department for non-emergency purposes
  - Drawbacks of interpretation include longer visits and the potential for interpretation errors
- Identified possible outcomes that hospitals could measure to assess cost-effectiveness
- Identified costs involved in delivering interpreter services, including interpreter salaries and benefits, as well as overhead

Researchers constructed a cost-effectiveness model that linked data from the registration system, the electronic medical record and elsewhere for active patients in the diabetes registry. The dataset included 1,604 patients whose preferred language of care was English ("English proficient") and 1,441 whose preferred language was not English ("limited English proficient").

Following an eight-month intervention period in which patients may have received language services during ambulatory visits, researchers measured four outcomes over the next six months:

- Hospitalization for any reason
- Emergency department visit for any reason
- Diagnosis of complicated diabetes
- Blood glucose level of 7 or greater

Key Findings

Researchers noted key findings in a report to RWJF.

- **More than 68 percent of patients with limited English proficiency sometimes received either formal interpreter services (in-person or by telephone) or care from a provider who spoke their preferred language ("language concordant").** However, only 14.5 percent received these at every visit.
- **Patients who received formal interpreter services were as likely to be hospitalized as English-proficient patients similar in age, sex, race and other characteristics.**
- **Limited-English-proficient patients who had either received no formal interpreter services or who had received care from a provider who spoke their language were significantly less likely to be hospitalized than English-proficient patients.**

Challenges

Among barriers to the study were difficulties in collecting and comparing data from disparate data sources, incomplete documentation of how patient's language needs were met and the short outcome period. Because improvement in clinical outcomes could not be documented, except with the use of language-concordant providers, it was not feasible to conduct a cost-effectiveness analysis.

A Conceptual Model for Economic Evaluation of Language Services

Researchers at Johns Hopkins University Bloomberg School of Public Health, Department of Health Policy and Management, developed a conceptual model for analyzing the costs and effects of language services for individuals with limited English proficiency (ID# 055880). This model, labeled the "Three-S Model," focused on:

- The symptoms that motivate a person to access the medical care system
- The situations that shape symptoms. For example, according to Project Director Kevin Frick, Ph.D., "someone with good insurance and a good primary care

relationship may get service within a week; someone without the insurance and primary care may take a lot longer."

- The multiple systems that affect health. "While the health care system may be most important, other systems, such as the educational system or criminal justice system, may also affect a person's health," said Frick.

In a report to RWJF, the researchers made a number of recommendations about what data should be collected for future economic evaluations. They also emphasized the value of broadening cost-effectiveness analyses to incorporate factors beyond the patient and the health care system.

Cost-Effectiveness of Language Services in Hospital Emergency Rooms

Mathematica Policy Research, Inc. conducted a randomized, controlled study of the cost-effectiveness of using professional medical interpreters with Spanish-speaking patients in the emergency department (ID# 055879). Mathematica is a research firm headquartered in Princeton, N.J.

The main study goal was to estimate the effect that professional interpreters have on patient/provider satisfaction and resource utilization, compared with a hospital's usual language services (typically, telephone interpretation or *ad hoc* interpreting by bilingual staff or a patient's family or friends).

At the emergency departments of two New Jersey hospitals, researchers administered brief satisfaction surveys to Spanish-speaking patients, triage and discharge nurses, and emergency physicians after each medical encounter with a participating patient. A unique feature of the study design was to compare the use of professional medical interpreter services and usual language services in time blocks of four to six hours.

Over a seven-month period:

- Some 242 patients were enrolled during 101 treatment time blocks (i.e., those during which professional medical interpreters services were available).
- Some 205 patients were enrolled during 100 control time blocks (i.e., those offering usual language services).

Researchers also analyzed billing records for participating patients and other cost data to determine the costs of professional interpreter services, usual language services and health care services used during the emergency department visit.

Key Findings

Patient/Provider Satisfaction. Researchers reported findings in an article entitled "Examining Effectiveness of Medical Interpreters in Emergency Departments for

Spanish-Speaking Patients with Limited English Proficiency: Results of a Randomized Controlled Trial," in *Annals of Emergency Medicine*, (57(3): 248–255, 2011; abstract available online).

- **Some 96 percent of patients who had received professional interpreter services were "very satisfied" with their ability to communicate during their emergency department visit, compared with 24 percent of patients only receiving usual language services.**
- **More than 94 percent of physicians and nurses were very satisfied with visits during the time blocks in which professional interpreters were available, while fewer than 23 percent reported satisfaction with usual language services.**

"We expected to see some differences in satisfaction levels," said Project Director Ann Bagchi, Ph.D., "but the magnitude was amazing."

Cost Findings. Researchers reported cost findings in a poster presentation entitled, "Costs and Benefits of Providing In-Person Professional Medical Interpreters in the Emergency Department: Results of a Randomized Controlled Study."

- **The number and types of tests and procedures, number of prescription drugs and the use of an IV did not differ significantly between the two study groups.**
- **Costs for services and visit length did not differ significantly between the two groups.**
- **The additional cost of providing professional, in-person interpretation was $96 per case.** "It was really quite marginal, given the total costs expended during an ED visit," said Bagchi.

Researchers concluded, "Providing these services may be cost-effective for hospitals, given the significant gains in satisfaction and the increased likelihood that patients will return to the same facility for future health care needs."

LESSONS LEARNED

Lessons Related to the Improvement Team

1. **Engage all stakeholders in improving language services, including hospital executives, health care providers and families.** "Our success was made possible with our administrative, physician and nurse champions and, of course, our interpreter staff," said Bustamente, manager of Interpreter Services at Phoenix Children's Hospital. "It is also important to collect reliable data. This means working with finance leadership and data-collection analysts."

   Said Ebel at Seattle Children's Hospital, "The team working on this effort has to be broadly multi-disciplinary." Standiford at University of Michigan agreed, "The thing

that made the biggest difference was that we had a group to work together (physicians, admissions people, etc.). Interpreter services can't do it alone. It takes a multidisciplinary team."

2. **Involve senior leadership in the improvement initiative.** Project staff at Regions Hospital in St. Paul, Minn., considered the involvement of senior leadership to be a key to the project's success. At the University of Rochester, project staff said the "senior leadership vision and support are crucial to effect change." Bellevue project staff called executive director leadership "essential."

3. **Use sentinel events and stories to convince hospital leadership that language services are critical to patient safety.** Project staff at UMass Memorial Medical Center found that compelling stories about poor patient experiences or outcomes could be "a more powerful motivator than data."

4. **Include a hospital information technology specialist on the project team.** This function is needed to initiate changes in the hospital registration system. (University of Rochester project staff)

5. **Identify a "champion" to initiate the interpretation process on individual units.** "Our nurse champion on the cardiovascular floor helped to identify and train other nurse champions," said University of Michigan's Standiford. "She had success on a few units and then identified other nurse champions. They do the spread work."

6. **Appoint a project manager to oversee the improvement effort.** At the University of Michigan, said Standiford, "The key was the project manager. He had dedicated time. He did the background work and got the technological advancements. He was our 'spread agent.' He made presentations—we have 120 ambulatory clinics—and he got the word out."

Lessons Related to Quality Improvement

7. **Establish a strong relationship with the hospital's quality improvement function. "Providing interpreter services is a quality issue and you must work with quality improvement," said Van Dyke at Regions Hospital.** "We found that the people working on the electronic medical record were critical in this."

8. **Integrate principles of quality and establish quality-improvement processes. "In marketing language services, we say: effective communication equals patient safety," said Camelo at UMass Memorial Medical Center.** "We get the language services staff involved in what we are doing. Now the staff is very, very thorough in documenting what they are doing. They know the data is essential to demonstrate what we do."

Lessons Related to Measurement and Data

9. **Be respectful of standardized approaches to measurement when constructing and testing new measures.** This gives rigor and credibility to the work. (RWJF Assistant Vice President Pamela Dickson)

10. **Recognize the importance of data to the success of an improvement program.** Collecting and reporting standardized performance measures is central to assess progress, drive grantee accountability and strengthen findings. These data are also key to engaging clinicians and leadership in implementing organizational change. "Without data, we are just an opinion," said Camelo. (National program staff and Connie Camelo from UMass)

11. **Measure unmet need.** "This is where the greatest opportunity for improvement lies," said Van Dyke at Regions Hospital. "We need to measure the unmet demand for language services to see where there are gaps. If they are using family members to interpret, that is an unmet need." Providers need to document gaps so the hospital knows where to focus its quality-improvement efforts.

12. **Create a password-protected website when collecting data from collaborative members.** It is an important vehicle for managing data collection and reporting and provides a single repository for documentation. (National Program Staff)

13. **Measure the impact of providing interpretation services to build a case for reimbursement.** "I can't say enough about interpretation as a core service that requires reimbursement," said Ebel. "Patients can't get better without it. We can't deliver quality care without it. It should be a paid service, but before you can get reimbursed for this, you have to measure it."

Lessons Related to National Programs

14. **It is important for a national program to connect with related but external organizations.** "Marsha [Regenstein, national program director] was in touch with many organizations," said RWJF's Dickson. "The health quality groups were aware of this work and we got buy-in and support from them." Said RWJF's Perez, "Key lessons should be shared with national organizations. Marsha had a good relationship with many organizations. This was an important added value of the program."

15. **Require senior leadership to attend grantee meetings.** This will raise the visibility of the project in the organization and enhance its chances for success. (National Program Staff)

Lessons Related to Communication

16. **Communicate about the need for language services in ways best suited to the particular audience.** Knowing your audience changes the script. For example:

- Physicians and clinical staff relate to evidence-based information and risk reduction.
- Administrators want to hear about national trends, data, risk reduction and budgetary efficiency.
- Interpreter staff wants information in the context of national standards, skills development and their own increased involvement. (Project Staff, Phoenix Children's Hospital)

17. **Employ multiple interventions to drive the successful development and evolution of programs.** These can include:
    - Presentations to multiple audiences in multiple settings
    - Highlighting interpreter services in hospital newsletters and other hospital communications.
    - Media recognition of the needs of non-English speaking families in health care settings.
    - Using data to develop the case for system change. (Project Staff, Phoenix Children's Hospital)

Other Lessons

18. **Ensure easy access to qualified interpreters.** This is the most important factor for increasing use of interpreters, according to Bellevue project staff. "Health care providers, no matter how dedicated to good service, will not take the time and probably do not have the time to wait," they said.
19. **Budget enough time to study cost-effectiveness of a program.** It takes time to determine the real costs of a program. (Project Director, Cambridge Health Alliance Cost-Effectiveness Study, Karen Hacker)

AFTERWARD

As of August 2010, the five performance measures developed under *Speaking Together*, along with the one additional measure on translation services, were accepted into the National Quality Measure Clearinghouse of the federal Agency for Healthcare Research and Quality (AHRQ). The clearinghouse is a public resource for evidence-based quality measures and measure sets. The six measures can be accessed on the clearinghouse website.

Most of the hospitals that participated in *Speaking Together* continue to emphasize the importance of language services and to pilot new strategies. For example:

- At UMass Memorial Medical Center, staff analyzed data from all patients hospitalized over three years and found that patients with limited or no English proficiency stayed one day longer if they were not provided with interpretation at admission and discharge.
- Staff at University of Michigan Health System piloted a Direct Interpretation Access Line in Spanish and Chinese so that patients can reach an interpreter if they have questions when they schedule a hospital appointment.
- Staff has also developed a short (15 to 20 minute) screening process to verify that providers can communicate effectively with patients in a language other than English. By contrast, commercial verification tests take at least an hour—more time than providers were willing to spend.
- At Seattle Children's Hospital, interpreters are embedded in clinical teams so that clinical staff understands that interpretation is immediately available when needed. "We have dispelled the myth that it is hard to get an interpreter," said Sarah Rafton, the project director.

Aligning Forces for Quality

The RWJF national program, *Aligning Forces for Quality*, includes a focus on language services in its design. *Aligning Forces for Quality* (AF4Q) is RWJF's signature effort to lift the overall quality of health care in 17 targeted communities, reduce racial and ethnic disparities and provide models for national reform.

"All the work of the program stresses the need to include the community and that, when dealing with disparities, language has to be attended to," says RWJF's Perez. "This is a major contribution of *Speaking Together*." RWJF's Dickson says, "When we constructed the first targets for AF4Q we drew heavily on successful programs, such as *Speaking Together* and several others, and used them to construct the first set of goals for hospitals and other providers. So we used the language techniques and measures from *Speaking Together* in AF4Q."

As of August 2010, nine hospitals in five *Aligning Forces* communities are participating in a 14-month learning collaborative using the five *Speaking Together* language services measures and testing the AHRQ's translation services measure. All nine hospitals report data on ST1 and ST2, as well as on one of the other three performance measures.

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RWJF Team: Quality/Equality

APPENDIX 1

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APPENDIX 2

Analysis of Hospital-Based Language Services

National program staff analyzed data supplied by the 71 hospitals that applied to participate in the *Speaking Together* learning network to generate general information about the characteristics of hospital-based language services and practices used to identify patients with limited English proficiency and to train interpreters.

Program staff reported findings in an article entitled "Challenges in Language Services: Identifying and Responding to Patients' Needs," published in the *Journal of Immigrant and Minority Health* in 2008 (abstract available online).

- Some 90 percent of the hospitals collect patients' primary language. Of these:
  - Spanish was cited by 93 percent as the most common language spoken by patients with limited English proficiency.
  - Vietnamese was cited by 18.3 percent as the second most common language spoken by limited-English-proficiency patients.
- Admissions of patients with limited English proficiency were not significantly correlated with language services encounters, suggesting that use of language services may not reflect actual demand.
- Some 84 percent of the hospitals either offer training in medical interpretation or require that interpreters have completed training programs.

Most (88.7 percent) hospitals housed language services in a designated department.

APPENDIX 3

Funded Projects in *Speaking Together*

Bellevue Hospital Center—New York City Health and Hospitals Corp. (New York, N.Y.)

ID# 055872 (November 2006 to May 2008): $61,652

Project Director: Edith M. Davis, M.P.H.

(212) 562-4525

Edith.Davis@bellevue.nychhc.org

Cambridge Public Health Commission d/b/a Cambridge Health Alliance (Cambridge, Mass.)

ID# 059408 (November 2006 to May 2008): $61,652

ID# 065129 (November 2008 to May 2010): $99,995

Project Director: Loretta Saint-Louis, Ph.D.

(617) 591-6955

lsaint-louis@challiance.org

Children's Hospital Foundation (Seattle, Wash.)

ID# 059407 (November 2006 to May 2008): $61,650

ID# 065127 (October 2008 to March 2010): $99,963

Project Director: Sarah A. Rafton, M.S.W.
(206) 987-3881
sarah.rafton@seattlechildrens.org

Hennepin County Medical Center (Minneapolis, Minn.)
ID# 059178 (November 2006 to May 2008): $59,640
Project Director: Anthony S. Gardner
(612) 904-4214
anthony.s.gardner@hennepin.mn.us

Phoenix Children's Hospital (Phoenix, Ariz.)
ID# 055873 (November 2006 to May 2008): $61,652
Project Director: Irma U. Bustamente
(602) 546-3352
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Regions Hospital Foundation (Saint Paul, Minn.)
ID# 055869 (November 2006 to May 2008): $61,650
Project Director: Sidney Van Dyke
(651) 254-3067
sidney.e.vandyke@healthpartners.com

University of California, Davis (Davis, Calif.)
ID# 055877 (November 2006 to May 2008): $61,151
Project Director: Sergio Aguilar-Gaxiola, M.D., Ph.D.
(916) 703-9114
sergio.aguilar-gaxiola@ucdmc.ucdavis.edu

University of Massachusetts Medical School (Worcester, Mass.)
ID# 059446 (November 2006 to May 2008): $59,992
Project Director: Warren J. Ferguson, M.D.
(508) 856-6669
fergusow@ummhc.org

University of Michigan (Ann Arbor, Mich.)
ID# 055874 (November 2006 to May 2008): $61,652
ID# 065128 (October 2008 to March 2010): $99,611

Project Director: Michelle Harris
(734) 615-3580
maharris@med.umich.edu

University of Rochester (Rochester, N.Y.)
ID# 055870 (November 2006 to May 2008): $61,652
Project Director: Kathy Miraglia
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APPENDIX 4

Tools and Resources from *Speaking Together*

Product Name	Description
Language Services Measures Development	
IOM Domains of Quality Adapted for Language Services, 2006	Establishes principles for language services based on the Institute of Medicine (IOM) domains of quality
Conceptual Framework: Principles of a High Quality Language Services Program, 2006	Builds upon the IOM principles of language services by establishing objectives for a high-quality language services program
Organizational Framework for Measures of a Hospital Language Services Department, 2006	Draws on "Performance Measures for Health Care Systems," Nerenz and Neil (2001) to map out an organizational framework for language services measures
Speaking Together Measures of Quality Language Services	
Speaking Together Language Services Measures Specifications, 2006	Descriptions and specifications of five measures, plus training and assessment data, to gauge the effectiveness, safety, timeliness and efficiency of a hospital language services program
Data Dictionary for Language Services Measures, 2006	Data dictionary that establishes variables and reporting periods for the language services measures described in the above document
Data Dictionary for Interpreter and Bilingual Provider Assessment and Training Information, 2006	Data dictionary that establishes variables and reporting periods for the interpreter and bilingual assessment and training information described in the above document
Data Collection, Communication and Reporting Tools	
Clinical Care Area Log (includes tool, instructions, and example)	Log to assist hospitals in collecting information on screening for preferred language and receipt of initial assessment and discharge instructions from qualified medical interpreters within a specific hospital unit
Screening for Preferred Language Data Reporting Template (includes template, instructions and example)	Data template for reporting the percent of patients who have been screened for their preferred spoken language
Services from Qualified Language Services Providers Reporting Template (includes template, instructions and example)	Data template for reporting the percent of limited-English-proficiency patients receiving initial assessment and discharge instruction from assessed and trained interpreters or from bilingual providers assessed for language proficiency
Interpreter Services Log Tracking Tool (includes tool, instructions and example)	Daily tracking tool for interpreters to use in keeping records of each encounter. Information collected in this document includes the clinical area where the interpretation was conducted, whether the encounter was planned or unplanned, patient name, language interpreted and encounter start and end time.

Patient Wait Time Reporting Template (includes template, instructions and example)	Data template for reporting the percent of encounters where the patient wait time for an interpreter is 15 minutes or less
Time Spent in Medical Interpreting Reporting Template (includes template, instructions and example)	Data template for reporting the percent of time interpreters spend providing medical interpretation in clinical encounters with patients
Interpreter Wait Time Reporting Template (includes template, instructions and example)	Data template for reporting the percent of encounters where the interpreters wait 10 minutes or more to provide services
Interpreter Assessment and Training Information Tracking Tool (includes tool, instructions and example)	Tracking tool that enables a manager or director of interpreter services to track the number of interpreters who have been trained and assessed for medical interpreting and language proficiency
Bilingual Provider Assessment Information Tracking Tool (includes tool, instructions and example)	Tracking tool that enables a manager or director of interpreter services to track the number of bilingual providers who have been assessed for language proficiency
Speaking Together website (discussion board and collaborative extranet)	A tool for facilitating discussion and making connections among the hospitals. The discussion board provides grantees with an opportunity to share user-generated content and obtain peer support and feedback on the delivery of language services, as well as on the various clinical focus areas that grantees are addressing in their work.
Patient Satisfaction Focus Group Survey	Maps patient experience with language services and identifies opportunities for improvement
Communications Tools	Media training, press releases and messages for raising the visibility of language services
Improving Language Services Delivery	
Engaging Health Care Providers: What are Quality Language Services? Video, Fact Sheet and Users Guide	This short video introduces efforts to improve the quality and availability of language services, integrate quality improvement, pilot performance measures, test interventions to improve timeliness and quality and reduce health care disparities associated with language barriers
Language Services Action Hierarchy Tool	A tool to organize, update and determine methods for improving health care and service delivery
PDSAs (Plan-Do-Study-Act) for Language Services	Catalog of interventions for improving language services and clinical care delivery for heart, diabetes and depression
Language Services Measures Implementation Guidance	Guide helps organizations incorporate language services measures into care delivery, providing information on the tasks and resources required, and how to best manage implementation. Presents challenges and key leveraging points.
Language Services Inventory Tools	Language services program assessment matrix Training and assessment matrix Definitions matrix

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PROFILE LIST

- Telephone Interpretation Services Can Serve Hospitals Well
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