Office guide to

Limited English Proficiency (LEP) patient care

About this guide:

This is a resource guide for physicians and health care staff to aid them in the outpatient care of patients with limited English proficiency (LEP). With the rising immigrant population in both rural and urban areas of this country, language barriers between physicians and patients are increasing. This guide will provide you with information on the ways that language barriers can affect patient care and help you in selecting effective strategies to address the language needs of patients in a culturally and linguistically appropriate manner.

FAQ

1 What does the term “LEP” mean?

The operational definition for LEP is a self-rated difficulty in understanding and speaking English. According to the U.S. Census Bureau, approximately 21.4 million individuals fall into this category.

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

The best way to find out is to ask the following questions:

a. Do you speak a language other than English at home?
☐ Yes ☐ No

b. What is this language?
(For example: Korean, Italian, Spanish, Vietnamese, etc.)

c. How well do you speak English?
☐ Very well ☐ Well ☐ Not well ☐ Not at all

Patients who identify themselves as not speaking English “very well,” probably have limited English proficiency, and require some form of language assistance. Even when patients indicate they speak English, if you sense they are not understanding what you’re saying, they may still have LEP. Cues that your patients need language assistance are the following: there are few patient generated questions, patients simply nod or say “yes” in response to everything you say, or they give inappropriate or inconsistent answers to your questions.

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

a. Inaccurate or incomplete medical history may be obtained
- *May result in:* misdiagnoses

b. Miscommunication of treatment plan
- *May result in:* medication errors, inaccurate behavioral strategies, lack of follow through by the patient

c. Lack of trust and confidence in the physician
- *May result in:* lack of willingness to follow prescribed treatment plans and to share all information vital to making accurate diagnoses

4 What is the relationship between language access and cultural competency in clinical practice?

Cultural and linguistic communication barriers usually exist simultaneously. Physicians should be alert to differences in health beliefs as described in the following scenarios:

a. Medical and surgical procedures, as traditionally presented, may not be acceptable to patients of other cultures because the mode of treatment may not be culturally appropriate. For example, a hysterectomy may be unacceptable to patients of South Asian origin, regardless of the medical need for this procedure.

b. Certain ethnic-specific beliefs, such as the Navajo "hozhooji" (the belief that negative thoughts and words can cause harm), can impede informed consent.

c. Numerous folk illnesses, such as "empacho" among Latinos (a term for chronic indigestion in children with diarrhea), can affect care because symptoms associated with this term often overlap with potentially serious biomedical conditions such as intestinal blockage or appendicitis.

d. The significance and the expression of the word "pain" vary between cultures.

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

a. Community-based medical interpreters are individuals *professionally* trained in medical terminology, communication skills, confidentiality issues and cultural issues. Unfortunately, training standards are only now in the process of being standardized, and no specific certification currently exists for use by all community training organizations.

Community based interpreters can be found through:

- Hospitals and clinics
- Local community-based language agencies
- Managed care organizations
- Community colleges
- Social service programs such as legal aid services, welfare assistance programs, immigration programs, migrant health clinics and English as a second language programs.

b. Language lines provide multilingual interpretation via off-site interpreters connected by telephone. Companies providing these services can furnish either wireless remote headsets for use in areas not wired for telephones or special dual hand set 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. Language lines work optimally when a specific telephone in the office is designated for use in interpretation, or one is placed in each exam room.

The Association of Language Companies *www.alcus.org*

Examples of companies that offer language line interpreters include:
AT&T *www.languageline.com*
Medica *www.member.medica.com/LanguageResources/default.aspx*
Tele-Interpreters *www.teleinterpreters.com*

c. Emerging technology:

- *Videoconferencing Medical Interpreting (VMI):*
  This emerging technology can provide patient and provider with real-time visual imagery representation of a medical interpreter who, in turn, can see both the patient and their provider, hear their words and assess their body language. More information 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 in multiple languages into spoken English, and from English into multiple languages. Commonly this technology, referred to as a "phraselator" or "speech to speech translation," is offered by a variety of companies. It is most useful in an urgent care situations. This technology, however, is still under development, and has not been formally tested. (However, it's worth noting that the capacity to print out information, such as discharge instructions, in multiple languages already exists.)

6 Should physicians use patient family and friends or other untrained interpreters?

The answer is "no." Research indicates that when family members, friends, strangers or other untrained individuals serve as interpreters (known collectively as "ad hoc" interpreters), significantly more interpreter 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. There is an especially high risk of adverse consequences when the ad hoc interpreters are children. The consequences can include not interpreting important clinical questions that are perceived as embarrassing or in violation of patient confidentiality by the ad hoc interpreter.

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

- Phone calls from LEP patients should be answered by bilingual office staff or on-site interpreters, if available.
- 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 the same non-English language(s).
- Telephones can be programmed for a rollover-direct telephone line with tele-intepreter services in the case of high volume of diverse LEP patients.
- If using an answering service, consider contracting with one whose language capacity mirrors your practice.

8 What can your office do to improve language access service for LEP patients?

For **all** practices:

- Assess the current and future needs for language access services in your practice by collecting data on English proficiency at patient intake, and familiarizing yourself with the demographic projections in your area.
- Identify existing resources for professional interpreter services and the logistical details involved in their use (e.g. availability, cost, number and appropriateness of languages offered).
- Determine how your staff is handling calls from LEP patients and develop procedures to help them with communication barriers.
- Based on these assessments develop a business plan that assesses capacity and need for language services (including for urgent and scheduled visits) and the potential for practice growth if services are efficiently provided.
- Find out if the Medicaid or State Child Health Insurance Plan in your state pays for interpreter services. In 10 states, reimbursement for interpreter services is either authorized directly or the State contracts with specific organizations to provide interpretation (see "Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English" National Health Law Program *www.healthlaw.org*).
- Negotiate for discounted rates with local hospitals that provide interpreter services.

If your practice has greater than **10 percent of LEP patients who speak limited English:**

- Assess language skills before hiring bilingual staff and ask interpreters, before you use them on a regular basis, to provide credentials or evidence of language proficiency and interpreter training.
- Hire and train clinical bilingual staff at all levels to provide accurate interpretation. Dual train non-practitioner staff.
- Designate a staff member to take the lead in incorporating language access services into continuous quality improvement activities.
- Contact community organizations in your area for possible volunteer interpreter services and offer them professional training in exchange for service commitment.
- Reserve blocks of time for LEP patients to be scheduled and arrange for interpreters to be available during these times.
- Provide vital documents and patient education materials in English and the language of your patients. Even though your patient may not read English, someone at home may. In addition, translated materials are often hard to understand without referencing the English version.
- Provide multilingual or symbol-based signage throughout the office.

If your practice has less than **10 percent LEP patients who speak limited English** (in addition to above recommendations):

- Develop collaborative contracts for use of telephone interpreter service with other physician practices in your region. Develop a protocol that includes a designated mobile phone (or one in an exam room) and a plan to minimize waiting time for the physician.

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