

Lessons Learned by

Speaking Together

National Language Services Network

In Any Language

Improving the quality and availability of language services in hospitals

Speaking Together

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY



Robert Wood Johnson Foundation

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For more information about *Speaking Together*, please visit our website www.speakingtogether.org.
To request copies of this report, please contact *Speaking Together* at info@speakingtogether.org.

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Improving the quality and availability of language services in hospitals

by

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Introduction

It is hard for most people to imagine getting sick, going to a doctor's office, entering an emergency department, or being admitted to a hospital, and not being able to speak the same language as the doctors, nurses, or staff. Yet for millions of people in America, this is a daily occurrence. They feel frustration and fear as they try to tell care providers what is wrong or what they are feeling. Sometimes, they have loved ones who can become their voice during the health care experience. All too often, however, they cannot be sure that what they are feeling is conveyed accurately, or what they are being told is all that the doctor said.

Communication is fundamental to receiving and providing high-quality health care, yet every day, in communities all across America, people are placed in exactly this frightening and dangerous situation. A growing body of evidence indicates that persons with limited English proficiency (LEP) are getting the short end of the stick when it comes to accessing high-quality health care. They have greater difficulty obtaining care, get less primary care,¹ receive fewer preventive services,² and—not surprisingly—are less satisfied with their care.³

Imagine a different scenario—where people with LEP get sick, contact the doctor's office or enter an emergency department—and are met with signage indicating the availability of language services to ensure effective communication for all patients in need of care. Imagine

them being joined by a trained interpreter—in person or over a telephone, speakerphone, headphones, or via video—as they describe symptoms to health care providers; get clarifications to ensure full comprehension between doctors and patients; ask questions about medications or other instructions; be able to relay fears or expectations and discuss these with the health care team. Imagine each of these patients leaving the hospital feeling as though they were active partners in their own care.

This latter scenario is playing out in many hospitals and other health care organizations across the country. Pioneers in language services delivery have spent the last few decades building and nurturing programs to respond to the needs of patients who would otherwise be at risk of receiving poor quality care and experiencing higher rates of medical errors.^{4,5}

Sprinkled across the country are hospitals that are actively engaged in delivering health care for diverse and rapidly changing patient populations. Anecdotally, whether large or small, experienced or novice, hospitals report that they are overwhelmed by the language needs of patients and uncertain about how best to address these growing demands.

This report showcases the work of some of these very pioneers—hospitals that have thrown commitment, resources, passion and energy behind one overarching goal: to provide the best care possible for patients who cannot rely on their English language skills to interact effectively with the health care system. Some of these hospitals have been operating language services programs for years; others are veritable new kids on the block. All face challenges in meeting the language needs of their patients in resource-stressed, highly complex, and busy environments.

Some of these hospitals have come together as part of a Robert Wood Johnson Foundation program designed to improve the quality and availability of language services in hospitals across the country. *Speaking Together: National Language Services Network*, an initiative housed at the George Washington University School of Public Health and Health Services, brings tried and true quality improvement tools to the field of language services. Until *Speaking Together*, few hospitals actively involved language services in quality improvement efforts.

Speaking Together was launched in November 2006, following a competitive grant application process that resulted in the selection of 10 participating hospitals. To be eligible, hospitals had to have a substantial number of LEP patients (in inpatient and outpatient settings) to make quality improvement efforts meaningful, an established language services department, and at least some on-site interpreters who were employees of the hospital. The hospitals selected to participate in *Speaking Together* each received a \$60,000 grant plus intensive technical assistance throughout an 18-month learning network. Table 1 includes information describing the participating hospitals and the language services that they provide.

This report highlights the experiences of the *Speaking Together* hospitals and showcases just some of the initiatives and interventions that been implemented in these health care organizations.⁶ It begins with a discussion of a set of performance measures that were developed to provide a common platform for working toward quality improvement in language services. The next sections of the report highlight the progress that the hospitals have made in achieving their goals around improved language services delivery. To this end, graphic illustrations are provided describing performance on the language services measures throughout the Learning Network. Also described are the structural, organization and procedural changes that took place in the hospitals to support and sustain change on behalf of patients with language needs. The final section provides some lessons born from experiences in *Speaking Together*. The hope is that these experiences will help other hospitals across the country tackle the tough challenge of advancing language services within their organizations.



- 1 Weinick RM, Krauss NA. Racial and ethnic differences in children's access to care. *Am J Public Health* 2000 Nov;90(11):1771-4.
- 2 Woloshin S, Schwartz LM, Katz SJ, et al. Is language a barrier to the use of preventive services? *J Gen Intern Med* 1997 Aug;12(8):472-7.
- 3 Andrulis D, Goodman N, Pryor C. What a difference an interpreter can make: Health care experiences of uninsured with limited English proficiency. The Access Project, 2003 Apr. Boston (MA).
- 4 Cohen AL, Rivara F, Marcuse EK, et al. Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics* 2005 Sep;116(3):575-9.
- 5 Divi C, Koss RG, Schmaltz SP, et al. Language proficiency and adverse events in U.S. hospitals: a pilot study. *Int J Qual Health Care* 2007 Apr;19(2):60-7. Epub 2007 Feb 2.
- 6 Hospitals participating in *Speaking Together* each worked on two clinical measures that could demonstrate a link between language services delivery and quality of patient care. Lessons and findings pertaining to these measures will be featured in subsequent reports.

TABLE 1
SPEAKING TOGETHER PARTICIPATING INSTITUTIONS

	Bellevue Hospital Center	Cambridge Health Alliance	Hennepin County Medical Center	Phoenix Children's Hospital
LOCATION	New York, NY	Cambridge, MA	Minneapolis, MN	Phoenix, AZ
NUMBER OF BEDS*	771	350	434	285
TOTAL ADMISSIONS*	26,068	15,263	22,117	11,712
ANNUAL INTERPRETER ENCOUNTERS‡	58,962	140,556	120,000	48,043
TOTAL FTE FOR LANGUAGE SERVICES‡	34.0	63.1	53.0	13.9
PERCENT OF INTERPRETATION ENCOUNTERS IN TOP 5 LANGUAGES‡	60% Spanish 26% Mandarin 6% Cantonese 3% Polish 2% French	55% Brazilian Portuguese 24% Spanish 7% Haitian Creole 2% European Portuguese 2% Hindi	60% Spanish 12% Somali 4% Russian 3% Hmong 1% Laotian	>99% Spanish

* Data from an analysis of American Hospital Association Annual Survey data, FY 2005. *AHA Annual Survey Database*. FY2005 ed. Chicago, IL: American Hospital Association; 2007.

‡ Data from a *Speaking Together: National Language Services Network* internal survey, 2006.

Speaking Together: Results In Brief

Ten hospitals used performance measures developed by Speaking Together over the course of 18 months to measure and improve five key aspects of language services delivery:

SCREENING FOR PREFERRED LANGUAGE

Due to efforts to verify the accuracy of screening processes, the percent of patients screened for preferred language actually declined slightly for the 10 participating hospitals—from 97 percent to 94 percent. For two

hospitals that performed lowest on this measure at the outset of the Learning Network, however, screening rates improved from 59 percent to 83 percent, and 50 percent to 90 percent, respectively.

PATIENTS RECEIVING LANGUAGE SERVICES (LS) FROM LS QUALIFIED PROVIDERS

The median percentage of patients with language needs who received initial assessment and discharge instructions with the assistance of a qualified interpreter or bilingual provider at all 10 hospitals increased from 35 percent to 53 percent.

Regions Hospital	University of Michigan Health System	University of Rochester (Strong Memorial Hospital)	Children's Hospital and Medical Center	University of California Davis Medical Center	University of Massachusetts Memorial Health Care
St. Paul, MN	Ann Arbor, Michigan	Rochester, NY	Seattle, WA	Sacramento, CA	Worcester, MA
399	802	973	250	526	731
22,827	42,811	36,321	11,608	27,946	44,231
28,887	21,503	14,885	40,690	65,000	59,134
12.1	16.0	10.4	7.9	22.8	28.5
50% Spanish 12% Hmong 10% Somali 9% Vietnamese 4% ASL	22% Spanish 18% Chinese 14% Japanese 12% Arabic 10% Russian	46% Spanish 35% ASL 3% Vietnamese 2% Russian 2% Arabic	55% Spanish 7% Vietnamese 4% Somali 4% Russian 2% Cantonese	58% Spanish 20% Russian 8% Mien 5% Hmong 5% Cantonese/Mandarin	62% Spanish 13% Portuguese 7% Vietnamese 5% Albanian 3% ASL

PATIENT WAIT TIME

For the 10 participating hospitals, the median percentage of patients who waited 15 minutes or less for an interpreter held steady at about 94 percent. At one hospital, the percent of patients waiting 15 minutes or less for an interpreter increased from 66 percent to 93 percent.

TIME SPENT INTERPRETING

For the 10 participating hospitals, the median time spent interpreting increased from 39 percent to 43 percent. Interpreter productivity increased on the whole, with a 10 percent relative increase among participating hospitals.

INTERPRETER DELAY TIME

For the 10 participating hospitals, the median percentage of encounters in which interpreters waited less than 10 minutes for a provider or patient improved from 83 percent to 89 percent. One hospital increased the percent of encounters in which interpreters wait less than 10 minutes for the provider or patient from 79 percent to 93 percent.

Measuring Quality in Language Services Delivery

Many hospitals across the country recognize that quality communication is critical to quality care, but without the tools to measure and strategically improve language services delivery they cannot ensure that their patients' language needs are being met. This project began with the premise that high-quality language services can be measured and achieved by moving them into the mainstream of service delivery and quality improvement activities.

Quality improvement cannot take place without a clear understanding of what constitutes high-quality care. Thus, before a learning network could be assembled around the delivery of language services in a hospital setting, a set of common measures that would clearly stand for high-quality service delivery had to be identified. Prior to *Speaking Together*, these measures did not exist.

What is Quality Improvement?

Quality improvement uses measures to assess whether processes are performing the way they are intended. Data is collected to identify areas for improvement and to develop and test changes in processes so that the overall system functions the way that it should. The emphasis is on processes and the system rather than on the individual or employee.

What did exist was a substantial amount of research, information, and technical specifications about qualifications of interpreters, the “architecture” of the interpreted health care encounter,⁷ and training programs to support the field of medical interpretation. Much of this wisdom was incorporated into the program.

Even with this prior work, however, the field of language services lacked measures that could be used by health care organizations to assess how well they were meeting the language needs of their patients. For this reason, *Speaking Together* developed a multi-staged process to identify a core set of measures that could ultimately be used by hospitals interested in doing quality improvement in this area.⁸

7 Much of the literature addresses how an encounter assisted by a medical interpreter should be conducted. For example, the positioning of the interpreter, how the interpreter interacts and conveys the message to the patient, and the role of the interpreter in the encounter (e.g., as a cultural broker of information versus strictly an interpreter) are all issues frequently dealt with in the literature.

8 Regenstein MJ, Huang JC, West C, et al. “Hospital Language Services: Quality Improvement and Performance Measures,” *Advances in Patient Safety: New Directions and Alternative Approaches*, AHRQ (to be released Spring 2008).

TABLE 2
INSTITUTE OF MEDICINE DOMAINS OF QUALITY ADAPTED FOR LANGUAGE SERVICES

DOMAIN	PRINCIPLE
SAFE	Avoiding injuries to patients from the language services that are intended to help them.
EFFECTIVE	Providing language services based on scientific knowledge that contribute to all who could benefit, and refraining from providing services to those not likely to benefit.
PATIENT-CENTERED	Providing services that are respectful of and responsive to individual patient preferences, needs, culture and values, and ensuring that patient values guide all clinical decisions.
TIMELY	Reducing waits and sometimes harmful delays for both those who receive and those who give care.
EFFICIENT	Avoiding waste, including waste of equipment, supplies, ideas and energy.
EQUITABLE	Providing language services that do not vary in quality because of personal characteristics such as language preference, gender, ethnicity, geographic location, and socioeconomic status.

Modified from: Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: a New Health System for the 21st Century*. Washington (DC): National Academies Press; 2001.

Several overarching principles guided the development of the measures:

- Health care organizations must know who among their patients could benefit from language services.** In practice, this means that all patients should be asked about their language preference. It also means that a patient-centered approach must be taken to ensure quality care.
- Health care organizations must know whether patients who need language services actually receive them.** Just knowing how many interpreted encounters were provided in any given year does not get to the more pressing issue of whether the patient got the service when he or she needed it.
- Health care organizations must develop a supply of high-quality language services.** Whether through on-site staff or contract employees, telephonic interpreting, video or remote simultaneous interpretation, or via bilingual clinicians and staff, health care organizations must be equipped to effectively communicate with all of their patients.
- Health care organizations must provide language services in a timely manner.** We learned from countless discussions with doctors, nurses and hospital administrators that if language services aren't easily accessible, they won't be used.

In addition to these guiding principles, the measures were driven by the idea that the same framework used to guide quality in other aspects of patient care can be used to guide quality in language services delivery. Table 2 describes the domains of quality, as articulated by the Institute of Medicine, adapted by *Speaking Together* for language services.



What emerged from this process were five measures that have been used throughout the *Speaking Together* Learning Network to gauge progress in the 10 participating hospitals. The Speaking Together (ST) measures are:

- **ST 1: Screening for Preferred Language**
The percent of patients who have been screened for their preferred spoken language.
- **ST 2: Patients receiving language services (LS) from qualified LS providers**
The percent of patients with language needs who receive initial assessment and discharge instructions from assessed and trained interpreters or from assessed bilingual providers.⁹
- **ST 3: Patient wait time**
The percent of encounters where the patient wait time for an interpreter is 15 minutes or less.
- **ST 4: Time Spent Interpreting**
The percent of time interpreters spent providing medical interpretation in clinical encounters with patients.
- **ST 5: Interpreter delay time**
The percent of encounters interpreters wait less than 10 minutes to provide interpreter services to clinician and patient.

⁹ For the purposes of this measure, we identified two instances in a patient's interaction with his or her provider during which adequate communication is absolutely necessary: during initial assessment and when receiving discharge instructions. Although there are other points in care in which language services may be necessary, we selected these two points as processes common to most patients in a hospital setting.

Performance Improvement in Language Services

The experiences of the Speaking Together hospitals demonstrate that with commitment, the right team and a solid foundation for success, health care organizations can measure and improve the performance of language services delivery.

FACTORS FOR SUCCESS

- **Using measurement to track language services performance.** Data are absolutely necessary to gauge how well patients' language needs are being met in the organization. Collecting data is key to driving change, engaging providers and directing improvement in the organization. Hospitals must adopt core measures for language services, such as the measures in this report, to track their performance.
- **Starting small before spreading to the rest of the organization.** Depending on the size of the hospital, its experience with language services and the distribution of patients across sites of care, hospitals can choose to focus more or less narrowly to begin their quality improvement work. However, all hospitals should test one or more of these measures to assess current performance and set targets for improvement before deciding to spread to the rest of the organization. Starting small allows for change and adjustment along the way, and can save valuable resources.
- **Placing clinical providers at the forefront of improvement efforts.** The language services department should work to make its services accessible and up to quality standards, but providers are ultimately responsible for ensuring that their patients' language needs are met. Without clinical involvement, an organization cannot get language services to patients who need them when they need them.
- **Working with the quality improvement department to develop and oversee strategies for change.** Language services must be linked with quality improvement in the organization in order to effectively embed language services into the organization and prioritize areas for improvement.
- **Engaging senior and executive leadership in achieving high-quality language services in the organization.** Meaningful change in the delivery of language services cannot occur without the strong support of leadership. A commitment to safe, effective, efficient, equitable, timely and patient-centered communication in the organization must come from above.

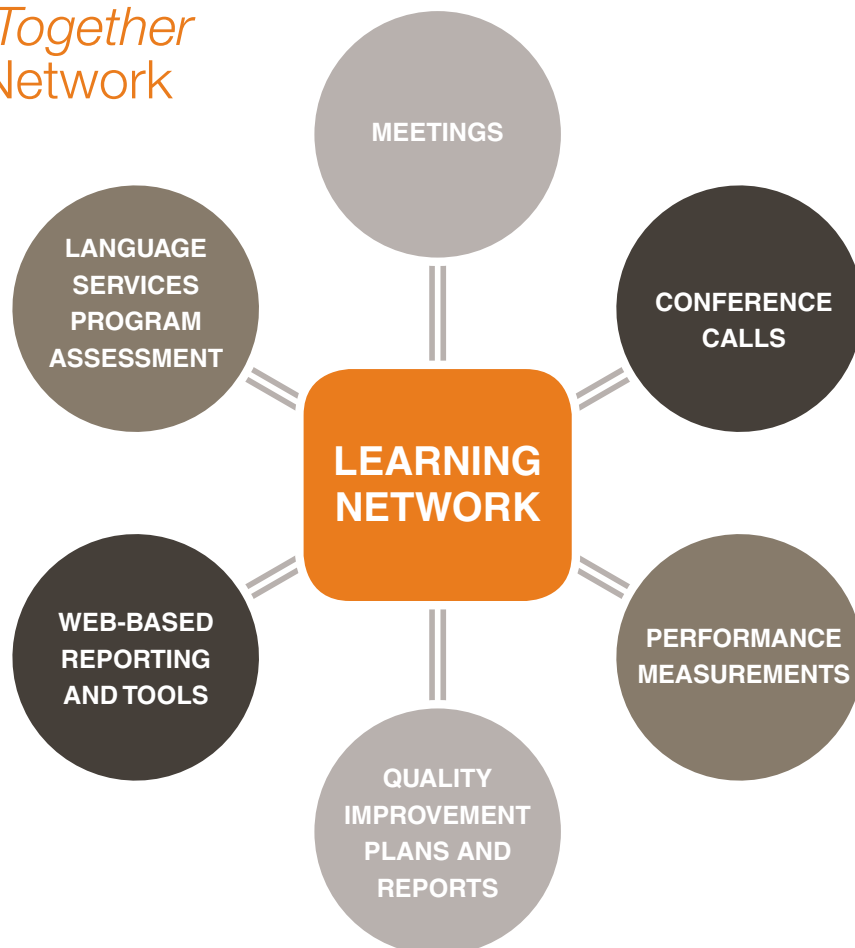
- **Developing a relationship with registration and scheduling departments as the first point of patient contact.** Accurate identification of a patient's language needs generally falls on registration and scheduling staff. An effective language screening process creates efficiencies in language services delivery and helps ensure that patients needing services receive them.
- **Seeking support from information technology to link systems.** Recording and tracking performance information can be burdensome without the right systems to support these processes. Language services

departments should work with information technology and quality improvement to identify ways to link with other key departments and systems in the organization, such as registration and scheduling.

SETTING THE STAGE FOR CHANGE

Performance improvement in language services requires more than commitment and a good foundation for success. Hospitals need tools to assess performance and implement change. In the *Speaking Together* Learning Network, the following tools, collaborative learning and mechanisms of support proved integral to improvement.

Speaking Together Learning Network Activities



Data Collection and Reporting

Beginning in November 2006, the 10 *Speaking Together* hospitals tracked progress in the delivery of language services using the five ST measures. This was a challenging undertaking for all hospitals involved, despite being chosen in part because of their ability to participate successfully in a quality improvement project.

The ST measures required the collection of new data elements and, in many cases, new data collection processes. Some hospitals developed relationships with their information technology departments to facilitate data collection efforts. Others created manual data collection processes to capture information about patients' receipt of language services during initial assessment and discharge. Several created working groups with registration staff to make certain that the language screening process made sense to staff and worked well for patients.

The *Speaking Together* project directors submitted monthly data reports on the five measures plus progress reports detailing challenges or successes from the previous month.

Technical Assistance

Hospitals received technical assistance from the *Speaking Together* quality improvement specialist, a nurse with substantial expertise in quality improvement, and other program staff. This assistance included two on-site team meetings with the QI specialist, as well as numerous targeted discussions to make certain that each hospital team understood the data collection requirements and progressed according to its own particular goals. A language services program assessment was conducted at the start of the Learning Network to gain an understanding of program structure and operations at each hospital.

Tools and RCC

Participants received training in rapid cycle change (RCC)—a quality improvement technique that uses a “plan-

do-study-act” model. RCC allows organizations to test and measure changes on a small scale before spreading to the rest of the organization. In addition to training, ST hospitals also received data collection and improvement tools to measure performance and document strategies.

Speaking Together developed a collection of sample strategies for change based on the experiences of the ST hospitals in their first months as Learning Network participants. The document, entitled “Tools for Improving Language Services Delivery” was provided to hospitals in later months of the project to spread tested strategies for change among the hospitals.

Collaborative Learning and Sharing

Teams from all of the hospitals met as a group four times during the course of the 18-month project—first to learn about the processes and science behind quality improvement, and later to share strategies and progress through peer-to-peer learning. They also participated in monthly conference calls that featured topical presentations and updates from each hospital. The meetings and conference calls were designed to foster both collaboration and friendly competition among the hospitals. In addition to web-based reporting of data, participants shared progress, success stories, strategies, and tools via a private Learning Network website.

STRATEGIES FOR IMPROVEMENT

The *Speaking Together* hospitals used a variety of strategies to improve the quality and availability of language services in their organizations. Collectively, hospitals in the Learning Network tested over 200 strategies using quality improvement techniques (a small sample is shown in Table 3). The strategies implemented by a given hospital were largely dependent on available resources, needs of the organization and the particular challenges facing that language services program.

TABLE 3
SAMPLE STRATEGIES

MEASURE	STRATEGY
SCREENING FOR PREFERRED LANGUAGE	<ul style="list-style-type: none"> • Develop scripts for registration and scheduling staff to use when asking about language preference • Create and revise a list that registration and scheduling staff can easily use to select and record the preferred language of the patient • Designate a place in the patient record for recording language needs
PATIENTS RECEIVING LANGUAGE SERVICES (LS) FROM QUALIFIED LS PROVIDERS	<ul style="list-style-type: none"> • Include language services in planned care models and work flows • Program electronic systems to automatically notify language services when appointments requiring an interpreter are scheduled • Assess bilingual providers for language proficiency • Place language next to patient's name of inpatient unit white boards
PATIENT WAIT TIME	<ul style="list-style-type: none"> • Notify clinics in advance which visits will be assisted with an in-person interpreter and which will be with 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
TIME SPENT INTERPRETING	<ul style="list-style-type: none"> • Use data related to the encounter type and location of encounter to determine how much time is needed to schedule the interpreter • Revise interpreter assignments to decrease travel time • Provide permanent interpreter assignments in high volume languages at high volume locations
INTERPRETER DELAY TIME	<ul style="list-style-type: none"> • Block schedule interpreters in clinics with a high volume of LEP patients speaking a particular language • Conduct daily morning huddles with clinical managers to review the day's schedule and interpreter needs • Place appointment reminder calls the day before

Learning Network participants documented tests of change in order to develop a record of their various strategies and to determine which strategies produced positive results. Using a rapid cycle testing (RCT) log, hospitals shared these tests with team members internally as well as other Learning Network participants.

RAPID CYCLE TESTING (RCT) SAMPLE LOG

RCT#	Date	Performance Measure Affected	Goal # and Title	Change Tested	Data Collection Processes	Responsible Person	Results
4	2/1/2008	ST3	Improve patient wait time to 15 minutes or less	Improved dispatching; Decreased from 4 departments managing dispatch to 2 departments. Interpreter services managing dispatch 8AM-11PM.	Interpreter log for 7 days	Interpreter services supervisors and interpreters	96% of interactions wait less than 15 minutes
5	2/4/08	ST3	Improve patient wait time to 15 minutes or less	Dedicated Spanish speaking interpreters added to ED and day surgery.	Interpreter log for 7 days	Interpreter services supervisors and interpreters	98% of ED interactions wait less than 15 minutes

FINDINGS OF THE SPEAKING TOGETHER LEARNING NETWORK

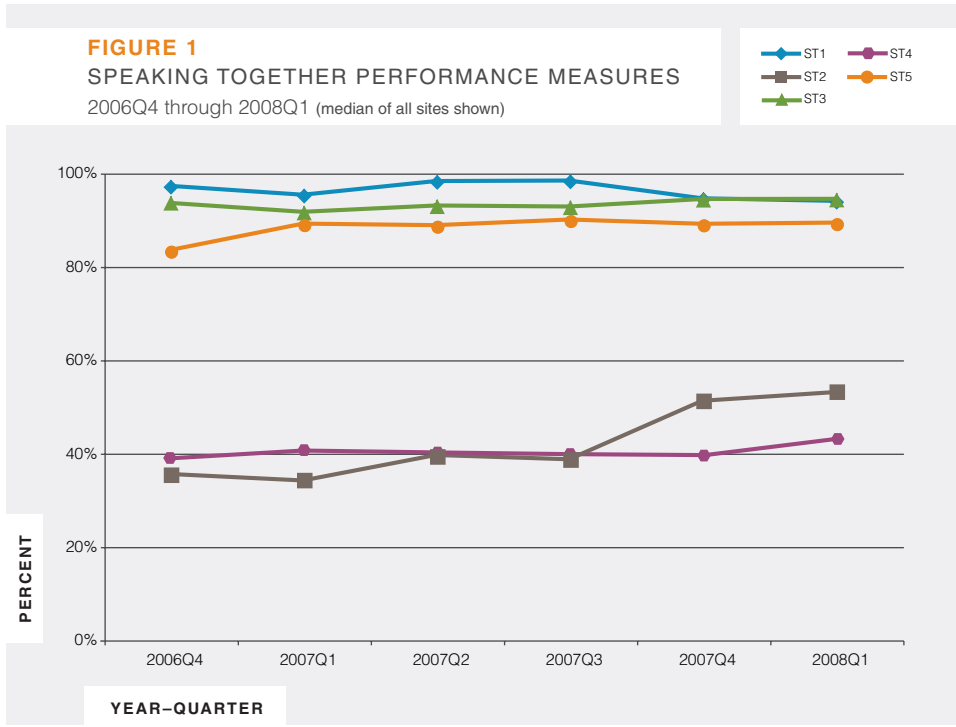
The *Speaking Together* Learning Network represents the first time that hospitals from across the country have come together to use measurable information to improve language services performance. The findings of the project include information that may be useful to an individual hospital looking to improve, as well as to the field of language services in general. Although the results should not be used to generalize the state of all language services programs nationwide, these data provide a first glimpse into performance improvement trends in language services.

Overall performance of the 10 hospitals participating in the *Speaking Together* learning collaborative is shown in Figure 1. Hospitals tracked their performance on five measures related to the delivery of language services in hospitals—each of these measures is shown as a separate line in Figure 1



- ST1:** Screening for Preferred Language
- ST2:** Patients Receiving Language Services (LS) from Qualified LS Providers
- ST3:** Patient Wait Time 15 Mins or Less
- ST4:** Time Interpreters Spend Interpreting
- ST5:** Interpreter Wait Time Less Than 10 Mins

FIGURE 1
SPEAKING TOGETHER PERFORMANCE MEASURES
 2006Q4 through 2008Q1 (median of all sites shown)



(illustrated by a separate color) over a 16-month period. Each line corresponds to the median value of all 10 hospitals.

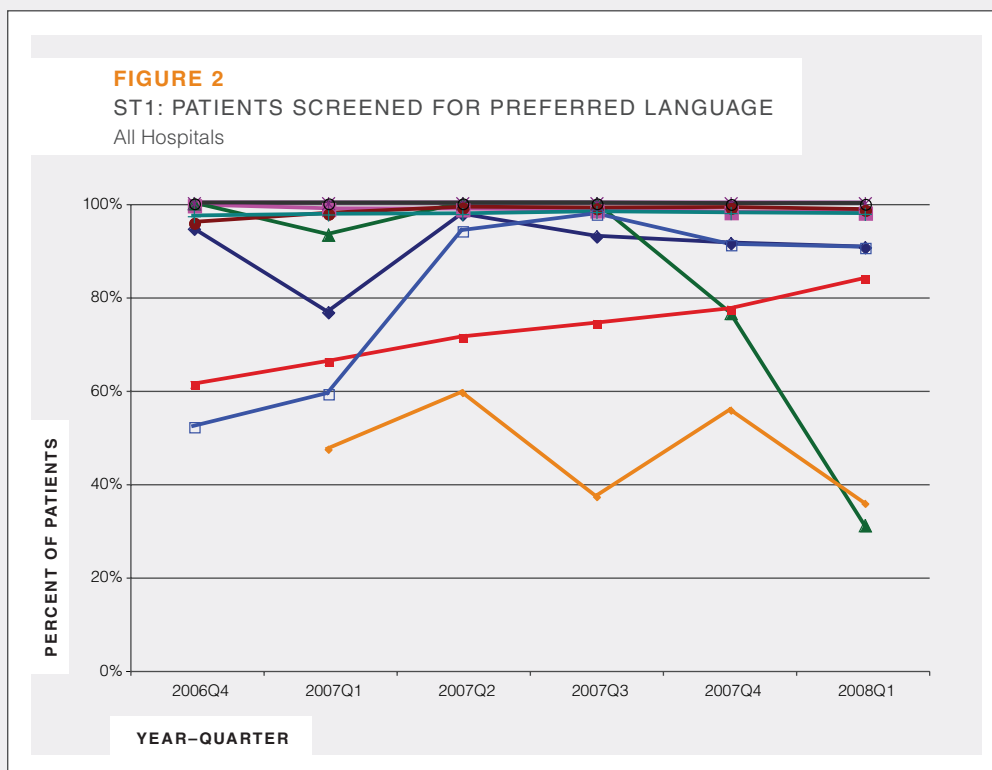
As Figure 1 graphically illustrates, performance is quite high for three of the measures and much lower for two others. Each measure is discussed separately below.

ST 1: Screening for Preferred Language

Speaking Together hospitals generally performed extremely well on the screening measure. This was an expected finding, since the selection process for participation in *Speaking Together* favored hospitals that had systems in place to screen for preferred language and capacity for data collection related to use of language services.

Most hospitals demonstrated their ability to screen most patients for language preference from the first several

months of the project; nevertheless, a few took time to begin to see improvements in this measure (see Figure 2). For example, at the beginning of the project, about 60 percent of patients at one hospital were screened for language preference. Through a combination of efforts, such as using data to open a discussion with the leaders of registration and scheduling; training staff on the how and why of screening for language needs; programming reminders in the registration and scheduling screens to prompt staff to complete the language field; and using scripts for language screening, the measure increased to over 80 percent. At another hospital, the use of similar strategies, together with integrating demographic information with other electronic systems in the organization, resulted in an improvement from approximately half of patients screened to nearly all patients by the second quarter of 2007.

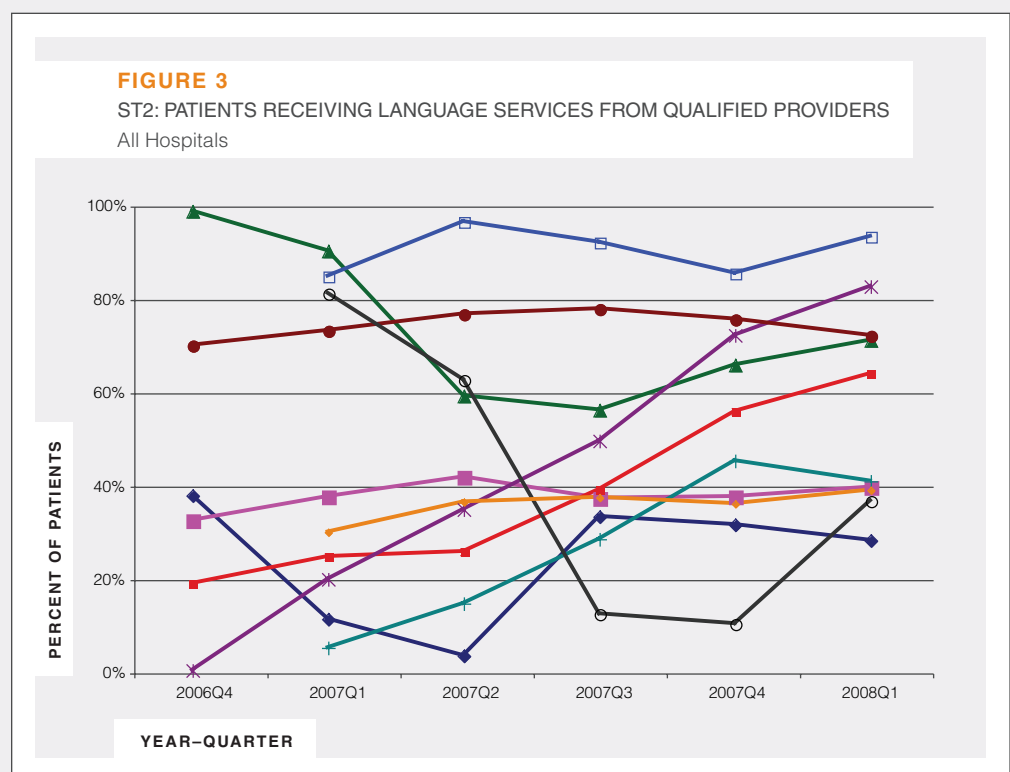


ST 2: Patients Receiving Language Services (LS) from Qualified LS Providers

ST 2 proved to be an extremely challenging measure for the hospitals and performance was highly variable across participants. As Figure 3 illustrates, about half of the hospitals showed improvement in their ability to provide appropriate language services to patients who needed them at initial assessment and discharge. Several hospitals worked for months to be able to track performance on this measure—an indication that even experienced and sophisticated language services programs have trouble determining whether patients who need language services actually receive them.

The performance of two of the hospitals with the most substantial improvement in ST 2 is shown in Figure 4. Hospital A¹⁰ began the project literally at zero—in this case, meaning that there was no documentation of patients receiving needed language services (whether they received them or not). After consistent and conscientious documentation efforts, interactions with clinic and unit nurses, physicians and other staff, targeted education efforts by the language services team and clearly articulated support from executive leadership, ST 2 began to improve and continued to show steady improvement throughout the project. Over each quarter, performance nearly doubled and by the end of the Learning Network, performance on ST2 was over 80 percent.

¹⁰ Hospital names are not the same throughout. For example, “Hospital A” in Figure 4 may not be the same hospital as “Hospital A” in Figure 7.



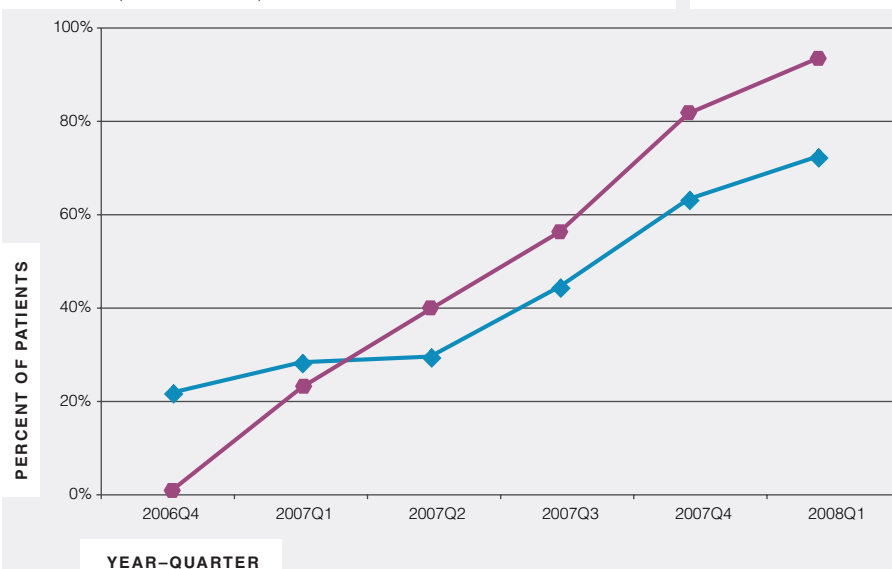
Hospital B began ST 2 at about 20 percent—meaning that only 20 percent of patients who needed language services were receiving them at initial assessment and discharge. By the end of the project, this measure had tripled to over 60 percent. This occurred because of efforts to educate providers, work with clinical staff to improve interpreter scheduling, greater use of telephonic interpreting and monitoring the use of bilingual providers.

We tracked performance on ST 2 across all patients needing language services and also looked within the measure to see whether there was variation in performance across language. We wanted to know whether patients who needed language services in Spanish, for example, were as likely to get those services as patients needing language services in Vietnamese, Haitian Creole, or any other language commonly spoken by patients at the hospitals.

As Figure 5 illustrates, Hospital C provided language services at initial assessment and discharge for approximately 25 percent of Spanish- and Chinese-speaking patients and 15 percent of patients speaking “other” languages at the beginning of the project. By the end of the Learning Network, 71 percent, 85 percent, and 46 percent of these patients received services from a qualified interpreter at these critical points of care, respectively. These improvements were the results of strategic efforts to target one language and one clinic at a time, and to use data as evidence to clinicians and the rest of the project team that their interventions were successful. More work will be done to continue monitoring access to language services to ultimately bring all language groups to the benchmark for Spanish- and Chinese-speaking patients.

FIGURE 4

ST2: PATIENTS RECEIVING LANGUAGE SERVICES FROM QUALIFIED PROVIDERS
Hospital A and Hospital B



ST 3: Patient Wait Time

Performance on ST 3—one of two timeliness measures tracked throughout the project—was consistently high for the majority of participants (see Figure 6). More than 90 percent of the time, patients waited 15 minutes or less for a language service (provided via on-site interpreter, telephonic services, remote simultaneous interpretation, or video).

Much of the improvement on ST 3 was sparked by an examination of timeliness of language services across languages and attempts to bring timely services to patients, regardless of the language spoken. For example, as Figure 7 illustrates, by tracking ST 3 performance, Hospital A learned that Chinese- and Vietnamese-speaking patients were much less likely to receive timely language services compared to Spanish- and Portuguese-speaking patients. As a result of initiatives designed to improve timeliness,

including revising schedules to staff interpreters based on daily or weekly peak times, by language and increasing access to remote interpreting methods for infrequent languages, nights and weekends performance for all language groups was consistently high. For Vietnamese-speaking patients, nearly 100 percent of encounters occurred with the patient waiting 15 minutes or less.

ST 5: Interpreter Delay Time

The second ST timeliness measure tracked wait times for interpreters—i.e., the time that interpreters wait with patients for the clinical encounter to begin. Anecdotally, we heard that interpreters waste substantial time waiting for physicians, nurses, and other providers. This can cause interpreters to be late for subsequent appointments, disrupt clinic schedules, and frustrate patients, clinicians and interpreters alike.

FIGURE 5

ST2: PATIENTS RECEIVING LANGUAGE SERVICES FROM QUALIFIED PROVIDERS
Hospital C by Language

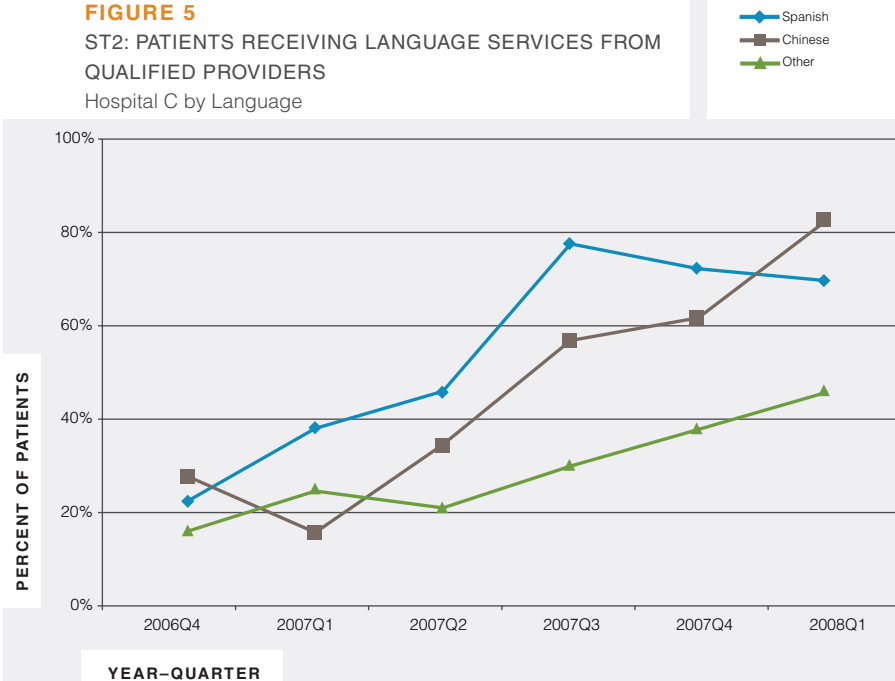


FIGURE 6
ST3: PATIENT WAIT TIME 15 MINS OR LESS
All Hospitals

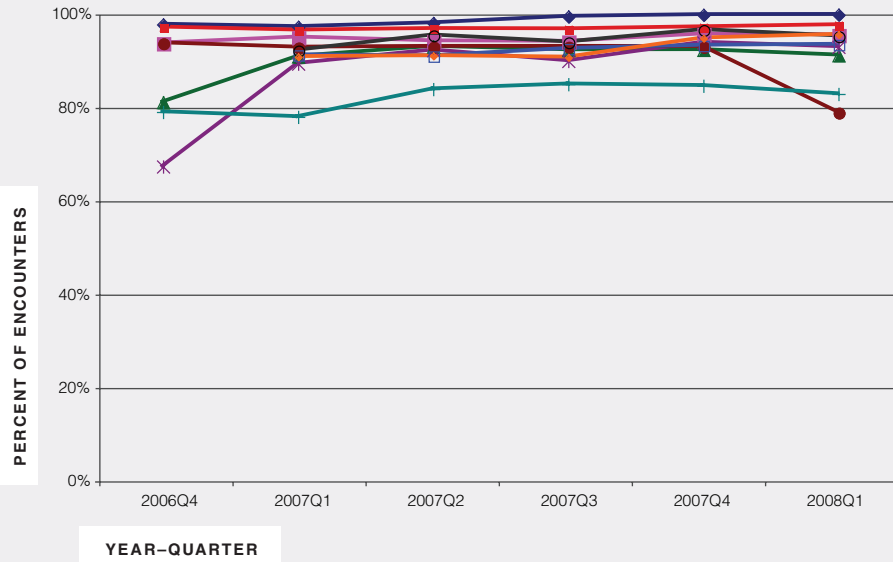
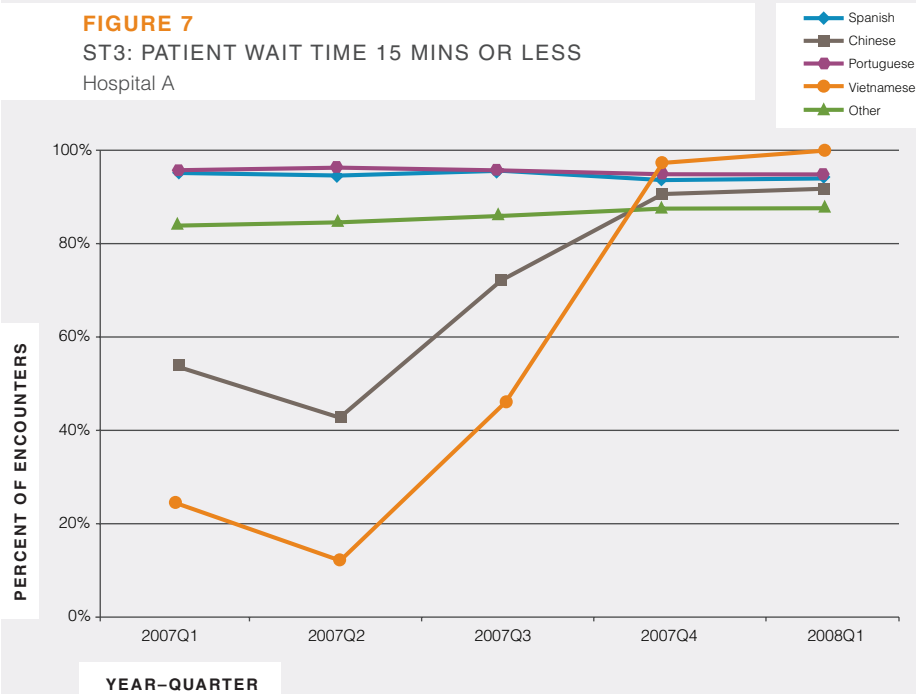


FIGURE 7
ST3: PATIENT WAIT TIME 15 MINS OR LESS
Hospital A



As can be seen in Figure 8, half of the hospitals report that at least 90 percent of the time, interpreters wait less than 10 minutes for the clinical encounter to begin. The other half of the hospitals did not perform as well on this measure, indicating that interpreters may be spending valuable time waiting with patients for a clinical encounter to begin.

At some of the hospitals, interpreter wait times were fairly consistent across languages—for example, at one hospital, performance was slightly lower for Vietnamese- and Somali-speaking interpreters, relative to Spanish-speaking interpreters, although the data indicate that the rates were very similar across the project period for all the languages

(see Figure 9). At another hospital, however, the data on ST 5 revealed that some interpreters consistently wait longer than others for encounters to begin (see Figure 10). While nearly all other interpreters wait less than 10 minutes for an encounter to begin, Chinese-speaking interpreters wait longer approximately 50 percent of the time. Performance on this measure dipped during the project period and then began to rise steadily for the remainder of the project. The rate increase can be attributed to the hospital's sharing of data with providers and emphasizing the idea that when interpreters wait, it subsequently delays other encounters for providers and patients.

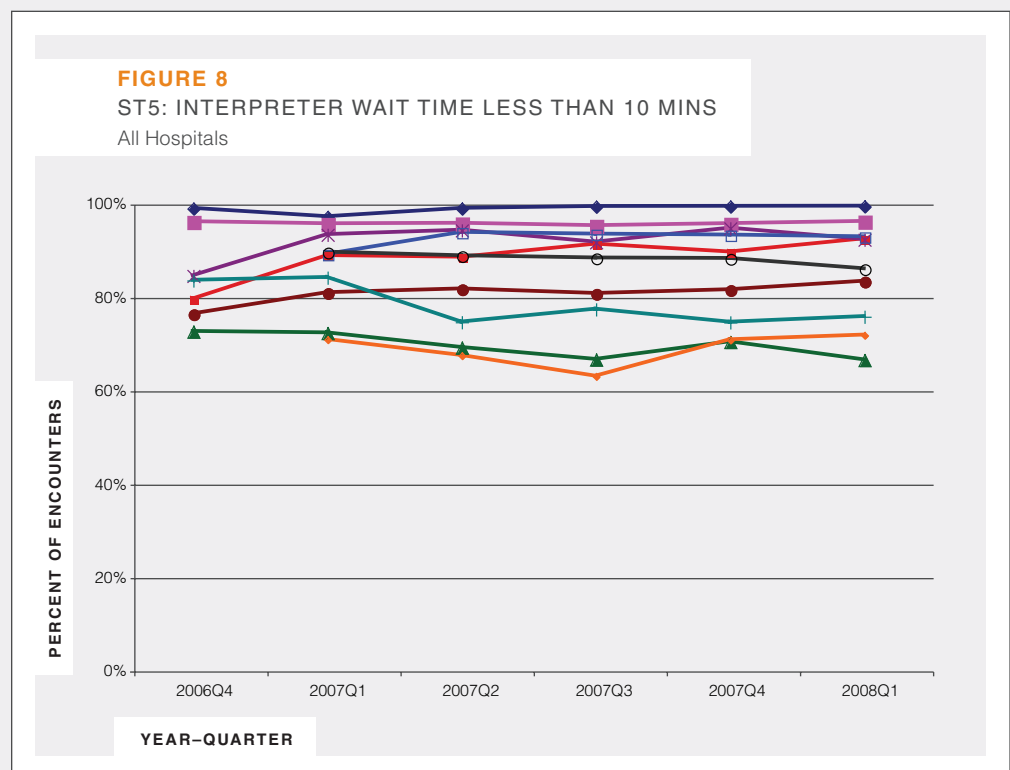


FIGURE 9
ST5: INTERPRETER WAIT TIME LESS THAN 10 MINUTES
Hospital A

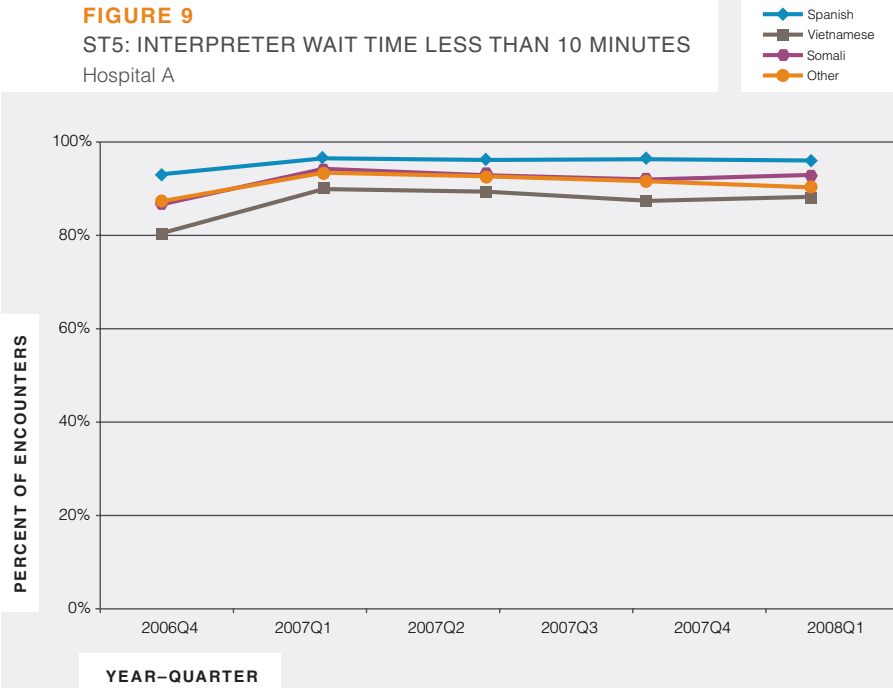
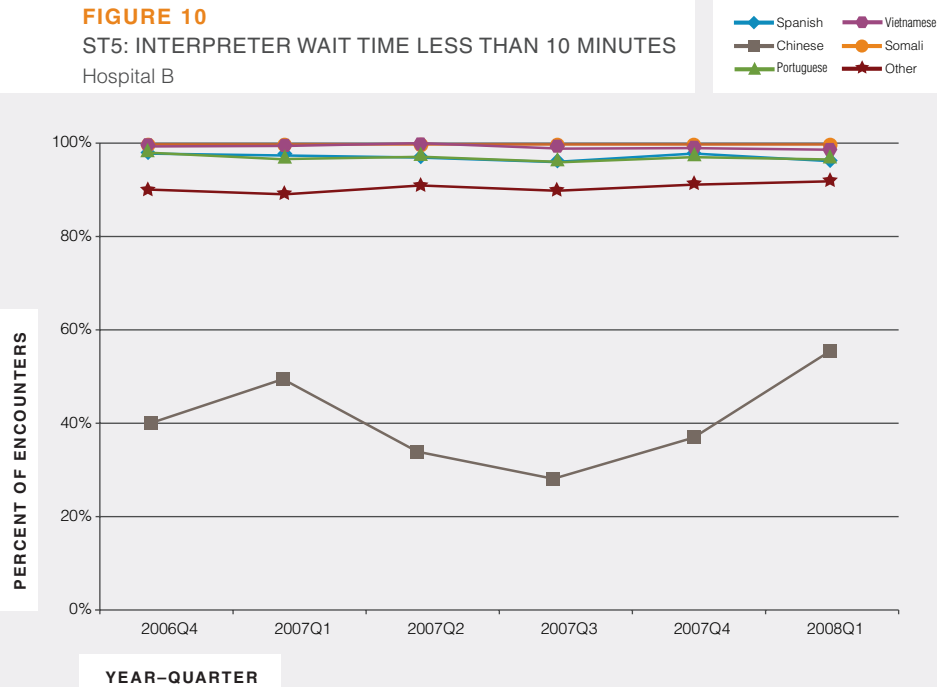


FIGURE 10
ST5: INTERPRETER WAIT TIME LESS THAN 10 MINUTES
Hospital B





ST 4: Time Spent Interpreting

As hospitals began to measure performance—and especially as they began to track the extent to which they provided language services to patients at critical points during their inpatient stay or outpatient visit—the question of whether there were sufficient resources to meet patient needs was bound to surface. Before hospitals can determine whether they are able to meet patient demand with current staffing, it is important to make certain that current resources are being deployed in the most efficient way.

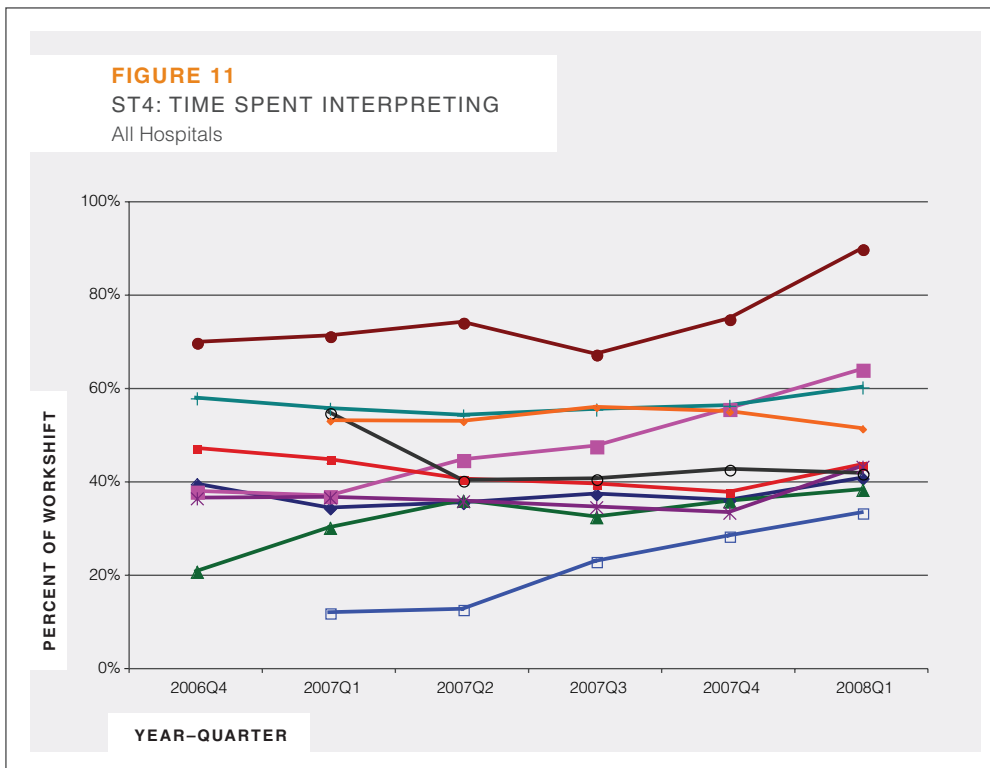
Each of the *Speaking Together* hospitals was asked to track the percent of time interpreters spend in medical interpreting to gather more information about whether capacity exists within current staffing to stretch interpreter activities to meet the needs of patients. Discussions with hospitals in *Speaking Together* and with many others across the country revealed that interpreters often take on responsibilities in addition to medical interpretation. Some interpreters serve as patient navigators; others contact

patients to remind them of appointments or assist with financial counseling and other non-medical interpreting encounters. The discussions also showed that interpreters often spend large chunks of their day walking to and from encounters with patients, filling out necessary paperwork, or helping with scheduling or other language services department duties. Still others have unfilled “downtime” between appointments or encounters.

Figure 11 illustrates performance on ST 4 and provides information on the percent of time in an interpreter’s work shift or work day that is spent in medical interpretation. As can be seen from the graph, performance on ST 4 is also highly variable and remained variable throughout the project period. In the first quarter of 2007 (when all hospitals were reporting on this measure), performance ranged from a high of 73 percent to a low of 10 percent—a 63 percentage point gap. By the end of the project, that gap was still extremely wide, at 60 percentage points.

Six of the hospitals indicate that interpreters at their hospitals spend, on average, approximately 40 percent or less of their time in medical interpretation. This does not imply that interpreters are not productive or that they are not busy at other tasks during various times at work. It does suggest, however, that there may be opportunity to target valuable interpreter resources to better meet the needs of patients at particularly important times during the health care experience. In *Speaking Together*, two points along the care experience were identified when the use of trained and assessed interpreters or assessed bilingual providers are absolutely critical—initial assessment and discharge. Hospitals and other health care organizations may identify additional points during which important resources cannot be compromised.

As part of this process, hospitals can use ST 4 to determine whether they are using their medical interpretation resources to the maximum benefit of patients. Hospitals should set a goal for interpreter productivity in terms of the amount of time spent in medical interpretation with a patient and clinician. Certainly, this goal should not be 100 percent of the time. Interpretation requires periodic breaks, time to move from encounter to encounter and time for adequate and appropriate documentation. A goal of 55-60 percent for ST 4 may be a reasonable place to set the bar since three of the hospitals document performance in this range.



Lessons Learned

Language services are absolutely critical for health care organizations with diverse patient populations and a desire to deliver safe, quality care. The work of Speaking Together has shown that hospitals can achieve high-quality by embedding language services into the fabric of clinical care. Among the many lessons learned:

- **Language services deserves a voice in every discussion about improving quality**—Communication is essential to quality. Language services need to be included in improvement efforts in the organization.
- **Meaningful improvement is possible**—The *Speaking Together* hospitals demonstrated that quality improvement techniques can be applied to language services for the purposes of measuring and improving performance.
- **The power is in the data**—Hospitals can report data on language services performance and use this data to engage clinicians and leadership in making change in the organization.
- **Clinician involvement is key**—Clinicians are ultimately responsible for making sure that the language needs of their patients are met. Without clinician involvement, an organization cannot ensure that all patients are receiving quality care.

- **Language services cannot “go it alone”**—The language services department can work to improve the quality and accessibility of services, but it takes a multidisciplinary team to measure and improve the quality of language services delivery— including, but not limited to clinicians, frontline staff, registration and scheduling staff, quality improvement departments and senior leadership.
- **Investment is necessary to achieve quality**—Like many services in health care, some investment of time and financial resources is necessary to improve the quality of language services. Individuals responsible for allocating resources in an organization need to make a commitment to language services in order to improve overall quality of care.

Advances in quality improvement do not come easily. The accomplishments of the *Speaking Together* hospitals show that with commitment, tried and true strategies and the right foundation for success, organizations can support high-quality language services delivery.

Speaking Together

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