Speaking Together
National Language Services Network

Tools for Improving Language Services Delivery

THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

Robert Wood Johnson Foundation

Speaking Together: Tools for Improving Language Services Delivery

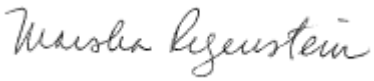
Foreword

The quality of communication between a patient and his or her health care provider is a strong determinant of whether a patient receives optimal care. By identifying specific strategies that help hospitals build effective language services programs, we can help improve health care quality and patient safety for millions of people.

In the past few months, the hospitals participating in *Speaking Together* have been testing new strategies to deliver high-quality language services to patients with limited English proficiency (LEP). These hospitals are at the forefront of efforts in examining how they communicate with LEP patients and how hospital staff can better structure and manage language services.

This document, which we refer to as "Tools for Improving Language Services Delivery," details a number of tools and ideas developed and tested in the learning collaborative that can be implemented by hospitals to facilitate effective, efficient and timely communication in their institutions. It was developed by Catherine West, MS, RN and reflects the insights she has gained from her interactions with the *Speaking Together* grantees. Much of the wisdom in this document comes directly from the progress that has already been made at many of the *Speaking Together* hospitals and is a direct result of the commitment, dedication and expertise of the *Speaking Together* teams who work so hard, each day, to improve care for their patients and communities.

Speaking Together thanks the Robert Wood Johnson Foundation for its support of this work and its ongoing dedication to improving health care for all Americans.



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Speaking Together: National Language Services Network is a national program funded by the Robert Wood Johnson Foundation aimed at improving the quality and availability of health care language services for patients with limited English proficiency (LEP). *Speaking Together* integrates quality improvement with language services, and brings together hospitals to pilot new performance measures and test valuable techniques for reducing health care disparities associated with language barriers. Visit *Speaking Together* online at www.speakingtogether.org.

Percentage of patients screened for their preferred spoken language

(ST1)

Barriers/Problems	Change Ideas
Registration Support 1. Other issues are a priority for registration/scheduling department 2. Registration/scheduling staff … "already have too much information to collect"	– Meet one-on-one with the director of registration/scheduling about *Speaking Together* program requirements. – Provide the director of registration/scheduling with the *Speaking Together* presentation, issue brief and show the video. – Add key members of the registration/scheduling staff to *Speaking Together* team meetings. – Present the registration/scheduling director with weekly reports on language screening errors. – Keep your CEO and executive sponsor involved and aware of progress and barriers with monthly reports. – Invite your CEO and executive sponsor to a *Speaking Together* team meeting.
Language Identification 1. Registration/scheduling staff are reluctant to ask seemingly fluent English patients about preferred language 2. Difficulty identifying exotic languages 3. Difficult to communicate with those who cannot read, speak or are unable to point to language posters/ 'I Speak' Cards 4. Patient/family concerns that interpreter services may delay treatment and/or are costly to the patient	– Show the *Speaking Together* video to registration/scheduling staff. – Meet with registration and scheduling staff to find out what barriers they have encountered. – Work collaboratively with registration/scheduling staff to create a preferred language screening script. – Implement and raise awareness about the availability of a preferred language screening script. – Use 'I Speak' cards or language posters patients can use to point to their language preference. – Give registration and scheduling staff direct access to modes of interpretation such as telephonic and video resources, and provide requisite training and equipment. – Display information about patient rights to interpreter services (and the fact that there are no charges for these services) in high traffic areas. – Create a short flyer or brochure about patient rights to free interpreter services and distribute the document in the registration area.

Education and Training
1. Registration / scheduling staff professional development
2. Problem solving skills and understanding implications of screening
	– Train registration/scheduling staff to:
	  – Use registration scripts that address language so staff understand why the hospital is asking about preferred language; why wording is important; that there are differences between preferred and primary language; and how this information is recorded;
	  – Give feedback to supervisors if things are not working (or alternatively, how they are working);
	  – Know how, when and who to ask for help or technical assistance;
	  – Understand how the hospital delivers language services; and
	  – Use tools for determining language preference: 'I Speak Cards,' language identification posters;
	– Develop user friendly reference manuals for registration.
	– Ask registration/scheduling staff to act as though they are a patient going through the registration process and use the feedback generated for brainstorming sessions.
	– Ask interpreter services staff to participate in the registration department's orientation process and develop training materials for new hires and volunteers.
	  – Add language screening as a module for employee orientation.
	  – Add language screening performance to annual employment review assessments.

Data Quality **Missing Fields/Screens** 1. Language field not on screens 2. Language fields labeled different in various systems/on different screens/on forms	– Add a language screening field to registration and scheduler's screens and forms – Change title of language field to 'preferred language' – Use a single, consistent title for the language field on all screens and forms where preferred language appears

Percentage of patients screened for their preferred spoken language

(ST1)

Barriers/Problems	Change Ideas
Information Technology Support 1. Needed changes are not a priority 2. Lack of technical support 3. Data to calculate measures is derived from 2 (or more) different systems/databases	– Meet one-on-one with the director of information technology (IT) about *Speaking Together* program requirements. – Provide the director of IT with the *Speaking Together* presentation, issue brief and show the video. – Add key members of the IT staff to *Speaking Together* team meetings. – Develop a list of changes needed to improve language screening at registration and scheduling (joint effort between the director of interpreter services and the director of registration and scheduling) and meet with the director of IT to discuss prioritization of the list. – Provide a written list of IT changes needed to calculate the language screening measure and meet with the director of IT to discuss next steps. – Keep your CEO and executive sponsor involved and aware of your progress and barriers through monthly reports. – Invite your CEO and executive sponsor to a *Speaking Together* team meeting.
Data Quality: Missing Data 1. Missing data; language field blank 2. Inconsistent collection	– Use 'forced fields' that cannot be bypassed to record preferred language. – Add preferred language to the information that automatically 'carries over' from prior admissions and encounters with your system. – Track data errors/missing data by person/day/time of day/shift. – Make language preference data entry error reduction a registration/scheduling department quality improvement project. – Provide data graphs to registration staff and schedulers at monthly staff meetings. – Expand the network of people that have access to the data on the *Speaking Together* website.
Data Quality: Missing Fields 1. Keying errors 2. Incomplete entries	– Use drop down language lists. – Make sure drop down language lists reflect your population. – Include English on the drop down language list. – Set the preferred language field default to 'not screened' so that you know when the screener did not really ask the question. – Track data errors/missing data by person/day/time of day/shift. – Make language preference data entry error reduction a registration/scheduling department quality improvement project. – Provide data graphs to registration staff and schedulers at monthly staff meetings. – Expand the network of people that have access to the data on the *Speaking Together* website.
Data Quality: Troubleshooting Errors 1. Inaccurate data entry 2. Incorrect data	– Ask the preferred language question every time the patient enters your system. – Verify preferred language at transition points in care and every time the patient enters the system, i.e., when the patient arrives for their appointment; upon arrival on the inpatient unit; when transferred from one unit to another. – Add language screening field to assessment forms and screens used by clinical staff. – Allow for users to have the ability to correct recorded language. – Designate a place to record preferred language across the hospital. – Give 'I Speak' cards to every limited English proficient patient. The 'I Speak' cards should include information instructing patients to present the card at every health care encounter – Track data errors/ missing data by person/day/time of day/shift – Make language preference data entry error reduction a registration department quality improvement project – Provide data graphs to registration staff and schedulers at monthly staff meetings – Expand the network of people that have access to the data on the *Speaking Together* website

Percentage of patients receiving language services from qualified providers

(ST2)

Barriers/Problems	Change Ideas
Provider knowledge, beliefs and practices 1. Provider/staff do not know the importance of using an interpreter 2. Provider accepts inadequate communication 3. Provider/staff think patient English 'good enough' 4. Providers believes they speak 'good enough' Spanish, etc. 5. Use of family and friends is the norm 6. Providers do not understand their role in meeting patients language needs	– Show the *Speaking Together* video to providers and clinical staff. – Add providers and clinical staff to the *Speaking Together* team. – Involve patient safety officer and risk managers in discussions with providers and clinical staff about the use of qualified language service providers for safe, effective and high-quality care. – Work with the organization's leadership to develop an institution-wide policy to use qualified medical interpreters or qualified bilingual staff for hospital determined appropriate medical encounters. – Review and discuss the policy on the use of qualified language service providers during hospital orientation. – Designate 2-3 clinical staff members on each unit as 'experts' to train others and serve as a resource about the importance of using qualified language service providers. – Assess provider language fluency and designate those passing the assessment as qualified bilingual providers. – Collaborate with clinical leaders to set goals for increasing the numbers of LEP getting both initial assessment and discharge supported by qualified language service providers. – Report data on the number of patients receiving language services from qualified language service providers at assessment and discharge to clinical leaders and the organization's quality and safety committees. – Stratify data on the number of patients receiving language services from qualified language service providers by location and disseminate to clinical unit managers and discuss at clinical unit staff meetings. – Add spaces for providers to document "How Language Needs Were Met "in clinical documentation forms and in systems used by providers. Include who provided encounter: bilingual provider, family, interpreter. Include encounter type: initial assessment; discharge instructions, consent, insurance, billing, reminder calls, etc.
Documentation 1. Providers do not document when language services used 2. Providers do not have access to interpreter documentation	– Meet with providers and clinical staff to identify problems and barriers to documenting how the patient's language need was met and when language services were used. – Meet with clinical leaders to develop policies, procedures, protocols and guidelines for documenting how a patient's language need was met. Include who should document and when; address requirements for inpatient care and outpatient care. – Create and/or revise forms and electronic systems for providers to document when language services were used. Include who provided encounter, e.g., bilingual provider, family, interpreter, etc. Include encounter type, e.g., initial assessment; discharge instructions, consent, insurance/billing, reminder call, etc. – Program electronic systems to print reminder to staff to document how language need was met. – Create interpreter services documentation screens. Include encounter type, e.g., initial assessment, discharge instructions; consent, insurance, billing, reminder calls, etc. – Program electronic systems so that interpreter documentation also appears on screens used by providers, providers would know when the interpreter service was provided. – Use stickers or stamps in the medical record to document interpreter involvement. Include spaces to fill in date/time, type of encounter, and interpreter name. – Attend clinical department staff meetings to learn problems, barriers and successes in documenting how the patient's language need was met and when language services were used.

Percentage of patients receiving language services from qualified providers

(ST2)

Barriers/Problems	Change Ideas
Providers do not have time to wait for interpreters 1. Critical/emergency situations 2. Have to go out in the hall to look for the interpreter 3. Interpreter not ordered 4. Interpreter late 5. Patient family arrives early to pick up patient	– Meet with clinical leaders to develop policies, procedures, protocols and guidelines on what to do in emergent situations, e.g., do not delay and do use phone interpreting until in-person interpreter arrives. – Train staff how to use phone equipment; include emergency department (ED) triage nurses, critical care units, etc. – Hire dedicated staff for high volume language(s) and base them permanently in the emergency department to function as a member of the ED team. – Increase telephone access to include ED triage and exam rooms, other critical care areas, hospital rooms and ambulatory care areas. – Include speaker phone on the crash cart and Rapid Response Team cart. – Meet with providers and clinical staff to identify problems and barriers to using interpreter services. Brainstorm to identify potential solutions. – Meet with clinical leaders to develop policies, procedures, protocols and guidelines on what to do in the absence of a face-to-face interpreter. – Provide alternative interpreter access, e.g. telephone/video in all clinical areas of the organization. – Train all staff how to use phone/video equipment. – Program electronic record systems to automatically notify interpreter services when patient registers/checks in. – Program electronic systems to print reminder to notify interpreter when the patient arrives. – Place a bright colored sticker on the medical record to remind staff to notify the interpreter when patient arrives. – Inform staff and provider when interpreter arrives for the appointment. – Inform provider if interpreter goes to the next patient/provider when provider schedule is delayed. – Assign patients to qualified same-language providers if possible and appropriate.
Anticipate needs 1. Providers and clinical staff do not anticipate the need for interpreter	– Use reports with registration's language screening results to identify LEP. Notify clinical units which interpreter is assigned. – Conduct interpreter rounds daily on clinical units. Tell patient about interpreter availability, that language services are free of charge; give 'I Speak' cards to patients and explain how to use the card to ask for an interpreter; let staff know interpreter available; ask staff what needs they anticipate. – Participate in clinical department 'daily huddles' to find out about discharges, procedures to consent, etc. – Program electronic systems to print out reminders to use interpreter for initial assessment and discharge instructions when the patient is admitted or checks in at the appointment. – Program electronic medical record systems to print out reminder to use interpreter when the pre-discharge notice is entered. – Program electronic medical record systems to automatically schedule the interpreter when the appointment is scheduled. – Implement computer order entry for interpreter requests. – Collaborate with clinical staff to identify ways to keep language needs in the forefront. For example: add 'Use of Interpreter for Initial Assessment and Discharge' to clinical pathways, standing orders and protocols; add language to patient lists used by providers; add language to daily census reports; add language to all forms used for transitions (ED to unit; unit to ICU; OR to unit); add languages for patients on departmental white boards; place a bright colored sticker on charts; place a sign on the door to the patient room; place a colored ID bracelet with patient's language written on it (i.e. similar to allergy ID band & fall risk ID bands). – Assign patients to qualified same-language providers when possible and appropriate. – Include language services in planned care models and work flows.

Percentage of patients receiving language services from qualified language service providers (ST2)

Barriers/Problems	Change Ideas
Provider fears offending patient and family 1. Provider and clinical staff have always used the family to interpret and fear offending the patient and family with change to medical interpreter	– Send letters to established clinic patients telling them the hospitals commitment to provide care in the patients preferred language, that interpreters will be used, and that family may continue to be involved in their care, if the patient wishes, but that family will not serve as the interpreter. – Create a flyer to give to patients upon admission or arrival at the appointment telling them the hospital's commitment to provide care in the patients preferred language, that interpreters will be used, and that family may continue to be involved in their care, but that family will not serve as the interpreter. – Collaborate with providers to create scripts providers can use when discussing the providers need for an interpreter with patients and their families.
Scheduling/request interpreter 1. Providers and staff do not know how to request / schedule an interpreter	– Meet with clinical staff to identify problems and barriers to interpreter request process. – Collaborate with clinical staff to develop written policies, procedures, and protocols for requesting interpreter services. – Provide training to clinical staff on how to request/schedule the interpreter. – Automate notification/scheduling of interpreter need when a language other than English is identified at registration or when an appointment is scheduled. – Use computerized order entry for language services. – Use easy-to-remember phone line (e.g., 987-SPEAK) to access language services. – Include 'How to Request an Interpreter' training module to the unit/department/clinic orientation.
How to use equipment 1. Providers/staff don't know how to use interpreting equipment (phone, video)	– Meet with providers and staff who use interpreting equipment to determine problems and barriers to use. – Include providers and staff that use the interpreting equipment in the evaluation of and decision- making for equipment purchases. – Provide department-level education on how to use interpreting equipment. – Designate interpreter staff to work with providers/staff for the first 2-3 times using the equipment to reinforce previous training, for troubleshooting, and supporting use. – Designate 2 or 3 staff members as clinic/department/unit 'experts' to train others and serve as a resource for information about interpreting equipment. Provide requisite training and updates. – Create user friendly "How To" guides for each type of interpreting equipment used. Involve clinical staff in the development. Place in easy-to-find location on the unit and on the organizations intranet. – Add instructional stickers to speaker phones with language line number and hospital code – Program phone line number on speed dial. – Use easy-to-remember phone line (e.g., 987-SPEAK) numbers. – Include 'How to Use Language Services Equipment' in departmental/unit/clinic orientation. – Attend clinical/department staff meetings to learn problems, barriers and successes in using language services/interpreting equipment.
Availability of equipment 1. Equipment is hard to find (when needed) 2. Equipment is broken	– Meet with providers and staff that use interpreting equipment to determine problems and barriers to finding equipment. – Include providers and staff that will use interpreting equipment to determine placement/ location of equipment on the unit/department/clinic. – Place LEP patients in exam rooms/beds where interpreting equipment is located. – Ensure a process is in place for maintaining equipment. Set a schedule to check equipment on a regular basis. Create a checklist of items to look for and report/replace. – Replace broken equipment as soon as reported. – Create a user-friendly " What to Do" guide when interpreting equipment broken/not working.

Percentage of encounters with assessed bilingual providers

(ST2)

Barriers/Problems	Change Ideas

Bilingual provider – identification
1. Don't know who the bilingual providers are.
	– Meet with the head of Human Resources about the *Speaking Together* program requirements.
	– Show the *Speaking Together* video and provide the issue brief to the head of Human Resources.
	– Working under the guidance of the organization's Human Resources department, implement methods to identify bilingual providers and staff, e.g.:
	  – Ask department and clinical managers which providers and staff are bilingual;
	  – Ask providers and staff on the clinical units which providers and staff they use when communicating with LEP patients;
	  – Send a letter to all employees asking them to identify other languages they use in their work with patients at the hospital/clinic;
	  – Identify languages during hiring process;
	  – Identify languages at the beginning of new resident rotation; and
	  – Verify current language fluencies during annual skills assessment updates.
	– Working under the guidance of the organization's Human Resources department, create a central repository of all bilingual providers and staff including title, language(s), and work location. Post on the organization's intranet.
	– Include information about how to locate/contact bilingual providers and bilingual staff during orientation to the department/unit/clinic.

Bilingual providers – managing and tracking qualifications 1. No one department has responsibility for tracking provider qualifications. 2. No mechanism to track qualifications.	– Working under the guidance of the organization's Human Resources department, meet with senior leaders, the department of nursing, and the medical staff office to discuss organizational responsibility for managing and tracking bilingual providers and bilingual staff qualifications. – Working under the guidance of the organization's Human Resources department, work with the medical staff office and nursing department to develop policies, procedures and guidelines for documenting bilingual provider and bilingual staff qualifications. – Working under the guidance of the organization's Human Resources department, identify existing tracking systems already in use and add provider and staff qualifications for bilingual care. – Work with physician leaders and the medical staff office to make assessing bilingual physician's fluency a part of the physician credentialing process. – Work with nursing leaders to make assessing bilingual nurse's fluency a part of nurse credentialing process. – Make assessment of bilingual nurses and staff part of annual competency assessment.

Percentage of encounters with assessed bilingual providers

(ST2)

Barriers/Problems	Change Ideas

Bilingual providers – qualifications
1. No organizational requirement to assess bilingual providers
2. No testing standard for bilingual provider fluency
3. Providers and staff will resent having language fluency tested
	– Working under the guidance of the organization's Human Resources department, meet with senior leaders, human resources, patient safety officers, and risk managers to discuss institution-wide policies to assess language fluency of bilingual providers and bilingual staff.
	– Working under the guidance of the organization's Human Resources department, collaborate with key clinical departments (e.g., the medical staff office, the department of nursing, etc.) to develop policies, procedures and guidelines for assessing language fluency of bilingual providers and bilingual staff.
	– Working under the guidance of the organization's Human Resources department, collaborate with the medical staff office, the department of nursing and hospital education department to identify, review and select language fluency testing options.
	– Meet with bilingual providers and staff to discuss patient safety/risk management reasons for assessing language fluency. Include patient safety officers and risk managers in the discussion.
	– Meet with bilingual providers and staff to identify issues related to testing bilingual providers and use feedback to inform work plan processes.
	– Create a timeline (e.g., 4 years) for assessing all bilingual providers and staff for language fluency. Consider starting with physician champions and 'volunteer' providers and staff. Assess all new staff upon hire and steadily increase the number of current providers and staff assessed over time. For example:
	  – Assess all "volunteers" by 8/2008
	  – Assess all new hires by 12/2008
	  – Assess all new residents by 7/2009
	  – Assess all bilingual nurses with birth date in an even month by 10/2009
	  – Assess all bilingual nurses with a birth date in an odd month by 4/2010
	  – Assess all physicians with a birth date in an even month by 10/2010
	  – Assess all physicians with a with a birth date in an odd month by 4/2011
	– Involve bilingual providers and staff in creating the timeline and assessing the organization's progress toward assessing bilingual fluency
	– Start assessing fluency with physician champions and 'volunteer' providers and staff. Ask them to share their experiences.
	– Share data graphs of the number of patients receiving language services from qualified language service providers at assessment and discharge. Annotate data points with number/percent of bilingual staff assessed with the organizations senior leaders, clinical providers, staff, and the organization's quality improvement department.
	– Report progress toward assessing bilingual providers and staff to the hospital's quality improvement committee.

Percentage of encounters where patient wait time is 15 minutes or less

(ST3)

Barriers/Problems	Change Ideas
Demand exceeds capacity 1. Interpreter staffing limited on nights/weekends 2. No staff for infrequent languages 3. More requests than interpreters	– Meet with clinical staff to discuss the modes of interpreting used in your organization. Discuss why these modes were selected and when they are used, whether they change based on time of day/day of week/language – Stratify data by day of week, time of day, location in health system, and by language to identify peak interpreter usage times. Include requests you were not able to meet. – Adjust staffing schedules as needed to cover most frequent languages. – Increase access to phone and video interpreters for infrequent languages, nights and weekends. – Add supervisor coverage on nights and weekends to manage on-call interpreter services. – Estimate the number of interpreters needed by language the day before. – Tell the clinical unit/department managers in advance how many patients are LEP and what languages to use the phone line or video so clinical staff are not waiting for in-person service delivery. – Collaborate with clinical staff to revise policies, procedures and protocols describing what providers should do when the interpreter does not arrive within 15 minutes, i.e., use phone line if interpreter does not arrive within 15 minutes.
Demand exceeds capacity 1. Staff use interpreters for all interactions with LEP 2. Policy not to use family	– Meet with clinical staff to discuss the modes of interpreting used in your organization. Discuss why these modes were selected and when they are used, whether they change based on time of day/day of week/language – Meet with clinical staff to identify when it is appropriate to use family i.e., encounters not addressing health status (e.g., does the patient prefer tea/ coffee, arranging transportation, or way finding) – Meet with clinical providers to identify when in-person interpreting is preferred or when phone/video are appropriate. – Work with clinical staff to create a language services care plan for the patient's stay. – Develop and implement communications tools to use with LEP patients for communication for times that an interpreter may not be medically necessary and family is not available, i.e., a laminated card with pictures the patient can point to (water, phone, rest room, etc) – Collaborate with clinical staff to create, revise and implement policies, procedures and protocols for appropriate use of language services.

Percentage of encounters where patient wait time is 15 minutes or less

(ST3)

Barriers/Problems	Change Ideas
Interpreter notification 1. Lag from time interpreter requested to time interpreter notified 2. Clinical staff experience delays when requesting interpreter (i.e., voicemail, busy signal) 3. Staff do not adhere to procedures for requesting interpreters 4. Insufficient information provided to interpreter, i.e. which provider needs interpreter	– Show the *Speaking Together* video to dispatchers, interpreters and clinical staff. – Add dispatcher, interpreter and key clinical staff to the *Speaking Together* team meetings. – Meet with dispatchers to identify problems and barriers in the dispatch process. – Meet with interpreters to identify information needed for the encounter. – Meet with clinical staff to identify problems and barriers to interpreter request process. – Track time from request for interpreter until the time the interpreter is actually notified as well as the time the interpreter is notified until the time the patient is seen. – Automate notification of interpreter need when language other than English is identified at registration/appointment scheduling. – Use computerized order entry for language services with mandatory fields to ensure that key information is available to interpreters. – Train clinical staff about information required when requesting language services. – Develop written policies, procedures, and protocols for requesting interpreter services. – Create and implement scripts for dispatchers for requesting information from clinical staff in order to schedule language services. – Create and implement check lists for dispatchers to use for scheduling interpreters. – Add 'How to Request an Interpreter' training module to the general hospital orientation.
Amount of time scheduled for appointment/encounter 1. Previous encounter took longer than scheduled	– Schedule the correct amount of time for the appointment/encounter – Interpreter services: Stratify data collected by encounter type, location in the organization, and by language to determine the average amount of time for each encounter type i.e., initial assessment; discharge instructions; informed consent, financial counseling, depression screening, diabetes teaching, etc. – Clinical staff: Factor in additional time in the appointment if an interpreter is needed. – Collaborate with clinical staff about the correct amount of time to schedule interpreted care appointments. – Work with clinical staff to implement/revise policies, procedures and protocols describing what providers should do if the interpreter does not arrive within 15 minutes, i.e., use telephone line. – Develop a method for interpreters to notify supervisors when encounters take longer than planned. Revise assignments as needed to keep subsequent appointments/encounters on time. – Schedule regular 'check points' with supervisor into interpreter daily assignments. – Revise interpreter schedules when delays occur to keep subsequent appointments on time. – Increase access to phone and/or video interpreting.

Percentage of encounters where patient wait time is 15 minutes or less

(ST3)

Barriers/Problems	Change Ideas
Geography/travel time 1. Multiple locations in the organization 2. Travel time from unit-to-unit/building-to-building 3. Parking issues 4. Travel time for on-call staff	– Schedule the correct amount of time for the appointment/encounter – Track the time it takes to get from location to location and factor travel time into interpreter assignments. – Stratify data by day of week, time of day, location, and by language and make adjustments to schedules. – Provide permanent on-site interpreters in high-volume languages and in high-volume locations. – Meet with clinical providers to discuss when in-person interpreting/phone/video is appropriate. – Increase access to phone and/or video interpreting. – Provide a parking space close to the entrance for language services staff. – Use on-call staff only when an on-site mode is unavailable and/or when a medical condition warrants an in person encounter. – Set expectation that all on-call or contracted staff will arrive within a specified period of time as a condition of employment.
Clinical unit/department practices 1. Patient arrives late 2. Patients cannot be seen for an appointment out-of-turn	– Collaborate with units and departments to notify interpreters when a patient does not arrive at scheduled time. – Proactively monitor scheduling systems for patient arrival/check in times. – Create an LEP Block: Schedule clinic appointments by language whenever possible, i.e., schedule appointments for Spanish speakers from 8 am to 10 am everyday.
Clinical staff preference for a particular mode of interpreting 1. Certain providers want only face-to-face and will not use phone or video options	– Add clinical staff to the *Speaking Together* team and discuss barriers that have been encountered. – Provide data graphs displaying timeliness of language services and discuss what language services is doing to reduce patient waits. Stratify data by mode of interpreting (e.g., in person, phone, video). – Meet with clinical staff to discuss modes of interpreting. Discuss why certain modes were selected, when they are used, and if they change depending on time of day/day of week/based on language. – Include staff that use the interpreting equipment in evaluation and decision-making of equipment used for interpreting as well as where the equipment is located on the unit or in the clinic. – Improve access to telephone and video interpreting by locating the equipment where it is easy to find. – Add instructional stickers directly to interpreting equipment; include hospital code; program phone to speed dial – Designate 2 or 3 staff members as clinic/department/unit 'experts' for phone and video options. Provide requisite training to staff. – Attend clinical staff meetings to learn problems, barriers and successes in using alternative interpreting options.

Percentage of encounters where patient wait time is 15 minutes or less

(ST3)

Barriers/Problems	Change Ideas
Demand exceeds capacity 1. Interpreter staffing limited on nights/weekends 2. No staff for infrequent languages 3. More requests than interpreters	– Meet with clinical staff to discuss the modes of interpreting used in your organization. Discuss why these modes were selected and when they are used, whether they change based on time of day/day of week/language – Stratify data by day of week, time of day, location in health system, and by language to identify peak interpreter usage times. Include requests you were not able to meet. – Adjust staffing schedules as needed to cover most frequent languages. – Increase access to phone and video interpreters for infrequent languages, nights and weekends. – Add supervisor coverage on nights and weekends to manage on-call interpreter services. – Estimate the number of interpreters needed by language the day before. – Tell the clinical unit/department managers in advance how many patients are LEP and what languages require the phone line or video so that clinical staff are not waiting for in-person service delivery. – Collaborate with clinical staff to revise policies, procedures and protocols describing what providers should do when the interpreter does not arrive within 15 minutes, i.e., use phone line.
Demand exceeds capacity 1. Staff use interpreters for all interactions with LEP 2. Policy not to use family	– Meet with clinical staff to discuss the modes of interpreting used in your organization. Discuss why these modes were selected and when they are used, whether they change based on time of day/day of week/language – Meet with clinical providers to identify when an interpreter is necessary for key medical encounters. – Meet with clinical staff to identify when it is appropriate to use family (i.e., times not addressing health status (e.g., does the patient prefer tea/coffee, arranging transportation, or way finding)) – Meet with clinical providers to identify when in-person interpreting is preferred or when phone/video are appropriate. – Work with clinical staff to create a language services care plan for the patient's stay. – Develop and implement communications tools to use with LEP patients for communication for times that an interpreter may not be medically necessary and family is not available, i.e., a laminated card with pictures the patient can point to (water, phone, rest room, etc) – Collaborate with clinical staff to create, revise and implement policies, procedures and protocols for appropriate use of language services.
Unscheduled requests 1. Language not screened at registration or when appointment scheduled 2. Providers knows of LEP patient appointment but interpreter services is not notified 3. Inpatient setting does not allow advance notice for discharge instructions	– Screen language preference for all outpatient procedures/clinic appointments/admission process/admission to the inpatient unit. – Track the number of add on requests/walk-ins by day/time of day/language and adjust staffing to meet previously unanticipated needs. – Stratify data by scheduled and unscheduled requests and share with clinical leaders during periodic meetings. – Collaborate with clinical leaders to set goals for increasing the number of scheduled requests. – Tell clinical unit/department managers in advance, how many patients and what languages to use the phone line or video so clinical staff are not waiting for service delivery. – Increase access to phone and/or video interpreting. – Clinical Staff: Send a list of next day 'potential' discharges to interpreter services. – Create a report with registration language screening results and pre-schedule a high volume language 'floater' on inpatient units.

Percentage of time interpreters spend providing medical interpretation in clinical encounters with patients

(ST4)

Barriers/Problems	Change Ideas
Use of trained medical interpreters for non-clinical encounters 1. Registration 2. Scheduling appointments 3. Reminder calls about appointments 4. Food preference 5. Way finding, giving directions to other departments 6. Escorting patients from one location to the next 7. Billing/insurance and financial issues 8. Other non-clinical interpreting encounters	– Meet with non-clinical and clinical staff to educate on the appropriate language service for non-clinical encounters – Use bilingual non-interpreter staff, volunteers, or family for non-clinical encounters – Provide permanent on-site, non-interpreter bilingual staff and or volunteers in high volume language and high-volume locations for non-clinical encounters – Supply non-clinical departments with lists identifying non-clinical bilingual staff and provide a schedule of bilingual volunteers by language – Collaborate with clinical and non-clinical staff to create, revise and implement policies, procedures and protocols for appropriate use of non-interpreter staff, volunteers, or family – Designate 2 or 3 staff members in clinical and non-clinical areas as department 'experts' to train others and serve as a resource for information about non-interpreter bilingual staff, volunteer, or family options. Provide requisite training and updates. – Increase access to phone interpreting in non-clinical departments, make it easy to locate and provide requisite training – Attend clinical staff and non-clinical department meetings periodically to learn problems, barriers and successes in using alternative options for non-clinical encounters – Schedule all requests, including non-clinical requests – Review scheduled non-clinical requests in advance and tell the department when to use non-interpreter bilingual staff, volunteer, family or phone interpreting
Recording encounter data/ information 1. Medical record documentation 2. Interpreter log documentation 3. Data entry	– Create interpreter services documentation screens with drop-down lists to reduce typing – Give interpreters access to computer entry at the location of the encounter – Design interpreter log documentation using check boxes to reduce the amount of time spent writing – Provide handheld devices with upload ability (to applicable database for data analysis) for interpreter documentation – Use non-interpreter staff to enter data from interpreter logs
Providers reluctant to use interpreters 1. Providers don't like having a 3rd party involved	– Show the *Speaking Together* video to providers and clinical staff – Involve patient safety officer, risk manager, and quality officer in presentations and discussions with providers and clinical staff about use of interpreters for safe, high-quality communication with patients
Providers reluctant to use interpreters 1. Have always used the family and fear offending patient and family with change to using medical interpreter	– Send letters to established clinic patients telling them the hospital's commitment to provide care in a patient's preferred language, that interpreters will be used, and that family may continue to be involved in their care, if the patient wishes, but will not serve as the interpreter – Create a flyer to give to patients upon admission or arrival at the appointment telling them the hospital's commitment to provide care in the patients preferred language, that interpreters will be used, and that family may continue to be involved in their care, but will not serve as the interpreter – Collaborate with providers to create scripts providers can use when discussing the providers need for an interpreter with patients and their families

Percentage of time interpreters spend providing medical interpretation in clinical encounters with patients

(ST4)

Barriers/Problems	Change Ideas
Providers reluctant to use interpreters 1. Interpreter not there when needed. Have to go out in the hall to look for the interpreter	– Meet with providers clinical staff to identify problems and barriers to using interpreter services. Identify potential solutions. – Add key members of the medical and clinical staff to the *Speaking Together* team. – Provide data graphs displaying timeliness of language services and discuss what language services is doing to reduce patient waits. Stratify data by location and mode of interpreting (in person, phone, video). – Collaborate with medical and clinical leaders to set goals for increasing the use of interpreters for key clinical encounters. – Inform staff and provider when interpreter arrives for the appointment. – Inform provider if interpreter goes to the next patient /provider when provider schedule is delayed. – Hang a bright colored sign on the door to indicate when interpreter is in the room with the patient and ready to begin. – Place a bright colored sticker on the medical record to remind staff to notify the interpreter when patient arrives. – Schedule the interpreter when patient appointment is made. – Add "How to Work with an Interpreter" to clinic and unit orientation. – Attend clinical staff and medical staff meetings periodically to learn problems, barriers and successes in using interpreters.
Geography / Travel Time 1. Multiple locations in the organization 2. Travel time from unit-to-unit/building to building 3. No parking	– Schedule the interpreter encounter. – Track the amount of time it takes to get from location to location and factor travel time into interpreter assignments. – Stratify data by day of week, time of day, location, clinical and non-clinical encounters, and by language. Adjust staffing accordingly. – Provide permanent on-site interpreters in high-volume languages and in high-volume locations. – Block schedule LEP clinic appointments by language whenever possible, e.g., schedule appointments for Spanish speakers from 8 am to 10 am everyday. Assign dedicated interpreter. – Meet with clinical providers to identify when in-person interpreting is preferred and when phone or video is appropriate. – Increase access to phone and or video interpreting by making equipment available and easily accessible. Provide requisite training. – Provide a parking space close to the entrance for the interpreter. – Review scheduled requests in advance and revise interpreter assignments to decrease travel time. – Collaborate with clinical units and departments to notify interpreter when patient does not arrive at scheduled time or when provider schedule is delayed. Revise interpreter assignments as needed. – Schedule regular 'check points' with supervisor into interpreter daily assignments. Revise assignment as needed to reduce travel time between locations. – Proactively monitor scheduling systems for patient arrival/check in times. Revise interpreter assignments as needed.

Percentage of time interpreters spend providing medical interpretation in clinical encounters with patients

(ST4)

Barriers/Problems	Change Ideas
Provider beliefs 1. Providers believe they are proficient in other languages	– Meet with bilingual providers and staff to discuss patient safety/risk management/quality reasons for using trained medical interpreters or qualified bilingual providers. – Assess provider language fluency and designate those passing the assessment as qualified bilingual providers.
Interpreter qualifications – provider confidence: *Staff interpreters* 1. Providers perceive some interpreters as not competent	– Meet with clinical staff to learn about problems and concerns encountered when using interpreters. – Meet with clinical staff to discuss what (in your organization) designates an interpreter as qualified. Identify the interpreter training, testing, continuing education and orientation requirements. – Share data about interpreter qualifications, including the number of assessed and trained interpreters, with clinical staff. Use graphs whenever possible. – Collaborate with providers to design education programs for interpreters for specific high-volume clinical conditions e.g., CHF, care for depression. Explain common terms, most frequent medications for the condition, what the interpreter can expect to hear from the provider, basic anatomy and physiology, etc. – Add 'How to Work With an Interpreter', 'What to Expect of the Interpreter', and 'How to Know How Well an Interpreter is Doing' to the hospital/clinic orientation program. – Ask providers (at the end of the encounter) for feedback about how the session was interpreted. Provide a simple card or form the interpreter hands to the provider to fill out and a box on each unit for forms to be placed. Include an option for the provider to sign the form. – Shadow interpreters periodically to ensure adherence to the interpreting standards of practice and hospital policy, procedure and guidelines.
Interpreter qualifications – provider confidence: *Non-staff interpreters* 1. Contract 2. Agency 3. Telephone services 4. Video services 5. State agency	– Call providers directly (at the end of the encounter) for feedback about how the session was interpreted. – Shadow non-employee interpreters periodically to ensure adherence to the interpreting standards. – Provide feedback about non-employed interpreters to vendors. Give both positive and negative feedback. – Request that vendors not send employees receiving negative feedback to your organization. – Meet with outside organizations/vendors you contract with to discuss the minimal acceptable requirements for interpreter training and assessment at your hospital. – Ask outside organizations/vendors that you contract with to provide written documentation of the training and assessment qualifications for their interpreters. – Document the obligation for the organization /vendor to provide only interpreters with your hospital's minimal acceptable training and assessment requirements in all contracts. State your hospital's minimal acceptable requirements in the contract. Require organization / vendor to provide proof of an interpreter's qualifications. – Contract only with those organizations and vendors that meet your hospital's minimal requirements.

Percentage of encounters interpreters wait 10-or-more minutes to provide interpreter services to provider and patient

(ST5)

Barriers/Problems

Scheduling issues, waits and delays

1. Patient arrives late
2. Patient taken to another department
3. Clinical provider late/ schedule delayed
4. Double and triple bookings at clinic (more than 1 patient in the same time slot for the same provider)
5. Clinic does not allow patients to be taken out of turn

Unanticipated request for services

1. Interpreted care takes longer

Change Ideas

- Stratify interpreter delay data by day of week, time of day, location, language, and provider. Present data to clinical staff and begin discussion on what interpreter services and providers can do to reduce the amount of time interpreters wait.
- Collaborate with clinical units and departments to notify interpreter when patient does not arrive at scheduled time. Revise interpreter assignments as needed.
- Proactively monitor scheduling systems for patient arrival/check in times. Revise interpreter assignments as needed.
- Conduct appointment reminder calls the day before and tell patients to arrive 15-minutes early.
- Collaborate with clinical units and departments to notify interpreter when patient taken to another department. Revise interpreter assignments as needed.
- Collaborate with clinical units and departments to notify interpreter when the provider is late or if the schedule is delayed. Revise interpreter assignments as needed.
- Block schedule LEP clinic appointments by language whenever possible, e.g., schedule appointments for Spanish speakers from 8 am to 10 am everyday. Assign dedicated interpreter.
- Schedule LEP patients with same language providers.
- Conduct daily morning 'huddles' with clinic and unit managers to review the day's schedule, who needs an interpreter, etc.
- Revise interpreter assignments when delays occur to avoid subsequent delays.
- Involve interpreter services in clinic redesign, planned care initiatives, and projects to improve flow in clinical areas.

- Schedule the correct amount of time for the appointment/encounter.
  - Interpreter services: Use data to determine the amount of time needed by encounter type. Stratify the data by encounter type, location in the organization, and by language to determine the average amount of time for each encounter type, e.g., initial assessment; discharge instructions; informed consent; financial counseling; depression screening; diabetes goal-setting, etc.
  - Interpreter services: Use data to begin collaboration with clinical staff about the correct amount of time to schedule interpreted care appointments.
  - Clinical staff: Identify other non-medical interpreting needs at the LEP appointment, e.g., completing paperwork, and scheduling follow-up appointments, etc. Factor this extra time in the appointment for interpreted care.
- Schedule unpredictable appointment lengths at end of the day or end of the block.
- Schedule regular 'check points' with supervisor into interpreter daily assignments. Revise assignment as needed to keep appointments/ encounters on time and avoid delays.