



Commission to End Health Care Disparities

Promoting appropriate use of physicians' non-English language skills in clinical care

Recommendations for policymakers, organizations
and clinicians

This paper was written under the direction of the Research and Data Resource Committee of the Commission to End Health Care Disparities.

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About the Commission to End Health Care Disparities

In 2004 the Commission to End Health Care Disparities was created to focus and coordinate the efforts of organized medicine to eliminate health care disparities. Today, the Commission comprises more than 70 state and specialty medical societies and aligned organizations (Appendix I). It is led by a Secretariat of the American Medical Association (AMA), the National Medical Association (NMA) and the National Hispanic Medical Association (NHMA). The commission's primary role is to support health professionals and health professional associations in their efforts to eliminate health care disparities. This is accomplished through: (1) proactively collaborating to increase awareness and education among health professionals about health care disparities; (2) producing clinical tools and resources that promote the use of effective strategies to combat disparities in practice; and (3) coordinating advocacy to support policy and action that will lead to the elimination of disparities in health care and thereby strengthen the health care system and our nation.¹

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Introduction

Inadequate, incorrect or incomplete communication has profound implications for patient care and is a leading cause of health and health care disparities for populations with limited English proficiency (LEP), whose access to quality care is often affected by language barriers. The elimination of disparities is a matter of great moral and practical concern for our nation, including the more than 70 professional societies and aligned organizations that comprise the Commission to End Health Care Disparities.

This white paper provides a set of consensus recommendations identified by the Research and Data Resources Committee of the Commission to End Health Care Disparities and approved by the Commission's Steering Committee. The recommendations were created to advance quality of care and promote effective communication between bilingual physicians, who might have varying levels of non-English language skills, and their LEP patients. The white paper provides guidance for policymakers and systems, for the leaders of care delivery organizations, and for individual bilingual physicians who strive to provide the highest quality care for all of their patients, including those with LEP. The white paper concludes with a research agenda to advance safe and effective care by clinicians caring for patients with LEP.

Background

For the more than 25 million U.S. residents (9 percent of the population) who speak English "less than very well" and are therefore considered "limited English proficient" (LEP), language barriers can adversely affect access to health care, quality of care, and the ability to understand and adhere to recommended courses of treatment.

To address quality, civil rights, legal and regulatory issues associated with providing effective care to patients with LEP, health care and policy leaders have taken several approaches. Most prominently, the U.S. Department of Health and Human Services (HHS) has published Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient

Persons (67 FR 41455, June 18, 2002), pursuant to Presidential Executive Order 13166 (**See Box 1**).

In addition, in 2001 the Office of Minority Health promulgated National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, which recommend that health care organizations provide adequate language assistance services to LEP patients, including that these organizations "assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff."² More recently, in 2010 the Joint Commission issued a set of principles for safer and higher-quality patient care that included explicit recommendations related to the use of trained interpreters and assessment of bilingual staff to address barriers to care for patients with LEP.³ The National Quality Forum (NQF) and the National Committee on Quality Assurance (NCQA) have also released guidance and standards for culturally and linguistically appropriate care that address language barriers and effective ways to work with bilingual providers and trained interpreters to provide safe and effective care.^{4,5} NQF also recently endorsed 12 quality measures focused on health care disparities and culturally competent care for racial and ethnic minority populations, which include quality metrics for evaluating language services.⁶ The CLAS standards are also in the process of being updated and enhanced, with publication of the new standards pending at the time of this writing.

In each of these guidance documents, a recognized option for providing high quality care to LEP patients is to use "bilingual" practitioners. Yet, while these guidance documents generally encourage organizations to ensure the competence of bilingual speakers, they have neither specified the necessary training nor precise measures of competence for bilingual clinical staff. This potentially opens the door for health professionals with a range of language skills to interact directly with LEP patients during clinical care.

In practice, "bilingual" clinicians' non-English language skills are heterogeneous, ranging from those with very limited competency, who might speak just a few words of another language, to those who are native speakers and even received their medical training in a non-English language.

In practice, “bilingual” clinicians’ non-English language skills are heterogeneous, ranging from those with very limited competency, who might speak just a few words of another language, to those who are native speakers and even received their medical training in a non-English language. In light of these heterogeneous skill levels, and the inherent complexity of providing clinical care, this paper aims to provide some guidance on the appropriate uses of non-English language skills by bilingual clinicians caring for LEP patients.

Note that this paper is not a legal document and does not provide advice on compliance with legal requirements regarding the provision of language assistance services. Organizations are encouraged to consult an attorney to ensure compliance with the legal requirements summarized

in Box 1. Rather, the white paper provides a discussion and recommendations on how bilingual physicians with variable non-English language skill levels can use these skills optimally and move towards ensuring the highest level of communication quality and safety for the patients under their care.

Quality, disparities and the use of trained interpreters

On a variety of measures and for a number of reasons patients with LEP often receive lower quality health care. For instance, patients with LEP have been shown to have poorer compliance with medical recommendations in general⁸ and they are at higher risk of medical errors.^{9,10,11} This probably reflects the fact that patients with LEP can have difficulties understanding their diagnosis¹² and

Box 1: Title VI and its legal background

Title VI of the Civil Rights Act of 1964 (“the Act”) prohibits the use of federal funds to support activities that discriminate on the basis of race, color or national origin.⁷ Because a person’s language can be a sign of their “national origin,” the Act has been interpreted by regulators and the courts as meaning that health care providers that receive federal funding (including any payments from Medicare or Medicaid, but excluding those only receiving Medicare Part B payments) must take reasonable steps to offer “meaningful access” to their services for patients with limited English proficiency.¹⁹ The definition of “meaningful access” requires careful deliberation and attention to details as described below.

Summary of Title VI and “meaningful access” to health care services for patients with LEP

[Presidential Executive Order 13166](#) (65 FR 50121, August 16, 2000), “Improving Access to Services for Persons with Limited English Proficiency,” required recipients of federal funds to provide “meaningful access” to their programs and benefits to persons with LEP, and asked the U.S. Department of Justice (DOJ) to develop guidance for all federal agencies.

In 2000, the DOJ [provided guidance](#) on what comprises “meaningful access.” The U.S. Department of Health and Human Services (HHS) then issued its own Guidance adopting the same principles where four factors are considered when determining whether recipients of federal funds are providing “meaningful access” to their services for LEP individuals. These four factors are:

1. The number or proportion of LEP individuals receiving services
2. Frequency of contact with the program for these LEP individuals

3. Nature and importance of the program to the LEP individuals
4. Resources available to the program for providing language access services

Recipients of federal funding are to balance these factors to determine the “correct mix” of appropriate language services to provide to LEP individuals in their program or service area.

Options for providing language access services

Recipients of federal funds have a number of options for providing oral language assistance to patients with LEP. Examples of options include:

- Hiring bilingual staff for patient and client contact positions
- Hiring staff interpreters
- Contracting for interpreter services
- Engaging community volunteers
- Contracting with a telephone interpreter service

The Office of Civil Rights (OCR) of HHS is responsible for enforcing compliance with Title VI and its associated regulations. It does so through procedures such as complaint investigations, compliance reviews, efforts to secure voluntary compliance and technical assistance. Individuals can file complaints with OCR through the federal funding agency or Federal Coordination and Compliance Section, Civil Rights Division. Traditionally, OCR always provides organizations the opportunity to come into voluntary compliance prior to initiating formal enforcement proceedings. In addition, OCR has noted that a recipient’s use of the methods and options discussed in their guidance will be viewed as evidence of a recipient’s intent to comply with Title VI.

why they receive particular types of care.^{13,14} Persons with LEP experience disproportionately high rates of infectious disease and infant mortality and are more likely to report risk factors for serious and chronic diseases such as diabetes and heart disease.^{15,16} They have lower adherence with diabetes¹⁷ and asthma care regimens^{18,19} compared to patients who are English speakers, and they have worse diabetes outcomes.²⁰ Research also shows that patients with LEP are particularly vulnerable to miscommunication when discharged from the emergency department^{21,22} and they have poorer follow-up after emergency department visits.²³ And discordant communication between LEP patients and physicians results in both lower patient^{24,25} and clinician²⁶ satisfaction.

On the other hand, physicians treating patients with LEP who have access to and who use the services of trained interpreters report significantly higher quality of patient-physician communication than physicians not using these services.²⁷ Having an interpreter to facilitate communication between patients and health professionals can mitigate or even eliminate the disparities in care that LEP patients regularly face.²⁸ For example, having an interpreter can level the playing field for LEP patients with diabetes, whose care with an interpreter present was found to be equal to or better than care received by non-LEP patients with diabetes.²⁹ LEP patients using an interpreter were also more likely than English-speaking patients to have had a mammogram over a two-year period.²⁵ In a study of the impact of interpreter services on low-income LEP patients, the availability of trained interpreters was associated with LEP patients having more office visits and filling more prescriptions, as well as reducing disparities related to flu vaccinations and fecal occult blood testing.³⁰

Yet, despite these and other potential benefits of using trained interpreters, interactions between patients with LEP and health professionals frequently occur without them. No published studies estimate the frequency of interpreter use among LEP patients across the entire U.S. health care system, but several studies provide evidence of substantial underutilization in the emergency department¹² and across physician practices and other ambulatory sites, as well as inpatient services.³¹

Barriers to the use of trained interpreters

Many considerations can impede use of trained interpreters. The most prominent of these might be that interpreter services, despite often being legally required, are generally not included as covered health benefits by health insurance plans, including Medicare and most Medicaid programs.^{32,33} As a result, clinicians and organizations often experience the use of interpreters as an “unfunded mandate.”

Moreover, studies show that even when interpreters are freely available in a health care setting, they are not always used in the care of patients with LEP.³⁴ Research conducted in collaboration with the Commission has uncovered at least eight other significant barriers to the routine use of interpreters, including the logistics associated with arranging for an in-person or telephone

interpreter to be present for an encounter, the extra time required for third-party interpretation, lack of understanding about how to use interpreters and the value they bring, and the potential effects on

the patient-clinician relationship of having a third party present during the clinical encounter.^{35,36}

In addition, despite guidance from the Joint Commission, HHS and others, some care delivery organizations have not yet established specific policies and procedures related to culturally and linguistically appropriate care and consequently have not set explicit expectations regarding interpreter use for patients with limited English proficiency.³⁷

Using the language skills of bilingual clinical staff

A potentially effective alternative to using interpreters is the use of bilingual clinicians to provide direct care to LEP patients and populations. Both use of interpreters and access to bilingual physicians have been shown to help bridge communication gaps for LEP patients and improve care.^{30,38} In particular, patients with LEP who receive care from bilingual physicians have shown improved adherence to medication regimens, less use of the emergency department, and higher satisfaction with care than their peers receiving care from non-bilingual physicians.^{18,39,40,41}

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Nearly nine out of ten U.S. hospitals report that they employ bilingual providers, though relatively few report assessing their clinical staffs' proficiency in other languages in any systematic way.⁴² Furthermore, relatively few hospitals have policies in place that address whether or when self-described bilingual clinicians should deliver care in a language other than English or when they should call a trained interpreter. Thus, in practice, it is often left to individual physicians to determine whether they have the requisite proficiency to communicate with any particular patient in a language other than English.⁴³

For bilingual physicians seeking to provide high quality care for their LEP patients, the ideal situation would be that every such physician would have formal, standardized documentation of an acceptable level of language proficiency for the given clinical encounter. In recent years, a number of investigators and commercial entities have begun developing standardized methods to assess language skill levels of physicians and other health care professionals.⁴³ As these tools are validated and disseminated, we expect them to become increasingly useful.⁴⁴ In the meantime, the Commission offers the guidance in this white paper to help advance quality care by physicians with non-English language skills and the organizations in which they work.

Recommendations to promote appropriate use of physicians' non-English language skills in clinical care

The process for developing these recommendations was multi-phased. We began with an extensive review of the literature to understand the circumstances associated with communication between physicians with non-English language skills and LEP patients. We also interviewed 25 physicians in different practice settings who, while not native speakers, routinely interact with LEP patients in the patient's language for at least some types of encounters, to understand their experiences communicating with LEP patients.³⁵ We then convened a group of experts in clinical care, clinical improvement and patient safety, language services for patients with LEP, and health services research (see Appendix III) to discuss findings from the literature review and physician interviews. Based on this discussion, the experts used a patient safety approach (a modified health care failure modes and effects analysis) to identify key areas to target to improve care for patients with LEP and to develop a set of potential recommendations.³⁶ These preliminary recommendations then underwent iterative refinements based on serial reviews by the Commission's Research and Data Resource Committee (see Appendix II), legal staff, and the Steering Committee of the Commission. The final set of recommendations was approved by the Steering Committee on Sept. 13, 2012.

The Commission believes that steps to help improve communication between clinicians and patients with LEP are possible at the system level, within organizations and by individual physicians who strive to provide the highest quality care for all of their patients.

Recommendations for policymakers and health system leaders

As with other aspects of health care quality improvement, system-level interventions will be critical for ensuring the appropriate use of physicians' second language skills in clinical care. Health care leaders and policymakers are responsible for establishing a health care climate that makes it easier for physicians to do the right thing with regard to effective and respectful communication with patients with LEP.⁴⁵ In this regard, the Commission identified five recommendations that address system and policy level improvements (**Box 2**).

Box 2: Recommendations for policymakers and health system leaders

1. **Create tools** to help clinicians appropriately use their non-English language skills
2. **Use patient safety and quality improvement systems** to address communication risks in the care of patients with LEP
3. **Develop payment models** that support the provision of quality care to patients with LEP
4. **Facilitate collection of language information** at health care encounters, to enable more rapid access to language services when needed
5. **Create and promote market opportunities** to encourage excellent care for LEP patients

First, despite the need for effective language services in health care encounters (and the requirement that organizations receiving federal funds have a plan to meet the communication needs of LEP patients), most organizations have not yet developed explicit policies to guide bilingual physicians and other health professionals who want to make safe and appropriate choices when determining whether to use their own non-English language skills when communicating with their patients with LEP. The Commission recognizes this gap and recommends that health systems and researchers create, test and disseminate new policies, tools and strategies to easily and efficiently assess clinicians' language skills and provide appropriately detailed guidance on the clinical use of these skills.

Second, substantial advances in care can be made by including language services and communication overall within established quality and safety protocols and processes. For example, reporting systems for safety events should include a common format to identify when language barriers, the use of an interpreter, or the provision of care in a non-English language might have been factors contributing to errors and harm. In addition, including interpreters or non-English speaking health professionals on quality improvement projects and safety/quality committees can elevate the issue of language barriers and the role that effective communication plays in patient care.

Third, for those clinicians with non-English language skills who require an interpreter for some or all encounters (and, of course, for ALL non-bilingual physicians, who are required always to use an interpreter when caring for LEP patients) the Commission emphasizes the urgent need for new payment models to cover the cost of interpreter services in clinical settings. Interpreter services are generally not reimbursable under private or public health insurance. Medicare does not cover interpreter services and only about a dozen state Medicaid programs reimburse health care providers separately for interpretation within a health care encounter.^{32,33} Health care organizations must therefore shoulder these costs as part of their administrative or overhead expenses, thus creating inequities for health systems, clinics, physician practices and other organizations that have high LEP patient volumes. A reassessment of payment policy to allow for reimbursement of interpreters is long overdue. Likewise, interpreted encounters generally take longer than encounters conducted in English. Payers should recognize and encourage safe and effective care of LEP patients who require complex and time-consuming encounters by developing enhanced payment rates for these encounters.

Fourth, to monitor, enhance and ensure quality of care for LEP patients, health systems must collect and record information about each patient's spoken and written language needs at the initial point of service. Doing so allows for assessments of quality care stratified by key demographic characteristics, including language, which is necessary for quality assurance and improvement. More immediately, knowing a patient's language needs can trigger recognition of the need for a trained interpreter. A previous white paper with consensus recommendations from the Commission on collecting and using race, ethnicity and language data in ambulatory settings was published in 2011.⁴⁶

Finally, health systems that invest in demographic data collection, effective language services, training for health professionals, assessment of the language proficiency of clinical staff, and other acts to improve the quality of care delivered to patients with LEP should enjoy a competitive advantage in the health care market, since these patients represent a growing U.S. population segment. This has not always been the case, since in the past providing care to patients with LEP, who are more likely to be

uninsured or under-insured and who require the added cost of interpreter services, has sometimes been seen as a losing business proposition.⁴⁷ But as more of these patients become insured as a result of health insurance expansions under the Patient Protection and Affordable Care Act,⁴⁸ the business case for improving language access is expected to strengthen. Moreover, high quality care that includes a suite of products and services that are attractive to diverse patient populations may serve to position health systems well, since the linguistic diversity of patients is expected to grow even more over the next several decades.⁴⁹

Recommendations for care delivery organizations

Many health care organizations, including hospitals, community health centers, clinics and physician practices, offer language services to facilitate communication between LEP patients and health professionals. The size and scope of language services provided is highly variable, with some offering very limited language services to patients who speak Spanish only, for example, and others employing dozens of interpreters covering 50 or more languages.⁵⁰ As noted earlier, policies and practices regarding training on the use of interpreters, assessment of clinicians' language proficiency, processes to access interpreters or other language services, and requirements related to recording patient language and use of language service for LEP patients, have also been highly variable.

The Commission identified four recommendations for organizations to help promote safer language services for their LEP patients (**Box 3**).

Box 3: Recommendations for care delivery organizations

1. **Provide integrated training to staff** on how best to work with interpreters in the organization
2. **Promote teamwork** with trained interpreters recognized as specialists in communicating with LEP patients
3. **Help clinicians plan** for appropriate communication in encounters with LEP patients
4. **Examine and address barriers** to using interpreter services

First, care delivery organizations should develop and strengthen training opportunities for physicians, as well as other health professionals and staff, to encourage optimal approaches to meeting the needs of LEP patients. Organizations typically have multiple opportunities to provide training on the use of language services essential to the health and safety of LEP patients, including at new employee orientation, periodic in-services, and special language service-specific sessions. All employees should receive training so that they understand when an interpreter should be used, how interpreter services can be accessed, what the language services options are (e.g., in-person, telephone, video, translation services) and documentation requirements for quality, utilization, billing and internal reporting purposes.

Training programs for clinicians should include, as a core component, the evidence supporting the use of trained interpreters and their impact on patient safety, quality, and satisfaction.

Organizational leaders as well as clinicians and other staff should understand who the organization's patients are, including the characteristics of their service area and communities, and learn ways to engage community and other useful resources for LEP patients. Training programs for clinicians should include, as a core component, the evidence supporting the use of trained interpreters and their impact on patient safety, quality and satisfaction.

Second, both in the context of this training and elsewhere throughout the organization, organizational leaders should encourage appropriate use of language services by promoting teamwork and recognizing trained interpreters as valued team members who provide specialized communication services for LEP patients. This is already occurring at many hospitals where interpreters make rounds as part of the clinical care team, or where interpreters are assigned to the emergency department and operate as essential members of emergency care teams.

Third, organizations can help clinicians make safer and more appropriate choices when it comes to the use of their non-English language skills by developing standard processes and protocols related to language services for LEP patients. The first step is to use standardized registration templates to collect language data and

to embed the processes as much as possible into an electronic health record or other recordkeeping system. Certain types of visits with LEP patients may take more time than a routine visit; scheduling systems can anticipate the need for longer encounters or extended use of an interpreter's time. At the same time, organizations can create efficiencies in terms of their interpreter services resources by scheduling groups of patients at times or practice locations where interpreters are accessible.

As a related matter, identifying the best ways to use interpreters in an organizational context requires a formal assessment of the needs of the populations served and the resources available in the organization, including service and staff capacity to meet patient communication needs. Hence, an ambulatory practice with the majority of physicians and staff who are native Spanish speaking may not require trained interpreters for its Spanish speaking patient populations (though health care organizations should note that even native speakers of languages other than English may not have sufficient proficiency to communicate in that language during a medical encounter).⁵¹ An otherwise similar ambulatory practice with few native speakers might identify substantial need for trained interpreters or clinicians who are proficient to conduct medical encounters in languages other than English. The only way to ensure these needs are being met, and that disparities are not being introduced, is to collect data and proactively track the care provided to patients with LEP.

Fourth, any assessment to determine language needs should specifically examine potential barriers to the appropriate use of trained interpreters. In this regard, the field of language services has, for the most part, so far not reaped all the potential benefits of technological advances and economies of scale. In some parts of the country, various health care organizations could develop shared services to maximize the availability of interpreters, especially for less common languages where trained interpreters are difficult to find.⁵² Likewise, organizations can and should take advantage of the variety of available modes of interpretation (in-person, telephone, video) to develop the most appropriate and efficient set of resources for their patient populations.⁵³

Finally, organizations should develop processes to test the proficiency of physicians and other health professionals who speak non-English languages with their LEP patients, though the Commission cannot at this time recommend a standard method for doing so. At the time of this writing, validated clinician language assessments are not readily available in the public domain, so health care organizations should encourage provider language assessment via the best and most feasible assessment method available to their organization. Many general language proficiency tests exist, but to our knowledge only one tool has been developed specifically to assess the clinical language skills needed for the direct delivery of medical care. This proprietary tool, called the Clinician Cultural and Linguistic Assessment, was developed by Kaiser Permanente and is administered by ALTA Language Services, a private organization.⁵⁴ If organizations do not have the means for formal assessments, they may consider alternatives such as informal assessments within their organizations by the language services department. In preliminary testing among medical students, even going through the process of an informal self-assessment of language skills was shown to be a good predictor of scores individuals might receive on more formal, validated language assessments.⁴⁴

Recommendations for clinicians

Ultimately, the responsibility to ensure the quality of communication in a health care encounter rests with the clinician. Physicians and other health professionals who speak a non-English language can serve a critically important role in the care of LEP patients. Yet those who speak a non-English language to some limited degree, and even those who are native speakers or fluent in the language, should regularly assess whether their language skills are sufficient for each particular type of encounter and patient. The Commission identified three recommendations to help clinicians make the important determination about the adequacy of their language skills for a given clinical encounter (**Box 4**).

Box 4: Recommendations for clinicians

1. **Monitor the quality of communications** with LEP patients
2. **Receive training** to promote effective communication with LEP patients
3. **Plan ahead** for LEP patient visits

First, all three of these recommendations arise from the recognition that patients with LEP often greatly appreciate it when physicians interact with them in their own language. Such direct interactions in the patient's language can provide a tangible demonstration of respect for the patient and can help to forge a stronger patient-doctor bond. At the same time, most clinicians today who interact with patients in a non-English language have not been formally tested for competency in the use of the language in medical contexts. As a result, the Commission's recommendations support physicians and other clinicians using their non-English language skills with patients whenever doing so is safe and effective. The Commission also emphasizes that for most physicians ensuring effective communication with all of their LEP patients will frequently require working with a trained and qualified interpreter.

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With these facts in mind, the Commission believes it is a primary professional responsibility of physicians to carefully monitor the quality of care delivered to their patients, including those with LEP. This entails tracking measures of clinical quality, collecting patient demographic information, including language needs, and monitoring for disparate quality by stratifying performance measurement data by patient language.⁴⁶

Another important aspect of quality assurance for bilingual physicians caring for LEP patients is to seek out the best available methods to assess their language skills if formal assessment tools are not available within their organization. A good first step, for example, would be to invite a trained interpreter to audit a handful of

patient encounters and provide feedback on the quality of the communication. These audits might simply verify the quality of communication, but they could also demonstrate deficiencies that might lead to helpful additional language training, or lead to the use of trained interpreters more broadly in the practice. Clinicians can also seek patient feedback to determine the effectiveness of their communication.

While most patient satisfaction and experience of care surveys do not address language issues directly, some organizational assessment tools have been developed specifically to address communication issues, including the AMA's Communication-Climate Assessment Toolkit (C-CAT),⁵⁵ which includes seven measures endorsed by the National Quality Forum (NQF) for monitoring health disparities and cultural competency. The COA-360 is a tool developed by researchers at Johns Hopkins to assess the cultural competency of healthcare organizations, which includes measures of language access services.⁵⁶ Recently, the U.S. Agency for Healthcare Research and Quality (AHRQ) released a special Consumer Assessment of Healthcare Plans and Systems Survey (CAHPS) "Cultural Competence Item Set" that can be used with the standard Clinician and Groups CAHPS surveys in group practice settings and which includes items on language access.⁵⁷ In addition, the standard CAHPS items can be used to evaluate variations in reported quality of care among patients speaking languages other than English.⁵⁸ The CAHPS surveys have also been NQF-endorsed. Finally, two additional language services quality measures were recently endorsed by NQF.⁵⁹ The measures were developed through a language services quality

improvement collaborative to assess whether patients are screened for preferred language and whether LEP patients receive language services from a qualified provider.⁵⁰

A second step is to receive training to improve communication quality for LEP patients. All clinicians should receive training to promote effective communication, and those providing care for LEP patients should receive focused training on communication issues likely to arise in their care. Whether in small- or medium-sized practices or large health systems, clinicians need to know when and how to access language services, what types of interpreter services work best for their patients in various clinical situations, and how they can most effectively interact with their patients using their own non-English language skills.

Third, planning ahead to accommodate the language needs of LEP patients is an important consideration. The more information a clinician and practice have on the language needs of its patients, the easier it will be to schedule an interpreter when necessary or group visits during blocks of time to optimize the use of language services resources. Clinicians should work together through professional societies or other groups to identify common needs and consider ways to share costs and resources to ensure quality care for patients with LEP.

Next steps: Setting a research agenda

The Commission believes that a targeted research agenda around these issues could provide critical support for health systems and clinical practices striving to

Box 5: Recommendations for future research

1. Research on appropriate care for LEP patients, such as:

- Research to develop standardized self-assessment tools for clinicians who speak languages other than English
- Research on the most common adverse events experienced by LEP patients
- The role of language and other communication problems in safety events
- Identification of factors that encourage or inhibit appropriate use of interpreter services

2. Research on roles, functions and value of interpreters, such as:

- Outcomes associated with the use of trained interpreters

- How to incorporate interpreters into evolving models of team-based care
- The value of specialty or subspecialty training for some interpreters

3. Clinical effectiveness research, such as:

- The comparative value of different modes of interpreting
- The relative effectiveness of various payment models for interpreter services
- The best ways to train medical students, residents and practicing physicians in the optimal use of second language skills and interpreter services
- The effectiveness of the "teach back" method among patients with LEP

provide the best possible care for patients with LEP. The Commission identified three sets of recommendations to shape a research agenda in this field (**Box 5**).

The first key area for research is to develop tools to support safer care for patients with LEP. This includes the urgent need for affordable and accessible assessment tools for bilingual physicians and other health professionals providing care to patients with LEP. These tools are essential to help bilingual clinicians determine whether they have the requisite language proficiency to communicate safely with individual patients or in specific types of clinical encounters.

Beyond this, there is a need for better understanding of adverse events most commonly suffered by patients with LEP, what role language and other communication problems might play in errors, and what factors might prevent (or facilitate) the appropriate use of interpreters.

A second area of research should help elucidate how to obtain optimal value from trained interpreters and bilingual staff. While prior research has demonstrated the value of interpreters in several settings, more detailed studies should explore cost and quality outcomes

associated with using trained interpreters, the potential for team-based services and other shared approaches that are being generated by technological advances, the relative value of trained bilingual staff compared to interpreters, and whether certain situations would benefit from specialty or even subspecialty trained interpreters.

Finally, a research agenda on comparative effectiveness could help systems and organizations determine whether and how to use different modes of interpretation

... a research agenda on comparative effectiveness could help systems and organizations determine whether and how to use different modes of interpretation.

(video versus in-person versus telephonic) in a variety of important scenarios (psychiatric care, emergency care, etc.). Various methods

of payment for interpreter services also need to be investigated, especially in light of evolving models of care delivery such as medical homes and accountable care organizations. In addition, how best to train students, physicians, and other health professionals on appropriate care for LEP patients deserves attention, as does the task of ensuring patient understanding. As one example, though several studies have shown that teach-back is an effective method of ensuring patient understanding in English, similar studies among LEP populations have not yet been published.

APPENDIX I: Commission to End Health Care Disparities member organizations

Alliance of Minority Medical Associations	American Podiatric Medical Association	Medical Society of the State of New York
AMA Council on Medical Education	American Psychiatric Association	Michigan State Medical Society
AMA Council on Science and Public Health	American Public Health Association	National Alaska Native American Indian Nurses Association
AMA International Medical Graduates	American Society of Addiction Medicine	National Association of Health Services Executives
AMA Minority Affairs Section	American Society of Anesthesiologists	National Association of Hispanic Nurses
American Academy of Allergy, Asthma and Immunology	American Society of Clinical Oncology	National Biotechnology & Pharmaceutical Association
American Academy of Dermatology Association	Association of American Indian Physicians	National Black Nurses Association
American Academy of Family Physicians	Association of American Medical Colleges	National Council of Asian-Pacific Islander Physicians
American Academy of Nurse Practitioners	Association of Clinicians for the Underserved	National Hispanic Life Sciences Society
American Academy of Ophthalmology	Association of Haitian Physicians Abroad	National Hispanic Medical Association
American Academy of Pediatrics	Association of Minority Health Professions Schools	National Medical Association
American Academy of Physician Assistants	AstraZeneca Pharmaceuticals*	National Minority Organ Tissue Transplant Education Program
American Association of Public Health Physicians	Blue Cross Blue Shield Association	National Pharmaceutical Council
American College of Cardiology	California Medical Association	Network of Ethnic Physicians Organizations
American College of Chest Physicians (CHEST Foundation)	California Medical Association Foundation	Oakland University William Beaumont School of Medicine
American College of Emergency Physicians	Charles R. Drew University of Medicine and Science	Ohio State Medical Association
American Congress of Obstetricians and Gynecologists	Chicago Medical Society	Pfizer, Inc*
American College of Physicians	Coca-Cola North America*	Purdue Pharma*
American College of Preventive Medicine	Connecticut State Medical Society	Renal Physicians Association
American College of Surgeons	Eli Lilly & Company*	Society of Critical Care Medicine
American Hospital Association	Florida Medical Association	Texas Medical Association
American Medical Association	Gay and Lesbian Medical Association	Uniformed Services University of the Health Sciences
American Medical Women's Association	Hopkins Center for Health Disparities Solutions	UnitedHealthcare*
American Osteopathic Association	Illinois State Medical Society	W. Montague Cobb/ NMA Health Institute
	Johnson & Johnson*	
	Massachusetts Medical Society	
	Medical Society of New Jersey	

Total organizations: 75

* Indicates corporate sponsor

APPENDIX II: List of Research and Data Resource Committee members

(as of August 2012)

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President
National Medical Association

Jeremy A. Lazarus, MD
President
American Medical Association

Permanent Steering Committee member

Elena Rios, MD, MSPH
President & Chief Executive Officer
National Hispanic Medical Association

Advocacy and Policy Committee

Chair: Evelyn Lewis & Clark, MD, MA
W. Montague Cobb/NMA Health Institute

Vice chair: Vacant

Finance Committee

Interim chair: Jacqueline Stiff, MD, MSPH
UnitedHealthcare

Vice chair: Vacant

Health Professional Awareness Education and Training Committee

Chair: Robert Like, MD, MS
Medical Society of New Jersey

Vice chair: Joseph M. Caporusso, DPM
American Podiatric Medical Association

Research and Data Resource Committee

Chair: Randall C. Morgan Jr., MD, MBA
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Vice chair: Lynne Richardson, MD, FACEP
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Workforce Diversity and Leadership Development Committee

Chair: Art Fleming, MD
Network of Ethnic Physicians Organizations

Vice chair: Alice Coombs, MD
Massachusetts Medical Society

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APPENDIX IV: Expert panel on appropriate use of physicians' second language skills

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Assistant clinical professor of medicine, DGIM, SFGH

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Assistant attending physician, Department of Psychiatry and Behavioral Sciences & Department of Medicine, Immigrant Health and Cancer Disparities Service

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Medical Effectiveness Research Center for Diverse Populations, Department of Medicine

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Survey specialist
Mathematica Policy Research

Sunita Mutha, MD

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Disparities Improvement and Quality Initiatives

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Wright Consulting
Professor of Biostatistics and Preventive Medicine
University of Colorado

Matthew Wynia, MD, MPH

Director, The Institute for Ethics
American Medical Association

APPENDIX V: Additional resources on caring for patients with limited English proficiency

- National Standards for Culturally and Linguistically Appropriate (CLAS) Services in Health Care: U.S. Department of Health and Human Services: Office of Minority Health; 2001: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>
Note: Updated CLAS Standards expected in 2012: www.thinkculturalhealth.hhs.gov/Content/clas.asp
- The Joint Commission, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: www.jointcommission.org/assets/1/6/aroamapforhospitalsfinalversion727.pdf
- National Committee for Quality Assurance, Standards aimed at improving health care for diverse groups released for public comment. www.ncqa.org/tabid/916/Default.aspx
- Standards and Guidelines for Distinction in Multicultural Health Care (MHC): www.ncqa.org/tabid/1157/Default.aspx
- National Quality Forum—A comprehensive framework and preferred practices for measuring and reporting cultural competency: www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_PREFERRED_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx
- National Quality Forum, Healthcare Disparities and Cultural Competency Measures: www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Healthcare_Disparities_and_Cultural_Competency_Measures.aspx
- American Medical Association. EPoCH: Addressing Language Barriers Between Physician and Patient: What are the Optimal Strategies? (click on video link below and come prepared to discuss in class) www.bigshouldersdubs.com/clients/AMA/Language.htm
- American Medical Association. Office Guide to Communicating with limited English proficient patients, 2nd edition www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf
- Civil Rights and Caring for Patients with LEP: Resources on language access law & compliance from federal Interagency Working Group on Limited English Proficiency, www.lep.gov/
- Language access assessment and planning tool, <http://go.usa.gov/jpJ>
- Federal Coordination and Compliance Section LEP Agreements and Settlements, <http://go.usa.gov/KTh>
- Resource for determining whether entity is recipient of sub-recipient of federal financial assistance, www.lep.gov/ffa/federal_financial_assistance.html
- Common language access questions, technical assistance and guidance for federally conducted and federally assisted programs, www.lep.gov/resources/081511_Language_Access_CAQ_TA_Guidance.pdf
- Language access assessment and planning tool for federally conducted and federally assisted programs, www.lep.gov/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf

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