Caring for Patients with Limited English Proficiency

Expires Thursday, October 31, 2019 Nursing Colleen Symanski-Sanders , RN

Objectives

1. Describe how the ethnic population of the United States will change in the next 25 years.
2. Explain how home care nurses can develop culturally appropriate verbal and non-verbal communication competency/skills.
3. Identify available options for selecting an interpreter and identify violations to patient federal and civil rights.
4. Incorporate new skills into their communication with patients and interpreters.

Article

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Author: Colleen Symanski-Sanders, RN, Forensic Nurse Specialist

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Introduction

Immigration patterns are changing, no longer isolating immigrants to certain geographic locations. Cultural disparity in healthcare is a real concern and healthcare professionals need to respond. Nowhere is this as obvious, than at the bedside of care. Home Care Nurses function in the patient's home where the patient's culture is most obvious and within the next ten years, the population will grow significantly older and more diverse. Racial and ethnic minority elders will constitute a growing proportion of this group. The resident population of the United States is currently about 290 million. An estimated three out of ten U.S. Residents have an origin that is something other than Caucasian. About one million immigrants enter the United States annually, mostly of Latin American or Asian origin. By 2006, the Hispanic population will outnumber the black population and by 2030, one out of four residents will be either Hispanic or Asian. It is critical for home care nurses to be aware of the current and projected characteristics of this diverse population to prepare for addressing their changing needs into the future.

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Communication is a vital component of healthcare services. While many home care nurses have managed a culturally diverse patient care population, there is little on established outcomes to determine how effective that management has been. But research provides insight that healthcare has significant disparities for patients of different ethnic and cultural backgrounds. Clinicians/home care nurses must build skills that enhance communication such as being open, honest, respectful, nonjudgmental, and willing to listen and above all, be willing to learn. Cultural competence is a home care competency item. Home care nurses are "culturally competent" when they are able to provide care to diverse populations including patient's with "Limited English Proficiency" (LEP) and can incorporate the patients values, beliefs, and behaviors and deliver care that meets the patients' social, cultural, and linguistic needs. This does require self-evaluation of one's own biases, beliefs, and stereotyping behaviors. Home Care nurses need to know state laws,

Federal regulations, and practice within the scope and standards of Home Health Nursing.

It's the Law – Title VI of the Civil Rights

Healthcare providers that receive federal dollars from the US Department of Health and Human Services are prohibited from conducting any of their programs, activities, and services in a manner that subjects any person or class of persons to discrimination on the grounds of race, color, or national origin. Simply stated, that means addressing language barriers is a law. In healthcare, a frequent violation of Title VI is the use of ineffective methods of communication between English-speaking healthcare providers and persons/patients who, because of their national origin, have limited English proficiency. So, on your next home health visit think twice before you "wing it" or use a patient's child to interpret for you. The Department of Health and Human Services' Office of Civil Rights (DHHS-OCR) issued a policy guidance on Title VI prohibition, August 2000. The guidance clarifies acceptable and unacceptable interpreter services provided to patients, which will be discussed in this article.

National Standards – a Clinician's Guide for Communication

As a home care nurse, you probably are knowledgeable about your agency's client population, including the primary language spoken. If you and your agency cares for primarily English-speaking patients than you will probably face the communication challenge when a patient with LEP is assigned to you. If you and your Agency are "bilingual" you also face similar challenges. There are more than 150 non-English languages spoken in this country. The Spanish-speaking population constitutes over 31 million people with over 26 million non-English speaking individuals.

In response to the culturally diverse population and the needs of direct care providers, the U.S. Department of Health and Human Services' Office of Minority Health (DHHS-OMH) developed recommendations for national standards for Culturally and Linguistically Appropriate Services (CLAS) for healthcare providers. The standards incorporate key laws, regulations, contracts, and standards currently in use by federal agencies, state agencies and other national organizations. These standards promote equitable and effective treatment in a culturally and linguistically appropriate manner. They are applicable to all cultures and are not limited to a particular racial, ethnic, or linguistic population. There are fourteen standards: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). There are also three types of standards of varying stringency as described below:

1. **CLAS mandates**: current Federal requirements for all recipients of Federal funds (Standards 4 to 7).
2. **CLAS guidelines**: activities recommended by the DHHS-OMH for adoption as mandates by Federal, State, and National accrediting agencies (Standards 1 to 3 and 8 to 13).
3. **CLAS recommendations**: suggested by the DHHS-OMH for voluntary adoption by healthcare organizations (Standard 14).

The National CLAS standards are taken directly from text written by the DHHS-OMH. These standards are applicable on an organizational wide basis as well as to the individual clinician. The CLAS standards are:

1. Healthcare organizations should ensure that patients receive from all staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Healthcare organizations should ensure that staff, at all levels and across all disciplines, receives ongoing education and training in culturally and linguistically appropriate service delivery.
4. Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Healthcare organizations must provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient).
7. Healthcare organizations must make available, easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

8. Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Healthcare organizations should ensure that data on the individual patient's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Healthcare organizations should maintain a current demographic, cultural, and epidemiological profile of the community, as well as, a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Healthcare organizations should develop participatory collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing CLAS-related activities.
13. Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and are capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients.
14. Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Communication via Language Assistance Services – The Choices

Healthcare agencies and organizations are required to provide translation services to patients with LEP. This also means that individual clinicians are required to practice within the law and according to acceptable community practices. There are four issues related to the use of translators that must be considered when implementing the services of translators: the use of friends, family, or minor children as interpreters; the use of competent interpreters, especially in medical interpretation; State and Federal laws and regulations; and a patient's right to confidentiality and privacy.

There are several choices available to home care clinicians. Each has distinct advantages and disadvantages, which you need to be aware of as you plan to communicate with your patients. They are:

1. Family Members or Friends
2. Professional Interpreters, which may be on staff or available per diem
3. Bilingual Staff
4. Language Line Services

1. Family Members or Friends

Healthcare facilities and providers are at risk for liability under Title VI if they require, suggest, or persuade an LEP person to use friends, minor children, or family members as interpreters. Bilingual family members or friends may have a working knowledge of the clinician's and patient's language; however, they are likely to lack training in areas essential to adequate medical interpretation. Breakdowns in communication are not always unintended. Family or friends of the patient sometimes will choose not to interpret a message accurately for a number of reasons, among them, the desire to protect the patient from the truth, particularly if the news is bad or embarrassing. These "well-intentions" can distort patient decisions or compromise the overall care that is provided. In addition, they may not appreciate the extent to which inadequate interpretation may have negative consequences upon a patient's health. Minor children of patients should never be used for translation/interpretation.

Clinicians may believe it to be more straightforward or even preferable to rely on the help of family members or friends who speak the language of both the patient and the clinician. Such individuals are already on the premises and can assist free of charge. In addition, they already have a relationship with the patient. However, on the possibility that family and friends may not be qualified to provide competent medical interpretation services or may compromise patient confidentiality, this could result in

- A breach of confidentiality
- A reluctance on the part of individuals to reveal personal information critical to their situations

- The possibility that family and friends are not competent to act as interpreters and/or are unfamiliar with specialized terminology

Once an LEP patient is informed of their right to free interpreter services they are entitled to decline and request a family member or friend as a translator. This information needs to be documented in the patient's record. Even if an LEP person waives his/her right to interpreter services and elects to use a family member or friend, the clinician should suggest that a trained interpreter sit in on the encounter to ensure accurate interpretation.

2. Professional Interpreters

The most preferred approach for clinicians is the use of professional interpreters. They are (or should be) screened for their language skills, trained in interpretation ethics and techniques, and contracted with the agency only to interpret. Larger agencies may have a professional interpreter on staff or may have a list of several on-call interpreters.

Competent medical interpretation requires a specialized set of skills beyond the knowledge of two languages, such as the ability to interpret in and out of a language (which is more challenging than communicating in it directly) and the competency to convey technical information with accuracy. The agency is responsible for insuring competency of individuals who provide interpreter services. In the training and screening of interpreters, the following skills should be documented:

- Demonstrated proficiency in both English and the other language, which means the ability to convey information in both languages accurately.
- Orientation and training that includes the skills and ethics of interpreting.
- Fundamental knowledge in both languages of any specialized terms, or concepts peculiar to the agency's program/service population.
- Sensitivity to the LEP person's culture.
- Interpersonal skills.

The CLAS standard's recommendation is formal training in the techniques, ethics, and cross-cultural issues related to medical interpreting. Formal training consists of a minimum of 40 hours as established by the National Council on Interpretation in Healthcare. However, competency does not necessarily mean formal certification as an interpreter, though certification adds to credentials. The trend in competency is moving toward development of standards for interpreters and certification requirement.

3. Bilingual Staff

Bilingual staff can include nurses or support staff. They may be used routinely or temporarily as the need arises. Competency requires more than self-identification as bilingual. This is an attractive option for clinicians and the agency because it offers immediate availability for the moment. However, untrained, unscreened, "bilingual staff" need to be used judiciously. They also tend to edit, add to, or change the message. Prior to using bilingual staff for medical interpretation, they should be screened for their language skills and provided with training as interpreters. Unless a person's command of both English and the non-English language are tested, it may be discovered that this person does not have the language skills or specialized vocabulary necessary to interpret well. Using bilingual support staff could cause conflicts in duties or create resentment in staff members or co-workers.

4. Language Line Services

A telephone interpreter service is another option available when interpreter services are needed. These services are appropriate for emergencies, for uncommon languages, and for patient-provider interactions that would take place over the phone anyway. Most language line services can cover over 140 languages 24 hours/day, 7 days/week. Interpreters are native speakers with training in interpretation and healthcare terminology.

However, using a language line is more expensive on a per-hour basis than an on-site interpreter and often requires prior arrangement by the agency. Clinicians and patients may find it awkward to talk to each other through a voice on the phone, and a speakerphone is highly recommended. The service can also be billed directly to the insurer.

Communication via Language Assistance Services – How to work with them

If you have already worked with translators, then this information may be a review, especially if you received formal training; however, if you haven't or expect to work with translators in the future, this material is foundational. Taken from the "Ethnic Specific Modules – Core Curriculum in Ethnogeriatrics" are ways to work with interpreters to ensure the best communication possible. These have been categorized into Agency Expectations, Clinician Expectations, and Translator's Expectations.

Agency Expectations

- The provider should meet with the healthcare team members who serve as interpreters on a regular basis to review interpreter roles and procedures, provide in-service training, and develop collegial relationship.
- The cost of translation services is not the responsibility of the patient.
- Acknowledge the additional costs and build it into the reimbursement structure.
- Use volunteer language programs cautiously as they have drawbacks, such as difficultly obtaining necessary screening, training, and standards from volunteers, plus the turnover can be high.
- Consider contacting your local Area Agency on Aging. Some have developed successful bilingual and bicultural programs for elders residing in the county.

Clinician Expectations

- Speak in short units and ask short questions. Interpreters will have difficulty interpreting long, involved statements without forgetting something important.
- Avoid technical terminology, abbreviations, and professional jargon.
- Avoid colloquialisms, abstractions, idiomatic expressions, slang, similes, and metaphors.
- Encourage the interpreter to translate the patient's words, as much as possible, rather than paraphrasing or polishing with professional jargon.
- During the interaction, look at and speak directly to the patient, not the interpreter.
- Be patient. Interpretation takes time when done right.
- Have the interpreter ask the patient to repeat, as accurately as possible, the information that has been communicated, to see if there are gaps in understanding.

Translator's Expectations

- Engage in conceptual transfer rather than verbatim translations.
- Make sure that concepts get across correctly in both directions of the clinical interaction.
- Technical clinical concepts in one language are translated into acceptable social terminology that conveys the clinical meaning in the second language.

Other Important Considerations for the Clinician and the Translator

- Pace of conversation: Some cultures are comfortable with long periods of silence, while others are fast paced and consider it appropriate to speak before the other person has finished talking.
- Proximity: Provide patients with a choice about physical proximity (personal space) by asking them to sit wherever they like. Some cultures will prefer a closer proximity, while others prefer a greater distance.
- Eye Contact: Observe the patient when talking and listening to get clues regarding appropriate eye contact. Some ethnic groups typically encourage members to look people in the eye when speaking to them, whereas others may consider this disrespectful or impolite. Some Moslem groups may consider eye contact inappropriate between men and women.
- Emotional expressiveness: Some cultures value stoicism, while others encourage open expressions of feelings, such as sorrow, pain, or joy. Elders from some backgrounds may laugh or smile to mask other emotions.
- Body Gestures: Body gestures can be easily misinterpreted based on what is considered culturally appropriate. Individuals from some cultures may consider some types of finger pointing or other typical American hand gestures or body postures disrespectful or obscene, while others may consider vigorous hand shaking as a sign of aggression. When in doubt, ask an interpreter or other cultural guide.
- Touch: physical touch is an important form of non-verbal communication, however, the etiquette of touch is highly variable across and within cultures.
- The patient's right to privacy in terms of the nature and amount of clinical/medical information shared in confidence: Patients may withhold sensitive information, even if it is critical to their care, rather than reveal it in front of individuals who know them socially or personally. Important medical information may be omitted when patients engage in censorship.

Addressing Language Barriers with Written Patient Education Information

The Administration on Aging developed a guidebook entitled "Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and their Families". It is an excellent resource for clinicians as well as administrators who care for a racially and ethnically diverse population. Communication and translation services information from the guidebook are referred to as "communication vehicles". Effective communication must involve capturing your patient's attention and understanding not only through his or her spoken language and dialect but also by the patient educational materials you provide to them. Recommendations in the Guidebook for Providers of Services to Older Americans and their Families for facilitating communication and overcoming language barriers are as follows:

1. Develop publications in the language of the population you are targeting. Have an individual from the same ethnic group you are trying to reach review any publications you intend to use for outreach. This will help to ensure the materials are both meaningful and do not include potentially offensive passages.
2. Avoid literal translations of existing material as they lose their meaning when syntax and vocabulary are not within cultural contexts.
3. In publications, use pictures that include the targeted group to promote identification of the issue as "being important to people like me".
4. Identify key minority-focused information web sites as a form of education.
5. Display information and educate minority caregivers through professional meetings, conferences, and publications. There are national associations of minority physicians, nurses, media professionals, attorneys, etc. that hold regular meetings, produce publications, and seek to educate their memberships through association activities.

The Following are Some Case Examples of Title VI Violations

Over the past 30 years of enforcing Title VI regarding LEP, OCR observed a number of recurring problems. The following are examples of frequently encountered policies and practices that are likely to violate Title VI:

1. A state welfare agency does not advise a mother of her right to free language assistance and encourages her to use her eleven year old daughter to interpret for her. The daughter does not understand the terminology being used and relays inaccurate information to her mother whose benefits are jeopardized by the failure to obtain accurate information.
2. A clinic uses a medical student as an interpreter based on her self-identification as being bilingual. While in college, the student spent a semester in Spain as an exchange student. The student speaks Spanish haltingly and must often ask patients to speak slowly and to repeat statements. On several occasions, she has relayed inaccurate information that has resulted in misdiagnosis.
3. A health clinic uses a Spanish-speaking security guard, who has no training in interpreting skills and is unfamiliar with medical terminology, as an interpreter for its Hispanic LEP patients. He frequently relays inaccurate information that results in inaccurate instructions to patients.
4. An HMO that enrolls Medicaid beneficiaries instructs a non-English speaking client to provide his or her own interpreter services during all office visits.
5. A health plan requires non-English speaking patients to pay for interpreter services.

Conclusion

Home Care Nurses are able to take the lead in reducing disparity in health care and creating methods and programs that meet the culturally diverse population. One of the measurement criteria in the Standards of Home Health Nursing Practice is "outcomes are culturally appropriate and realistic in relation to the client's present and potential capabilities". This requires that nurses from all cultural and ethnic backgrounds be culturally competent and continually educate themselves in diversity. I recall fondly, the traditions of my culture passed down to me from my Grandparents and how important they are to my spiritual needs, religious beliefs, and how they influence behavior. I wouldn't give them up, would you? The home care nurse knows that patients shouldn't give them up either – that's why we are "nurses".

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Colleen Symanski-Sanders, RN, Forensic Nurse Specialist, has been a Registered Nurse for over 18 years. She has extended her education into forensic nursing, criminal profiling, and psychopathy receiving a Certificate as a Forensic Nurse Specialist. She has over 16 years experience in public health and home care nursing.

Colleen has been an author of educational material for St. Petersburg College, St. Petersburg, Florida. She has also lectured on a variety of topics at numerous nursing symposiums and conferences across the country. She is on the Editorial Board for "Home Health Aide Digest" and "Private Duty Homecare" publications.