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System Analysis of Communication with Hospitalized Spanish-Speaking Patients with Limited English Proficiency

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Abstract

This paper presents a study of the documentation of the methods of interpretation and instruction utilized for Spanish-speaking patients with limited English proficiency (LEP) who were hospitalized in a middle Georgia hospital. Hospital employees have been instructed by the hospital administration to utilize a telephone interpreter service as their primary interpretation resource; a reference list of local Spanish-language interpreters is available in the Human Resources Department and in the hospital’s computer information system to be utilized if needed. Data were collected from a small random sample of inpatient medical records selected by Health Information Services to determine whether these services are being utilized and documented as well as to examine any other documented methods of interpretation and instruction. The paper concludes with recommendations for improving the practice and documentation of Spanish interpretation at this facility.

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In the past year, the number of deliveries performed in a hospital in the Middle Georgia region has increased by more than 8 percent; the number of obstetrical outpatients treated has also increased sharply. In the same time frame there has been a steady rise in the number of Spanish-speaking patients with limited English proficiency treated on the obstetrical unit (the Women’s Center) as well as in the hospital’s medical-surgical units. The U.S. Department of Health and Human Services (DHHS) Office for Civil Rights (OCR) has designated the term “limited English proficient” (LEP) to define the portion of the population that is non-English speaking or limited-English speaking (Woloshin, Bickell, Schwartz, Gany, & Welch, 1995). Over 95% of the LEP Hispanic obstetrical patients are admitted as “uninsured indigent” or Medicaid clients, requiring them by state law to receive health care in their county of residence. The recent closure of the obstetrical unit at the county’s only other hospital has necessitated that all uninsured or Medicaid-eligible obstetrical clients in the county receive care at this facility, leading to a further increase in the number of LEP Hispanic patients.
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The U.S. Department of Health and Human Services OCR views inadequate interpretation in the healthcare setting as a form of discrimination based on Title VI of the Civil Rights Act of 1964 (Woloshin et al, 1995). Health programs funded by the DHHS are required to provide patients with limited English skills access to services equal to those provided to English speakers, and programs not in compliance risk the loss of all federal funding, including Medicare and Medicaid reimbursements (Woloshin et al). Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of handicap has also been determined to be applicable to non-English-speaking patients (Headley, 1992; Putsch, 1985), and several tort cases have determined failure to communicate adequately due to inadequate interpretation to be a form of medical negligence (Elderkin-Thompson, Silver, & Waitzkin, 2001; Woloshin et al).

The Health Insurance Portability and Accountability Act of 1996 HIPAA contains a privacy rule which requires all healthcare providers, including nurses, doctors, and hospitals, to take reasonable measures against unauthorized uses and disclosures of personal medical information and prescribes penalties for individuals and institutions found to be non-compliant (Ziel & Gentry, 2003). The use of a patient's family or friends as interpreters in the healthcare setting is considered a violation of HIPAA due to the possibility of unauthorized, undesired disclosure of the patient’s sensitive personal medical information to these interpreters in the course of routine medical assessment and treatment.

System Description

The system discussed in this analysis is a medium-sized, not-for-profit, acute care hospital located in Middle Georgia. This system exists within the environment of a small city with an increasing population of LEP Spanish-speaking residents. This population includes both legal and illegal immigrants from Mexico and other Central American countries. The system analysis was initially limited to communication with Spanish-speaking patients of the Women's Center of the hospital, but the scope of the analysis was broadened to include inpatients on the hospital's medical-surgical units as well as a comparison unit. The hospital has three primary methods of assisting its staff to communicate with Spanish-speaking patients. These are the availability of a telephone interpretation service, the provision of discharge instructions in a Spanish-language video and in written Spanish-language instruction sheets, and the utilization of identified hospital employees as interpreters.
Data Collection of System Problem

The primary method of data collection for this analysis was a chart audit of randomly selected patient medical records. The Health Information Management department provided records for 15 former patients of the Women’s Center who had been identified as LEP, and for 15 medical-surgical patients with Hispanic surnames. Two records from the Women’s Center (WC) contained charts from multiple hospital admissions, leading to a final WC sample size of 17. The records of the medical-surgical patients were then reviewed to determine whether the selected patients met the criteria of being LEP. Of the 15 medical records reviewed, only 8 medical-surgical (M-S) patients met these criteria. One of these records also contained charts from multiple admissions, creating a final M-S sample size of 10. This resulted in a total sample size of 27 records to be reviewed for this study.
Table 1

<table>
<thead>
<tr>
<th>Communication Method</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone interpreter service</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Interpretation by fully identified hospital employee*</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Interpretation by partially identified hospital employee**</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Interpretation by unidentified interpreter***</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Interpretation by family member/visitor</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>Interpretation based on observation only</td>
<td>7%</td>
<td></td>
</tr>
</tbody>
</table>

*Fully identified interpreter means that the interpreter was identified by full name and job title in the medical record.
**Partially identified interpreter means that only a first or last name and/or a job title were documented in the medical record.
***Unidentified interpreter means that the interpreter was identified only as "interpreter" in the record.

Documentation of current interpretation practices, as recorded in the medical records audited, is presented in Table 1. As seen in the table, the telephone interpretation service was not documented in the sample of charts that was reviewed. When the use of an interpreter was recorded, a complete identification of an interpreter provided by the hospital was documented only 33 percent of the time. Family members and visitors were the documented interpreters 34 percent of the time, while partially
identified hospital employees accounted for five percent of the recorded interactions. The designation “interpreter” without further explanation or identification was recorded 21 percent of the time, making it impossible to determine whether the interpretation was provided by a hospital employee, a family member, or some other available bilingual individual. Finally, seven percent of the documented communication consisted solely of gestures and observations.

<table>
<thead>
<tr>
<th>Instructional Method</th>
<th>Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Written</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Video</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

Table 2

Documentation of the language used for patient education and discharge instructions in the reviewed charts is detailed in Table 2. The entire medical record, including all flow charts and narrative notes, was examined for evidence of patient education and/or instruction. The provision of Spanish-language oral instruction was documented in 50 percent of the Women’s Center charts reviewed. There was also documentation of the provision of written Spanish-language materials in 50 percent of the Women’s Center charts. Provision of Spanish-language video instruction was documented in 21 percent of the Women’s Center charts. The language in which patient education and discharge instructions were provided was not documented in any of the medical-surgical charts reviewed.

Discussion

According to hospital policy, a telephone interpretation service is to be utilized as the primary means of communication with LEP patients. There was no mention of the use of this service in any of the 27 charts reviewed for this study. Legal precedent has consistently declared that
procedures not recorded in the medical record are to be considered "not done". When a hospital representative was questioned about the lack of recorded use of the telephone service by hospital employees, they responded that the service is being utilized by "some employees" because the hospital receives billing for its use.

The absence of full identification of most of the persons providing interpretation services in the records reviewed is also a significant finding. It would be difficult or impossible to determine the interpreter's identity and/or qualifications from the information recorded, particularly if the information was required months or years later as is common in medico-legal investigations.

The use of unknown or untrained interpreters in a healthcare setting can lead to potentially important information being omitted ("lost in translation") by the interpreter. These omissions can be due to a lack of understanding of the medical terminology used as well as a lack of knowledge of the possible importance of seemingly trivial patient information in clinical diagnosis and treatment. Such miscommunications could have legal as well as medical implications as potential violations of the civil rights of LEP patients as detailed in the introduction to this paper. Elderkin-Thompson, Silver, and Waitzkin (2001) and Woloshin, Schwartz, Katz, and Welch (1997) have published studies detailing the frequency of inaccurate and/or incomplete translation of information by personnel untrained in medical interpretation and advocating for the training and competency testing of all interpreters utilized in healthcare settings.

Another area of concern identified during the analysis was related to the materials used for education and discharge instruction of LEP Spanish-speaking patients. Documentation of viewing a Spanish-language discharge instruction video and of providing Spanish-language written
instructions was present in some of the charts reviewed from the Women's Center. No language was specified for the oral or written instructions documented as given in the charts reviewed from the medical-surgical units (see Table 2). Even though the majority of charts in the Women's Center group contained documentation of the provision of written Spanish-language instructions, there is another gap that needs to be addressed: the ability of Spanish-speaking patients to understand medical terminology and instructions even when the instructions are provided in their native or primary language. A study by Williams, Parker, Baker, Parikh, Pitkin, and Coates (1995) examined the ability of Spanish-speaking patients to understand basic medical instructions and dosages of prescribed medication (health literacy). A cross-sectional survey of 767 primarily Spanish-speaking patients presenting for acute care in the emergency department of a California medical center were asked to complete a Spanish-language version of the Test of Functional Health Literacy in Adults (TOFHLA), a previously validated written instrument that measures the ability to read and understand medical instructions and health care information presented in prose passages and in passages containing numerical information (e.g., prescription bottle labels and appointment slips). They discovered that of the Spanish-speaking subjects tested utilizing a Spanish-language test of health literacy, 41.9 percent of those tested demonstrated inadequate functional health literacy with an additional 19.8 percent scoring in the marginal health literacy category. Patients with inadequate functional health literacy often misread Spanish-language medication dosing instructions, appointment slips, and radiology instructions; those with marginal literacy performed better on those tasks but frequently misread other information on prescription bottles (including instructions to take all the pills in a bottle and to take medications on an empty stomach) and had difficulty comprehending other health-related information (William et al).

The hospital has attempted to address the problem of language-appropriate discharge instructions by providing each inpatient unit with access to a Krames Health Education module, via computer, which can provide printed English and Spanish-language educational materials written for a low literacy level on a variety of health-related topics. (The system can also provide limited information in several other languages.) However, no staff education was provided on the use of the program or on the rationale for its use. Use of Krames material was not documented on any of the charts reviewed.

Multiple factors contributing to communication difficulties were identified during this analysis. They are included on the cause and effect diagram found in Appendix A. Although many factors contribute to the difficulty in communicating with Spanish-speaking patients, the issues surrounding existing resources are the focus of this discussion. A significant
challenge to communication with Spanish-speaking patients is that hospital employees lack knowledge of the available communication resources. Instructions in the computer information system for using the “Online Interpreter Service” (known to hospital employees as telephone interpreter service) referred questions to a patient relations representative, who stated that she knew that several departments were utilizing this service because she received the bills, but she was unaware of other communication resources and referred further questions and concerns to the Human Resources (HR) Department. The HR Department is responsible for maintaining the employee interpreter list, but there are no competency requirements or training for inclusion in the interpreter listing.

Another factor contributing to the communication problems is the difficulty of using the computer-based listing of hospital interpreters. The computer information system contains a file labeled “Foreign Language List”. When this file is opened, the screen has blanks for the insertion of “Name”, “Contact Information”, and other information but no instructions for use. When the HR representative was questioned about access to the list from this screen, she first stated “you scroll down to the line that says, “Language”, type in “Spanish”, and hit the “Return” key.” When contacted again after this failed to lead to another screen or further instructions, she suggested several other keys which also did not change the screen (this process consumed the better part of an hour because there was no telephone available in reach of the computer terminal). When contacted for the third time, the HR representative came to the Women’s Center, where it was discovered that the use of three function keys (not normally utilized by staff) is necessary to access the list from the nursing units. When access to the list was finally obtained, it was noted that department telephone numbers for several employees were more than one year out of date (they had transferred to different departments/extensions) and that many hospital employees who frequently act as interpreters are not included in the list. According to the site, the list was last edited in October, 2003.

Most hospital employees, when questioned regarding the use of visitors and family members to interpret for patients, felt that this was usually the most effective means of communicating with LEP patients. These employees initially found it difficult to comprehend why this practice would constitute a potential HIPAA violation. Three employees reported having utilized the telephone interpreter service to communicate with LEP patients and/or their families. Most stated that it was inconvenient and not useful for routine communication with patients because there is only one telephone that must be passed back and forth between the patient and the healthcare provider. Few employees were aware of the existence of the “Foreign Language List” in the computer information system; the few that were aware of it had been unable to access the list.
Recommendations

This analysis uncovered numerous factors contributing to the overall problem of communication with LEP Spanish-speaking inpatients at the hospital. The most efficient method of addressing these concerns would be the creation of a multidisciplinary team to further examine and improve the processes already present in the system.

Current policies and procedures regarding services for LEP patients should be reviewed and compared with those from other area hospitals with the goal of updating and clarifying them to reflect current standards of care. Changes in policies should reflect compliance with HIPPA, Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973.

The current sites for the “Foreign Language List” and the “Online Interpreter Service” should be combined into a single “Foreign Language Interpretation” site in the computer information system. The “Online Interpreter Service” page should be designated as the “Telephone Interpreter Service” to better describe the service offered. The “Foreign Language List” should be reconfigured so that the desired language is the initial prompt on the site rather than being buried in the text, and the site should be reformatted to provide easy access to the list and to instructions for its use. Hospital personnel who are willing to interpret should be tested for competency and trained in medical interpretation prior to inclusion on an updated list, and documentation of competency should be maintained in their personnel files. Personnel included on the updated list should be recognized and compensated for their foreign language skills, and a policy should be developed detailing their responsibilities to their primary department and to departments utilizing them for their language skills.

Dual telephones connected by a single-line adapter which can be plugged into the telephone jack in patient rooms should be made readily available on all nursing units to facilitate use of the telephone interpreter service. The telephone number and the codes needed to access the service should also be readily available (possibly on the back of employee badges, phone stickers, or posters) to further improve ease of use.

Spanish-language instructional videos and other instructional methods which are not literacy-dependent should be acquired by the hospital education department and made readily available to the nursing units for patient education when indicated. Staff education in the use of the Krames Spanish-language education module should be provided so that language-appropriate instructions are provided to every patient.

Mandatory training in the revised policies and procedures should be provided for hospital personnel after the previous recommendations are
implemented. These training sessions should include the rationales for the changes made (to include the civil rights, HIPAA, and legal liability implications) and instructions on the use of the hospital interpreter list, the telephone interpreter service (to include the policy for use of the dual telephone units), the Krames Spanish-language education module, and other available resources as appropriate. This information should also be included in the annual employee update process and in the orientation process for new employees.

In conclusion, this study finds the systems currently in place at this facility for communication with LEP, Spanish-speaking patients are not sufficient. Although many of the necessary components are present, their use is inconsistent due to the lack of staff training and the difficulties encountered in using the current systems to access the interpreter list and the Krames module. Staff education and system modifications as discussed in the recommendations section of this paper are necessary to bring this facility into compliance with currently mandated standards of care.

Works Cited


Appendix A
Cause and Effect Chart for Communication Problems