Transcription dated 08-20-24

Ryan White Planning Council Quality Improvement Committee

2:00 p.m., Tuesday, August 13, 2024
Bering Church, 1440 Harold Street, Houston, Texas

Transcription of Public Comments

GEORGINA GERMAN (Needs Assessment Survey Interpreter): Yes, I have a public comment. This is something that I witnessed and I experienced. Two months ago, it was actually in May, I was a what you do to help other Ryan White Planning Council to do that customer survey at one of the clinics. Actually, I'm going to say the clinic: Thomas Street on Quentin. I was able to do two days. It was on a Tuesday and a Thursday. One of those days, I encountered, while we were encouraging some of the clients, the patients they attend the clinic, to complete the survey, I know almost going to the end of the day, one of the clients, that he was a monolingual, Spanish-speaking person. I'm not going to get into detail what the person looked like or anything like that, but we offer, along with completing the survey, we offer food to the people that we're completing, right? And also, an incentive.

So one person came with a case manager. I wouldn't have had it like that. The case manager was an English monolingual person. This client expressed that it was his first time to attend the clinic. It was a newly diagnosed person, and the client had his kids with him, as well. You know, when it's a first appointment, going through the whole process, it takes usually like hours, right? The client asked for extra food. We give him extra food for his kids.

What I observed in the moment, it was: The case manager was a really nice person, but the way he/she was communicating with the patient, the client, he was using Google Translate. At the moment I saw that, how can I say? He expressed to be confused on the process but also appreciated that the case manager was helping him, you know, like even though that the case managers, what you see, this Google Translate, that is not the appropriate way how we communicate or we provide services to our clients or to our patients, and I would say especially, especially when it's your first appointment, when you have been newly diagnosed and you require way more information to (audio dropout). So it was kind of confusing. He showed confusion, but was more eager to go through the process and just, you know, like doing the labs, continue what he needed to do. Like I said, the case manager was very nice. I saw how they were interacting.

But using a Google app to translate, my observation was: not correct at the moment, because it's more than really translating to our client. It's being able to communicate, educate, explain what is going to be the process so they can continue with their care. And I think that I witnessed in person, as a previous, being a prevention manager, the same experience as my team had encountered; that it was difficult for them to find bilingual people in the clinics.

Did I finish my time? Okay, sorry. Thank you.

* * * * *

STEVEN VARGAS: I'm going to start my public comment. I hope you-all can catch it. Three minutes. I'm here essentially just looking at the data we've been looking at for this entire year, when it looks like when it comes to Latinos, just newly diagnosed, increasing our numbers of people living with HIV, as well, those numbers have been spiking across the country.

Pete (the Committee Chair), I'm sure you're probably aware of this, also, just of your travels and helping out other areas. It's what I've seen, as well. And we know that here in our own state of Texas, Latinos, led the pack of late diagnoses since the beginning of this century, and now we're seeing young Latino MSMs becoming positive at an alarming rate across the country and in our own city, not just our state.

I think it's about time that we start redoubling our efforts to focus in on Latinos, to help them realize their HIV status and capitalize on the treatment advances when it comes to getting to viral suppression. Right now, I am going to be trying to push for folks to redouble our efforts to duplicate what we did about a quarter century ago. When we saw the numbers of African Americans living with HIV, our city created a state-of-emergency response and put monies from our own city's coffers and health departments to address the issue. Well, I'm going to be doing the same with our own city, and I'm calling on this council to basically do what you can. We've done what we can to address this inasmuch as we can. And at this point, I think we need to do what we need to do and not just what we can.

I know that the grant administration has mentioned that we encourage and prefer to hire folks that are bilingual to help with our Latinos that are monolingual speaking, to help them with their facilitation and access the maintenance in care. But we know, just from what we just heard from this first public comment, that is not meeting the mark. We did what we can. Now we need to do what we need to do. We need to demand that bilingual staff be hired at every CBO and clinic that the Ryan White Planning Council funds in Houston. Not recommend. Not would be nice to have. Demand. Make it mandatory that everyone receiving any funding from Ryan White-funded services — care or support — needs to have people that are bilingual so that we can get this under control when it comes to Latinos living with HIV. And so we'll be repeating the same information with the city and the county judge's office. My hope is that we can follow suit, and that's the end of my comments.

Thank you.

* * * * *

ADRIANA DIBELLO (AAMA, Inc.): Hello, good afternoon, everyone. I definitely echo the message Steven shared a few minutes ago: increasing job opportunities for individuals who are bilingual and making it almost mandatory for many of these funded Ryan White locations.

I, myself, have been at AAMA now for — I'm going on 19 years, you guys. So 19 years, and throughout this time frame, we've had a lot of programs around HIV prevention services or HIV early intervention services. And throughout the time that I have been here and working also with the City of Houston Health Department, our Latino population has always needed a little extra support because they face maybe twice to three times the challenges that any other individual may have. And needless to say, there are also — you know, there's a lot of fear factors involved with this specific population. And so, many times it's navigating the system: what documents to bring, what services they can utilize and what they can't. Being able to educate a lot more. I'll tell you that if we do not have that type of what we call intensive, supportive case management service, then you're going to continue seeing an increase amongst this population, and it's just going to evolve even greater.

Thank you.

* * * * *

ELIA CHINO (FLAS, Inc.): Good afternoon, everyone. Nice to see you. Thank you for the opportunity to let me speak on behalf of the Latino community. We've been challenging forever this problem. The Latino community in Houston, it's still the stigma is a huge barrier that we are facing. As I expanded the organization, we are celebrating this year be 30 years. And I've been involved with Ryan White for all these years, and you know what? FLAS never received any support from Ryan White whatsoever. But I also think we need to — acting as Steven and Adriana, they already mentioned about all the needs. I think we need to allocate money from the City of Houston and Harris County to provide more support for the CBOs, because we are challenges. Our community needs transportation. Our community, they need food to bring to the tables. They need to do whatever they have to do to continue surviving, to continue facing the discrimination, the transphobia, the homophobia across all the clinics. We need to have more bilingual people that are work and to have empathy for the population that we serve because that is not happening nowhere, and we need to address these issues because we need support. We need more funding.

Thank you.

* * * * *

GLORIA SIERRA (Chair, Latino HIV Task Force): I am the chair of the Latino HIV Task Force, and this has been an issue since as long as I've been in HIV, which has been at least 30 year now. What I see, the continued issue, is that while we have monies to do testing and things like that, it's always our HIV providers that are getting this money, and yes, they target certain populations, and that's always been a somewhat unspoken rule that they do testing, they stick to their own, they go to the gay communities. But as our Latino communities, they're never out there. They're never testing there.

Why not look beyond the usual HIV — the five to seven clinics that get funding all the time? To look beyond and look at some other clinics that are in the communities, to get some testing money for the ones that do visit these clinics, and maybe we can get some more people onboard and not just the same five or six. And I'm counting Texas Children's Hospital in there, as well. I'm not avoiding that we don't do the same thing, but we get people to come to us. But as the chair of the Latino Task Force, this has been an issue.

I mean, about seven years ago, we did a micro mystery shoppers, where we didn't have any agencies that are out there with monies that had Spanish speakers. And then they treated us terrible. This is just not okay, and we continue to have this same issue, and it hasn't gone away.

When is the City of Houston, the Ryan White Planning Council, going to look at all of this and really do something about it and get us some assistance, get us some help? And I'm not talking about avoiding the African-American or the young gays or whoever, but let's all work together and try to get everyone to do whatever it is we need to do for everyone to get tested so we can all know what our status is.

Thank you.

* * * * *

DANIEL RAMOS (ViiV Healthcare): Thank you, and thank you, committee members, for your time and your work today. My name is Daniel Ramos. I am a community engagement specialist with ViiV Healthcare, but I've been living here in the Houston area and working here for a few years.

I used to be a planning council member at the Austin TGA Planning Council between the years 2019–2021. There, we had very similar conversations with regard to providing interpretation and translation services to clients with limited English proficiency. So this is absolutely something that I believe is not unique to the Houston EMA, but absolutely something that's very ubiquitous in planning councils all over: How do we provide services, again, to our clients who have limited English proficiency?

Now, keep in mind that any healthcare organization that receives federal funding is regulated. It is required to offer translation and interpretation services to any clients of limited English proficiency. And let me just rattle off three: Title III of the Americans with Disabilities Act does speak to this need. Section 1557 of the Affordable Care Act also has information related specifically to healthcare providers needing to offer these services. And last but not least — there are others — but Title VI of the Civil Rights Act, as well.

So with that in mind, keep — I know that you are all very well savvy with regard to Ryan White funds being funds of last resort. We're only using our funds to provide services as need be. Keep in mind that all of the contracted agencies that are providing services under Ryan

White have to be able to provide services for translation and interpretation from clients with limited English proficiency, out of their own funds. Out of their own funds.

Yes, I think it's important that if we do need to oversee and support rollout of better interpretation services at all Ryan White grantee spaces, that some funds be allocated for that. But keep in mind, these agencies have — it's imperative that they provide services, and not only through apps or through phone lines, but actual live, in-person interpretation.

Now, I want to mention and corroborate kind of what Georgina had mentioned earlier. I, myself, was at Quentin Mease a couple of months ago, waiting for an appointment with one of my customers, and I overheard a case manager, in the hallway, using a Google app, Translate, on their phone, speaking in English to their phone, and it spouting out Spanish to the client, in a hallway. Absolutely, patient confidentiality was out the window. That's unheard of.

Aside from hiring people that are bilingual, organizations need to provide services by certified translators and certified interpreters. Now, I'm more than happy to share the American Translators Association information, atanet.org, and I know people in Austin and around the state who can connect us with more information if that's necessary.

Thank you so much for your time today.

* * * * *

KIMMY PALACIOS (FLAS, Inc.): Good afternoon. My name is Kimmy Palacios. I'm a project director here at FLAS. I've been here close to 13 years, and I'm just going to share a story.

A couple of years ago, I'm going to talk about 11 years ago, I had to provide transportation and translation services — I am not certified — to a transgender client. This particular person had to have a breast exam with a very specific machine, and the doctor, from the very beginning, was very, very rude to her. He did not use she/her pronouns. He was very rude, and when he had to use the machine on her breast to see the size of the ball that was growing in her breast, he was very, very aggressive. He was pushing on the machine very — I could tell that he was doing it in a mean way. He not a caring person, you know, and very softly. No, he was like pushing down on the thing and hurting her breast. And I could not say anything to the doctor. I was just there holding her hand as she was getting this procedure done.

She cried in the vehicle, and I cried with her too, because I thought in Houston, we're a melting pot. There are so many Latinos. How dare we stay in the shadows? How dare we stay in the damn shadow? We have to speak up for our people because this is not fair. They're making money out of our people when they go to every single appointment. And it's not fair that they get the trust here at FLAS, where we have to send them out for these other services that we don't have in-house. And for what? So you can get mistreated? They're not getting their pronouns correctly? They come with trauma: escaping cartels; escaping their small villages; from their hometowns, getting burned alive just because of who they are and their sexual orientation or for who they love. Do you think that's fair? They don't cross one border. They don't cross two. They cross up to five damn borders to get here. And for what? The American dream? To get mistreated when they're looking for services? We have to demand better services for our people.

* * * * *

OMAR TOIRAC (FLAS, Inc.): Hello, good afternoon. My name is Omar Toirac, and I'm employed here at FLAS for almost 10 years. All this mistreating our clients has been going since I've been here, and I've always been an advocate for them. When I got the opportunity to be a case manager for people that were getting diagnosed with HIV and they were only Spanish speakers, we will go to mainly St. Hope Foundation, and we were able to be the translators for them. But all of a sudden, they stopped us and say if we were certified to be translators. And the reason why we were translating to them, because many of the uncertified translators were not speaking whatever the doctor was telling the patient, and we were just stopped. They just stopped us to be their translators. They were not using the medical terms that they were supposed to. If they're going to be hiring these big companies that translate for them, they need to make sure they hire the right people to translate in the proper medical language that they need to be using.

A week ago, I got a call from one of my clients, and he was literally crying because at St. Hope, he was scheduled an appointment on a day that they were closing early. He was there early for his appointment, and they just told him that they were not going to be able to see him. You know, these people come from other countries and they find little jobs that can pay them the minimum wage and abuse them. And when we have all these big clinics that are making mistakes on their appointments, I don't think it's fair. They need to do their job properly.

Like I once told one of the supervisors there, they need to treat our people, especially our Latino people, they need to treat them right, how they treat — I've seen firsthand how they treat black Americans. That's the same treatment we deserve. We deserve better treatment. That day, I told the supervisor that she needed to talk to my people the way she talks to their people because it's not fair that they're receiving all this money for what? Just to make them bigger and not giving good service to our Latino community? I think we need to get funding to the right clinics and make sure, do inspections or whatever it takes, for them to give the right and proper treatment to our clients.

Thank you so much for letting our voice heard, and I really appreciate it. Thank you.

* * * * *

OMAR NAVARRO (FLAS, Inc.): Hi, good afternoon. I'm Omar Navarro. I'm the program manager at FLAS. I've been here 10 years, and I'm also an HIV navigator, so I'm with Omar Toirac on everything he said.

We go to the appointments with the clients, especially on the first appointment, which is, I guess, like the most important appointment because they have to go through eligibility and then the medical, so it's like three hours to four hours. Recently, it was this year, where in one of the clinics — I don't know if I can mention the name, but I'll go ahead — it was Avenue 360 where I went, and the provider asked me, "Are you certified to translate?"

I said, "No."

So she said, "Okay." Well, she just turned around, made the call, and they were doing the translation, but it was not the correct one. The client didn't really understand what the person was telling him, so I had to still be translating. And I feel like the service is not the same because they just do it, but it's like they don't care. Case managers, as well. And it's not only in that clinic. It's in other clinics, like they mentioned St. Hope.

So I feel, like Steven Vargas mentioned, we need to hire people that are bilingual so they can have a better service. They're not using the medical terminology. They really don't care about our patients. So I just wanted to address that, as well, and thank you.

* * * * *

ESMERALDA OREGON (FLAS, Inc.): Again, my name is Esmeralda. I'm with FLAS. I'm the housing support coordinator here.

I have worked as a HOPWA case manager for 11 years now, and just as everyone has been saying, the number one barrier is language. Navigating the system, even calling to make an appointment, to set a doctor appointment, to set a dentist appointment, the pharmacy, there's no way of them communicating because there's no one there that speaks Spanish.

I've had a client, a previous client, went to pick up her medication at the pharmacy, and she was given somebody else's medication because they didn't understand, I guess, her birthday or her full name. Maybe her name was common. I don't know. But she received somebody else's medication, and she reached out to me. I was in the same building, and I tried to assist.

But yes, I mean, it was difficult even to help them within the same agency that I was working at, which was Avenue 360, but it was even difficult for me to try to help them sometimes, or if I wasn't available. So yes, we need more Spanish speakers because there's a lot of need for them in the community.

Thank you.

* * * * *

EVELIO SALINAS ESCAMILLA (Latino Commission on AIDS): Hello, my fellow colleagues on this committee. Of course, I'm making a public comment as a private citizen.

We have had this conversation ever since my first tenure on the planning council, which was, I don't know, more than 10 years ago. I've served in different capacities with prevention agencies at U of H, and then I've also worked in a Ryan White serving agency, and this constantly comes up all the time. I'm a firm believer of language justice, and it's not just about translation, but translation is very important. But when you have a client and they come into your office, they need to make sure that that client has an increased level of health literacy, and whether a Google app or a translator or whatever, but the idea is that the client really has to know how to manage his care.

Hispanics are great at managing their care if you give them an opportunity. At six months, most Hispanics exceed their white counterparts in reaching viral suppression. They fall behind after one year.

These are things that we have to talk about, about quality improvements. The service categories that we always have, have always a little loophole. That loophole has to be closed. I am very sorry, but they have to be closed. They have to be. They have to have staff. We have to see what the performance measures are for these service categories. We have to see what — if there's an MAI service category for Hispanics, people that are using that service category better be Hispanic, and there better be, as well, not Hispanic, but at least there better be Spanish-speaking staff, bilingual Spanish-speaking staff.

These are very important issues. We need to increase the literacy of our population not only within our Hispanic community, but also in our black and African-American communities, too. We need to help motivate them to really reach better health outcomes.

And so I'm just seeing that there's way too many gaps, way too many loopholes, way too many, you know, sometimes excuses. And so we really need to think about, then, figuring out ways to having good performance measures that are health-outcome-based. Not just money being spent. Not just unduplicated clients. I want to see where they're really becoming healthier individuals. That's what quality improvement is. It's not just throwing money at a problem and see whether it works or not.

So we really need to think about this, and I'm hoping that we all can work together on this committee to be a lot more scrutinizing about the services that we are looking at as a quality improvement committee because health outcomes are what provides better quality of life.

* * * * *

WRITTEN PUBLIC COMMENT SUBMITTED ON 08/13/24

Sent: Tuesday, August 13, 2024 2:49 PM
Subject: S.Vargas Public Comment

I am here to provide Public Comment to help offset the disturbing trend in rising numbers of Latinos with HIV. Back in 2008, Latinos in Houston comprised about 20% of the newly diagnosed individuals. That percentage was increasing about a percentage point a year. However, we reached about 25% of newly diagnosed individuals being Latinos a year earlier than anticipated. We are continually underestimating the effect of HIV on Latino communities. It shows up in the number of Latinos who receive a late diagnosis of HIV, already having reached Stage 3 HIV, or what we called AIDS. Latinos have led the pack in late diagnoses this entire century in our state and city.

Today, though we see a decrease in overall numbers of new cases of HIV, we still see an increase among young Latinos who have sex with men. We have done what we can to address this, and we still see this trend. We need to do what we need now. That means no longer recommending hiring bilingual staff, but mandating bilingual staff be hired. This I recommend for our Ryan White Planning Council, Houston Health Department, Harris County Commissioners Court and Houston City Council.

About a quarter century ago our city recognized a need to address the rising numbers of African Americans living with HIV by declaring a state of emergency response. Today, we need the same commitment to be demonstrated on behalf of Latinos in Houston. We need specific funds to be allocated to help Latinos in Houston in their attempts to avoid acquiring HIV, and for Latinos living with HIV in their attempts to access and maintain their life-extending care. We demand, not recommend, the hiring of bilingual staff of various educational backgrounds to help our communities.

I'm available for continuous dialogue on this,

Steven Vargas,
HIV Advocate and Long Term Survivor

END OF PUBLIC COMMENT

Harris County
Public Health
Building a Healthy Community

RWA Case Management Translation Assessment
RWPC Quality Improvement Committee
11/19/2024

Mauricia Chatman, MPH
QMD Coordinator
Ryan White Grant Administration

HCPHTX.ORG

Accredited Health Department • Public Health Accreditation Board
PHAB
Advancing public health performance

The Assessment

Quality Improvement Committee:

Public Comment

August 13, 2024

Data was collected on 9/11/24

RWA QMD

Virtual Collection

#of participants

N=6

Tool consist of 9 questions

Reminders

- Ryan White A does not fund Linguistic Services
- Client Satisfaction Survey (CSS) captures indirect indicators for language barriers (i.e., Cultural humility questions)

The Tool

Ryan White Grant Administration
Quality Management Assessment
Bilingual/Monolingual Translation Services

Agency Name:

Date:

1. What linguistic (translation) services or apps do CM/frontline use at your organization for bilingual clients?	
2. What process does CM/frontline follow at your organization when assisting Spanish speaking clients? How is this process different or the same for monolingual Spanish speakers?	
3. What barriers have you identified, or observed, at your organization for bilingual speaking clients accessing quality services efficiently?	
4. If your organization has a Community Advisory Board/Group, what percentage of the group identifies at Hispanic and/or Spanish speaking?	

RWA Quality Management

September 2024

1

The Tool

Ryan White Grant Administration
Quality Management Assessment
Bilingual/Monolingual Translation Services

5. What percentage of frontline staff, at your organization, are bilingual?	
6. Have you ever experienced turning a client away due to lack of translation services?	
7. What best practices does your organization do well when servicing monolingual clients? What could improve?	
8. How can the Administrative Agent support your organization with identified barriers for monolingual Spanish speaking clients?	
9. Please share any addition comments for the Administrative Agent to consider in the improvement of the overall quality and satisfaction for bilingual and monolingual clients.	

Thank you for your feedback!

Question #1 *What linguistic (translation) services or apps do CM/frontline use at your organization for bilingual clients?*

Agency A	MasterWord and Globo services are ordered for English/non-Spanish Bilingual patients.
Agency B	We schedule interpreters for all languages except Spanish from MasterWord and Crabtree GLOBO agencies. We have the state services grant that allows us to order interpreters for all RW agencies. A 3-day advance notice is required to request interpretation services along with submission of eligibility documentation. One of our case manager receives the requests and places the order to MasterWord or GLOBO depending on the language of the client.
Agency C	Frontline staff utilizes multiple robust linguistic services to ensure that bilingual clients receive the care they need without language barriers. The services include over-the-phone on-demand interpretation available 24/7 in over 250 languages, Video Remote Interpreting (VRI) for critical languages like Spanish, Vietnamese, and Mandarin, and In-person Spanish interpreters available at all locations. These services ensure that language does not hinder effective communication between staff and clients.
Agency D	Translation Line, we also have a bilingual MCM who provides mental health services.
Agency E	Boostlingo's interpreting services expand language access and improve communication with innovative technology. The solutions include on-demand Video Remote Interpretation (VRI) and Over-the-Phone Interpretation (OPI), interpreter management, simultaneous interpretation, remote simultaneous interpretation, and AI captioning and translations.
Agency F	A language line for phone appts and use a virtual interpreter for in clinic appointments.

Question #2 *What process does CM/frontline follow at your organization when assisting Spanish speaking clients? How is this process different or the same for monolingual Spanish speakers?*

Agency A	Spanish-speaking medical staff are used for medical and Spanish-speaking CM Team staff are utilized for case management appointments. Process is the same but utilizes in-house staff instead of translator agencies.
Agency B	All of our front desk staff are bilingual and assist all clients equally with our eligibility documentation. Our eligibility forms are in both English and Spanish. Half of our Clinical Case Managers are bilingual as well as our Lead Case Manager who assists with assignment of clients.
Agency C	For Spanish-speaking clients, frontline staff utilizes the over-the-phone on-demand interpretation service line or in-person interpreters as needed. Additionally, Video Remote Interpreting (VRI) is employed for a more immediate and visual interaction. A dedicated team of qualified bilingual staff members who can directly communicate with Spanish-speaking clients, ensuring that monolingual Spanish speakers receive the same level of care and service as other clients. The process remains consistent across the board, whether the client is monolingual or bilingual, to ensure that all communications are clear and effective.
Agency D	Process is the same, we have bilingual staff. Specifically for mental health side, patients referred for services that are Spanish speaking are sent to the Spanish speaking clinician.
Agency E	A diverse staff with at least 90% of the front-end staffing being bilingual in English and Spanish. For those staff members who do not speak Spanish or clients who speak an alternative language, we are using Boostlingo for any translation needs.
Agency F	Utilizing cultural competent forms, reading out loud so the if the client can’t read successfully, utilizing

Question #3 *What barriers have you identified, or observed, at your organization for bilingual speaking clients accessing quality services efficiently?*

Agency A	In-house, we do not have enough Spanish-speaking Medical Case Managers. External agencies, we rely on interpreter translation but have found medical information can often be misinterpreted as interpreters may not have full medical understanding. We have also seen difficulty securing interpreters for several languages.
Agency B	Documentation in Spanish can be a barrier as flyers describing outside services or referral forms to outside agencies are not frequently in Spanish. Bilingual staff often have full caseloads so clients may have to wait a short time for on-going case management. Our Lead Case manager will call clients to assess for immediate needs and offer resources as needed while clients wait to for assignment to a clinical case manager.
Agency C	No significant barriers have been identified at this time, we are committed to providing comprehensive language services to all clients. The organization continuously educates and reinforces the importance of utilizing available interpretation services among staff. However, a potential area for improvement could be increasing the availability of iPads for Video Remote Interpreting (VRI) to further streamline access to interpretation services, including American Sign Language (ASL) for hearing-impaired clients.
Agency D	None identified, services are provided if requested by patient.
Agency E	Prior to the usage of Boostlingo barriers that we experienced with translations included either the patient not attending the appointment and more so the patient attending the appointment and the translator not attending. With the implementation of Boostlingo, our team can obtain virtual and phone translation assistance within 60 seconds of the request.
Agency F	No barriers that I have experienced.

Question #4 *If your organization has a Community Advisory Board/Group, what percentage of the group identifies at Hispanic and/or Spanish speaking?*

Agency A	There is a CAB, but statistical information is not available to case management team.
Agency B	We are currently in the process of forming a Community Advisory Board and are accepting applications. The board is set yet so I am unable to provide data at present.
Agency C	Three out of seven members of the Community Advisory Board/Group identify as Hispanic and/or are Spanish speakers, reflecting the organization's commitment to inclusivity and representation in its advisory processes.
Agency D	Unknown
Agency E	We are currently in the process of establishing a community advisor in which the goal would be to have a percentage of Hispanic and Spanish Speaking members to match the percentage of our Hispanic population.
Agency F	N/A

Question #5 *What percentage of frontline staff, at your organization, are bilingual?*

Agency A	For Case Management, 60% of staff are bilingual in Spanish & English. Percentage unknown for our frontline staff.
Agency B	100% font desk staff and 50% of CCMs are bilingual (and one CCM is actually trilingual English/Spanish/French). 75% of case managers from other departments are bilingual. We have one staff who is bilingual in ASL.
Agency C	Approximately 25% of its staff who are Spanish-speaking. At high traffic clinic, about 45% of the staff are Spanish-speaking, ensuring that there is adequate bilingual support available for Spanish-speaking clients.
Agency D	1 MCM staff, 3 CMSL. We also have front desk staff at our sites that are bilingual.
Agency E	About 90% of our frontline staff are bilingual.
Agency F	40%

* QMD inserted language to deidentify agency.

Question #6 *Have you ever experienced turning a client away due to lack of translation services?*

Agency A	Yes, but for non-Spanish speaking patients. Often this is due to Interpreter Agency unable to secure an interpreter, though sometimes due to an interpreter not showing.
Agency B	Monolingual clients who speak Spanish are not turned away as we ask staff (from other departments if needed) who are bilingual to assist the client. Staff who meet with monolingual clients request interpretation services ahead of their scheduled appointment.
Agency C	No client has ever been turned away due to a lack of translation services. The comprehensive language access services ensure that all clients receive the necessary communication support, regardless of the language they speak.
Agency D	No
Agency E	We have never experienced turning a client away due to a lack of translation.
Agency F	No, not at all.

Question #7 *What best practices does your organization do well when servicing monolingual clients? What could improve?*

Agency A	MasterWord and Globo services are ordered through partnered agency for English/non-Spanish Bilingual patients.
Agency B TMC	We operate in an integrative care approach and collaborate with other departments to ensure all of our clients receive services. This team approach is helpful when monolingual clients are receiving services. Staff frequently consult with each other about unique resources for our monolingual clients and for clients who do not have legal documentation/residency. Increasing the number of bilingual staff would allow us to serve monolingual clients quickly for CCM services.
Agency C	Agency excels in identifying and tagging clients in the Epic system who need an interpreter, specifying the language required. This tagging ensures that language needs are immediately recognized and addressed. The system also supports a wide range of translation services, including American Sign Language (ASL) for the hearing impaired. For non-common languages, the Interpreter Services team arranges for in-person interpreters to assist patients directly. Additionally, the organization offers an 8-week Spanish class to all staff members interested in improving their language skills, further strengthening their ability to serve monolingual clients. One area for improvement could be securing more iPads to enhance access to interpretation services, including ASL.
Agency D	We provided services mental health and case management services to our monolingual clients with a bilingual staff. We have also offered in the past Spanish speaking support groups. Marketing materials have provided in Spanish to market services to the clients.
Agency E	Best practices used when serving monolingual clients include through communication with clients and/or representatives prior to the visit to best prepare for the visit.
Agency F	We have staff that speaks a variety of languages including English, Spanish, French, mandarin, ASL and Portuguese.

* QMD inserted language to deidentify agency.

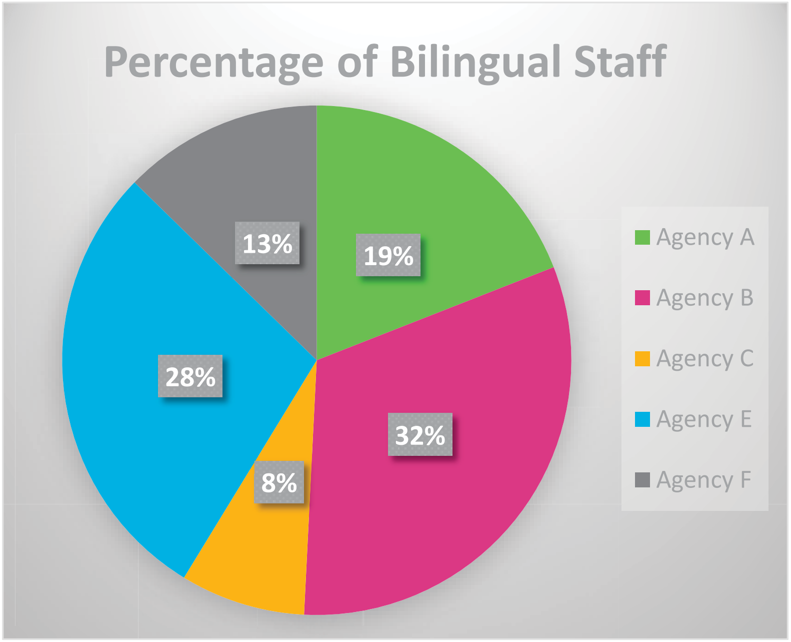
Question #8 *How can the Administrative Agent support your organization with identified barriers for monolingual Spanish speaking clients?*

Agency A	Funding for additional resources and securing longer appointment standards.
Agency B	Recruiting bilingual LMSWs is difficult as the salary we are able to offer is below what a bilingual social worker can earn at other agencies. A unit rate increase for salaries is essential in securing bilingual LMSWs.
Agency C	The Administrative Agent can support us by providing additional funding to secure more iPads, which would enhance access to Video Remote Interpreting (VRI) and American Sign Language (ASL) services. Moreover, the Agent could share barriers identified by other organizations and disseminate this information to all Ryan White-funded organizations, along with educational resources to address these barriers effectively.
Agency D	None identified at this time
Agency E	No support is needed currently.
Agency F	Have more RW funded agencies that have Spanish speaking clients.

Question #9 *Please share any addition comments for the Administrative Agent to consider in the improvement of the overall quality and satisfaction for bilingual and monolingual clients.*

Agency A	N/A
Agency B	Ensuring that all Ryan White forms are in Spanish such as the CPCDMS registration and update forms.
Agency C	To improve overall quality and satisfaction for bilingual and monolingual clients, Ryan White could consider including language access as a core component of patient care and confidentiality standards. Additionally, offering a differential incentive for frontline staff members who are bilingual certified, funded by Ryan White, could encourage more staff to become certified, thereby improving language access services across the organization.
Agency D	None at this time
Agency E	Over time and through much review, we have implemented systems and feel we are in a good place to provide services to monolingual clients.
Agency F	No comments at this time.

- **Includes:**
  - Front Desk Staff
  - Medical Case Mangers
  - Non-Medical Case Mangers (SLW)
  - Clinical Case Managers
    - (*include one trilingual)



Themes

1. Every Part A agency has at least one bilingual frontline staff member, and at least one clinician
2. No consistency of 3rd party translation services/organizations
   - Boostlingo
   - MasterWord
   - GLOBO
   - Video Remote Interpreting utilized for ‘critical’ languages (Vietnamese, and Mandarin)
3. Larger institutions have stronger infrastructure to support language services including, but not limited to RW.
4. 1/6 agencies have turned away a client due to lack of access to translation services

Barriers

- Not enough Spanish speaking MCMs
- Documentation/resources not printed in Spanish
- Two of four agencies does not have a CAB

Ensuring the right to health for migrants and refugees

https://doi.org/10.1016/S2352-3018(24)00275-3

See Series pages e861 and e873

Climate change, conflict, economic and political crises, and other events have led to markedly increased migration and forced displacement in the past decade. By 2020, 280·6 million people were considered international migrants, refugees, and asylum seekers (henceforth, migrants and refugees), with the majority in low-income and middle-income countries (LMICs).[1] Some migrants and refugees arrive in their destination country living with HIV, but stereotypes that they spread HIV are inaccurate and have led to harmful laws, regulations, and public health responses. Migrants and refugees are at risk of acquiring HIV and of experiencing treatment delays due to social vulnerabilities, insufficient protections, and exclusionary policies in transit and after arrival to their destinations.[2,3] The global community should urgently and collectively invest in strategies to mitigate these risks, not only as a moral obligation, but also as a pragmatic and proactive approach to public health in the face of continued displacement for the foreseeable future.

Two Series papers by Claudia P Cortes and colleagues[2] and Alena Kamenshchikova and colleagues[4] focus on access to HIV services among international migrants and refugees. The Series identifies key challenges for all populations on the move, regardless of the impetus for migration, and highlights social and structural issues that impede access to HIV diagnostics, prevention, and care.[2,4] The main recommendations from the Series broadly include ensuring access to confidential HIV testing and services without deportation or refoulement, providing health care regardless of migration status, and involving migrants and refugees in the planning and delivery of HIV services to ensure they are culturally and linguistically appropriate, affordable, and accessible.[2,4]

The right to health for migrants and refugees is protected by international humanitarian and human rights laws, which have been almost universally ratified (appendix). However, governments have often adopted a restrictive approach to migration under the pretext of preventing cross-border transmission and reducing potential health expenditures.[5] Despite insufficient public health justification, many of these discriminatory policies continue today.[5] Furthermore, in 2024, the HIV Policy Lab reported that most (114 of 194) countries had only partial policies or had not adopted national policies ensuring that migrants receive similar access to HIV services and primary care as citizens.[6] Countries with the largest numbers of migrants and refugees are least likely to have such policies. The discrepancy between commitments to the right to health and actual implementation reflects anti-migrant and anti-refugee sentiments, as well as insufficient funding, political will, and accountability for human rights and humanitarian law.

Universal health care that is inclusive of migrants and refugees is fundamental to addressing HIV. Very few countries, however, integrate migrants and refugees into government health programmes, including in terms of health insurance.[7] Short of universal health care, other strategies can be implemented to ensure the right to health for migrants and refugess. In Thailand, for example, where national health coverage is restricted to nationals, regular migrants are eligible for health coverage under the Social Security Scheme or Migrant Health Insurance Scheme.[8] In other countries, changes to migration policies have indirectly provided such access. At the height of a period of increased migration from Venezuela to Colombia, the Colombian government created a 10-year temporary protection status for approximately 1·8 million Venezuelans, ensuring access to health coverage through a contributory employment scheme or a subsidised scheme for those not formally employed.[9] The same occurred for Ukrainian refugees in the EU.[10] Although these models have limitations, they provide examples for settings where migrants and refugees are unable to access health care.

Acknowledging the challenges that increased migrant flows create in transit and destination countries, most of which occur in LMICs, is crucial.[1] However, integrating migrants and refugees into HIV prevention and care benefits both migrants and refugees and host communities by reducing HIV transmission, lowering health expenditures, and promoting a healthy workforce.[7] Although the inclusion of migrants and refugees into social insurance schemes requires early investment, it can lead to substantial economic growth. A 2022 analysis showed that early investment in integration of Venezuelan migrants and refugees costs countries (ie, Brazil, Chile, Colombia, Ecuador, and Peru) up to 0·5% of their GDP but is projected to increase in

See Online for appendix

their GDP by as much as 4·5% by 2030.[11] Furthermore, integrating migrants and refugees into efforts to achieve universal health care might improve the quality of health services for both nationals and displaced people by streamlining national and international financing into a single health system.[12] Avoiding parallel health systems might also dispel the perception that migrants and refugees receive better or lower-cost services than do local populations.[12] Ultimately, integrating migrants and refugees into government-funded social services requires strong political leadership to address concerns from underserved host communities. All donors, including HIV-specific funders, should prioritise supporting the needs of all vulnerable people, not just migrants and refugees.

Migration and forced displacement will inevitably continue and probably increase, intensifying the need for substantial funding to achieve universal health care, particularly in LMICs. Achieving universal health care includes the provision of HIV services for all populations within their borders. The call for renewed adherence to human rights and humanitarian law,[2,4] increased funding from non-traditional sources, and innovative financing strategies has never been more pressing. Although the recommendations for addressing HIV among these populations might not all be new, the time to implement these solutions is now, before the opportunity is lost.

ALW receives funding from ViiV Healthcare to her institution for unrelated observational research. All other authors declare no competing interests.

*Andrea L Wirtz, Kathleen R Page, Paul B Spiegel
awirtz1@jhu.edu

Department of Epidemiology, Center for Public Health and Human Rights, Johns Hopkins University Bloomberg School of Public Health, Baltimore, MD 21205, USA (ALW, KRP); Department of International Health, Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA (ALW, KRP, PBS); Division of Infectious Disease, Johns Hopkins School of Medicine, Baltimore, USA (KRP)

1 International Organization for Migration. World Migration Report 2024. International Organization for Migration, 2024.
2 Cortes CP, Sued O, Wong WCW, et al. Humanising and optimising HIV health care for refugees and asylum seekers. *Lancet HIV* 2024; published online Nov 10. https://doi.org/10.1016/S2352-3018(24)00233-9.
3 Spiegel PB, Bennedsen AR, Claass J, et al. Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: a systematic review. *Lancet* 2007; **369:** 2187–95.
4 Kamenshchikova A, Peters CMM, Nöstlinger C, et al. Interventions to ensure access to and continuity of HIV care for international migrants: an evidence synthesis. *Lancet HIV* 2024; published online Nov 10. https://doi.org/10.1016/S2352-3018(24)00175-9.
5 Ekerin O, Shomuyiwa DO, Lucero-Prisno DE 3rd, et al. Restrictive migration policies and their impact on HIV prevention, care and treatment services. *Health Res Policy Syst* 2024; **22:** 91.
6 HIV Policy Lab. CT7: migrants access to healthcare. 2024. https://www.hivpolicylab.org/policy/CT7 (accessed Sept 23, 2024).
7 Legido-Quigley H, Pocock N, Tan ST, et al. Healthcare is not universal if undocumented migrants are excluded. *BMJ* 2019; **366:** l4160.
8 International Labour Organization. Social protection in action: building social protection floors for all: country brief: Thailand. December, 2021. https://www.social-protection.org/gimi/gess/gess/Media.action?id=18734 (accessed Sept 24, 2024).
9 UN Refugee Agency, International Organization for Migration. UNHCR and IOM welcome Colombia's decision to regularize Venezuelan refugees and migrants. Feb 8, 2021. https://www.unhcr.org/uk/news/news-releases/unhcr-and-iom-welcome-colombias-decision-regularize-venezuelan-refugees-and (accessed Sept 24, 2024).
10 European Commission. Temporary protection. 2022. https://home-affairs.ec.europa.eu/policies/migration-and-asylum/common-european-asylum-system/temporary-protection_en (accessed Sept 30, 2024).
11 Alvarez JA, Arena M, Brousseau A, et al. Regional spillovers from the Venezuelan crisis: migration flows and their impact on Latin America and the Caribbean. Dec 5, 2022. https://www.imf.org/en/Publications/Departmental-Papers-Policy-Papers/Issues/2022/12/01/Regional-Spillovers-from-the-Venezuelan-Crisis-Migration-Flows-and-Their-Impact-on-Latin-525729 (accessed Sept 24, 2024).
12 Spiegel P, Chanis R, Scognamiglio T, Trujillo A. Innovative humanitarian health financing for refugees. In: Bozorgmehr K, Roberts B, Razum O, Biddle L, eds. Health policy and systems responses to forced migration. Springer International, 2020: 35–52.

Addressing HIV prevention and the PrEP gap among migrants

Published **Online**
November 10, 2024
https://doi.org/10.1016/S2352-3018(24)00272-8

See **Series** pages e861 and e873

Tremendous successes have been achieved in treating and caring for people living with HIV and in developing HIV prevention technologies such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).[1] However, this progress has not been distributed evenly among key populations.[2] In fact, migrant populations have experienced great disparities despite their increased vulnerability to HIV acquisition.[3]

Existing research in migrants mostly focuses on access to the HIV continuum of care, whereas research on primary HIV prevention is comparatively scarce. Minoritised and racialised populations are easily labelled as hard-to-reach, but researchers might have insufficiently innovative strategies for sampling, identifying, recruiting, and interviewing them. As a result, minoritised and racialised populations are under-represented in HIV research. For instance, few studies have investigated peer-led and community-based outreach activities to promote HIV combination prevention, including HIV testing, despite the promising results of such approaches.

Published in final edited form as:
Nurs Manage. 2018 April ; 49(4): 20–27. doi:10.1097/01.NUMA.0000531166.24481.15.

Strategies for overcoming language barriers in healthcare

Allison Squires, PhD, RN, FAAN [associate professor, member]
Rory Meyers College of Nursing at New York University in New York, N.Y, National Council on Interpreting in Health Care.

Language barriers between nurses and patients increasingly affect nursing practice, regardless of where care is delivered. In the United States, a language other than English is now spoken at home in one of five households, the highest level since just after World War I.[1] Patients with limited English skills are referred to as patients with limited English proficiency (LEP).

This article provides background information about language barriers between nurses and patients, and how these barriers affect patient outcomes. Practice-based strategies are offered to improve outcomes and reduce readmissions. Although this article doesn't address barriers to communicating with patients with hearing loss, many of the same principles apply to these patients.

Sources of spoken language barriers

Globalization means more people move around the world for work and educational opportunities.[2] When people migrate, they tend to follow immigrant networks and start recreating communities in their new country.[3] People also migrate and become refugees due to wars and civil conflicts.[3] Countries that accept these refugees place them in communities where they can recover from the trauma of their migration experiences while seeking work and learning about their new country. Structured refugee resettlement has been going on in the United States since after World War II.[4] With the exception of Native Americans, just about everyone in this country is descended from immigrants. When patients have a language barrier, it's often related to when they migrated to the United States.

The largest group of migrants in the last 30 years speaks Spanish.[5] With only 5% of U.S. nurses identifying as Hispanic or Latino, it's very common for patients in this group to encounter a language barrier.[6] (No publicly available record of language skills of U.S. nurses exists.) Mandarin and Cantonese Chinese speakers are the next largest group.[1] They're also underrepresented in nursing.[7] The number of Russian-speaking people in the United States is growing quickly. However, for many Russian-speaking patients, Russian is their second or third language. In many countries under Soviet rule in the latter half of the 20th century, people continued to speak their original languages as well as Russian. With the dissolution of the Soviet Union, their preferred language may be the language of their home country.[8]

In some parts of the United States, some older immigrants still face a language barrier. For example, many Italians who migrated to the United States in the early 1900s never developed English language skills and may still need interpreter services.[9] Language demographics depend on who's moved into your organization's service area. As people age, some may lose skills in their second language due to how the brain changes with aging.[10] Even those who developed strong fluency in English as adults can lose those skills if they have significant age-related neurologic events. Some of these older adults may end up needing interpreter services.

Another trend involves adults who migrated to the United States and then brought their parents over to join the family.[11] Although the adult children who brought their parents to the United States may speak English well, their parents may not speak English well enough to communicate effectively with a healthcare provider.

How migration dynamics affect nurses

Patients with language barriers change how nurses work and organize patient care. These changes are needed not only to meet communication needs for the patient, but also for legal reasons. In 1964, the U.S. Civil Rights Act helped ensure that a lack of English language skills wouldn't be a source of discrimination.[12,13] U.S. law requires that healthcare organizations provide interpreter services to patients with LEP.[14] Regulations implemented as part of the Affordable Care Act place new restrictions on the use of family members and validating language skills of healthcare workers.[15]

Much evidence shows how language barriers impact patient outcomes and healthcare delivery. (See Table 1.) Patients with LEP have longer lengths of stay than English-speaking patients, even if they have a higher socioeconomic status.[16-18] They also have a higher risk of 30-day read-mission, by as much as 25%.[18,19]

How nurses and other healthcare providers respond to the communication needs of patients with LEP also has a significant impact on patient satisfaction, with effective use of interpreter services or bilingual healthcare professionals contributing to higher patient satisfaction ratings.[20-26]

A closer look at medical interpreters

Aside from facilitating communication between patients and healthcare providers, medical interpreters can also serve as cultural brokers.[27-30] The medical interpreter helps bridge the cultural divide between patients and clinicians. The translation process ensures that what a nurse says is delivered not only with technical accuracy, but also with culturally specific phrasing. Nurses can assess the quality of medical interpreters' cultural brokerage by observing how the patient responds to the interpreter through his or her body language.

Medical interpreters have a professional code of ethics that binds them to the same patient confidentiality requirements as every other healthcare team member.[31] Most interpreters hired by healthcare organizations have undergone some kind of medical interpreter training because healthcare has its own language.[32] According to the National Council on Interpreting in Health Care, no minimum number of course hours is required for interpreter training at this time, but it recommends that programs adhere to its curriculum standards, which were developed in 2011.[33] Implementing a course that meets the standards usually requires a minimum of 40 hours of study and successful live demonstration of the ability to interpret a medical encounter. Participants receive a certificate after they've completed the course. They can then take a national exam to become a board-certified medical interpreter.[34] Board certification is voluntary at this time.

Improving care quality and outcomes

How can nurses help improve outcomes for patients with LEP? These evidence-based strategies can help nurses better organize their care to improve outcomes and meet The Joint Commission requirements for bridging language barriers.

Use the organization's interpreter resources.

Interpreter resources typically include in-person interpreters employed by an organization, in-person interpreters contracted through external agencies, and telephone- or technology-based interpreter services. (See Table 2.)

Some organizations deal with language barriers all of the time and have excellent resources. They may have an interpreter services department to manage the demand for language interpretation services. Some locations have experience with certain language groups and need interpretation for only a few languages. However, many healthcare organizations are seeing more diversity and have a greater need for interpreters. Most organizations begin with interpreter phone services and, if the demand becomes high enough, hire fulltime interpreters.

Telephone interpretation can work if implemented well. A good telephone interpretation session requires minimal waiting time for the phone interpreter, adequate sound quality so that everyone can hear clearly, and an outcome in which both the patient and provider obtain the information needed.[35]

Nonetheless, both nurses and patients have reported problems with interpretation quality, expressing dislike for the depersonalization of the patient encounter when using the interpreter phone.[20,36-39] However, when no other option is available, telephone interpreter services are the best way to bridge the language barrier. New options with live video interpretation are also coming onto the market and may replace telephone interpreters.

Inappropriate interpreter use, including nonvalidated translation apps on a nurse's smartphone, puts the organization at legal risk. Many apps for interpretation are available for smartphones, but their accuracy can be poor and most aren't compliant with the Health Insurance Portability and Accountability Act (HIPAA). The quality of translation is rarely evaluated systematically or using rigorous approaches. Many of these apps are also designed for translating only basic sentences, such as how to order dinner when traveling. Most computer programs don't yet have the sophistication needed to translate the language of healthcare. Use only those apps sanctioned by your employer that have undergone a thorough internal review and are HIPAA-compliant.

As a general rule, family members, especially children younger than age 18, shouldn't serve as interpreters, except under extenuating circumstances such as an immediate threat to life.[40,41] Using a family member to interpret increases the risk that something won't be translated correctly. For instance, a family member may not feel comfortable conveying some sensitive types of information to the patient, such as about sexual health, substance abuse, or a terminal diagnosis. Using a family member also increases the risk of medical errors.[35] Depending on the situation, it may also violate patient confidentiality protocols. Err on the side of caution: Don't use family members for interpretation.

Get your professional staff members who speak other languages fluently certified for their skills and help them obtain medical interpreter training.

It's inevitable that staff members who speak other languages will get pulled in to interpret at the last minute or when an interpreter isn't available. Help reduce the risk of adverse outcomes related to poor quality translation by getting your staff certified and trained.

Use care when other staff members provide interpretation.

Staff members who speak the same language as the patient are a common resource for interpretation, but this practice has its own set of risks. Use coworkers with language skills appropriately, but only when necessary. The Agency for Healthcare Research and Quality (AHRQ) has developed guidelines for how to better utilize staff members with language skills.[27] According to the evidence, choosing a nurse or other healthcare professional who speaks the patient's language and who's had his or her language skills professionally evaluated by a language assessment expert is best.[32]

Unlicensed assistive personnel or housekeeping staff members, who are commonly asked to interpret, may not have the medical vocabulary needed to accurately translate for the patient and family. If they become certified as medical interpreters or the organization assesses their language skills, however, they can then be used to translate.

Organizations that are implementing the AHRQ guidelines use name badges that designate the staff member's language skills. Those employees have had a formal language skills assessment, understand medical terminology in the languages they speak, and speak the language well enough to safely communicate with patients and families.[27]

Every time you ask professional staff members to interpret, you take them away from their own patients and add to their overall patient case load.[30,39,42,43] Consider developing an agreement for the patient care unit so that nurses with other-than-English language skills, with their permission, can be assigned to language-matching patients. Even if this means the staff member doesn't have a "geographically efficient" assignment, it will help to streamline his or her work.

Document the use of medical interpreter services.

Documenting interpreter use is just as important as documenting wound care or any other clinical intervention. Document not only when an interpreter was used, but also the type of interpretation. For example, state whether it was at admission or discharge, or for informed consent or patient teaching. Then document whether the interpretation was done by a medical interpreter on staff by telephone or with a computer, and the interpreter's name. In some cases, depending on the organization's policy, the interpreter will be required to document the encounter as well. The interpreter will include information such as the patient's unique identifier, time and duration of the encounter, and any other information required by the organization.

When a nurse has to rely on a staff member to interpret, either because no interpreters were available or because of technologic difficulties, documenting the decision making behind that choice will also help protect the nurse. Showing that every effort was made to adhere to organizational policy means the nurse has done what's legally required.

Time interpreter use strategically.

Research shows that the three critical times when nurses should use interpreters are at admission, during patient teaching, and at discharge. Using interpreters at these times decreases the risks of medical errors and hospital readmissions.[18,36,44-46]

How will it help? During admission, using an interpreter will provide more accurate baseline information. That, in turn, will help the healthcare team create a more accurate care plan. An interpreter can also help nurses tailor patient teaching to the needs of patients and their educational level. At discharge, having an interpreter present is equally critical, even if it delays discharge by a few hours. A good patient discharge process with an interpreter will decrease the risk that patients will be readmitted because they didn't understand how to take their medications or other discharge instructions.[18,46]

An idea for a clinical ladder project is to have discharge instructions and patient education materials translated into languages spoken by many patients. Bilingual discharge instructions also ensure that when patients are referred for home health services, home healthcare nurses who don't speak their language can also read the discharge instructions. The more resources that can be used for teaching and facilitating discharge for patients with LEP, the less likely they are to be readmitted or visit the ED.[18,46]

Prioritize patient understanding of medication management.

Medication adherence is complex when patients speak English, but even more so when patients have LEP.[47,48] First, medications may have different names in other countries, even in other English-speaking countries, and may require translation. Second, whenever possible, medication instructions should be in the patient's preferred language. Remember that even when someone speaks some English, he or she may not be able to read it. A review of medications using teach-back techniques helps promote adherence, reduce readmissions related to failure to take new medications or understand changes to the old regimen, and help with care coordination with community-based providers.[27]

Prioritize hiring professional staff members who speak the languages of your patients.

If you have professional staff members who speak the language of your LEP patients, you have an excellent chance of improving patient outcomes and satisfaction. You can determine the demand for these nurses by looking at the census of your non-English-speaking patient population. It's also worth paying them at a higher hourly rate because their language skills will reduce interpreter costs, improve outcomes, and reduce the risk of costly adverse events.[43]

Speaking up

These evidence-based tips for bridging language barriers between nurses and patients with LEP help nurses provide optimal patient care. They can apply to nearly every healthcare delivery setting, with some modification. Remember: Nurses have the responsibility to do their best to bridge language barriers with their patients to adhere to practice standards and improve patient outcomes.

Acknowledgments

The author has disclosed that work for this article was funded by the Agency for Healthcare Research and Quality R01HS023593. The author previously completed consulting work for policy analyses with the Migration Policy Institute. The author and planners have disclosed no other potential conflicts of interest, financial or otherwise.

REFERENCES

1. Ryan C Language use in the United States: 2011. www.census.gov/prod/2013pubs/acs-22.pdf.
2. Shaffer FA, Davis CR, To Dutka J, Richardson DR. The future of nursing: domestic agenda, global implications. J Transcult Nurs. 2014;25(4):388–394. [PubMed: 24595160]
3. Czaika M, de Haas H. The globalization of migration: has the world really become more migratory? http://onlinelibrary.wiley.com/doi/10.1111/imre.12095/full.
4. Miner SM, Liebel D, Wilde MH, Carroll JK, Zicari E, Chalupa S. Meeting the needs of older adult refugee populations with home health services. J Transcult Nurs. 2017;28(2):128–136. [PubMed: 26711884]
5. U.S. Census. Facts for features: Hispanic Heritage Month 2015. www.census.gov/newsroom/facts-for-features/2015/cb15-ff18.html.
6. U.S. Health Resources and Services Administration. The future of the nursing workforce: national- and state-level projections, 2012-2025. https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/nursingprojections.pdf.
7. U.S. Health Resources and Services Administration. Sex, race, and ethnic diversity of U.S. health occupations (2011-2015). https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/diversityushealthoccupations.pdf.
8. Shpilko I Russian-American health care: bridging the communication gap between physicians and patients. Patient Educ Couns. 2006;64(1-3):331–341. [PubMed: 16859861]
9. Hudelson P, Vilpert S Overcoming language barriers with foreign-language speaking patients: a survey to investigate intra-hospital variation in attitudes and practices. BMC Health Serv Res. 2009;9:187. [PubMed: 19832982]
10. Antoniou M, Gunasekera GM, Wong PC. Foreign language training as cognitive therapy for age-related cognitive decline: a hypothesis for future research. Neurosci Biobehav Rev. 2013;37(10 Pt 2):2689–2698. [PubMed: 24051310]
11. Acevedo-Garcia D, Bates LM, Osypuk TL, McArdle N. The effect of immigrant generation and duration on self-rated health among US adults 2003-2007. Soc Sci Med. 2010;71(6):1161–1172. [PubMed: 20624666]
12. The Joint Commission. Language access and the law. Title VI of the U.S. Civil Rights Act (1964). www.jointcommission.org/assets/1/6/Lang%20Access%20and%20Law%20Jan%202008%20(17).pdf.
13. Ku L, Flores G. Pay now or pay later: providing interpreter services in health care. Health Aff (Millwood). 2005; 24(2):435–444. [PubMed: 15757928]

14. Diamond LC, Wilson-Stronks A, Jacobs EA. Do hospitals measure up to the national culturally and linguistically appropriate services standards? Med Care. 2010;48(12):1080–1087. [PubMed: 21063229]
15. Youdelman M Short paper #5: the ACA and language access. www.healthlaw.org/issues/health-care-reform/aca-and-language-access#.WVaOD4Tyt0w.
16. Karliner LS, Kim SE, Meltzer DO, Auerbach AD. Influence of language barriers on outcomes of hospital care for general medicine inpatients. J Hosp Med. 2010;5(5):276–282. [PubMed: 20533573]
17. Levas MN, Cowden JD, Dowd MD. Effects of the limited English proficiency of parents on hospital length of stay and home health care referral for their home health care-eligible children with infections. Arch Pediatr Adolesc Med. 2011;165(9):831–836. [PubMed: 21536949]
18. Lindholm M, Hargraves JL, Ferguson WJ, Reed G. Professional language interpretation and inpatient length of stay and readmission rates. J Gen Intern Med. 2012;27(10):1294–1299. [PubMed: 22528618]
19. Prescott HC, Langa KM, Iwashyna TJ. Readmission diagnoses after hospitalization for severe sepsis and other acute medical conditions. JAMA. 2015;313(10):1055–1057. [PubMed: 25756444]
20. Bagchi AD, Dale S, Verbitsky-Savitz N, Andrecheck S, Zavotsky K, Eisenstein R. Examining effectiveness of medical interpreters in emergency departments for Spanish-speaking patients with limited English proficiency: results of a randomized controlled trial. Ann Emerg Med. 2011;57(3):248–256.e1–4. [PubMed: 20678825]
21. Diamond LC, Tuot DS, Karliner LS. The use of Spanish language skills by physicians and nurses: policy implications for teaching and testing. J Gen Intern Med. 2012;27(1):117–123. [PubMed: 21773850]
22. Fatahi N, Mattsson B, Lundgren SM, Hellström M. Nurse radiographers' experiences of communication with patients who do not speak the native language. J Adv Nurs. 2010;66(4):774–783. [PubMed: 20423365]
23. Nápoles AM, Gregorich SE, Santoyo-Olsson J, O'Brien H, Stewart AL. Interpersonal processes of care and patient satisfaction: do associations differ by race, ethnicity, and language? Health Serv Res. 2009;44(4):1326–1344. [PubMed: 19490162]
24. Radwin LE, Cabral HJ, Woodworth TS. Effects of race and language on patient-centered cancer nursing care and patient outcomes. J Health Care Poor Underserved. 2013;24(2):619–632. [PubMed: 23728032]
25. Taylor RA, Alfred MV. Nurses' perceptions of the organizational supports needed for the delivery of culturally competent care. West J Nurs Res. 2010;32(5):591–609. [PubMed: 20693336]
26. Whitman MV, Davis JA, Terry AJ. Perceptions of school nurses on the challenges of service provision to ESL students. J Community Health. 2010;35(2):208–213. [PubMed: 20012473]
27. Betancourt JR, Renfrew MR, Green AR, Lopez L, Wasserman M. Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals. Rockville, MD: Agency for Healthcare Research and Quality; 2012.
28. Dohan D, Levintova M. Barriers beyond words: cancer, culture, and translation in a community of Russian speakers. J Gen Intern Med. 2007;22(suppl 2):300–305. [PubMed: 17957415]
29. Hilfinger Messias DK, McDowell L, Estrada RD. Language interpreting as social justice work: perspectives of formal and informal healthcare interpreters. ANS Adv Nurs Sci. 2009;32(2): 128–143. [PubMed: 19461230]
30. Lo MC. Cultural brokerage: creating linkages between voices of lifeworld and medicine in cross-cultural clinical settings. Health (London). 2010;14(5):484–504. [PubMed: 20801996]
31. National Council on Interpreting in Health Care. National Council on Interpreting in Health Care develops national standards for interpreters. www.ncihc.org/ethics-and-standards-of-practice.
32. Hull M Medical language proficiency: a discussion of interprofessional language competencies and potential for patient risk. Int J Nurs Stud. 2016;54:158–172. [PubMed: 25863658]
33. National Council on Interpreting in Health Care. National standards for healthcare interpreter training programs. www.ncihc.org/assets/documents/publications/National_Standards_5-09-11.pdf.

34. The National Board of Certification for Medical Interpreters. Written exam. www.certifiedmedicalinterpreters.org/written-exam.
35. Tuot DS, Lopez M, Miller C, Karliner LS. Impact of an easy-access telephonic interpreter program in the acute care setting: an evaluation of a quality improvement intervention. Jt Comm J Qual Patient Saf. 2012;38(2):81–88. [PubMed: 22372255]
36. Gany F, Kapelusznik L, Prakash K, et al. The impact of medical interpretation method on time and errors. J Gen Intern Med. 2007;22(suppl 2):319–323. [PubMed: 17957418]
37. Gany F, Leng J, Shapiro E, et al. Patient satisfaction with different interpreting methods: a randomized controlled trial. J Gen Intern Med. 2007;22(suppl 2):312–318. [PubMed: 17957417]
38. Grover A, Deakyne S, Bajaj L, Roosevelt GE. Comparison of throughput times for limited English proficiency patient visits in the emergency department between different interpreter modalities. J Immigr Minor Health. 2012;14(4):602–607. [PubMed: 21947693]
39. McDowell L, Hilfinger Messias DK, Estrada RD. The work of language interpretation in health care: complex, challenging, exhausting, and often invisible. J Transcult Nurs. 2011;22(2):137–147. [PubMed: 21317402]
40. Brisset C, Leanza Y, Laforest K. Working with interpreters in health care: a systematic review and meta-ethnography of qualitative studies. Patient Educ Couns. 2013;91(2):131–140. [PubMed: 23246426]
41. Rosenberg E, Seller R, Leanza Y. Through interpreters' eyes: comparing roles of professional and family interpreters. Patient Educ Couns. 2008;70(1):87–93. [PubMed: 18031970]
42. Bourgeault IL, Atanackovic J, Rashid A, Parpia R. Relations between immigrant care workers and older persons in home and long-term care. Can J Aging. 2010;29(1):109–118. [PubMed: 20202269]
43. Coomer NM. Returns to bilingualism in the nursing labor market–demand or ability. J Socio Econ. 2011;40(3):274–284.
44. Dowsey MM, Broadhead ML, Stoney JD, Choong PF. Outcomes of total knee arthroplasty in English- versus non-English-speaking patients. J Orthop Surg (Hong Kong). 2009;17(3):305–309. [PubMed: 20065369]
45. Jackson C, Shahsahebi M, Wedlake T, DuBard CA. Timeliness of outpatient follow-up: an evidence-based approach for planning after hospital discharge. Ann Fam Med. 2015;13(2):115–122. [PubMed: 25755032]
46. Leanza Y, Boivin I, Rosenberg E. Interruptions and resistance: a comparison of medical consultations with family and trained interpreters. Soc Sci Med. 2010;70(12):1888–1895. [PubMed: 20378224]
47. Moreno G, Lin EH, Chang E, et al. Disparities in the use of internet and telephone medication refills among linguistically diverse patients. J Gen Intern Med. 2016; 31(3):282–288. [PubMed: 26311200]
48. Regenstein M, Andres E, Nelson D, David S, Lopert R, Katz R. Medication information for patients with limited English proficiency: lessons from the European Union. J Law Med Ethics. 2012;40(4):1025–1033. [PubMed: 23289703]

Table 1:

Evidence-based impact of language barriers on patient outcomes[27]

Length of stay if interpreter isn't used at admission or discharge	↑ (3 days)
30-day readmissions (among certain chronic diseases)	↑ risk (15%–25%)
Central line-associated bloodstream infections	↑ risk
Falls	↑ risk
Surgical site infections	↑ risk
Pressure injuries	↑ risk
Surgery delays	↑ risk
Medication management (for example, adherence, understanding discharge instructions)	↑ risk
Preventive screening	↓ chance
Access to the healthcare system	↓ chance

Table 2:

10 tips for working effectively with an in-person medical interpreter

1	1. For an in-person interpreter, call the interpreter service and specify the language needed and about how much time the interpretation will take.
2	When the interpreter arrives, introduce yourself and provide a brief report on the work needed and a brief patient history.
3	Greet the patient and introduce the interpreter. Explain to the patient what will happen, and let the patient know that he or she can ask the interpreter anything, even if it isn't the main reason for the interpretation. Then begin the activity.*
4	When working with the interpreter and patient, communicate directly with the patient. Resist the temptation to talk to or look at the interpreter, unless you need clarification of something he or she said.
5	Speak in shorter sentences than normal. Doing so makes it easier for the interpreter to remember the sentence and improves the translation's accuracy.*
6	If the interpreter appears confused about something you've said, ask the interpreter if clarification or rephrasing is needed to improve interpretation quality for the patient.*
7	Try not to interrupt the interpreter when he or she is translating the patient's reply. Guessing what the patient is about to say may not always be right, and some cultures perceive interruptions as rude behavior.*
8	If the interpreter seems to be taking a long time to translate for the patient, it may mean that he or she is trying to phrase the sentence in a way that will be best received. Conversely, if an interpreter simply translates, for example, "yes," to something the patient took a long time to say, it may be an indication of poor translation quality. Make sure that the interpreter interprets patients' responses completely. Don't accept a "yes" or "no" when the patient gave a lot of information, even when you're in a hurry.
9	When the encounter finishes, ask the patient if he or she needs anything else while the interpreter is there. Many patients have more needs, and often the interpreter encounter makes them feel comfortable enough to express them.*
10	After leaving the room with the interpreter, review the encounter to ensure that both you and the interpreter ended up on the same page. The interpreter may also have some cultural insights to share that can help with care planning.

[*] These steps also apply to telephone or video interpretation.

Choose Specialty ▾

Improve patient outcomes by speaking their language

April 5, 2024

By Nic McMahon

Blog Article

Medical practices can choose from a wide array of tools to enable communication with patients from diverse backgrounds

© Cienpies Design - stock.adobe.com

Patients with limited English proficiency (LEP) face poorer health outcomes due to low health literacy and language barriers.

In a recent systematic review, 75% of studies showed that LEP patients experienced better outcomes when they spoke the same language as their providers.Written translation also supports connection. In a recent study 91% of Spanish-speaking parents preferred to receive translated copies of their children's written discharge instructions to improve comprehension.

How can health care professionals build the trust they need to successfully treat culturally and linguistically diverse patients? A language access plan offers a roadmap to help practitioners build cultural competence to connect with patients. Planning ahead allows for efficient use of resources and effective communication.

Here's how to create an effective, patient-centered language access plan for your practice:

Assess community needs

The first step is to understand the population you serve. To determine which languages are spoken in your community, refer to the U.S. Census Bureau's language tables. For greater precision, artificial intelligence tools can fill in missing data based on the known demographics in your practice area. Once you understand your patients' needs and preferences, you can begin to meet those with communications that connect.

Keep in mind which points of contact these patients are likely to have with your practice team. Whether they're telephoning, using an online portal, or visiting the office for an appointment, ensure that your team is offering meaningful language access at each touchpoint.

Create your connection toolkit

Next, create a comprehensive language services toolkit. Consider the following questions when creating your plan:

Which types of interpreting will you offer? A review by the Wellesley Institute found that providing trained interpreters improved health outcomes and increased preventative care.

There are several ways to provide this service, and your practice will probably want to offer a mix of options. On-site interpreting and video remote interpreting (VRI) both offer face-to-face interaction for improved communication, allowing both the patient and interpreter to respond to important non-verbal cues like facial expressions and body language. VRI may provide a quicker, more cost-effective way to provide access to an interpreter in a patient's preferred language, allowing you to provide service to more communities.

Over-the-phone interpreting is the best fit for follow-ups or non-emergency situations when there isn't enough time to arrange for an on-site interpreter.

Remote simultaneous interpreting (RSI) is rapidly gaining popularity due to the recent increase in remote care. RSI is concurrent, which means the interpreter interprets while the other patient speaks, so there's no delay.

With RSI, the interpreter is in another location, so communication is handled through video and headsets. Although the interpreter is not in the room, patients often find the immediacy of RSI reassuring. Children’s hospitals have used It to assess children in a global clinical trial. There’s also evidence that RSI is the most effective interpreting method for reducing the rate of clinically significant medical errors.

How will you translate documents? Providing professionally translated documents helps ensure that patients fully understand their health care, insurance, and billing options. This is not only practical but also a matter of compliance: regulations like Section 1557 of the Affordable Care Act require specific documents to be available in the patient's preferred language.

But truly meaningful access requires not only making translated material available but going beyond minimum compliance mandates. A culturally competent approach to communication promotes equity and patient satisfaction by ensuring your patients understand their health status and treatment plan.

Machine translation technology can speed up the process, but only in tandem with specialist translators who understand the medical field and thus avoid translation errors that could harm patients or lead to frustration.

Some patients may have difficulty with written information, even when it's written in their home language or at or below the recommended fifth-grade reading level. A medical interpreter may be required to read the written documents to the patient and assist you with any follow-up questions.

Provide training

Train your staff so that everyone understands their specific role in implementing the plan. This includes training in both cultural competence and the technology used to provide language access to patients.

Cultural competence in health care goes beyond language to include skills such as fostering health literacy for diverse patient populations and navigating social and cultural differences in communication. To promote consistency in training and procedures, appoint one person on your team to the role of language access coordinator.

When everyone in your office can confidently handle requests for language access, patients will feel more confident in the care you provide.

Build community awareness

Now it’s time to let your community know that language isn't a barrier to getting care at your practice through an awareness campaign that includes the major marketing channels your patients use.

With growing diverse populations, your practice needs a plan that supports equal access to care. A language services provider has the expertise to assist with translation, language asset management and navigating regulations. This partnership increases accuracy, compliance and overall efficiencies.

The good news is that more language access tools than ever are at your team’s disposal. Using these tools to connect with patients can ensure everyone in your diverse community gets the care they need to improve their health in a culturally relevant way.

Nic McMahon is CEO of United Language Group, *a leading language solutions provider.*

Expert Review of Pharmacoeconomics & Outcomes Research

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/ierp20

The value of communicating with patients in their first language

Piyush Ranjan, Archana Kumari & Charu Arora

To cite this article: Piyush Ranjan, Archana Kumari & Charu Arora (2020) The value of communicating with patients in their first language, Expert Review of Pharmacoeconomics & Outcomes Research, 20:6, 559-561, DOI: 10.1080/14737167.2020.1835474

To link to this article: https://doi.org/10.1080/14737167.2020.1835474

EXPERT REVIEW OF PHARMACOECONOMICS & OUTCOMES RESEARCH
2020, VOL. 20, NO. 6, 559–561
https://doi.org/10.1080/14737167.2020.1835474

Taylor & Francis
Taylor & Francis Group

EDITORIAL

The value of communicating with patients in their first language

Piyush Ranjan[a], Archana Kumari[b] and Charu Arora[c]

[a]Department of Medicine, All India Institute of Medical Sciences, New Delhi, India; [b]Department of Obstetrics and Gynaecology, All India Institute of Medical Sciences, New Delhi, India; [c]Department of Food and Nutrition, University of Delhi, New Delhi, India

ARTICLE HISTORY Received 3 August 2020; Accepted 8 October 2020
KEYWORDS Communication skills; doctor; doctor-patient relation; doctor-patient communication; barriers, language, patient care

1. Introduction

In today's era of globalization, clinicians have to deal with a diverse patient population, coming from a varied range of cultural, linguistic, and socio-economic backgrounds. Modern-day medicine emphasizes shared decision making that mandates active discussion between the clinician and patients. The clinician's choice of speaking his patients' language is of paramount importance in building a healthy clinician-patient relationship and overall better patient experience [1].

Communicating across linguistic barriers is a challenge for clinicians and healthcare workers all over the globe. Both clinicians and patients face problems because of language barriers. Sometimes, the patients are unable to understand the language of their clinicians and clinicians too find it difficult to gauge the extent to which their patients understood what was conveyed to them. Not just the use of different languages, but partial language barriers such as difficulty in finding words, problems with pronunciation or understanding of utterances, or just a different accent can make a clinician-patient conversation ineffective.

The barriers and challenges encountered in medical interactions are highly context-specific. Many clinicians, mainly the budding medical practitioners, tend to ignore the patient's level of understanding and their ability to process the information given to them. They often overlook that 'How' information is being communicated is as important as 'What' information is being communicated. The ground condition and challenges of medical practice and consultations are, in reality, quite different from communication models described in medical textbooks. As each patient is unique and has his/her way of expressing their health problem, they communicate essential information in different ways.

2. Components of effective communication: all are important

A clinician's conversation with his/her patient is not just about the choice of words or language. The attention with which the clinician listens to his/her patient, along with his/her non-verbal clues such as the body language, posture, gestures and para-verbal components such as tone, pitch and volume, all convey a strong message. Active listening is also a vital component of clinician-patient communication. It is essential for patients to feel that the clinician is actively attending to them and they should not be interrupted while explaining their problems. It is an excellent practice to ask the patient if he/she would like to add anything before closing the conversation/interview. Patients might not fully understand the nature, course or prognosis of the disease or the required treatment due to intellectual or linguistic barriers. Still, they sense the style of communication, which directly impacts their level of satisfaction, adherence to treatment and clinical outcomes [2].

3. Linguistic barriers in medical communication: impact and consequences

When patients and clinicians speak different languages, the whole process of treatment, including the signing of consent forms, reading disease-related printed material, understanding treatment-related expenses etc. becomes even more complicated for the patients. It has been seen that many clinicians often end up making crucial treatment-related decisions on their own without involving the patients due to language barriers. If a language barrier prevents doctors from ensuring that their patient understands the warnings or risks of a medication, those clinicians may be liable in tort for breaching the duty to warn [3]. Miscommunication due to linguistic barriers has been regarded as one of the common precursors for workplace violence in hospital settings [4]. A research study done in South India shows that one of the significant reasons behind patients filing lawsuits against clinicians is due to the inability to understand the nature of medical procedures to which they gave their consent. This is why so much emphasis is given to take informed consent from patients in understandable non-medical terms, preferably in the local language. The diagnosis, nature of the treatment, risks involved, prospects of success, prognosis if the procedure is not performed and alternate treatment options should all be well explained to the patient, in the language that he/she comprehends well [5].

CONTACT Piyush Ranjan ✉ drpiyushaiims@gmail.com Department of Medicine, All India Institute of Medical Sciences, New Delhi 110029, India

This article has been republished with minor changes. These changes do not impact the academic content of the article.

4. Benefits of talking in the patient's language

> "Patients do not remember the doctor's prescription; they remember the doctor's communication"
> - Prachi Keakar.

Talking to the patient in the language that he/she understands increases their confidence in the clinician. Not only does a common language facilitate comprehension of medical information, but it also allows for better assessment of patients' needs, perceptions, and expectations [6]. The patient feels comfortable in sharing his/her personal information about the disease without the fear of getting judged by the clinician. The two-way communication improves the diagnostic accuracy of the clinician, as they can extract crucial information from the patients. Not just the ease in diagnosis, even treatment compliance can be significantly improved through effective communication with the patients. Studies suggest that clinician-patient interactions if done in the patient's language enhances compliance with the treatment plan [7].

5. Strategies for learning skills to communicate in the patient's language

Medical aspirants in many parts of the world are selected based on national level entrance examinations which score them based on their subject-related knowledge. Soft skills like language, communication skills, attitude, etc., although important, are not an essential determinant for admission to medical schools in many parts of the world, especially in developing countries. Students from one region of the country take admissions in medical colleges in far off areas based on their ranks and choice. As a result, many clinicians end up working in areas where they are not familiar with the mother tongue of the local people. In situations like these, it becomes essential to train them at a young age, using questionnaire-based training modules to pick up the locally spoken language. At an individual level, such clinicians should make conscious efforts to involve themselves with friends and colleagues who belong to that area to be able to learn the key terms of the local language.

Not just learning the language, there are many patient-friendly communication strategies that clinicians should adopt to increase their efficiency in providing patient-centric care. It is always better to ask the patient what language he/she is comfortable with. A doctor should not assume that a multilingual patient can process his/her language well. Even while speaking the patient' language, the clinician must avoid the use of medical jargons. Instead, he/she should use simple terminologies/layman language that is well understood by the patient. For example, instead of using the term 'myocardial infarction' the clinician can use the word 'heart attack', similarly instead of 'hyperlipidemia', the term 'high cholesterol' can be used. A clinician can also use similes to make his/her patients understand complex information. It is also a good idea to ask the patient to repeat the given instructions. If the patient fails to do so, then the instructions should be provided in a simpler language.

Along with the delivery of information, it is equally important to master the art of active listening. This skill can help a clinician sail through the linguistic barriers to quite an extent. With experience and training, physicians are often able to understand the patient much better just by paying attention and listening to them carefully. To further enhance the communication process, a clinician should go beyond words. He should make use of drawings, pictures and illustrations which may help the patient in comprehending complicated health issues better. Visuals, models, videos can also be used to make patients understand about surgical procedures. A clinician must also acquire the knowledge, attitude and skills for meeting the cultural competency of the patient as this would help them resonate better with the values, beliefs and concerns of the patient. Hospitals and medical colleges must try to have time to time questionnaire-based assessments to evaluate the communication skills of their clinicians and healthcare staff to ascertain barriers to excellent communication and work on improving them [8].

6. Expert Opinion

Effective doctor-patient communication lays the foundation for a successful doctor- patient relationship. It is essential not only for correct medical diagnosis but also ensures adherence to treatment as well as patient satisfaction. Doctors all over the world face various hurdles while communicating in the patient's first language, which complicates the treatment process and sometimes may become precursor to violence in the hospitals. Learning the native language of the area where the doctor works, helps in facilitating doctor patient communication. Active listening is a strong pillar that supports communication across linguistic barriers. It is important that medical graduates appreciate the value of effective communication with the patients and invest time and energy in polishing their verbal and non verbal communication skills.

Funding

This paper was not funded.

Declaration of interest

The authors have no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties.

Reviewers disclosure

Peer reviewers on this manuscript have no relevant financial relationships or otherwise to disclose.

Funding

This paper was not funded.

References

Papers of special note have been highlighted as either of interest (•) or of considerable interest (••) to readers.

1. Ferguson WJ, Candib LM. Culture, language, and the doctor-patient relationship. Fam Med. 2002 May;34 (5):353–361.
   - **This review determines how differences between physicians and patients in race, ethnicity, and language influence the quality of the physician-patient relationship.**
2. Ranjan P, Kumari A, Chakrawarty A. How can doctors improve their communication skills? J Clin Diagn Res. 2015 Mar;9(3): JE01–4.
   - •• **This review provides a bird eye view of the the importance of different components of communication for building a trustworthy doctor-patient relationship.**
3. Van Kempen A. Legal risks of ineffective communication. Virtual Mentor. 2007 Aug 1;9(8):555–558.
4. Kumari A, Kaur T, Ranjan P, et al. Workplace violence against doctors: characteristics, risk factors, and mitigation strategies. J Postgrad Med. 2020 Jul-Sep;66(3):149–154.
5. Gowda SL, Bhandiwad A, Anupama NK. Litigations in obstetric and gynecological practice: can it be prevented? A probability to possibility. J Obstet Gynaecol India. 2016 Oct;66(Suppl 1):541–547.
6. Ha JF, Longnecker N. Doctor-patient communication: a review. Ochsner J. 2010 Spring;10(1):38–43.
   - •• **This is a comprehensive review on how communication helps in building a therapeutic doctor patient relationship, which is the heart and art of medicine.**
7. Martin LR, Williams SL, Haskard KB, et al. The challenge of patient adherence. Ther Clin Risk Manag. 2005 Sep;1(3):189–199.
8. Baitha U, Ranjan P, Sarkar S, et al. Development of a self-assessment tool for resident doctors' communication skills in India. J Educ Eval Health Prof. 2019;16:17.
   - **This study contains a validated questionnaire for the self assessment of resident doctors' communication skills.**

IMS Health & Quintiles are now IQVIA™

White Paper

TALKING THE PATIENTS' LANGUAGE

The importance of effective, health literate, patient-centered engagement

JOHN PROCTER, Vice President, Patient Engagement & Medical Affairs, IQVIA
REBECCA GALBRAITH, Head of Medical and Patient Communications, IQVIA
CLARE MOLONEY, Program Insights and Design Lead, Medical and Patient Communications, IQVIA

TABLE OF CONTENTS

EXECUTIVE SUMMARY

FOSTERING POSITIVE HEALTH BEHAVIORS

This white paper explores evidence that improving patient engagement leads to positive outcomes for all healthcare system stakeholders. The clinical encounter is at the core of patient engagement, supporting and fostering positive health behaviors. This engagement can be amplified by patient support programs designed using the principles of behavior change, adult learning, health literacy and instructional design. Based on multimodal instructional design, such programs can enhance engagement of patients with different learning styles, using a range of modalities – print, video, digital, mobile, or face-to-face training. Behaviorally driven mobile health interventions are of particular interest, potentially offering an interactive channel to address pathways linked to sustained behavior change, although the benefits of face-to-face interaction should not be underestimated.

INTRODUCTION: USING PATIENT ENGAGEMENT TO OPTIMIZE HEALTHCARE OUTCOMES

Effective patient engagement and empowerment – driving patients' involvement in their own healthcare and decision making – has potential to improve treatment adherence, health outcomes and patient quality of life. However, while engagement is critical for better patient outcomes, as many as 56% of healthcare consumers in the United States show little or no engagement in their health.[1]

Over the past decades, clinical practice has gradually been increasing its focus from an "authoritative/paternal" model to a more "collaborative/consumer" model. This shift often calls on patients as consumers to become more active in their own healthcare decisions, and to move from "adherence" to "self-management" where they have a full understanding and belief in their treatment plan. As the number of chronic disease patients is growing significantly across the world, the healthcare industry has responded to the call for increased "patient engagement," with governments also supporting this trend.

PATIENT ENGAGEMENT IS DEFINED BY THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ) AS

"The involvement in their own care by individuals (and others they designate to engage on their behalf), with the goal that they make competent, well-informed decisions about their health and healthcare and take action to support those decisions."[2]

This response aligns with a growing body of evidence demonstrating that patient-reported and quality outcomes and patient experience are improved when patients become more actively involved in their own healthcare.

The rise in patient engagement activities represents a shift in approach within the current values and outcomes era. This increase in patient engagement accompanies the changes in long-term disease prevalence and therapies, an aging population, the presence in individuals of multiple chronic medical conditions (multimorbidity), simultaneous use of multiple drugs to treat a single ailment or condition (polypharmacy), and cancer increasingly becoming a long-term condition rather than a terminal disease.

Pharmaceutical company pipelines are also shifting, placing a new emphasis on patient identification, and patient education and training. The regulatory environment continues to evolve, with requirements to demonstrate that patient engagement activities meet a need, are non-promotional, and support patient autonomy. There is also increasing interest in use of eHealth (healthcare practice supported by electronic processes and communication) and mHealth (the use of mobile phones and other wireless technology in medical care).

An awareness of current policymaker agendas is essential. Of equal importance is the need to show value of a product if costs are increased, a push for greater citizen engagement, changes in the healthcare workforce, and availability of supporting technology.

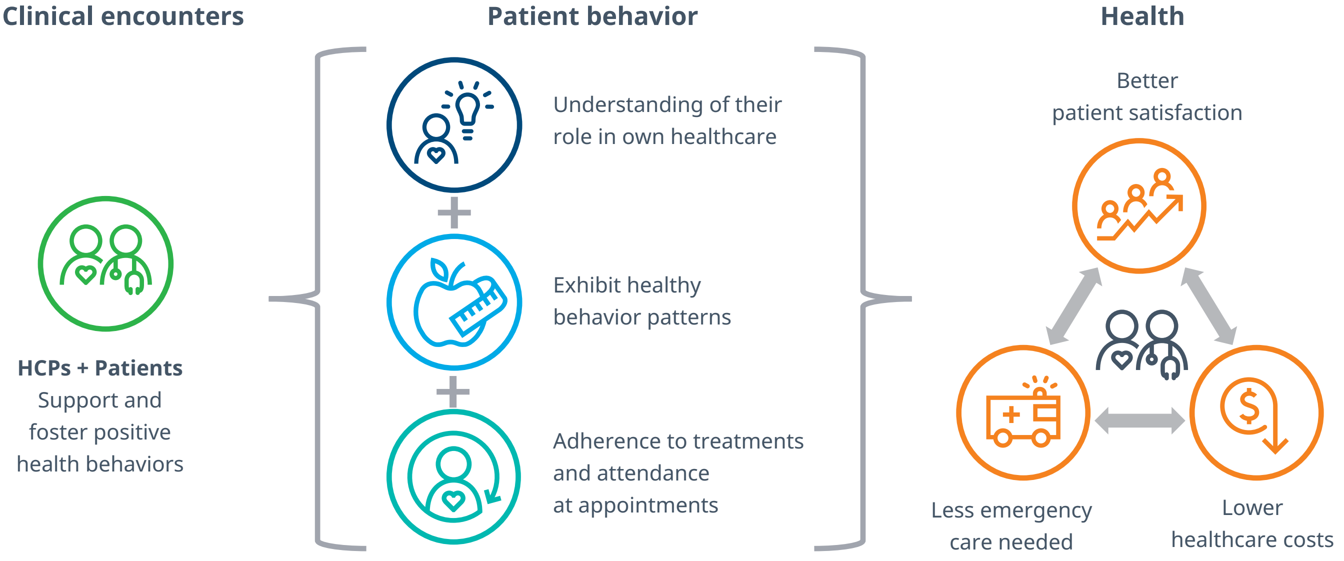
DRIVING PATIENT ENGAGEMENT, LEARNING AND RETENTION

The clinical encounter is at the heart of interactions between patients and the healthcare system, and this drives patient engagement, supporting and fostering positive health behaviors (Figure 1).

It is now widely recognized that increasing someone's level of involvement in the learning process is a key consideration when designing patient engagement services.[3] This moves us away from just providing passive content to considering ways in which people can engage and "be involved." In addition, multimodal programs incorporate multiple learning approaches to cater to the many learning styles that adults bring to training environments (Figure 2).

> ***Good patient engagement strategies using multimodal design can help enhance learning by building engagement through a variety of formats, which can benefit patients with many different learning styles.***

Figure 1: Patients actively participating in their own healthcare can achieve positive outcomes



Clinical encounters

HCPs + Patients
Support and
foster positive
health behaviors

Patient behavior

Understanding of their role in own healthcare

\+

Exhibit healthy behavior patterns

\+

Adherence to treatments and attendance at appointments

Health

Better patient satisfaction

Less emergency care needed

Lower healthcare costs

Figure 2: Considering different styles of learning

VISUAL LEARNERS

- Learn by seeing
- Best understand words that evoke images
- Respond well to demonstrations
- Enjoy visually pleasing presentations

KINESTHETIC LEARNERS

- Learn through trial-and-error
- Prefer hands-on approaches
- Use multiple senses to engage with material
- Enjoy solving real-life problems

AUDITORY LEARNERS

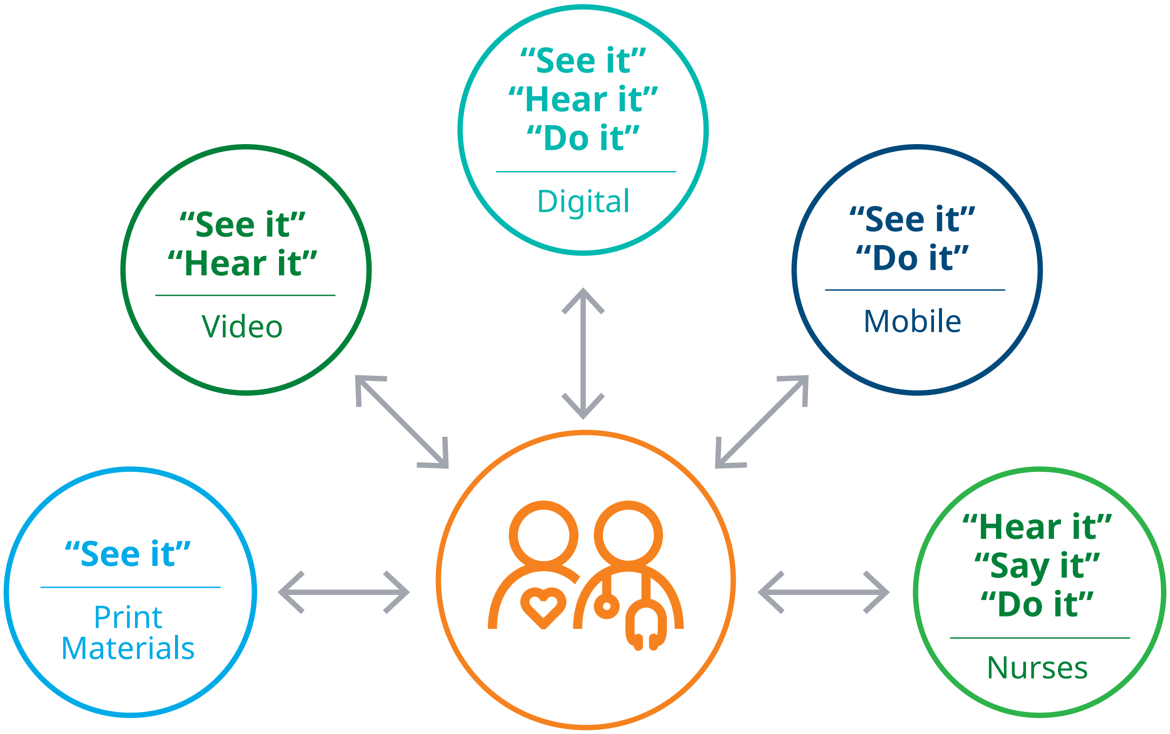
- Learn by listening and verbalizing
- Listen for keywords and phrases
- Respond well when things are explained aloud
- Think in a linear fashion

READ-WRITE LEARNERS

- Learn by reading and writing
- Best understand explanations on paper/screen
- Organize thoughts and make lists
- Translate lessons into words

Good patient engagement strategies using multimodal design can help enhance learning by building engagement through a variety of formats – print, video, digital, mobile and face-to-face training with healthcare providers (Figure 3). Varied formats can enable engagement of patients with many different learning styles. For example, informational content can be delivered via printed materials (“see it”). Patient stories and emotional engagement can be delivered via videos (“see it, hear it”). Action planning, goal setting and tools can be delivered to patients via digital channels, including the Internet and apps (“see it, hear it, do it”). Symptom trackers and text reminders are good examples of these channels, and allow patients to be prompted (“see it, do it”). Live discussions can take place through nurse educator or pharmacist contact, in person or through a call center (“hear it, say it, do it”).

Figure 3: Using multimodal design to enhance learning



“See it, hear it, say it, and do it”

DEVELOPING EFFECTIVE CONTENT FOR PATIENT ENGAGEMENT PROGRAMS

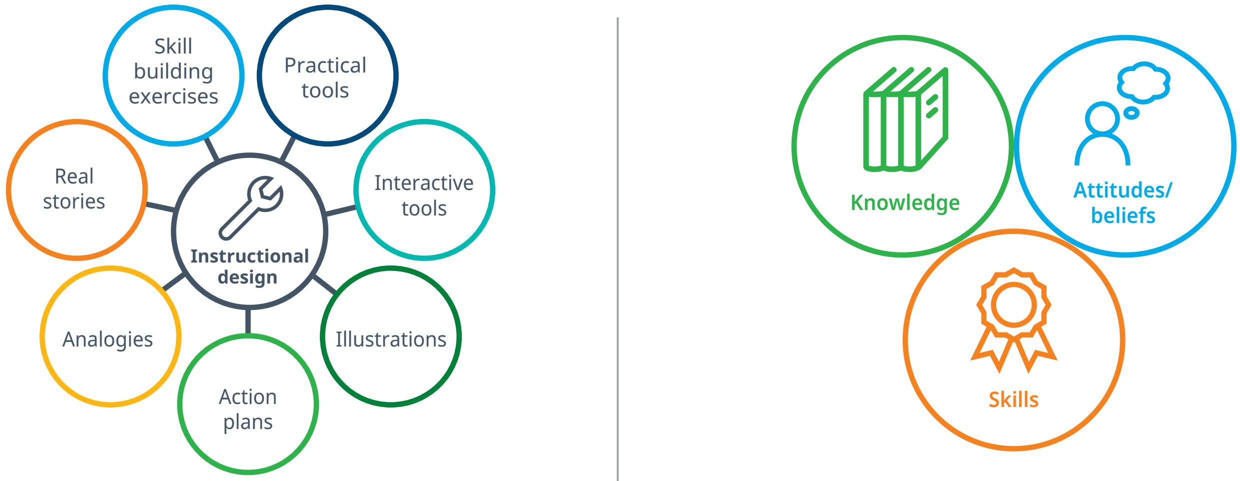
Effective content can be developed for patient engagement programs by using the principles of behavior change, adult learning and health literacy (Figure 4). Instructional design takes advantage of elements such as skill-building exercises, practical and interactive tools, illustrations, action plans, analogies and real stories. Behavior change models – taking account of patient knowledge, attitudes/beliefs and skills – have been applied to almost every disease state. In addition, incorporating evidence-based behavior change techniques into content, such as action planning and self-monitoring of behavior, increases the likelihood of effecting meaningful change.[4]

The 3 pillars of instructional design, behavior change and health literacy models can be a powerful combination to help engage patients, and should form the foundations of any patient support program. This combination provides:

- **Tools** to address values, beliefs, attitudes, emotions
- **Education** to address gaps and barriers, and justify the patient engagement program or product
- **Practical training** to increase self-efficacy, confidence and skill
- **Materials** that leverage the entire support network (HCPs, nurses, dieticians, physician assistants, pharmacists, advocacy, family)
- **Resources** to support access and overcome cost barriers
- **Action plans** that offer a linear path, showing the various steps the patient needs to follow (Figure 5)
- **Multimodal design** to accommodate multiple learning styles

Figure 4: Developing effective engagement content

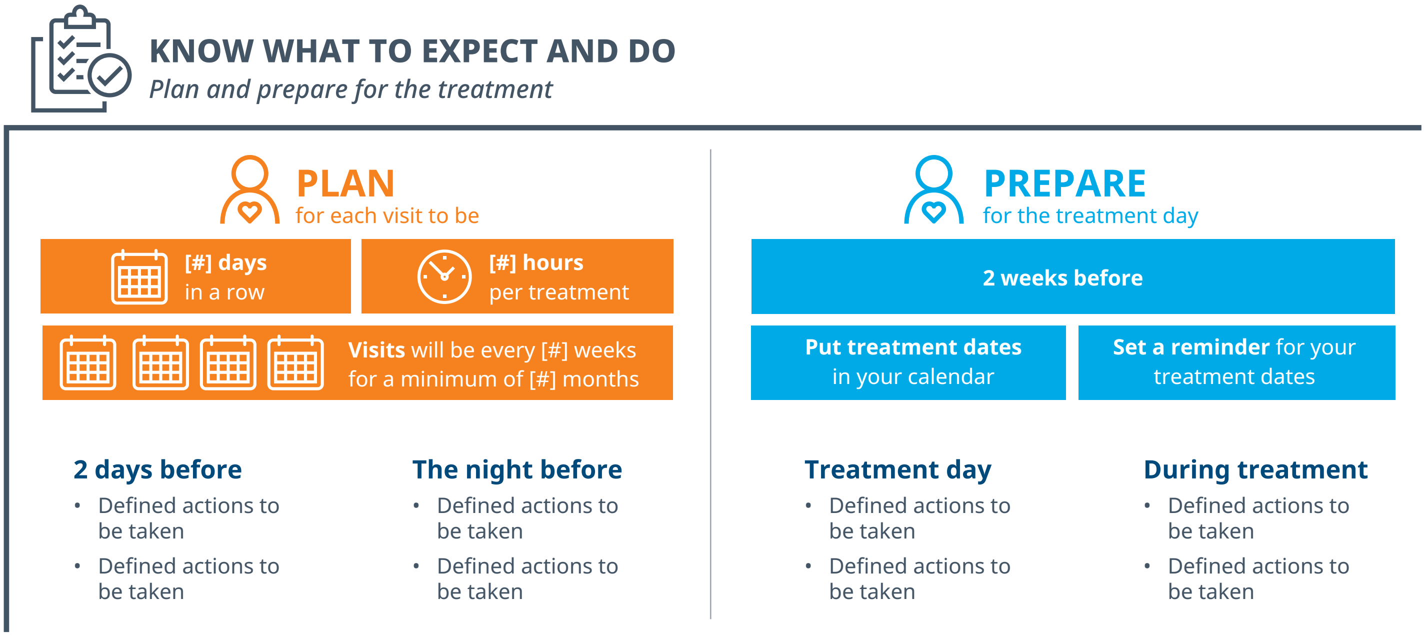
Using the principles of instructional design, behavior change and health literacy



Instructional design
comprises practical tools and behavior change techniques for health communication

Behavior change models and techniques
help us to understand, predict and change behavior

Figure 5: Action plans: Applying the theory to patient materials



KNOW WHAT TO EXPECT AND DO

Plan and prepare for the treatment

PLAN

for each visit to be

[#] days
in a row

[#] hours
per treatment

Visits will be every [#] weeks
for a minimum of [#] months

2 days before

- Defined actions to be taken
- Defined actions to be taken

The night before

- Defined actions to be taken
- Defined actions to be taken

PREPARE

for the treatment day

2 weeks before

Put treatment dates in your calendar

Set a reminder for your treatment dates

Treatment day

- Defined actions to be taken
- Defined actions to be taken

During treatment

- Defined actions to be taken
- Defined actions to be taken

THE IMPORTANCE OF HEALTH LITERACY

Health literacy is much more than being able to read. Patients need to be able to find information in print materials, online and through health and advocacy organizations. They can use this information to manage their health condition(s) by:

- **Understanding** treatment choices and recommendations, including risks and benefits
- **Interpreting information** – for example, risks for disease recurrence or progression – that may use numerical concepts such as percentages and probability
- **Asking questions** for clarification; and managing appointments and insurance-related tasks.

Health literacy is one of the strongest predictors of health status and outcomes, with low health literacy being associated with incorrect use of medicines, less knowledge of disease prevention and self-care strategies, more hospitalizations and emergency visits, and higher levels of illness.[5,6] Health literacy is a stronger predictor of health status than income, education, employment status, or racial or ethnic group.

HEALTH LITERACY IS DEFINED AS

"The ability to find, understand, and use basic health information and services needed to make appropriate health decisions."[7]

Despite its importance, health literacy remains a major problem around the world.[8,9] In Europe, fewer than 1 in 8 adults have excellent health literacy and one-half of adults have problematic or inadequate health literacy. In the United States, fewer than 1 in 10 adults have proficient health literacy, and more than one-third of adults have basic or below-basic health literacy.

PRINCIPLES FOR ENSURING CLEAR COMMUNICATION

To ensure clear communication, it is helpful to adopt proven principles for developing materials that are easy for patients to understand and use. Health literacy principles from the U.S. Centers for Disease Control and Prevention include:[10-12]

Providing content that solves problems, based on knowledge about the intended audience (Figure 6), by ensuring that the writer:

- Makes the purpose of the piece evident
- Validates patient/caregiver challenges
- Limits the number of concepts to what can reasonably be learned in the time allowed
- Focuses on behaviors, rather than medical facts
- For data/statistics, uses ratios with (or instead of) percentages
- Reviews key takeaways.

Figure 6: Characteristics of the intended audience

Values, emotions, beliefs and attitudes
- Barriers and motivators to behavior

Surrounding environment
- Socioeconomic factors
- Family/other personal experience with illness
- Access and coverage

Knowledge
- Disease and Rx
- Treatment experience
- Gaps and myths

Support network
- Family and friends
- Online discussions and resources
- Advocacy organizations
- HCP team

Self-efficacy
- Skills and self-confidence
- Practical skills

Writing and editing content for easy reading, including using an active voice, choosing common words that are a good fit, and being consistent with word use, are all essential approaches, which also facilitate the process of translating patient materials into other languages. New terms should be defined within the text, abbreviations spelled out at the first mention, and context provided when offering new information. Writing should be tailored to 6th to 8th grade reading level (U.S.) or 7th to 9th grade reading level (Europe), or lower, using the Fry readability assessment.[13] Subheads should be used, and information subdivided with bullet points, with no more than 7 items in a bulleted list.

Barriers to applying health literacy principles may exist, including Institutional Review Board (IRB) and Ethics Committee (EC) requirements, branding guidelines, the need for age-specific design (e.g. pediatrics), production specifications due to budgetary issues, and client preferences. Many companies and regulatory bodies, such as the FDA, are increasingly recognizing the importance of health literacy, and in some cases providing recommendations and requirements for material reading levels.

Designing for easy reading, using a general checklist:

- Provide adequate white space around the text and graphics. This helps keep the design simple and enables readers to focus on the main feature and message. White space helps readers feel less overwhelmed when trying to focus on content.
- Ensure that design is appropriate for the patient demographic (age, ethnicity, etc.), and provides consistency in layout from page-to-page, with an appropriate font style and size, left-justified body text, and limited use of italics and underlining.

Using color with purpose, providing contrast between text and background, and using blocks of color to highlight key messages in a “Tips” section or glossary. Dark text on a light background can be easier to read than white text on a dark background.

Using visuals for emphasis, to explain information, reinforce important content, and provide relief from large areas of text. Photos and illustrations can help demonstrate desired behaviors, with images chosen to represent the target audience. Tables, charts and diagrams should be used to explain information. Readers with low literacy levels might rely on pictures to help them understand information and what they need to do. Placing these images close to copy describing the desired behavior, as well as providing captions to the visuals, helps readers comprehend the information and, hopefully, moves them toward engaging in the positive action that is being depicted.

Involving the reader by validating the challenges that patients and caregivers face, and using a positive and friendly tone. Opportunities to interact with the material – via checklists, action plans, Q&A sections or notes pages – can help readers understand, absorb and apply the information.

AN EXAMPLE IN PRACTICE: THE BIOPSYCHOSOCIAL ASSESSMENT MODEL

When designing materials and methods to engage patients it is important to move beyond the medication and intentional non-compliance and consider psychosocial barriers. In many clinical situations, unintentional adherence barriers and treatment decisions are driven by psychosocial concerns. One example in practice, the Biopsychosocial Assessment Model,[14] provides a holistic view of patient and caregiver needs in 7 key areas (Figure 7).

> ***The IQVIA approach to digital innovation challenges the assumption that behavior change can be established through simple reminders, tracking and alerts, and supports the idea that behaviorally driven mobile health interventions can address multiple pathways associated with sustained behavior change.***

Figure 7: The Biopsychosocial Assessment Model

Ensures that we know the needs, drivers and barriers of the audience

Figure 8: The Biopsychosocial Assessment Model applied to chronic pain

Medical

- Disease: Low quality of life
- Treatment: No cure/Temporary relief
- Comorbid with many conditions

Confidence

- Low self-efficacy/skill
- Low confidence in HCPs/Rx

Educational needs

- Coping strategies
- Treatment options
- Overcoming stigma
- Accessing services

Occupational

- Negatively impacts work/school/volunteering and valued roles/hobbies

Support

- Negative impact on relationships
- Active online seeking peer connection and validation
- Fragmented advocacy presence
- Many feel invalidated by healthcare system and government

Emotions and beliefs

- Feel invalidated/frustrated
- Depression
- Anxiety
- Helplessness
- Misunderstood/stigmatized

Access/cost

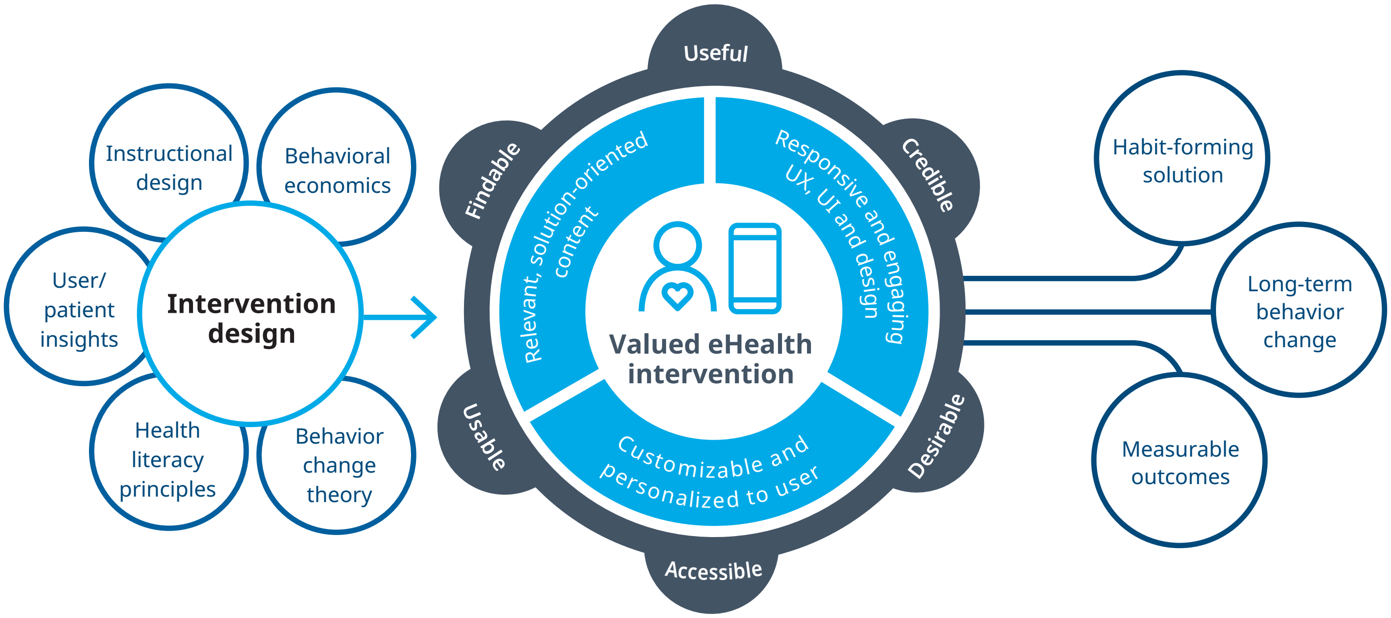
- Low socioeconomic status due to lost work/wages
- Access/coverage challenges

As an example, effective patient engagement material can be designed for the patient with chronic pain having first considered all relevant factors within this assessment model (Figure 8). This will include content, style and mode of delivery, which all need to be considered against the background of the assessment model results.

DIGITAL SOLUTIONS DRIVING ENGAGEMENT AND SUSTAINED BEHAVIOR CHANGE

Digital innovations may enable a nimble approach based on patient needs, helping to initiate and track behaviors, and encourage longer-lasting behavior changes and best practices. The IQVIA approach to digital innovation challenges the assumption that behavior change can be established through simple reminders, tracking and alerts, and supports the idea that behaviorally driven mobile health interventions can address multiple pathways associated with sustained behavior change (Figure 9).

Figure 9: Opportunities for digital innovation to drive engagement and efficiency



CONCLUSION: FACE-TO-FACE INTERACTIONS AND TECHNOLOGY CAN OPTIMIZE CARE AND OUTCOMES

Successful patient engagement programs depend on a tailored combination of face-to-face interactions and technology – including behaviorally driven mobile health approaches – with oversight from healthcare professionals. These programs need to respond to ongoing changes in disease prevalence, R&D pipelines, the regulatory environment and policymaker agendas. Based on best practices in supporting health literacy, such programs can prove their worth in enabling pharmaceutical and biotech companies to help optimize patient care and outcomes, while clearly demonstrating the benefits of their therapies. Continuing to talk the patients' language – through effective, patient-centered engagement – will build on this success in years to come.

REFERENCES

1. Deloitte 2015 Survey of US Health Care Consumers. *Health care consumer engagement: No "one-size-fits-all" approach* (2015). Retrieved June 29, 2017, from: https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/health-care-consumer-engagement.html
2. Irizarry T, DeVito Dabbs A, Curran CR. Patient Portals and Patient Engagement: A State of the Science Review. Eysenbach G, ed. *Journal of Medical Internet Research.* 2015;17(6):e148. doi:10.2196/jmir.4255. Retrieved June 29, 2017, from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4526960/
3. Dale E. Audio-Visual Methods in Teaching (3rd Edition), Holt, Rinehart, and Winston (1969). Retrieved June 30, 2017, from: https://www.researchgate.net/figure/283011989_fig1_Figure-2-Edgar-Dale-Audio-Visual-Methods-in-Teaching-3rd-Edition-Holt-Rinehart-and
4. Michie, S., Johnston, M., Francis, J., Hardeman, W., & Eccles, M. (2008). From theory to intervention: mapping theoretically derived behavioural determinants to behaviour change techniques. *Applied Psychology,* 57(4), 660-680
5. Nielsen-Bohlman L, Panzer AM, Kindig DA, eds. *Health Literacy: a Prescription to End Confusion.* Retrieved June 19, 2017, from: http://www.nap.edu/catalog/10883.html.
6. Weiss BD. *Health Literacy and Patient Safety: Help Patients Understand. Manual for Clinicians.* 2nd ed. Retrieved June 19, 2017, from: http://med.fsu.edu/userFiles/file/ahec_health_clinicians_manual.pdf.
7. U.S. Department of Health and Human Sciences. *Quick Guide to Health Literacy.* Retrieved August 11, 2017, from: https://health.gov/communication/literacy/quickguide/factsbasic.htm
8. Doak CC, Doak LG, Root JH. *Teaching Patients With Low Literacy Skills.* 2nd ed. Philadelphia, PA: JB Lippincott; 2007.
9. Educational Testing Service. *Adult Literacy in America.* 3rd ed. Washington, DC; National Center for Education Statistics; 2002.
10. Health Literacy for Public Health Professionals. *Guides and Manuals.* Retrieved August 8, 2017, from: https://www.cdc.gov/healthliteracy/training/page5741.html
11. U.S. Department of Health and Human Sciences. *Simply Put. A guide for creating easy-to-understand materials 2010.* Retrieved August 8, 2017, from: https://www.cdc.gov/healthliteracy/pdf/simply_put.pdf
12. Centers for Disease Control and Prevention 2016. *Plain Language Materials and Resources.* Retrieved August 9, 2017, from: https://www.cdc.gov/healthliteracy/developmaterials/plainlanguage.html
13. The Fry Graph Readability Formula. Readability Formulas. Retrieved August 8, 2017, from: http://www.readabilityformulas.com/fry-graph-readability-formula.php
14. Engel GL. *The need for a new medical model: a challenge for biomedicine.* Science. 1977 Apr 8;196(4286):129-36. Retrieved June 19, 2017, from: https://www.ncbi.nlm.nih.gov/pubmed/847460

ABOUT THE AUTHORS

JOHN PROCTER

Vice President, Patient Engagement & Medical Affairs, IQVIA

John leads our patient engagement, medical affairs, medical communications and market access businesses across Europe where he works with clients to address practical barriers to the uptake and use of medicines and medical devices. John's business focuses on building innovative and creative solutions through strong design and development capabilities alongside ensuring excellence in delivery from outsourced teams of nurses, Medical Scientific Liaison and pathway redesign specialists. He took up this position in September 2017 after two years as Senior Director for Global Service Development in Integrated Market Access.

His expert knowledge and insight of patient service delivery and working in and with the NHS is gained from 25 years in the healthcare industry in the UK.

John has been with IQVIA since October 2010 and previously spent eleven years at Pfizer. He started his career as an NHS Management Trainee with NHS Wales and worked in a number of hospital trusts in both operational and strategic roles over his eight years in the NHS.

John is a graduate of the University of Keele and holds a Diploma of Health Management from the University of London.

REBECCA GALBRAITH

Head of Medical and Patient Communications, IQVIA

Rebecca is responsible for the design and implementation of multichannel patient support and adherence communications programs at IQVIA. She has over 15 years' experience of patient and healthcare professional communications and leads a team of communications, behavioral and multichannel experts to ensure the right blend of patient interventions in each program.

CLARE MOLONEY

Program Insights and Design Lead, Medical and Patient Communications, IQVIA

Clare provides oversight and strategic direction for patient, caregiver and healthcare professional programs to promote health related behavior change as well as behavioral science thought leadership and product design. A health psychology specialist with a strong academic and commercial skill set, Clare has extensive experience in health behavioral research, intervention design and evaluation. For over 8 years, Clare has designed and overseen the delivery of global patient support services across a wide range of therapeutic areas and led strategic product design to promote sustained health behavior change.

ACKNOWLEDGEMENT

The authors thanks Jill Dawson, PhD, for medical writing support.

CONTACT US

iqvia.com/contactus

IMS Health & Quintiles are now

IQVIA™

INTERPRETATION REQUEST PROCESS

Date of Referral:

Client's first name:

Client last name:

Client preferred name:

CPCDMS Code:

TCT Code:

Client phone number: (   )   -

Is voicemail allowed on the number provided? ☐ Yes ☐ No

Client's Email:

Referring Agency:

Staff member making referral:

Staff member contact number:

Staff member email:

Check the following boxes:

☐ I have verified that the client's CPCDMS is not expired

☐ I have verified that client's eligibility in TCT is not expired

Please attach the following documents (Failure to provide all documents listed below will result in delay of services)

- ✓ Completed Interpreter Request Form §1.5.1.1
- ✓ Proof of HIV status
- ✓ Copy of ID (if available)
- ✓ Copy of insurance card (if applicable)
- ✓ Completed copy of Interpreter Services Consent for Services & Release/Exchange of Information §1.5.1.2
- ✓ Completed copy of Consent for Release/Exchange of Information to Verify Eligibility for Services and for Care Coordination §2.5.4

Please send completed packets through encrypted email to: (interpretationrequest@montrosecenter.org)

Contact Robbin Uwadia (713-529-0037, ext. 351) or William Lopez (713-529-0037, ext. 315) with any questions.

1.5.1.1 INTERPRETER REQUEST

Requested by: ____
(Name of Person and Agency Requesting service)

If internal the Center request, note program in which client's services are funded: ________________________

Faxed Date: ____/____/____ Confirmed Date: ____/____/____ By: ________________________

Client Name/11 Cha Code: __________________________ Apt Type: ________________________
(Medical, Dental, Eye Clinic, Counseling, Please Specify)

Appt Start Time: _________ End Time: ____________ Appt Date: ____/____/____

APPOINTMENT LOCATION

Address: ____

Contact: ____

Language: _______________________Special Instructions: ____________________________
(Country/State/Province/Name of Interpreter)

the Center USE ONLY

Interpreter Service Provider: ___________________________ Telephone: _____/_______-_________

Date ISP Notified of Need by FAX: _____/_____/_____ By: ________________________

Confirmed on: _____/_____/_____ By: ________________________

ISP Representative Confirming: ________________________

Name of Interpreter: _____________________________ Interpreter Level: ________________________

Canceled by: _________________________ Date Canceled: _____/_____/_____

Verification Recd Service Provided: ☐ Yes ☐ No All Documents in File/ OK to Bill: ☐ Yes ☐ No

If No, Document(s) Missing: ________________________

Funding: ☐ DSHS-HIV ☐ DSHS-SAS ☐ HHSC ☐ Private

VERIFICATION OF SERVICE PROVIDED

Service Provided as described above: ☐ Yes ☐ No If no, reason: ________________________

Length of Appointment: _____ hours Verified By: ________________________

Signature of Verifying Official: ________________________

Documents Attained at Appt: ________________________

Date Documents Delivered to the Center: _____/_____/_____ Method of Delivery: ☐ Fax ☐ Mail

Comments: ____

____

Note: Eligibility criteria for this service to be funded under DSHS-HIV contract includes: HIV positive; resident of Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton Counties; and income under 300% of the poverty level. If this is the first time an interpreter has been scheduled for this client, verify that all eligibility documentation has been received before scheduling. If documentation not provided to the Center by Requesting Agency within 2 days following initial appointment, Requesting Agency will be billed for interpreter service. 5/09

1.5.1.2 INTERPRETER SERVICES CONSENT FOR SERVICES & RELEASE/EXCHANGE OF INFORMATION

Name ____

Address ____ Zip _____________ Phone _________

Consent for Services: I understand and have received an explanation of and copy of the client rights and grievance procedures. After being fully informed of all of the above, I hereby agree to receive interpreter services through the Montrose Center which are underwritten by a grant provided by the Texas Department of State Health Services – HIV/STD or others. Interpreter services may be provided only in connection with other HRSA approved services.

Release of Information: I, _____________________________, hereby request and authorize:
Client's Name
______________________________ to exchange information, including HIV status, with the Montrose Center Interpreter Services about my care for the purpose of coordinating Interpreter Services.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 CFR, Part 2, Section 33 of Public Law 91 - 616 as amended by Public Law 93-282, HIPAA Privacy Act, §45 CFR 160-164 and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as effective and valid as the original.
Further, I understand that this consent shall expire one (1) year after my last contact with the Montrose Center or one (1) year after the last CPCDMS registration expires whichever is later, or ____ other _______________________________________ unless I revoke it as provided for above.

____________________________	____/____/____	________________________________
Client's Signature	Date	Parent's, Guardian's or Authorized Representative's Signature

Return to: Interpreter Services, 401 Branard, 2nd Floor, Houston, TX 77006
713.529.0037 713.526.4367 (fax)

2.5.4 CONSENT FOR RELEASE/EXCHANGE OF INFORMATION TO VERIFY ELIGIBILITY FOR SERVICES & FOR CARE COORDINATION

Client 11-Character Code												**TCT Code**					

By signing the Consent for Services form, you allow the Center to enter the information you give us during client registration into a database. All identifying information will stay on the Center's computer. The information that is transmitted to the CPCDMS will be identified by the scrambled 11 character code above. If you agree to paragraph 2, your case manager or therapist at the Center will be able to access information through the database about dates when you attended those services. They will not receive details about the visit. This form allows your the Center caregiver to access data to coordinate your services. **It does not allow other agencies to see information about your services here, however authorized data system administrators may view such information stored at the Center site.**

I, ____, Date of Birth _____/_____/_____, hereby authorize the Montrose Center to access the ***Centralized Patient Care Data Management System (CPCDMS) or Take Charge Texas (TCT)*** to verify my enrollment at any agency currently participating in the ***CPCDMS/TCT*** maintained by Harris County Public Health Services and Department of State Health Services and to verify my receipt of Ryan White services, Department of State Health Services (DSHS) – HIV/STD or Substance Abuse Services.

Furthermore, I authorize my Case Manager/Care Director to access the encounters information for any Chemical Dependency Treatment, Psychiatric Treatment**,** and/or Professional Counseling services I have received to verify my receipt of these protected services at any of the agencies participating in the ***CPCDMS/TCT*** maintained by Harris County Public Health Services/Department of State Health Services. I do understand that the content of these services will not be accessed without a separate release of information by me.

The purpose of this exchange is to verify my eligibility for Ryan White A or DSHS funded services provided by this agency and to coordinate my service delivery, monitor the service(s) and is limited to the following specific types of information:

- my registration date and client status (open or closed; active or inactive)
- name of the agency maintaining my client record
- my eligibility expiration date
- my HIV/AIDS status
- my zip code and county of residence
- my financial eligibility level

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, §42 CFR, Part 2, HIPAA Privacy Act, §45 CFR 160-164, §33 of Public Law 91-6161 as amended by Public Law 93-282; Texas Health & Safety Code, Chapter 81, Section 81.050 and all applicable state and local laws, rules and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I am authorizing this release/exchange of information of my own free will and with informed consent. I may revoke this consent in writing at any time, except to the extent that action may already have been taken in reliance on it.

Further, I understand that this consent shall expire one (1) year after my last contact with the Montrose Center or one (1) year after the last CPCDMS registration expires whichever is later, or ____ other ______________________________________ unless I revoke it as provided for above.

A photographic copy of this authorization shall be considered as effective and valid as the original.

____________________________________ _____/_____/_____ ____________________________________
Client's Signature Date Parent, Guardian, or Authorized
Representative's Signature