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To Federal Coordinating Council on Comparative Effectiveness Research

Meeting the Urgent Healthcare Needs of Individuals with Limited English Proficiency (LEP) Using Cost-Effective and Evidence Based Approaches

Almost 52 million people—over 19% of the U.S. population—speak a language other than English at home. The Census Bureau's 2005 American Community Survey documented that over 29% of all Spanish speakers, 22% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English "not well" or "not at all." Non-English speaking and limited English proficiency are a growing population. Estimates of the number of people with LEP range from a low of about 12 million, or 4.5% of the U.S. population—who speak English "not well" or "not at all"—to over 23 million people, or 8.6% of the U.S. population—if one includes those who speak English less than "very well."

Effective communication is an essential element of quality within the health care experience. Communication barriers arise when patients are limited in their English proficiency. These barriers can result in misdiagnoses, poor treatment decisions, a lack of trust between patient and provider, and limited adherence to treatment plans and therapies. Linguistic barriers can impede access to timely health care, as well as patients' ability to communicate symptoms, follow medical advice, and understand medication instructions.

Evidence shows that effective communication between patients and clinicians is a critical component of providing high-quality health care. Despite mandates and legislation that require culturally and linguistically appropriate services in health care settings, these services are largely under-utilized in many hospital departments and healthcare facilities. Multiple studies have shown that LEP status has a significant effect on health care utilization and health status. Compared with English speaking patients, LEP patients report less satisfaction with medical encounters, have different rates of diagnostic testing, longer hospital stays, receive less explanation on medication and treatment, and follow-up. Other studies have shown that patients who have LEP endure increased clinic visit time and hospital admission length of stay.

Health care providers from across the country have reported language difficulties and inadequate funding of language services to be major barriers to limited English proficiency (LEP) individuals' access to quality health care. When communication is compromised by language barriers, the quality of care is also compromised. Consequently, providing individuals with LEP the means to communicate effectively with their health care providers is critical to improving their experience in the health care setting, the quality of care they receive, and their health outcomes. As racial and ethnic diversity in the United States continues to increase, so does the demand for appropriate and effective language services.

Nearly 80% of hospitals encounter individuals with LEP frequently, and only 3% receiving direct reimbursement for providing language services with funds coming from Medicaid. Reports demonstrate that most of those in need of language services are also part of the uninsured population seeking care through hospital facilities. As hospitals today face multiple issues connected to their financial stability, and struggle to maintain healthcare quality with reduced staffing and decreasing revenues, the question and challenge arises: *Who will pay for these services and how do we meet the demand for these services in the most cost effective, pro-patient outcome method?*

Current practice in many healthcare facilities is the utilization of telephonic language line services or on-site interpreters. Telephone-based language lines have quick connect times, but are perceived as difficult or cumbersome to use due the asynchronous nature of handing a phone back and forth and the clumsy nature of the lines. Some major metropolitan facilities that support a large community of LEP patients are starting to introduce video over internet interpretation systems as a means to providing language assistance.

Medically trained on-site interpreters are more efficient and have been shown to decrease clinic wait times when compared to telephonic interpretation; however, wait time still can be greater in healthcare facilities than with telephonic service as the on-site interpreter is frequently not in the needed hospital unit and needs to travel from one area to another within the facility. This increased 'connect time' can be problematic in areas of high patient turnover/throughput such as the ED, surgical and recovery area, and urgent care hospital-based clinics. Where frequent or detailed communication is required such as at the onset of the triage process; to identify or discuss patient history or current condition updates; confer patient needs during and after a procedure; to explain discharge instructions; or when clinically indicated, explain informed consent for procedures stage of the patient encounter, multiple connects are needed on demand and service must be sustainable.

The use of teleconferencing (video over internet) has been well accepted in many other areas of healthcare. It has provided a means for medical consultation, access to healthcare in rural and remote areas, and more. There are only a handful of facilities pocketed around the nation that currently use this technology for video medical interpretation (VMI) as an option for patient language service. The newer technology of VMI provides around-the-clock real-time services via a mobile closed circuit videoconferencing network. VMI allows patients and providers to interact in much the same way as if an interpreter was physically present in the room, but with a connect time that is similar to telephonic service.

In a London study it was reported that patients had an equivalent satisfaction with hands-free telephone and VMI but agreed that VMI allowed for a more personal interaction. In California, a limited study of 60 Spanish speaking, 50 Cantonese speaking and 5 Vietnamese speaking patients at the county hospitals showed a definite preference for the use of VMI over telephonic-based service by both patients and providers.

There are many studies that compare telephone-based interpretation services with on-site services. It is generally agreed that on-site interpretation because of its more personalized nature, has a higher patient satisfaction rate, but there are no studies that compares the two most commonly used interpretation services to video interpretation. Additionally, there are no studies that indicate the impact of VMI on quality of care, health outcomes, or overall comparison to other interpretation methods for cost effectiveness.

We resolve that resources for Comparative Effectiveness Research should be targeted toward evaluating and improving language services for all patients that have limited English proficiency. In an era where healthcare facilities are being charged to provide high-quality care to all populations while struggling to meet the economic challenges that encroach their local communities, it is essential that efforts be made to help identify the best methods of serving LEP patients in the most cost effective manner that will ensure greater patient satisfaction, improve patient outcomes, and reduce patient and facility costs. Hospitals that commit to providing high-quality language services to their patients likely will be rewarded with greater patient and staff satisfaction, which can provide them with a competitive advantage as the demographics of the United States continue to change.

