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Race, Ethnicity and Language

The following summaries of recent peer-reviewed articles describe considerations for meeting the patient experience, clinical quality, and patient safety needs of individuals of diverse race, ethnicity, and language. Citations are linked to full-text articles **[*]** when available.

Race/Ethnicity

Study	Objective	Conclusion
Shen, M. J., Peterson, E. B., Costas-Muñiz, R., Hernandez, M. H., Jewell, S. T., Matsoukas, K., & Bylund, C. L. (2018). The effects of race and racial concordance on patient-physician communication: a systematic review of the literature. *Journal of Racial and Ethnic Health Disparities, 5*(1), 117-140.	To examine the effect of black race and racial concordance on patient-physician communication.	▪ In most cases, black patients are less satisfied with patient-physician communication than white patients. ▪ Black patients report less information-giving, partnership-building, participatory decision-making, and positive talk; more negative talk; shorter visits; physicians who were more verbally dominant; and worse outcomes on non-verbal communication, respect, and support. ▪ Racial concordance is a consistent predictor of better patient-physician communication, with the exception of communication quality.
[*] Centers for Medicare & Medicaid Services (2017). *Racial and Ethnic Disparities in Health Care in Medicare Advantage*.	To summarize how the care received by racial/ethnic minority groups compares with the care received by Whites of the same gender.	▪ There is evidence that racial and ethnic differences in health care may vary by gender, including: – Getting appointments and care quickly: ▪ Asian or Pacific Islander (API), Black, and Hispanic women report getting appointments and care less quickly than White women. ▪ API, Black, and Hispanic men report getting appointments and care less quickly than White men. – Doctor communication: ▪ API women report worse doctor communication than White women. Black, Hispanic, and White women report similar experiences to each other with doctor communication. ▪ API men report worse doctor communication than White men. Black, Hispanic, and White men report similar experiences to each other with doctor communication. – Care coordination: ▪ API, Black, and Hispanic women report worse care coordination than White women. ▪ API and Hispanic men report worse care coordination than White men did. Black and White men report similar experiences to each other with care coordination.

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Foo, P. K., Frankel, R. M., McGuire, T. G., Zaslavsky, A. M., Lafata, J. E., & Tai-Seale, M. (2017). Patient and physician race and the allocation of time and patient engagement efforts to mental health discussions in primary care: An observational study of audiorecorded periodic health examinations. *Journal of Ambulatory Care Management, 40*(3), 246-256.	To investigate racial differences in patient-physician communication around mental health versus biomedical issues.	▪ Differences in communication can appear in subtle ways, such as whether a physician demonstrates more empathy or allocates more time for patients to speak when the conversation changes from a biomedical to a mental health issue. ▪ The average physician spends more time and more patient engagement effort on mental health topics than on biomedical topics. ▪ Physician race predicts differences in the time spent on mental health topics, whereas patient race predicts differences in physician-demonstrated empathy. ▪ Compared with White physicians, encounters with Asian American/Pacific Islander physicians had relatively less time devoted to mental health topics than to biomedical topics. This difference was largely due to patients, of all races, spending less time talking about their mental health concern with Asian American/Pacific Islander physicians than with White physicians. ▪ Other race minority patients (i.e., non-Black, non-Asian American/Pacific Islander) were less likely to receive the relative increase in physician empathy that White patients received around mental health topics.
Hays, R. D., Chawla, N., Kent, E. E., & Arora, N. K. (2017). Measurement equivalence of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medicare survey items between Whites and Asians. *Quality of Life Research*, *26*(2), 311-318.	To determine if Asians' lower CAHPS scores when compared to Whites are due to true differences in care received, expectations about care, or survey response styles.	▪ Differences between Whites and Asians on CAHPS patient experience measures are unlikely due to lack of measurement equivalence. This finding is important because research shows that Asians are less likely than Whites to use the extremes of response scales. ▪ The CAHPS survey generally performs similarly for White and Asian patients and provides support for comparisons of patient experiences of care by race/ethnicity.
Nagarajan, N., Rahman, S., & Boss, E. F. (2017). Are there racial disparities in family-reported experiences of care in inpatient pediatrics? *Clinical Pediatrics, 56*(7), 619-626.	To evaluate the association of race with patient experience scores in an inpatient pediatric tertiary care hospital.	▪ Disparities exist in how families of racial minorities perceive the quality of care delivered to children. ▪ Families of children who belong to minority racial groups are less satisfied than families of White children with respect to family-centered care, patient-provider communication, and cultural competence. ▪ Training can help providers acknowledge and overcome racial biases that may exist in the ways they treat minority patients and their families.
[*] Agency for Healthcare Research and Quality (2016). *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*.	To provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different	▪ Disparities related to race persist among measures of quality (e.g., patient-centered care, effective treatment, healthy living, patient safety, care coordination, care affordability) and access (e.g., having health insurance, having a usual source of care, encountering difficulties when seeking care, receiving care as soon as wanted), although disparities in access tend to be more common.

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	racial, ethnic, and socioeconomic groups.	▪ Person-centered care disparities are common, especially for Hispanics. ▪ From 2002 to 2013, the percentage of adults who reported poor communication with their health providers significantly decreased overall and among all racial/ethnic (i.e., White, Black, Hispanic) groups. ▪ Blacks and Hispanics are more likely than Whites to report poor communication with their health providers.
[*] Elliott, A. M., Alexander, S. C., Mescher, C. A., Mohan, D., & Barnato, A. E. (2016). Differences in physicians' verbal and nonverbal communication with black and white patients at the end of life. *Journal of Pain and Symptom Management, 51*(1), 1-8.	To test whether hospital-based physicians use different verbal and/or nonverbal communication with black and white simulated patients and their surrogates.	▪ Hospital-based physicians have similar verbal communication behaviors when discussing end-of-life care for otherwise similar black and white patients, but exhibit significantly fewer positive, rapport-building nonverbal cues with black patients. ▪ Fewer positive, rapport-building nonverbal cues could contribute to family members' choosing more aggressive treatment for critically and terminally ill black patients if they perceive less availability, attention, warmth, encouragement, respect, understanding, empathy, and affiliation from the provider.
Figueroa, J. F., Zheng, J., Orav, E. J., & Jha, A. K. (2016). Across US hospitals, Black patients report comparable or better experiences than White patients. *Health Affairs (Millwood), 35*(8), 1391-1398.	To compare Blacks' and Whites' responses on HCAHPS measures of overall hospital rating, communication, clinical processes, and hospital environment.	▪ Across U.S. hospitals, Blacks report comparable or even better patient experience than Whites. These differences vary somewhat by educational status, with wider racial gaps among patients with lower levels of education than those with more education. ▪ Black patients generally report more positive experiences with both physicians and nurses than White patients. ▪ Whites are less satisfied than Blacks with the level of quietness of the hospital, suggesting they may have different expectations for hospital quietness. ▪ Minority-serving hospitals have lower performance than other hospitals on patient experience of care for both Blacks and Whites. Such hospitals may lack the resources or technical skills needed to provide patient-centered care to the extent of other hospitals.
Mayer, L. A., Elliott, M. N., Haas, A., Hays, R. D., & Weinick, R. M. (2016). Less use of extreme response options by Asians to standardized care scenarios may explain some racial/ethnic differences in CAHPS scores. *Medical Care, 54*(1), 38-44.	To explore whether lower Extreme Response Tendency (ERT) is observed for Asians compared to Whites in response to standardized vignettes depicting patient experiences of care, and whether ERT might, in part, explain Asians reporting less high-quality care than Whites.	▪ Asians' reports of less high-quality experiences with care than Whites may be due in part to differences in response tendency between the groups. ▪ Asians exhibit lower ERT than Whites in response to standardized scenarios, strengthening existing evidence that Asians may exhibit less ERT than Whites when reporting on their patient experience. ▪ Because CAHPS data are predominantly near the positive end of the scale, the lower ERT observed in Asian respondents may partially explain the lower mean CAHPS scores observed for Asians overall. ▪ CAHPS scores by Asians are often >4 points lower than those of Whites on a 0–100 scale, so in addition

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		to differences in scale use, true disparities in patient experience for Asians may also exist.
Martino, S. C., Elliott, M. N., Hambarsoomian, K., Weech-Maldonado, R., Gaillot, S., Haffer, S. C., & Hays, R. D. (2016). Racial/ethnic disparities in Medicare beneficiaries' care coordination experiences. *Medical Care, 54*(8), 765-771.	To investigate the extent to which racial/ethnic disparities exist in the receipt of coordinated care by Medicare beneficiaries.	▪ Racial/ethnic minority group members experience more problems with their care coordination than non-Hispanic Whites, potentially increasing their risk of hospital readmissions, confusing and conflicting care plans, medical errors, and adverse health outcomes. ▪ Hispanic, Black, and Asian/Pacific Islander (API) beneficiaries report that their personal doctors have medical records and other relevant information about their care significantly less often than non-Hispanic White beneficiaries. ▪ Hispanic, Black, and API beneficiaries report significantly greater difficulty getting timely follow-up on test results than non-Hispanic White beneficiaries. ▪ Hispanic and Black beneficiaries report that help is provided in managing their care significantly less often than non-Hispanic White beneficiaries. ▪ API beneficiaries report that their personal doctors discuss their medications and have up-to-date information on care from specialists significantly less often than non-Hispanic White beneficiaries.
[*] Riley, P., Hayes, S. L., & Ryan, J. (2016, July 15). Closing the equity gap in health care for black Americans. *The Commonwealth Fund*.	To describe the health care disparities that exist for black Americans.	▪ On average black Americans experience worse access to care, lower quality of care, and poorer health outcomes than the nation as a whole. ▪ Black Americans remain more likely to be uninsured than Whites, which may lead to problems accessing and affording care. ▪ Health care facilities that treat large shares of minority patients may face greater challenges in providing high-quality care than those that do not. It is critical to ensure that these providers have adequate financial and technical support to be able to improve the quality of care and offer services that address the physical, behavioral health, and social needs contributing to poor health outcomes among black Americans.
Sweeney, C. F., Zinner, D., Rust, G., & Fryer, G. E. (2016). Race/ethnicity and health care communication: does patient-provider concordance matter? *Medical Care, 54*(11), 1005-1009.	To examine the effect of patient-provider race/ethnicity concordance on patient-reported provider communication quality.	▪ Because of the racial and ethnic makeup of US health care providers, white, non-Hispanic clinicians attend to the needs of more minorities than do minority health professionals. Thus, some patients who might prefer a minority provider still may not have sufficient access for that arrangement. ▪ Minorities may seek the services of minority providers, but they are not more satisfied with the patient-provider communication experience than when in race-discordant provider arrangements.

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[*] Health Research & Educational Trust. (2015). *Diversity in Health Care: Examples from the Field*.	To highlight diversity initiatives at six hospitals across the U.S.	▪ Increasing diversity and inclusion cannot be accomplished by one department. It must be embedded system-wide so that all leaders are held accountable for driving and sustaining it. ▪ Leaders set the tone for promoting diversity and cultural competence by modeling respectful behavior and recruiting a diverse team. ▪ It is critical to invest in the development and management of diverse talent, increasing the likelihood of retaining diverse employees. ▪ Cultural competency training should be part of orientation for all employees; additional training in relevant topics and by specialized disciplines should also be provided. ▪ Establishing a Diversity Leadership Council can help to increase the diversity of senior executive staff and board members.
Smith, L. M., Anderson, W. L., Kenyon, A., Kinyara, E., With, S. K., Teichman, L., Dean-Whittaker, D., & Goldstein, E. (2015). Racial and ethnic disparities in patients' experience with skilled home health care services. *Medical Care Research and Review, 72*(6), 756-774.	To examine the effects of race and ethnicity on patients' experience of care with skilled home health services.	▪ Although patient experience of care is generally high across all groups, minority groups are somewhat less satisfied with the overall process of how skilled home health care is delivered. ▪ Asian non-Hispanic patients consistently reported the poorest experience with home health care of all minority groups. The next largest reported differences were for Native Hawaiian/Other Pacific Islander non-Hispanic, American Indian non-Hispanic, and patients of multi-race or unknown race. ▪ Although patient experience with home health care is high across patient groups, the consistent lower ratings by some non-White patient groups may suggest the need for greater cultural competency among all home health agency staff members. ▪ Minority patients may have different expectations for care than White patients. Some home health agencies may not be well-equipped to recognize and meet these expectations.
Zickmund, S. L., Burkitt, K. H., Gao, S., Stone, R. A., Rodriguez, K. L., Switzer, G. E., Shea, J. A., … Fine, M. J. (2015). Racial differences in satisfaction with VA health care: A mixed methods pilot study. *Journal of Racial and Ethnic Health Disparities, 2*(3), 317-329.	To investigate the possible underlying reasons for racial differences in VA health care patient experience between African Americans and Whites.	▪ African Americans are less satisfied with some aspects of their VA health care than Whites. ▪ Poor trust in medical providers is an important issue for African Americans. ▪ When prompted to share concerns with care, some African Americans note experiences of racial profiling and perceived denial of treatment based on race. ▪ Concerns related to provider distrust, feelings of disrespect, and stigmatization suggests that perceptions of discrimination may contribute to racial differences in patient experiences of care.

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Hausmann, L. R., Gao, S., Mor, M. K., Schaefer, J. H. Jr., & Fine, M. J. (2014). Patterns of sex and racial/ethnic differences in patient health care experiences in US veteran affairs hospitals. *Medical Care, 52*(4), 328-335.	To compare inpatient experiences by gender and race/ethnicity within and between VA hospitals.	▪ Male, black, and Hispanic patients treated in VA hospitals report more positive experiences than female and white patients at the same facilities. ▪ Less positive experiences are reported by patients overall in hospitals that serve larger populations of women and racial/ethnic minorities. ▪ Efforts to ensure equitable experiences across racial/ethnic groups should focus on VA inpatient facilities serving higher proportions of black and Hispanic patients.
Hodge, D. R., Sun, F., & Wolosin, R. J. (2014). Hospitalized Asian patients and their spiritual needs: Developing a model of spiritual care. *Journal of Aging and Health, 26*(3), 380-400.	To examine the relationship between addressing the spiritual needs of hospitalized Asians and their overall patient experience of care.	▪ The relationship between older Asians' spiritual needs and overall patient experience is fully mediated by five variables: nurses, physicians, the discharge process, visitors, and the admissions process. ▪ Nurses, physicians, and social workers administering the discharge process play a critical role in the process of effectively addressing older Asians' spiritual needs. ▪ Providers can enhance care by working collaboratively with family members and other visitors to address patients' spiritual and medical needs.
Delphin-Rittmon, M. E., Andres-Hyman, R., Flanagan, E. H., & Davidson, L. (2013). Seven essential strategies for promoting and sustaining systemic cultural competence. *The Psychiatric Quarterly, 84*(1), 53-64.	To offer seven essential strategies to promote and sustain organizational and systemic cultural competence.	▪ Seven strategies to promote and sustain organizational and systemic cultural competence: 1. Provide executive-level support and accountability (e.g., institute accountability strategies for ensuring multicultural change) 2. Foster patient, community, and stakeholder participation and partnerships (e.g., hire peer and community members as staff) 3. Conduct organizational cultural competence assessments (e.g., conduct patient experience assessments, as well as assessments of patient performance and outcome data based on race, ethnicity, and gender) 4. Develop incremental and realistic cultural competence action plans (e.g., convene a workgroup comprised of executive level staff, patients, etc. charged with developing and overseeing the implementation of the agency cultural competence action plan) 5. Ensure linguistic competence (e.g., post signs and disseminate information about the availability of trained interpreters, bilingual/bicultural staff, and other linguistic support services) 6. Diversify, develop, and retain a culturally competent workforce (e.g., institute ongoing cultural competence education and training for staff at all levels of the agency) 7. Develop an agency or system strategy for managing staff and patient grievances (e.g., hire bilingual/bicultural staff to assist with the grievance reporting and resolution process)

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Study	Objective	Conclusion
Hausmann, L. R., Gao, S., Mor, M. K., Schaefer, J. H. Jr., & Fine, M. J. (2013). Understanding racial and ethnic differences in patient experiences with outpatient health care in Veterans Affairs medical centers. *Medical Care, 51*(6), 532-539.	To investigate racial/ethnic differences in outpatient health care experiences within and between VA medical facilities.	▪ There are significant differences in both negative and positive experiences of outpatients treated in VA medical facilities across multiple domains of health care, with unique patterns for each minority group. ▪ The unique pattern of findings across racial/ethnic minority groups suggests that different strategies are needed to ensure that patients of all racial/ethnic groups have positive experiences. ▪ The between-facility differences for black and Hispanic patients indicate the need for targeted efforts at facilities with high proportions of black and/or Hispanic patients.
[*] Health Research & Educational Trust. (2013). *Becoming a Culturally Competent Health Care Organization*.	To explore the concept of cultural competency and offer recommendations for improving cultural competency in health care organizations.	▪ Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from patients, increased participation from the local community, lower costs, and fewer care disparities. ▪ Hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education, and to help eliminate racial and ethnic disparities in care. ▪ The steps to becoming culturally competent begin with understanding the background of the community and patient population, the effect that cultural influences have on care delivery, and the skills needed by clinicians and staff.
[*] American Hospital Association, Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems (2012). *Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned*.	To identify best practices for increasing the collection and usage of race, ethnicity, and language preference (REAL) data; increasing cultural competency training for clinicians and support staff; and increasing diversity in governance and management.	▪ To ensure accuracy of REAL data, ask patients to self-report their information or train staff using scripts to have appropriate discussions regarding patients' cultural and language preferences during the registration process. ▪ Leverage the diversity of the existing workforce by providing additional training opportunities for bilingual staff to improve their abilities to communicate medical information and education to patients. ▪ Set measurable goals for increasing the percentage of diverse candidates who interview for and fill positions in leadership and governance.
Cox, E. D., Nackers, K. A., Young, H. N., Moreno, M. A., Levy, J. F., & Mangione-Smith, R. M. (2012). Influence of race and socioeconomic status on engagement in pediatric primary care. *Patient*	To understand the association of race/ethnicity with engagement in pediatric primary care and to examine how any racial/ethnic disparities are influenced by socioeconomic status.	▪ Engagement during pediatric visits differs by the family's race/ethnicity. For example: – Asian families experience less relationship-building by their physicians – Latino families engage in less information-gathering – African American families engage less in decision-making

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Education and Counseling, 87(3), 319-326.		▪ Differences in engagement during pediatric visits are eliminated by accounting for socioeconomic status. ▪ Effective targeting of interventions to reduce health disparities through improving engagement will need to focus beyond race/ethnicity alone to consider the influence of other factors such as disadvantaged status among minority families.
Weech-Maldonado, R., Elliott, M., Pradhan, R., Schiller, C., Hall, A., & Hays, R. D. (2012). Can hospital cultural competency reduce disparities in patient experiences with care? *Medical Care, 50*(Supplement), S48-S55.	To examine the relationship between hospital cultural competency and inpatient experiences with care.	▪ Hospitals with greater cultural competency have better HCAHPS performance for doctor communication, hospital rating, and hospital recommendation. ▪ Greater hospital cultural competency may improve overall patient experiences, but may particularly benefit minorities in interactions with nurses and staff. ▪ Improved cultural competency may not only serve longstanding goals of reducing racial/ethnic disparities in inpatient experience, but may also contribute to general quality improvement.

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[*] Berkowitz, R. L., Phillip, N., Berry, L., & Yen, I. H. (2018). Patient experiences in a linguistically diverse safety net primary care setting: Qualitative study. *Journal of Participatory Medicine, 10*(1).	To help understand the impact of language on patient experience.	▪ English-, Mien-, and Spanish-speaking patients emphasize the importance of a high-quality relationship with their doctor and staff. This includes the importance of empathetic listening, supportive explanations of health issues and treatments, and a demonstration of understanding a patient's history during a visit. ▪ Mien- and Spanish-speaking patients emphasize the importance of having an interpreter available when language concordance with a provider is not an option. However, these patients highlight the frustration of having to wait for an interpreter before they can discuss their concerns, particularly because appointment times tend to be so truncated. ▪ With respect to having to work through an interpreter, patients describe a general concern as to whether doctors and patients fully understand each other. ▪ If a physician notices a patient's lack of ability to communicate effectively about medical circumstances, the physician may inadvertently alter the way that he or she provides care, giving an impression of impatience or lack of concern. This can have a detrimental effect on patient experience as it leaves the patient feeling as if the doctor is not actively cultivating the patient-provider connection.
[*] Ahmed, S., Lee, S., Shommu, N., Rumana, N., & Turin, T. (2017). Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis. *Patient Experience Journal, 4*(1), 122-140.	To provide a summary of communication barriers that may arise between physicians and immigrant patients, and the effects of these barriers on quality of care.	▪ Physician communication with immigrant patients may take extra time to ensure appropriate information is provided and that there is a reasonable level of understanding achieved by the patient. Consequently, physicians may choose more direct communication with immigrant patients, rather than choosing open conversation and shared decision making. ▪ It can be challenging for immigrant patients when physicians lack knowledge of their culture. For many immigrant patients, a power differential exists between the physician and the patient, which results in a lack of open and free communication unless prompted by the physician. ▪ Immigrant patients believe that, due to their limited language proficiency, physicians will be less likely to understand their concerns.
Collins, R. L., Haas, A., Haviland, A. M., & Elliott, M. N. (2017). What matters most to whom: Racial, ethnic, and language differences in the health care experiences most important to patients, *Medical Care, 55*(11), 940-947.	To determine whether the aspects of health care most important to patients differ according to patient race, ethnicity, and language preference.	▪ Improvements in doctor communication have the greatest potential to improve patient experience among whites, English-preferring Hispanics, and African Americans. ▪ The greatest improvement for the broadest set of patients is likely to be achieved by addressing access issues (i.e., getting needed care and getting it quickly). ▪ There are cultural differences in beliefs and expectations regarding care, so tailoring quality improvement

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		interventions based on patient characteristics may have greater utility than a one-size-fits-all approach.
[*] Heath, S. (2017, September 26). Addressing language barriers in patient-provider communication. *Patient Engagement HIT.*	To discuss how language barriers can hinder patient-provider communication.	▪ Language barriers put about nine percent of the US population at risk for an adverse patient safety event. ▪ Language barriers keep patients from engaging in seamless conversations with their doctors, and interacting with the health care industry at large. ▪ An attending physician who does not share the same language as the patient must still focus on how he or she delivers care. Non-English-speaking patients still look for compassion from their providers, and clinicians must offer that using body language and non-verbal cues. ▪ Interpreters must be trained in medical interpreting, HIPAA privacy regulations, as well as the key interpersonal aspects of the patient-provider relationship. Each of these factors are essential to improving the patient experience even for those patients experiencing language barriers.
Parker, M. M., Fernández, A., Moffet, H. H., Grant, R. W., Torreblanca, A., & Karter, A. J. (2017). Association of patient-physician language concordance and glycemic control for limited-English proficiency Latinos with type 2 diabetes. *JAMA Internal Medicine, 177*(3), 380-387.	To evaluate changes in risk factor control among limited-English proficiency (LEP) Latinos with diabetes who switched from language-discordant (i.e., English-only) primary care physicians (PCPs) to language-concordant (i.e., Spanish-speaking) PCPs or vice versa.	▪ Health systems caring for LEP Latinos with diabetes may improve glycemic control by facilitating language-concordant care, even if it means switching PCPs. ▪ The prevalence of glycemic control among LEP Latinos with diabetes improves when they switch from a language-discordant to a language-concordant PCP. ▪ There are several compelling non-clinical reasons for providing language-concordant care when possible, including increased patient satisfaction and facilitating communication.
Balakrishnan, V., Roper, J., Cossey, K., Roman, C., & Jeanmonod, R. (2016). Misidentification of English language proficiency in triage: Impact on satisfaction and door-to-room time. *Journal of Immigrant and Minority Health, 18*(2), 369-373.	To investigate the impact of language discordance on ED door-to-room time and patient experience.	▪ In triage, nurses frequently misclassify patients' language proficiency, and formal interpreter services are rarely used. This impacts patient experience and nursing satisfaction with the triage encounter. ▪ Patients themselves may play a role in this misunderstanding. They may be reluctant to admit they have limited English proficiency because of the stigma of being less educated or an immigrant. Patients may also perceive they may receive worse medical care because of their language.

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[*] Stoneking, L. R., Waterbrook, A. L., Garst Orozco, J., Johnston, D., Bellafiore, A., Davies, C., Nuño, T., … Adamas-Rappaport, W. (2016). Does Spanish instruction for emergency medicine resident physicians improve patient satisfaction in the emergency department and adherence to medical recommendations? *Advanced in Medical Education and Practice, 7,* 467-473.	To determine if integrating Spanish and cultural competency into an emergency medicine residency curriculum improves patient experience and adherence to medical recommendations in Spanish-speaking ED patients with limited English proficiency.	▪ Incorporating Spanish language and cultural competency into residency training has an overall beneficial effect on patient experience in Spanish-speaking patients with limited English proficiency. ▪ Spanish language and cultural competency residency training improves adherence to medical recommendations. ▪ Resident physicians feel that becoming proficient in medical Spanish improves their efficiency in the ED. It allows them to save time by not having to use interpreter phones.
Arthur, K. C., Mangione-Smith, R., Meischke, H., Zhou, C., Strelitz, B., Acosta Garcia, M., & Brown, J. C. (2015). Impact of English proficiency on care experiences in a pediatric emergency department. *Academic Pediatrics, 15*(2), 218-224.	To compare ED care experiences of Spanish-speaking, limited-English-proficient (SSLEP) and English-proficient (EP) parents, and to assess how SSLEP care experiences vary by parent-perceived interpretation accuracy.	▪ In a pediatric ED with around-the-clock access to professional interpretation, SSLEP parents report poorer experiences than EP parents with access/ coordination of care, including perceived wait times. ▪ SSLEP parents' experiences with the provision of information/education and partnership with clinicians are similar to those of EP parents. ▪ SSLEP parents who perceive poor interpretation accuracy report more problems understanding information provided about their child's illness and care.
Dunlap, J. L., Jaramillo, J. D., Koppolu, R., Wright, R., Mendoza. F., & Bruzoni, M. (2015). The effects of language concordant care on patient satisfaction and clinical understanding for Hispanic pediatric surgery patients. *Journal of Pediatric Surgery, 50*(9), 1586-1589.	To assess the effects of patient-provider language concordance on a pediatric surgery practice.	▪ In a pediatric surgery clinic, language-concordant care improves patient experience and understanding for Hispanic families in comparison to language discordant care. ▪ Beyond language translation, other communication resources such as gestures, signs, and body language establish rapport and build stronger trust between the physician and his/her patient and their family. ▪ Clearer comprehension of physician instructions could lead to better patient/family education about medical ailments, improved compliance, and more positive clinical outcomes.
Menendez, M. E., Loeffler, M., & Ring, D. (2015). Patient satisfaction in an outpatient hand surgery office: A comparison of English- and Spanish-speaking patients. *Quality Management in Health Care, 24*(4), 183-189.	To compare patient experience with hand surgery office visits between Spanish- and English-speaking patients.	▪ Spanish-speaking patients are less satisfied than English-speaking patients with hand surgery office visit care. ▪ Spanish speakers report more dissatisfaction with provider communication (e.g., surgeon not listening carefully) and with both the time spent in the waiting room and the time the surgeon spent with them.

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Study	**Objective**	**Conclusion**
[*] Hines, A. L., Andrews, R. M., Moy, E., Barrett, M. L., & Coffey, R. M. (2014). Disparities in rates of inpatient mortality and adverse events: Race/ethnicity and language as independent contributors. *International Journal of Environmental Research and Public Health, 11*(12), 13017-13034.	To investigate inpatient mortality rates and obstetric trauma for self-reported speakers of English, Spanish, and languages of Asia and the Pacific Islands (API), and to compare the quality of care by language with patterns by race/ethnicity.	▪ Speaking a non-English principal language and having a non-White race/ethnicity does not place patients at higher risk for inpatient mortality; the exception is significantly higher stroke mortality for Japanese-speaking patients. ▪ Patients who speak API languages—or who have API race/ethnicity—have higher risk for obstetric trauma than English-speaking White patients. ▪ Spanish-speaking Hispanic patients have more obstetric trauma than English-speaking Hispanic patients.
Eskes, C., Salisbury, H., Johannsson, M., & Chene, Y. (2013). Patient satisfaction with language-concordant care. *Journal of Physician Assistant Education, 24*(3), 14-22.	To describe the level of satisfaction of Spanish-speaking patients with health care providers based on their ability to provide language-concordant care.	▪ Spanish-speaking patients whose provider speaks Spanish fluently may have better a patient experience. ▪ If a provider's ability to communicate rudimentary medical Spanish with a Spanish-speaking patient does not improve patient experience with the encounter, the patient may not be as willing to follow up with recommendations from the provider or take medications as prescribed during that encounter.
[*] Betancourt, J. R., Renfrew, M. R., Green, A. R., Lopez, L., & Wasserman, M. (2012). *Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals. Agency for Healthcare Research and Quality, Publication No. 12-0041.* Rockville, MD.	To help hospital leaders better understand how to address the issue of patient safety for limited-English-proficient (LEP) and culturally diverse patients.	▪ Unaddressed language barriers put patients at high risk for adverse events. ▪ LEP patients have greater difficulty understanding discharge instructions, including how to manage their condition, take their medications, recognize symptoms that should prompt a return to care, and know when to follow up. ▪ Common causes of adverse events for LEP and culturally diverse patients include the use of family members/friends or nonqualified staff as interpreters and clinicians' use of basic language skills to "get by." ▪ To prevent high-risk scenarios (e.g., medication reconciliation, patient discharge, informed consent, ED care, surgical care) from becoming safety events: – Require the presence of qualified interpreters – Provide translated materials in the patient's preferred language – Use "teach-back" to confirm patient understanding ▪ To improve team communication when caring for LEP patients: – Identify patient's language needs – Call for an interpreter – Have interpreter present for entire encounter – Empower interpreter as a member of care team

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Study	Objective	Conclusion
Grover, A., Deakyne, S., Bajaj, L., & Roosevelt, G. E. (2012). Comparison of throughput times for limited English proficiency patient visits in the emergency department between different interpreter modalities. *Journal of Immigrant and Minority Health, 14*(4), 602-607.	To compare ED visit throughput times for limited-English proficient (LEP) families based on type of interpretation provided (i.e., in-person interpretation, remote telephonic interpretation, bilingual providers).	▪ In-person interpretation is more efficient than telephonic interpretation, resulting in shorter overall visit times. ▪ In-person interpretation significantly decreased ED throughput times for LEP visits by decreasing the time between provider evaluation and disposition. ▪ In-person interpretation may be more efficient because it provides some of the interpersonal aspects of care (e.g., expressions of empathy, visual cues, control of turn-taking processes) that are lacking in the remote nature of telephonic interpretation.
[*] Jimenez, N., Moreno, G., Leng, M., Buchwald, D., & Morales, L. S. (2012). Patient-reported quality of pain treatment and use of interpreters in Spanish-speaking patients hospitalized for obstetric and gynecological care. *Journal of General Internal Medicine, 27*(12), 1602-1608.	To determine whether interpreter use was associated with quality of acute pain treatment among Latina patients with limited English proficiency (LEP).	▪ Use of interpreters by LEP patients is associated with better patient reports on: – Quality of pain treatment – Timely response to pain needs – Perceived helpfulness of health care providers to provide pain treatment ▪ Promoting the consistent use of interpreters will improve provider-patient communication and potentially improve clinical assessment and treatment of pain. ▪ Use of interpreters may be particularly valuable to facilitate communication around pain control with obstetric LEP patients who have lower levels of education, are new to the health care system, and have poor knowledge of analgesic alternatives for labor and delivery.
Welty, E., Yeager, V. A., Ouimet, C., & Menachemi, N. (2012). Patient satisfaction among Spanish-speaking patients in a public health setting. *Journal of Healthcare Quality, 34*(5), 31-38.	To examine the differences in patient experience between English- and Spanish-speaking patients in a local health department clinical setting.	▪ Despite the availability of interpreters, differences in patient experience exist between Spanish- and English-speaking patients. ▪ Spanish-speaking patients are more likely to report problems with making appointments and less likely to report having their medical problems resolved when leaving their visit compared to English-speaking patients. ▪ Some communication problems may not be directly related to verbal interactions, but rather cultural factors that prevent Spanish-speaking patients from offering unsolicited comments or asking questions of physicians. ▪ Reporting less satisfaction with care on specific measures, but similar satisfaction with their overall care, suggests that Spanish-speaking patients may have lower expectations for their health care encounters in general.

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Study	Objective	Conclusion
Wofford, J. L., Campos, C. L., Johnson, D. A., & Brown, M. T. (2012). Providing a Spanish interpreter using low-cost videoconferencing in a community health centre: A pilot study using tablet computers. *Informatics in Primary Care, 20*(2), 141-146.	To examine the audio and video technical fidelity of iPad/ FaceTime™ software and the acceptability of using videoconferencing to provide Spanish interpreter services.	▪ Although in-person language interpretation by a certified interpreter has many advantages, there are times when a qualified interpreter is not available. ▪ Patients in this study had a positive experience with the overall quality of the videoconferencing device and the technical quality of the audio and video. They were in favor of using videoconferencing as a means of providing interpreter services during future visits. ▪ With adequate technology to deliver interpreter services, clinicians can be reassured that the quality of the clinical encounter will not be compromised.