NH AIM/ERASE Monthly Webinar
September 12, 2024

WELCOME!

- We will begin shortly
- Reminder, we will be recording this session
- Your line will be muted upon entering. Please enter comments or questions in the chat
- Julie Bosak & Stephanie Langlois will monitor the chat box and call on you to unmute yourself
- If you have trouble connecting, please email **Stephanie.E.Langlois@hitchcock.org**

To Receive CME/CNE Credit for Today's Session
Text: 833-884-3375
Enter Activity Code: 143625
Need help? **clpd.support@hitchcock.org**

CE is ONLY available for live attendance.

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September 12, 2024

REMINDERS:

- Please feel free to share the recording with colleagues and those you feel would benefit if they are unable to attend @ **www.NNEPQIN.org:** Educational Offerings | NNEPQIN
- We HIGHLY value your input. Please be sure to **complete the evaluation** that Karen Lee will send to you immediately following the webinar. It takes less than 5 minutes to complete.

AIM ALLIANCE FOR INNOVATION ON MATERIAL HEALTH
NHPQC New Hampshire Perinatal Quality Collaborative
NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK
NH DIVISION OF Public Health Services Improving health, preventing disease, reducing costs for all

"Practical approaches for language and communication access to assure high quality perinatal care"

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Today's Agenda

AIM Bundle Updates
Julie Bosak, DrPH, CNM

AIM PMHC data
Maddie Bridge

Language Communication Access and High Quality Perinatal Care
Trinidad Tellez, MD

NOTE: Todays speakers have nothing to disclose

Gender Statement

We recognize that pregnant people have a variety of gender identities. There may be gendered language in this presentation, especially when citing other sources but the content of this presentation is applicable to all pregnant people.

A quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes and save lives.

AIM

ERASE MM
Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

CDC works with MMRCs to improve review processes that inform recommendations for preventing future deaths.

https://saferbirth.org/

https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html

Critical Collaborations: NNEPQIN/NHPQC, ERASE and AIM

Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in care

Maternal Mortality Review Committees conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts

Perinatal Quality Collaboratives mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies

Created from a Centers for Disease Control, Division of Reproductive Health source

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REVIEW to ACTION
WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

Improve policies related to language access for all aspects of patient care, communication and coordination between the patient and care team

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AIM PMHC data

Maddie Bridge

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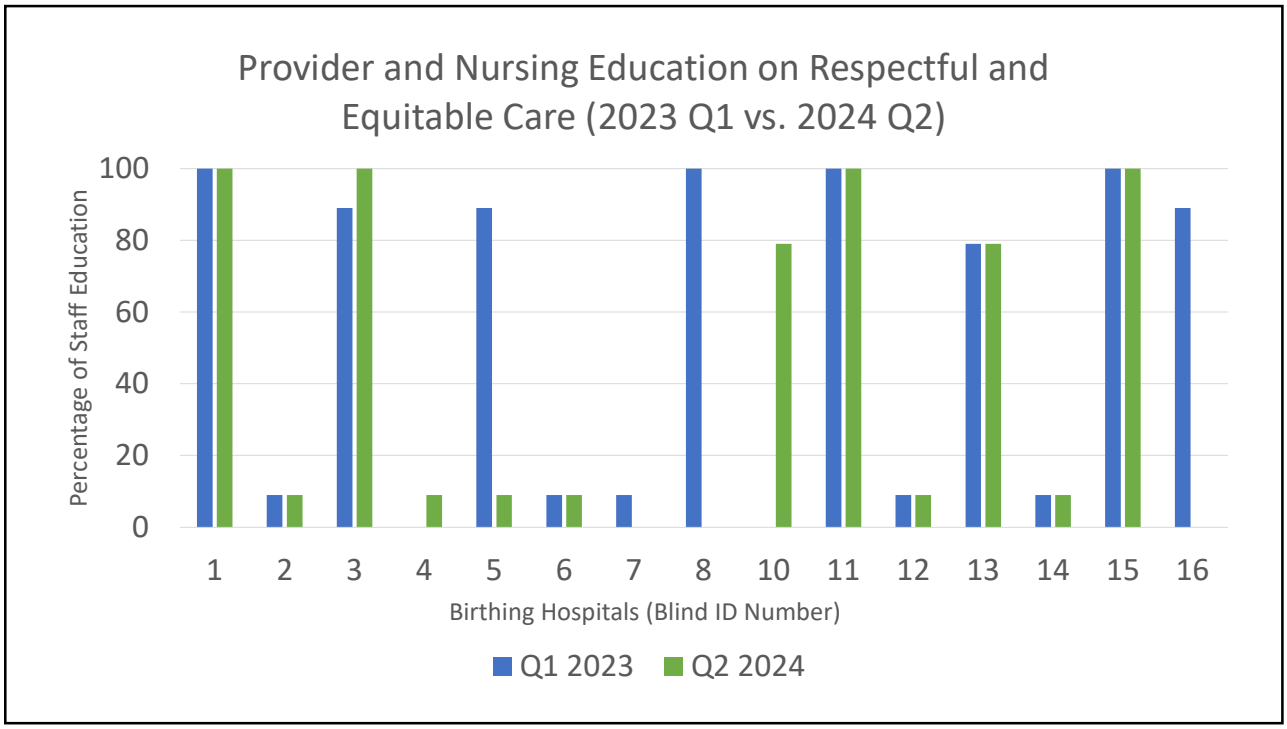
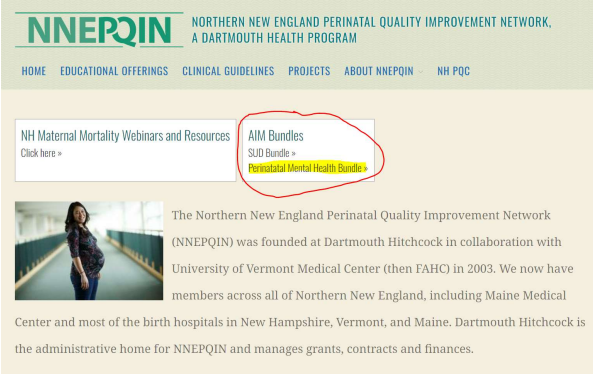
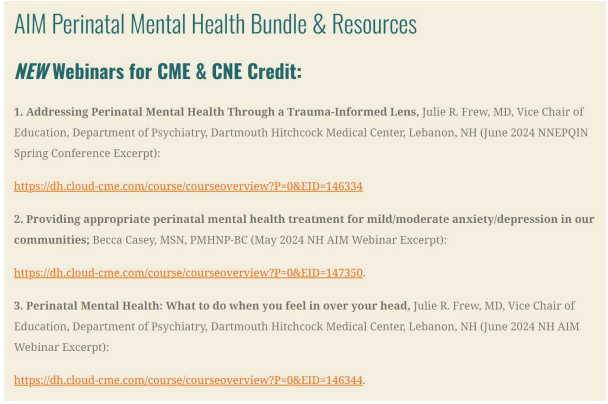


Respectful and Equitable Care Education Resources

- Goal of at least two hours every two years
- Recorded webinars for CME and CNE credit available on NNEPQIN website
  - We are able to help you track participants through this option
- Attend monthly AIM/ERASE Maternal Mortality webinars
  - We are able to help you track participants through this option
- Self-directed learning, journals

NNEPQIN Website Navigation





PMHC P2 Measure Clarification

Sample patient charts or report for all patients:

Denominator: All pregnant and postpartum people during their birth admission, whether from sample or entire population

Numerator: Among the denominator, those with documentation of having received verbal and written education on perinatal mental health conditions and when to seek care before discharge

- If PMHC patient education is well-integrated in your discharge process, the answer should be 100% of your quarterly birth volume
- If PMHC patient education is not yet integrated for every patient's discharge, we ask that you sample ~10 patient charts to determine the number of patients who received education at discharge

Birth Certificate Surveillance QA for PMHC Plan

- Timeframe: **September 16 through September 29**
- Instructions: Keep track of how many PMHC patients deliver on your unit, and how many of those patients were referred to/received treatment
- Resources: review the June QA webinars for information on improving the accuracy of this data
- Please let **Maggie and Maddie** know if you have any questions (Margaret.A.Coleman@hitchcock.org and Madalynne.M.Bridge@hitchcock.org)
- If your hospital still needs to submit Q2 data for PMHC P2 Measure, you can perform the PMHC P2 and QA chart reviews at the same time.

Language Communication Access and High Quality Perinatal Care

Trinidad Tellez, MD

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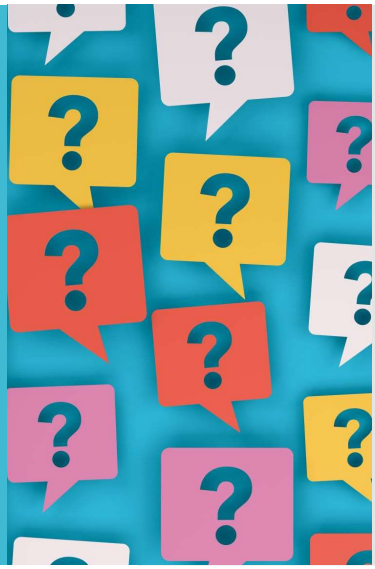
Practical approaches for language and communication access to assure high quality perinatal care:
Why, What & How

Trinidad Tellez, MD
NNEPQIN / NHPQC - AIM/ERASE Webinar
September 12, 2024



Trinidad Tellez, MD

She, Her, *Ella*

Family Physician
Community Based Health Disparities Researcher
Educator
Public Health & Health Policy Strategist
Equity Consultant

No Disclosures

Objectives

At the end of this session participants will be able to:

- Describe the *"Why"* for provision of language and communication access
- List the essential elements of language and communication access to be able to effectively care for patients
- Identify one new strategy or resource to implement in our own practice

Remember…

- This is a big content area!
- There is ALWAYS a gap between how things are *supposed* to be working and how they *actually* work in real life

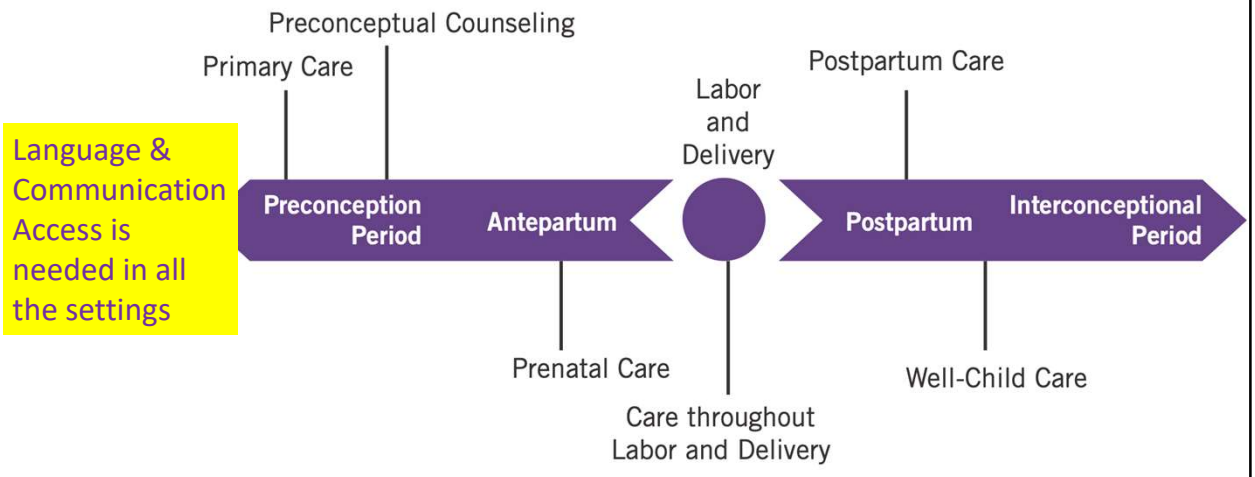
Why?

Why language & communication access in perinatal care?

Bidirectional, *effective* communication is key for good care/services…

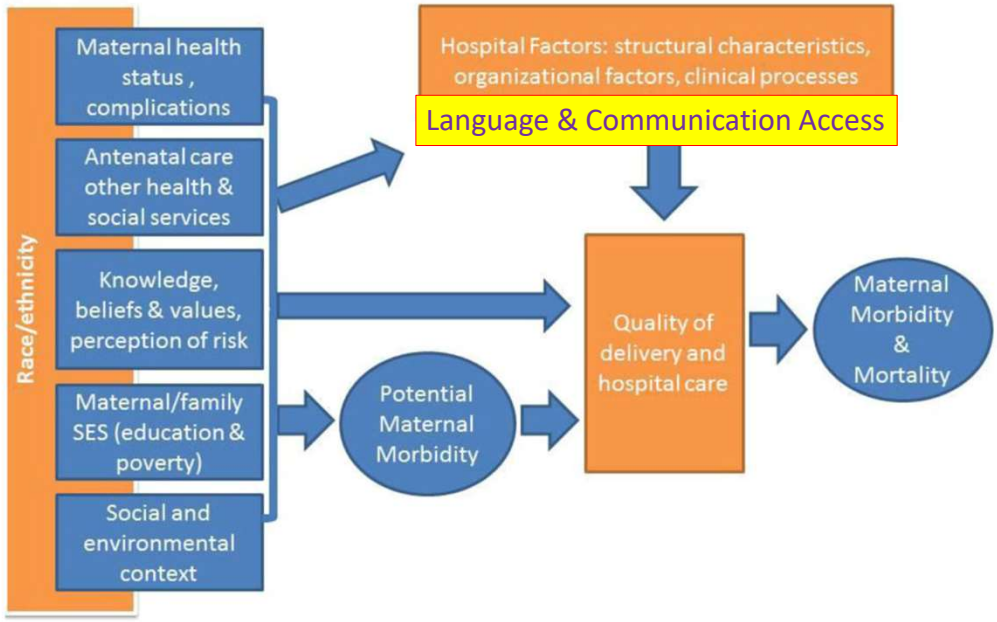
Lack of understanding ➔ Lack of quality

Clinical care in the context of a life-course perspective

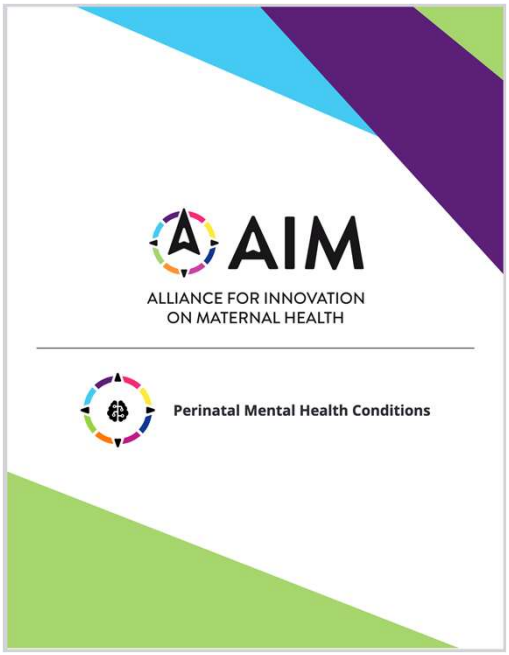


Ahmed V. Calvo, et al., Transformational Maternal and Child Health through Expanded Healthcare Coordination and Community Engagement in: *The Practical Playbook III: Working Together to Improve Maternal Health*. Edited by: Dorothy Cilenti, et al., Oxford University Press. © de Beaumont Foundation 2024. DOI: 10.1093/oso/9780197662984.003.0004
https://debeaumont.org/news/2024/moving-from-crisis-to-collaboration-advancing-maternal-health/

Pathways Linking Hospital Organization and Quality to Disparities in Severe Maternal Morbidity and Mortality



Howell, Elizabeth A., and Jennifer Zeitlin. "Improving Hospital Quality to Reduce Disparities in Severe Maternal Morbidity and Mortality." Seminars in perinatology 41.5 (2017): 266–272. Web. https://doi.org/10.1053/j.semperi.2017.04.002



Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

Respectful Care Element	Key Points
Include each pregnant and postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team.	Patient support networks may include nonfamilial supports, such as doulas and home visitors, who should be welcomed with the pregnant or postpartum person's permission. Inclusion should involve: • Establishment of trust • Informed, bidirectional shared decision-making • Recognizing patient values and goals as the primary driver of this process • Align with health literacy, culture, language, and accessibility needs

Reporting and Systems Learning - Every Unit

Reporting Element	Key Points
Identify and monitor data related to perinatal mental health care, with disaggregation by race and ethnicity at a minimum, to evaluate disparities in processes of care. + Language	**Systems collecting and reporting quality improvement data should consider:** • Persons marginalized by racism and socioeconomic disadvantage, experience inequities at every step along the perinatal mental health care pathway especially in access to treatment. Maternity care programs should review their data, disaggregated by race, ethnicity, and payor (as surrogate for income level) to identify and address discriminatory practices. • Disaggregating data by various parameters may result in small numbers for certain subgroups which may have implications for the feasibility of data comparisons. • Participation in a state or national collaborative, if available, may be helpful for sharing data, comparing performance, and driving quality improvement. • Monitored data could include elements such as screening, linkage to treatment, hospitalization/SMM related to perinatal mental health, maternal mortality (including both pregnancy-related and pregnancy associated) related to perinatal mental health.

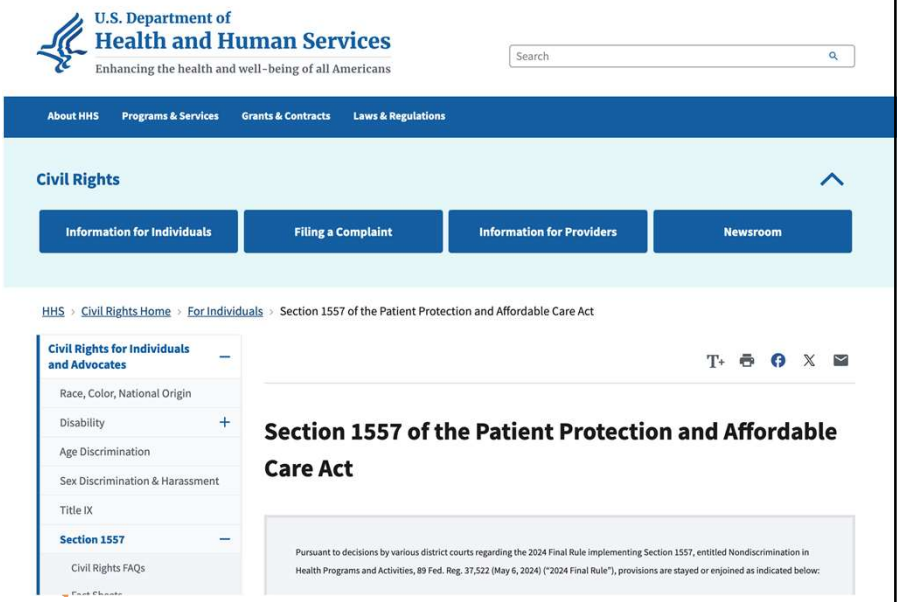
https://saferbirth.org/wp-content/uploads/R1_AIM_Bundle_PMHC-EID.pdf

It's the Law!

- Federal Civil Rights Laws
  - Title VI of the Civil Rights Act of 1964
  - Section 504 of the Rehabilitation Act of 1973
  - Americans with Disabilities Act of 1990
- State Laws and rules/regulations

April 26, 2024 – Final Rule issued for Section 1557, the non-discrimination provision, of the Affordable Care Act (ACA).

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in specified health programs or activities, including those that receive Federal financial assistance.



https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
https://www.kff.org/affordable-care-act/issue-brief/the-biden-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca/

Eight Healthcare Provider Requirements From Updated Section 1557 Nondiscrimination Rule

1. **Implement a Section 1557 coordinator** within 120 days of the effective date or by Nov. 2, 2024. The 2024 rule provides deadlines with reference to the effective date. McGuireWoods has included the anticipated dates, but these are unofficial deadlines and could be impacted by weekends, holidays and subsequent pronouncements.
2. **Implement new Section 1557 policies and procedures** within one year of the effective date or by July 5, 2025.
3. **Implement Section 1557 training** within 30 days of the new policies and procedures, and no later than one year of the effective date or July 5, 2025.
4. **Provide patients a notice of nondiscrimination** within 120 days of the effective date or by Nov. 2, 2024.
5. **Provide patients a notice of availability of language assistance services and auxiliary aids and services** within one year of the effective date or by July 5, 2025.
6. **Ensure meaningful access for individuals with limited English proficiency (LEP), which may include interpreter and translation services**, by the effective date or July 5, 2024.
7. **Ensure effective communication and accessibility for individuals with disabilities**, including the requirement to make reasonable modifications by the effective date or July 5, 2024.
8. **Identify and mitigate discrimination in the use of patient care decision support tools** within 300 days of the effective date or by May 1, 2025.

https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html and https://www.hhs.gov/civil-rights/for-individuals/section-1557/faqs/index.html

What?

Interpretation & Translation
… remember the difference!

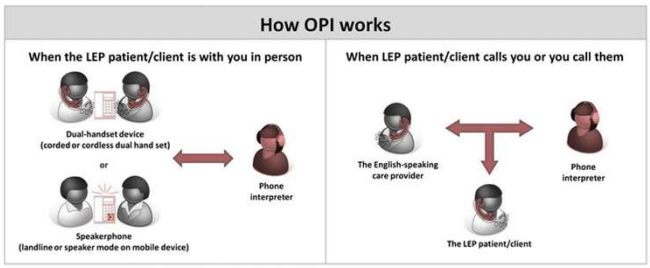
Interpretation
- Spoken Language
- American Sign Language (ASL), oral interpreter, cued-speech interpreter, or tactile interpreter

LIVE interactions

Translation
- Written Materials

Paper and virtual

Interpretation - Various modalities
- In-person
- Telephonic / Over-the-Phone Interpretation (OPI)
- Video Remote Interpretation (VRI)

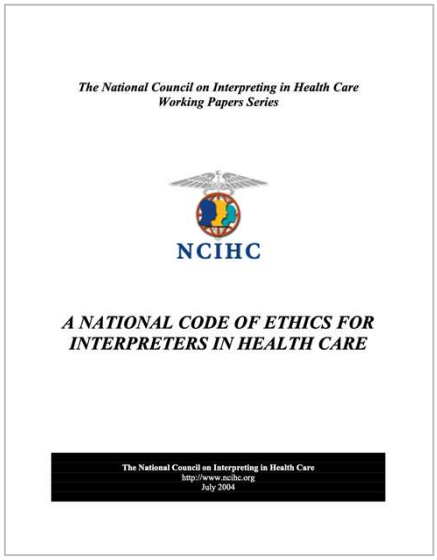


Graphic from: https://www.researchgate.net/journal/International-Journal-for-Equity-in-Health-1475-9276/publication/282036929_Shrinking_the_language_accessibility_gap_A_mixed_methods_evaluation_of_telephone_interpretation_services_in_a_large_diverse_urban_health_care_system/links/5fc3b3a792851c933f72de2f/Shrinking-the-language-accessibility-gap-A-mixed-methods-evaluation-of-telephone-interpretation-services-in-a-large-diverse-urban-health-care-system.pdf

Image from: https://www.tuftsmedicine.org/for-patients/interpreter-services

Use *Qualified* Professional Interpreters

https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Standards%20of%20Practice.pdf



https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Code%20of%20Ethics.pdf

Accommodating Communication Access Needs: Auxiliary Aids & Services

For people who are deaf, have hearing loss, or are deaf-blind

- A qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter
- Real-time captioning: CART (Communication Access Real-Time Translation) / Real-time transcription Services
- Written materials / Printed script of a stock speech
- Assistive technologies and listening devices
- Providing a qualified notetaker

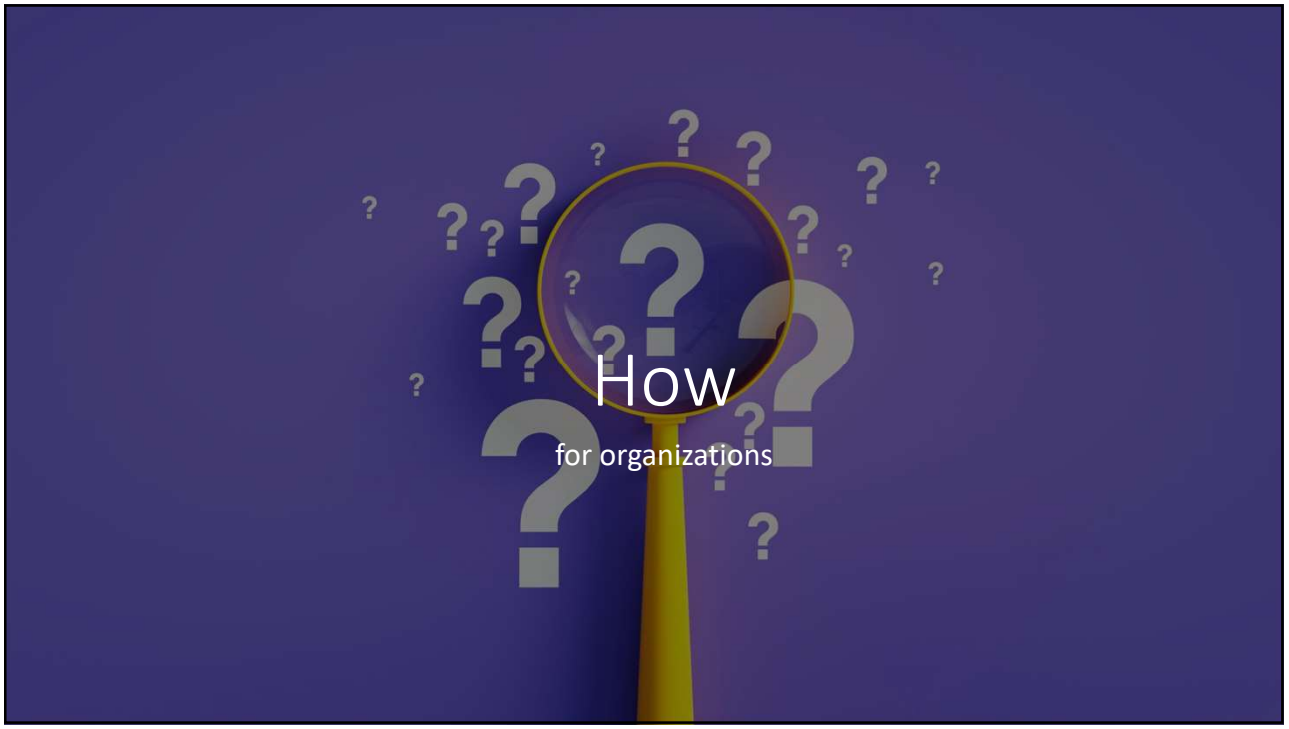
For people who are blind, have vision loss, or are deaf-blind

- Providing a qualified reader
- Accessible formats such as:
  - Large print
  - Braille
  - Electronic document for use with a computer screen-reading program
  - Audio recording of printed information

https://www.ada.gov/effective-comm.htm

Current Virtual Times: Online Meetings & Telehealth

- Spoken language interpreters
- American Sign Language (ASL)
- CART / live-captioning by qualified CART Interpreter
- Auto-Generated Transcripts
  - Note: Auto-captions *must* be verified for accuracy and are not sufficient for an accommodation request



1. Post signage – it's available & free

- "You have the right to an interpreter – at no charge"
- Signage in the most prevalent languages

2. Plan and be prepared to accommodate any communication access needs for *ALL* the people you serve – for *ALL* live interactions

Telephone, Walk-in, Virtual

- People with Limited English Proficiency (LEP) who need spoken language interpretation
- For people who are deaf, have hearing loss, or are deaf-blind who need ASL or other interpreters or CART, or other Auxiliary Aids & Services
- For people who are blind, have vision loss, or are deaf-blind who need Auxiliary Aids & Services

3. Use only *qualified* interpreters & translators

- Professional interpreters and translators are trained and abide by a professional code of conduct
  - Some have additional topical training – such mental health, infectious disease/HIV, etc.
  - Legal interpretation has additional training and requirements
  - ASL is licensed in some states
  - Certification varies by state
- Waver process if a patient/client/customer insists on using a family member or declines an interpreter

Do *not* use relatives/friends, especially minors

4. It is our responsibility to identify the need

- we should not be waiting to be told

Ask *meaningful* questions...

- "What language do you speak at home?"

  Vs.

- "What is your preferred language…?"

5. Know the most prevalent languages of your catchment area

- Know the community

Languages spoken in NH by people, age 5 and older, who **speak English *less* than "very well"** (Limited English Proficiency, LEP)

2022 data from the one-year ACS file
https://www.migrationpolicy.org/data/state-profiles/state/language/NH//

	Language Spoken at Home	Number who Speak English less than "very well" (LEP)	Percent of Total NH Household Population, Age 5 and Older
1	Spanish	14,382	1.08%
2	Chinese (including Mandarin, Cantonese)	3,286	0.25%
3	French	2,260	0.17%
4	Portuguese	1,776	0.13%
5	Vietnamese	1,018	0.08%
6	Nepali, Marathi or Other Indic Languages	883	0.07%
7	Thai, Lao, or Other Tai-Kadai Languages	670	0.05%
8	Swahili or Other Languages of Central, Eastern, and Southern Africa	646	0.05%
9	Korean	622	0.05%
10	Arabic	580	0.04%
11	Other Slavic Languages	558	0.04%
12	Russian	472	0.04%
13	Other Indo-European Languages	466	0.03%
14	German	389	0.03%
15	Tagalog (including Filipino)	386	0.03%
16	Telugu	345	0.03%
17	Gujarati	283	0.02%
18	Yoruba, Twi, Igbo, or Other Languages of Western Africa	277	0.02%
19	Japanese	268	0.02%
20	Other Languages of Asia	268	0.02%
21	Italian	222	0.02%
22	Haitian	196	0.01%
23	Polish	158	0.01%
24	Punjabi	117	0.01%
25	Ilocano, Samoan, Hawaiian, or Other Austronesian Languages	117	0.01%
26	Bengali	114	0.01%
27	Amharic, Somali, or Other Afro-Asiatic Languages	103	0.01%

Languages spoken in NH by people, age 5 and older, who **speak English less than "very well"** (Limited English Proficiency, LEP) *by* percentage of group

2022 data from the one-year ACS file

Language Spoken at Home	% of Language group who have LEP
Yoruba, Twi, Igbo, or Other Languages of Western Africa	75.30%
Haitian	74.80%
Thai, Lao, or Other Tai-Kadai Languages	70.20%
Vietnamese	61.80%
Punjabi	53.20%
Chinese (including Mandarin, Cantonese)	51.90%
Amharic, Somali, or Other Afro-Asiatic Languages	51.00%
Bengali	41.60%
Korean	40.80%
Gujarati	39.90%
Spanish	39.40%
Swahili or Other Languages of Central, Eastern, and Southern Africa	36.20%
Portuguese	31.10%
Nepali, Marathi or Other Indic Languages	30.90%
Other Languages of Asia	27.50%
Japanese	26.10%
Other Slavic Languages	24.70%
Other Indo-European Languages	23.60%
Russian	23.40%
Armenian	21.40%
Arabic	19.40%
Tagalog (including Filipino)	19.40%
Italian	18.40%
French	14.80%
Telugu	13.70%
Ilocano, Samoan, Hawaiian, or Other Austronesian Languages	13.60%
German	13.50%
Other and Unspecified Languages	11.90%
Polish	11.50%
Malayalam, Kannada, or Other Dravidian Languages	5.80%
Hindi	2.30%

https://www.migrationpolicy.org/data/state-profiles/state/language/NH//

6. Record/flag the need

- Document an individual patient's/client's preferred language
  - Demographic profile
  - Electronic Health Record alert

- This allows us to anticipate the need and be appropriately prepared…
  - *Before* an appointment
  - *Before* we mail a letter/written materials

7. Assure the language proficiency of any bilingual staff who do their job in another language

- Verify level of fluency/competence for speaking, reading and writing

- Hopefully provide a pay differential!

8. Make written materials readily available in the most common languages.

- Determine what languages
- Determine what materials: Vital documents plus more!

Translation of Written Materials

Consider which documents are "vital" documents, or those that "contain information that is critical for obtaining services and/or benefits."

Vital documents and/or health materials may include:

- Application forms including those for benefits
- Consent forms, including consent to treat, release of information, or consent to immunize
- Complaint forms
- Eligibility forms
- Financial payment policies
- Patient rights and responsibilities, including the availability of language access services as discussed in the Notices section
- Intake/information forms
- Patient instructions, including what to do in follow-up from an appointment, such as in a discharge summary, or what to do in preparation for a procedure, such as fasting prior to bloodwork

CMS Guide to Developing a Language Access Plan 2023

Remember: Do not use web-based translation for vital documents!

at this point in time

9. Have readily understandable and accessible grievance procedures

- For reporting by both patients/clients/customers as well as staff and the public
- Website, signage, handouts, etc.

10. Always seek to assess/improve: QA/QI

- You can assess it:
  - Is it present?
  - How is it offered?
  - What proportion of people get it?
  - How often are staff trained?
  - Are staff trained to work with interpreters?
  - Are all administrative staff…:
    - Screening for interpretation and communication access needs?
    - Asking respectfully?
    - Scheduling accommodations when needed?
    - Setting up alerts?

Remember: Access is more than just us providing the service, it's whether the person can actually utilize the service (or not)

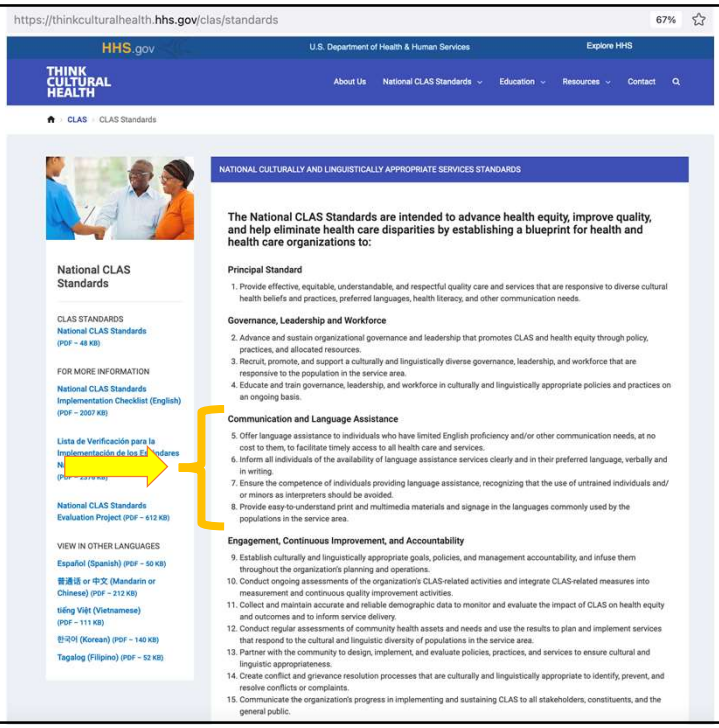
SUMMARY: How *for organizations*

Provide regular & ongoing training to ALL staff on all processes

1. Post signage – it's available & free
2. Plan and be prepared to accommodate any communication access needs for *ALL* the people you serve – for *ALL* live interactions
3. Use only *qualified* interpreters & translators
4. It is our responsibility to identify the need
5. Know the most prevalent languages of your catchment area
6. Record/flag the need
7. Assure the language proficiency of any bilingual staff who do their job in another language
8. Make written materials readily available in the most common languages.
9. Have readily understandable and accessible grievance procedures
10. Always seek to assess/improve: QA/QI

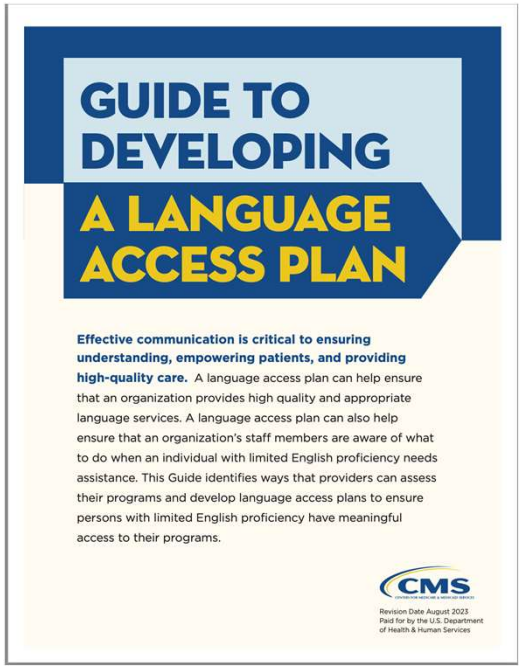
National Culturally and Linguistically Appropriate Services (CLAS) Standards

https://thinkculturalhealth.hhs.gov/clas/standards



Operationalize the CLAS Standards for
Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.



- A formal plan is now required

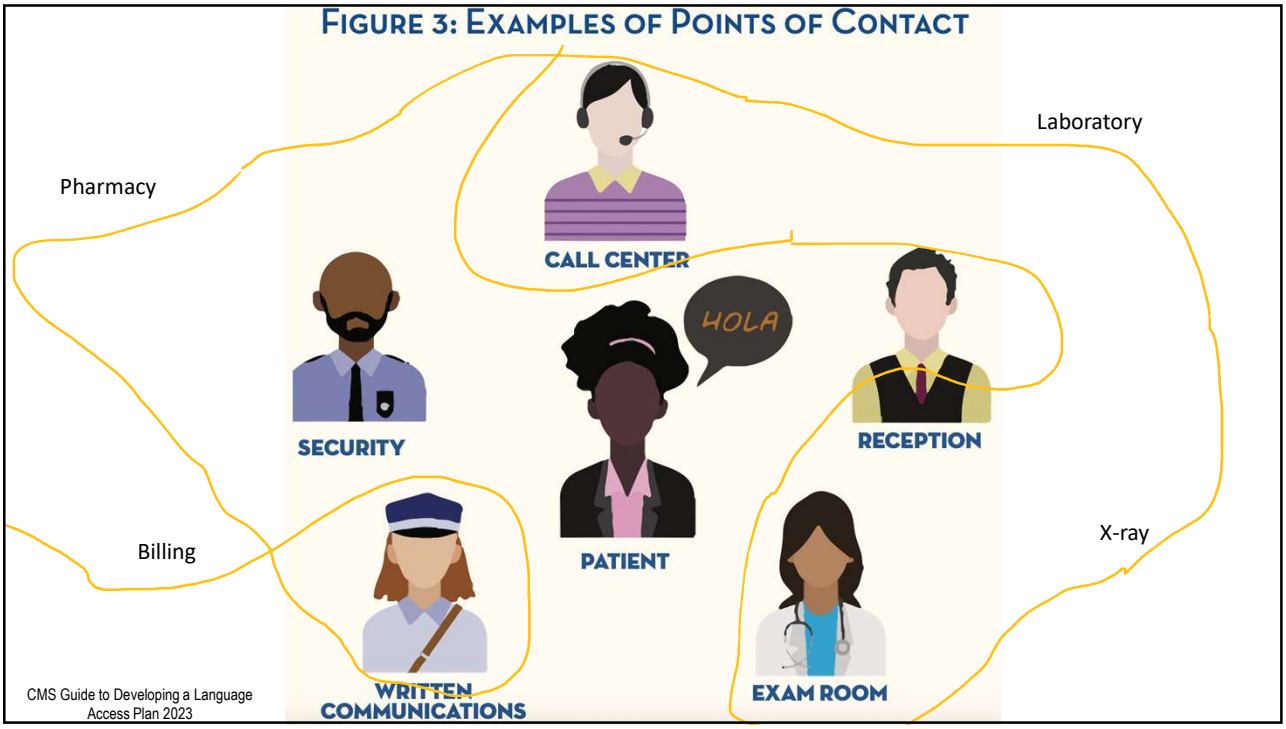
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf

Components of a Language & Communication Access Plan

NEEDS ASSESSMENT	Number of individuals with limited English proficiency
	Points of contact
	Level of interaction
	Stakeholder engagement
LANGUAGE SERVICES	Develop policies and procedures
	Interpretation services
	Translation services
NOTICES	"I speak" cards
	Patient rights
	Taglines
	Signage
TRAINING	Front-line staff
	Providers
	Leadership
EVALUATION	Monitor complaints or suggestions
	Keep current on community demographics
	Track utilization

CMS Guide to Developing a Language Access Plan 2023

FIGURE 3: EXAMPLES OF POINTS OF CONTACT



CMS Guide to Developing a Language Access Plan 2023

As an individual clinician / healthcare provider

- Learn how to determine whether a pt needs an interpreter *before* their visit
- Ensure arrangements have been made and/or you know how to access the interpreter for the visit/appointment
- If you have identified the need for an interpreter, be sure to note it in the EHR
- Always remember, interpreters & translators are qualified professionals
- Work effectively with an interpreter:
  - Converse directly with the pt, *not* the interpreter
  - Pause periodically to allow time for the interpreter to tell the pt what you said
  - Plan to huddle before encounters
  - Understand interpreters will do cultural brokering and may call a timeout for clarification; also, potentially, advocacy if they fear for the pt's safety
- AND, remember to graciously accept the presence of a trusted friend or family member while also gently insisting on the presence of the qualified, professional interpreter… the quality of your encounter depends on it!

Medicine is its own language…
Remember the importance of "translating" the concepts and knowledge so they are readily understandable

- Use plain language and avoid jargon
- *Especially when using an interpreter!*

Use QI Approach to Improvement

Resources/Examples

Open access Original research

BMJ Open **Language Access Systems Improvement initiative: impact on professional interpreter utilisation, a natural experiment**

Leah S Karliner ,[1] Steven E Gregorich,[1] Sunita Mutha,[1] Celia Kaplan,[1] Jennifer Livaudais-Toman,[1] Sarita Pathak,[2] Maria E Garcia,[1] Lisa Diamond[3]

To cite: Karliner LS, Gregorich SE, Mutha S, *et al*. Language Access Systems Improvement initiative: impact on professional interpreter utilisation, a natural experiment. *BMJ Open* 2024;**14**:e073486. doi:10.1136/bmjopen-2023-073486

► Prepublication history for this paper is available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2023-073486).

Received 07 March 2023
Accepted 17 November 2023

ABSTRACT

Objectives This study aims to evaluate the Language Access Systems Improvement (LASI) initiative's impact on professional interpreter utilisation in primary care and to explore patient and clinician perspectives on professional interpreter use.

Design Multi methods: Quantitative natural experiment pre-LASI and post-LASI, qualitative semistructured interviews with clinicians and focus groups with patients post-LASI.

Setting Large, academic primary care practice.

Participants Cantonese, Mandarin, Spanish, English-speaking adult patients and their clinicians.

Intervention LASI initiative: Implementation of a clinician language proficiency test and simultaneous provision of on-demand access to professional interpreters via video medical interpretation.

Main outcome measures Quantitative: Proportion of

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Detailed categorisation of patient English and clinician non-English language skills to determine no, partial or full language concordance at primary care visits.
⇒ Use of inverse probability weighting to evaluate the impact of the Language Access Systems Improvement intervention natural experiment.
⇒ Qualitative investigation of patient and clinician perspectives and experiences with language concordance and professional interpreters to add context to the quantitative results.
⇒ High professional interpreter utilisation prior to the intervention may lead to underestimation of potential for improvement in health systems with lower utilisation.

BMJ Open: first published at 10.1136/bmjopen-2023-073486 on 4 January 2024. Downloaded fr

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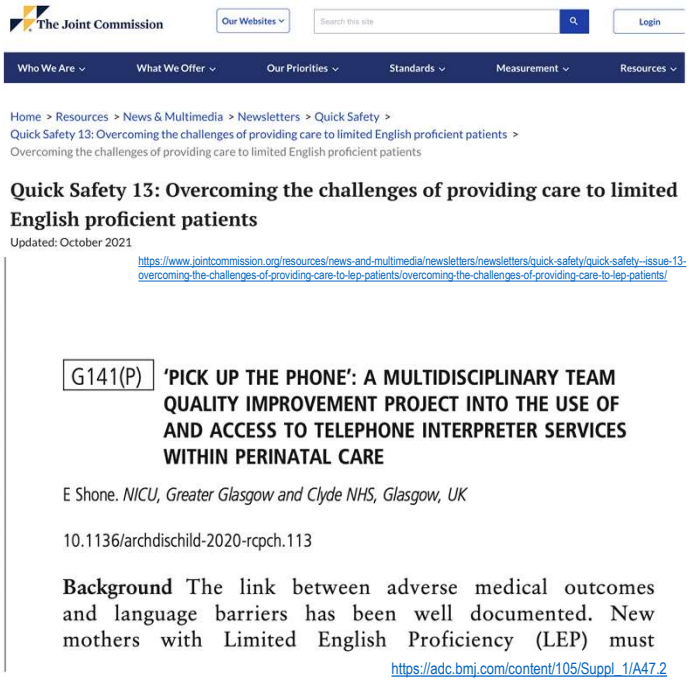

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Quick Safety 13: Overcoming the challenges of providing care to limited English proficient patients

Updated: October 2021

https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-13-overcoming-the-challenges-of-providing-care-to-lep-patients/overcoming-the-challenges-of-providing-care-to-lep-patients/

G141(P) **'PICK UP THE PHONE': A MULTIDISCIPLINARY TEAM QUALITY IMPROVEMENT PROJECT INTO THE USE OF AND ACCESS TO TELEPHONE INTERPRETER SERVICES WITHIN PERINATAL CARE**

E Shone. *NICU, Greater Glasgow and Clyde NHS, Glasgow, UK*

10.1136/archdischild-2020-rcpch.113

Background The link between adverse medical outcomes and language barriers has been well documented. New mothers with Limited English Proficiency (LEP) must

https://adc.bmj.com/content/105/Suppl_1/A47.2

Potential Respectful Maternity Care Indicators for Quality Improvement

Dignified care

1. Women treated with respect (subject to women's/local interpretation)
2. Providers introduce themselves to women
3. Women treated in a friendly manner (subject to women's/local interpretation)
4. Women called by name

Privacy and confidentiality

5. Physical privacy ensured (e.g., examined behind screens or curtains and other physical visual barriers)
6. Auditory privacy ensured (Private patient health information not heard by others)
7. Patient records and medical files are kept confidential (not accessible to people not involved in care provision)

No abuse

8. No verbal abuse (insults, intimidation, shouting, scolding, threatening)
9. No physical abuse (slapping, hitting, pushing, pinching, restraining, or otherwise beating the patient)
10. No episiotomy given or sutured without anesthesia

Autonomy

11. Providers explain to women what to expect and any medications administered, or procedures performed
12. Women give informed consent prior to procedures and examinations
13. Women and family involved in care (e.g., decision making on treatment and procedures)
14. Women allowed to assume position of choice during labor and delivery

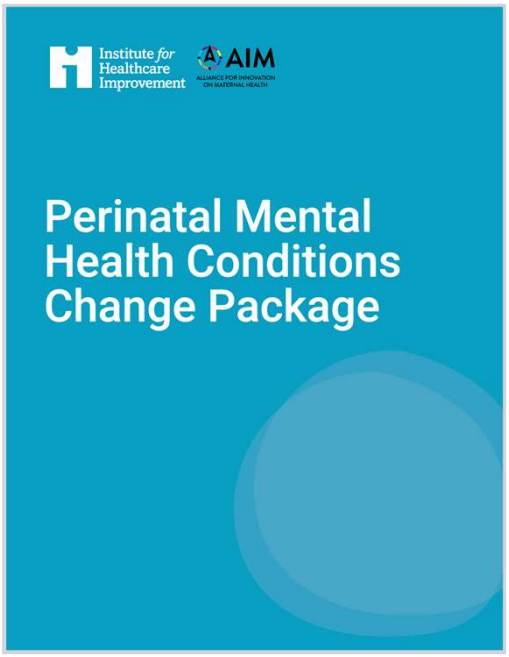
Communication

15. Women encouraged to and able to ask questions
16. Providers speaks to women in a language and at a language-level that they understand

Supportive care

17. Women allowed to have choice of companion during labor and delivery
18. Not denying women care (e.g., refusing care for any reason)
19. Not abandoning women during labor and delivery (e.g., not responding to woman's call for help)
20. Providers ask about emotional feelings and concerns of women
21. Women trust staff (subject to women's interpretation)1

A Rapid Review of Available Evidence to Inform Indicators for Routine Monitoring and Evaluation of Respectful Maternity Care
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7108935/



Respectful, Equitable, and Supportive Care

https://saferbirth.org/wp-content/uploads/Perinatal-Mental-Health-Conditions-Change-Package-Updated-May-2024.pdf

Respectful, Equitable, and Supportive Care

Change Concept	Change Idea	Key Resources and Tools
Include each pregnant and postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team	Engage patients and their families in decision making about their care at every point during prenatal visits and in the hospital, from admission through discharge, including during rounds ◊ *Provide tools and scripts for providers to use for shared decision-making conversations* * ◊	AHRQ: The SHARE Approach: 5 Essential Steps of Shared Decision Making[115]
	Facilitate open conversations to ensure that patient concerns are adequately addressed, and investigate possible causes when patients express that something is "off." Consider ways in which implicit bias and structural racism may influence response to patient concerns ◊	Centers for Disease Control and Prevention (CDC): HEAR HER Campaign Resources for Healthcare Professionals[116] Hospital Careers: 15 Bedside Manner Techniques to Improve Patient Experience[117]
	Ask patients if they would like to be accompanied by their support person for any exams, procedures, and discussions ◊ *Create and use wall signage to inform patients that they can be accompanied by their support person for any exams/procedures and discussions about their care* * ◊	
	Involve patients and families in process improvement in inpatient and outpatient settings, and co-design tools and resources ◊ *Identify opportunities for patients to share their feedback outside of formal surveys* * ◊	National Institute for Children's Healthcare Quality (NICHQ): Powerful Partnerships: A Handbook for Families and Providers Working Together to Improve Care[118] IHI: Experience-Based Co-Design of Health Care Services[119] National MCH Workforce Development Center: Successful Engagement With People Who Have Lived Experiences[120]

Respectful, Equitable, and Supportive Care

Change Concept	Change Idea	Key Resources and Tools
Engage in open, transparent, empathetic, and trauma-informed communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans	Provide communication in the patient's preferred language and support access to interpretation services; provide educational materials for patients in common languages spoken in your community ◊	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care[29]
	Educate clinicians on providing respectful care by engaging in the life-long learning of cultural humility, understanding that individuals cannot learn all aspects of any culture, including their own ◊	Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): Respectful Maternity Care Implementation Toolkit[121] ACOG Respectful Care eModules[51] The Cycle to Respectful Care: A Qualitative Approach to the Creation of an Actionable Framework to Address Maternal Outcome Disparities[122] Respectful Maternity Care and Maternal Mental Health Are Inextricably Linked[123] AIM Community Care Initiative (AIM CCI): Racial Equity Learning Series (RELS)[124]
	Talk with patients about mental health in a way that is strength-based and trauma-informed to minimize judgment and stigma ◊ Use inclusive and person-centered language ◊ *Avoid using medical jargon and abbreviations and use teach-backs to ensure that patient understands diagnosis and treatment plan* * ◊	American Psychiatric Association (APA): Stigma, Prejudice, and Discrimination Against People with Mental Illness[125]

Questions & Comments?

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NH AIM/ERASE Monthly Webinar

Next webinar: October 10th 2024

Creating comprehensive postpartum support in these challenging times

Announcements

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