

## **Appendix B-1**

### Guiding Questions for Authors

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### Assessing the Impact of Physician-Patient Communication Barriers on the Cost and Quality of Health Care

#### Guidance for Writing Analytical Briefs

Assigned Area of Interest: \_\_\_ Communications/Language Barriers in Health Care  
\_\_\_ Medical Errors and Patient Safety  
\_\_\_ Health Care Quality and Health Care Disparities  
\_\_\_ Health Economics/Cost-Benefit Studies in Health Care

The purpose of the analytical briefs is to inform the Office of Minority Health (OMH), the project team, and the project expert panel (PEP) of the nature and extent of current and recent literature and research related to the overall focus of the project and the specific products to be developed. Your initial task will be to: 1) review existing literature and research in the assigned area of interest; 2) determine whether work similar or related to the project at hand has been done and, if so, how such work might inform the tasks, processes, and products of the project; and 3) develop a brief of your findings (to be submitted in draft form to the Contractor).

The brief should not be a bibliography. Rather, the paper should represent an *analytical report* that summarizes the existing literature in the area of interest. Specific questions to be addressed in your particular brief are attached. These questions, however, are not intended as a structural framework for the report nor are they intended to limit your efforts to address other pertinent questions that may occur to you as you proceed with your review and analysis. Keep in mind, it will also be important to include an analysis of schools of thought and areas of controversy as they relate to the area of interest and the project, as well as an analysis of *gaps* in the current literature in order to inform future research.

Also, although the focus of the project, at a minimum, will be on the impacts of barriers to verbal communications between physicians and patients who speak different languages during clinical encounters, the analytical briefs should examine barriers associated with physician-patient verbal communications in general. Other types of verbal communication barriers between physicians and patients may include: lack of linguistic clarity (where physician and patient speak the same language but an unfamiliar or heavy accent impedes understanding); lack of health literacy (where health concepts conveyed by the physician are unfamiliar, unclear, or too complex for patient understanding); or physicians' use of technical language or jargon (where medical terms are used that are unfamiliar to the patient and result in diminished or total lack of understanding). Throughout the course of the project, we hope to promote an appreciation not only for the *different types* of verbal communication barriers that can occur during clinical encounters, but also for the notion that *understanding and being understood* is a critical component of health care quality.

The length of each brief will vary based on the depth and breadth of relevant literature. Because the project will be informed by the *content* of each brief rather than its length, we are hesitant to offer guidance to authors on the length of the briefs. Depending on the particular area of expertise, some briefs may be 2-3 pages and others may be 20-25 pages. Please let the literature and your analysis guide the length of your particular brief.

Please submit your completed analytical brief in draft form to Dr. Angela Ware, Project Director at COSMOS Corporation, **no later than Friday, April 4, 2003**. Upon receipt of all four briefs, the project team will disseminate the materials to all PEP members prior to the two-day meeting in the Washington, DC area. As an author, your remaining tasks will be to do a presentation of your brief at the PEP meeting and, following the meeting, to revise and finalize the brief based on feedback received from OMH, the project team, and PEP members.

If you have any questions or concerns throughout the writing process, please do not hesitate to contact Dr. Ware directly (301-215-9100, ext. 254 or aware@cosmoscorp.com).

## **COMMUNICATION AND LANGUAGE BARRIERS/ CULTURAL COMPETENCE IN HEALTH CARE**

1. What is the nature and extent of research on communication and language barriers in health care?
  - health care-related vs. non-health care related
  - verbal communications vs. written communications
  - English speakers vs. limited English speakers vs. non-English speakers
  - between patient and physician vs. patient and other health care provider or staff (e.g., pharmacists, lab technicians, nursing personnel, appointment clerks)
  - between physician-patient during clinical encounters vs. other encounters
  - related to language dissonance (different spoken languages) or limited English proficiency (LEP) vs. lack of linguistic clarity (same language but spoken with an unfamiliar or heavy accent) vs. use of technical terminology or jargon vs. lack of health literacy
  
2. What is the nature and extent of research on strategies and interventions that address communication barriers and facilitate physician-patient communications and understanding?
  - telephone language line
  - bilingual family members or friends of patient
  - untrained, bilingual non-clinical personnel (e.g., receptionist, appointment clerk, secretary, custodial staff, etc.)
  - untrained, bilingual, non-physician professional staff
  - trained non-medical interpreters (sequential and concurrent)
  - trained medical interpreters (sequential and concurrent)
  - bilingual physicians
  - patient support services to ensure understanding during and after the encounter
  
3. What evidence exists of research, programs, or interventions to promote communication/ language skills and abilities *among patients and health plan members* as well as among physicians and other health care providers?
  
4. To what extent are researchers and others working in the areas of cultural competence, communication, and/or language barriers in health care examining relationships with health care quality, health care disparities, medical errors/patient safety, or cost? What is the nature of the links/relationships? How are these links/relationships defined or determined?

## HEALTH CARE QUALITY AND DISPARITIES

1. To what extent are researchers and others working in the area of health care quality recognizing and investigating relationships with communication and language issues and barriers?
2. What is the nature and extent of research on communication/language barriers and health care quality?
  - different types of communication barriers (language dissonance vs. lack of linguistic clarity vs. use of technical terminology and jargon vs. lack of health literacy)
  - patient-physician vs patient-other health care provider or staff
  - impacts on patient access, utilization, satisfaction, etc.
  - relationship to clinical consequences and health outcomes
3. What evidence is there that communication/language barriers result in compromised quality of health care (e.g., through underuse, misuse, or overuse of clinical procedures or other aspects of care)?
4. What is the impact of communication/language barriers on the likelihood that clinical decisions are made on evidence and/or clinical guidelines?
5. How do factors (actual or perceived) associated with health care disparities, cost, liability, etc. inhibit or promote provision of quality improvement initiatives or services to address communication/language barriers in health care?

## **MEDICAL ERRORS/PATIENT SAFETY**

1. What research has been done to identify, classify, or otherwise describe various types of medical errors that can/do occur in the course of health care?
2. What, if any, taxonomies or classification schemes have been developed relative to medical errors? How are medical errors classified?
3. What efforts have been made to identify medical errors related to communication issues, including but not limited to physician-patient communication barriers (verbal and otherwise)?
4. What is the nature and extent of research related to root causes associated with various types of medical errors? Are verbal communication barriers considered a primary root cause of medical errors in current literature?
5. What strategies have been implemented in health care settings to identify and reduce various types of medical errors, particularly those that result from communication issues and barriers (verbal or written)?
6. What does the research tell us about the relationship between promoting physician-patient communication/understanding and patient safety?

## **COST-BENEFIT STUDIES IN HEALTH CARE/HEALTH ECONOMETRICS**

1. What is the nature and extent of research on direct and indirect costs associated with providing health care to limited English proficient (LEP) patients vs non-LEP patients?
2. a. What is known about the direct and indirect costs associated with the provision of linguistically appropriate services to LEP populations in the U.S. (or any patient population or language minority whose spoken language differs from the predominant language spoken in the health care setting)?
  - costs for various types of linguistically appropriate services (e.g., telephone language lines, trained non-medical & medical interpreters, bilingual physicians, etc.)
  - costs to health plans and individual providers
  - costs to LEP patients and to health plan members
  - costs to society
- b. Is there any evidence of cost *savings* and other benefits received in return for the investment in linguistically appropriate services?
3. What is known about the direct and indirect costs associated with NOT providing linguistically appropriate services to LEP populations in the U.S. (or other patient populations whose spoken language differs from that used in the health care setting)?
  - costs to health plans
  - costs to individual providers
  - costs to LEP patients
  - costs to health plan members
  - costs to society
4. What costs have been associated with various types of medical errors? What costs have been associated with medical errors associated with communication barriers, especially those between patients and their physicians (whether due to language dissonance, lack of linguistic clarity or health literacy, or use of technical terminology and jargon)?