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. **[PG]** denotes Press Ganey research.

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Study	Objective	Conclusion
[PG] Mahoney, D. (2021). New research identifies racial barriers to vaccine acceptance. *Industry Edge*.	To describe the findings of a new report on COVID-19 vaccine hesitancy and acceptance.	▪ Black/African American patients reported the lowest likelihood of accepting the COVID-19 vaccine compared with other racial segments in an analysis of more than 100,000 responses to proprietary vaccination questions on Press Ganey patient experience surveys. ▪ Low levels of confidence in the safety and effectiveness of the COVID-19 vaccine and in advice from the government influence vaccine hesitancy in Black/African American patients. ▪ Regularly collecting, segmenting, and analyzing vaccine readiness data through patient experience surveys provides the insight needed to design targeted education and outreach to address the unique needs of different patient segments and build trust in healthcare.
[PG] Press Ganey. (2020). Diversity and inclusion: Building workforce engagement and improving outcomes in healthcare. South Bend, IN: Author.	To examine the association between employee engagement and perceptions of diversity, and the influence of race, gender, and job type on that association.	▪ Clinician and employee engagement is higher when individuals believe their organization values diversity and is committed to ensuring an inclusive environment. This association is preserved across employee race, gender, and job type groupings. ▪ Because excellence across safety, quality, experience, and financial outcomes in healthcare depends on engaged and aligned team members, healthcare leaders should make diversity and inclusion an organizational priority. ▪ Healthcare leaders committed to ensuring that all employees feel engaged and supported in their work should track key diversity and inclusion metrics as part of a comprehensive improvement strategy.
[*] Takeshita, J., Wang, S., Loren, A. W., Mitra, N., Shults, J., Shin, D. B., & Sawinski, D. L. (2020). Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA Network Open*, *3*(11), e2024583.	To examine whether patient-physician racial/ethnic or gender concordance is associated with the patient experience as measured by scores on the Press Ganey Outpatient Medical Practice Survey?	▪ Patient-physician racial/ethnic concordance is associated with patients' reported experience with their physicians. ▪ Findings support the clinical benefits associated with racially/ethnically concordant patient-physician interactions, including better patient-physician communication, patient care, and outcomes. ▪ The training of underrepresented minority medical students and residents should be vigorously supported along with ensuring the promotion and retention of underrepresented minority physicians. ▪ The provision of healthcare to minority patients should not fall solely to minority physicians, so it is imperative that we also improve cultural

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Study	**Objective**	**Conclusion**
		mindfulness among all physicians so that they are prepared to care for a diverse patient population in an equitable manner.
[PG] Doyle, A. (2019). The Mount Sinai Health System targets bias through diversity, equity, and inclusion training. *Industry Edge*.	To describe a training program designed to educate leaders and staff on the impact of unconscious bias and the role that diversity, equity, and inclusion awareness plays in patient-centered care.	▪ Diversity, equity, and inclusion in healthcare can positively influence the patient experience while unconscious bias can have the opposite effect. ▪ Unconscious biases can lead to unintentional discrimination that can cause caregivers and clinicians to make poor decisions regarding the care of their patients. These decisions not only can negatively impact the patient experience but also can compromise patient safety and result in poor outcomes. ▪ Inclusion is not just about race and ethnicity. It is also about including other people's ideas and perspectives. ▪ Reinforcing the principles of diversity, equity, and inclusion—and training on how to practice self-awareness and recognize and mitigate unconscious bias—improves the patient experience and advances patient safety.
Ogbolu, Y., Scrandis, D. A., & Fitzpatrick, G. (2018). Barriers and facilitators of care for diverse patients: Nurse leader perspectives and nurse manager implications. *Journal of Nursing Management, 26*(1), 3-10.	To examine chief nurse executives' perspectives on the barriers and facilitators associated with implementing culturally and linguistically appropriate services.	▪ Chief nurse executives report the following best practices to assist with the adoption of National Standards for Culturally and Linguistically Appropriate Services (CLAS): – Patient and family advisory committees – Community outreach advocates – Mobile health vans – Specialized cultural competency programs – Nurse leader rounds – Implementation teams
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.

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Study	Objective	Conclusion
[*] Centers for Medicare & Medicaid Services (2017). *Racial and Ethnic Disparities in Healthcare 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 healthcare 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.
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 concerns 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

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		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 healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups.	▪ 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. ▪ 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.

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Study	Objective	Conclusion
[*] 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 to differences in scale use, true disparities in patient experience for Asians may also exist.

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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 healthcare for black Americans. *The Commonwealth Fund*.	To describe the healthcare 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. ▪ Healthcare 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 healthcare 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 healthcare 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 Healthcare: 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 healthcare 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 the patient experience of care is generally high across all groups, minority groups are somewhat less satisfied with the overall process of how skilled home healthcare is delivered. ▪ Asian non-Hispanic patients consistently reported the poorest experience with home healthcare 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 healthcare is high across patient groups, the consistently 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., Bayliss, N. K., Meiksin, R., Walsh, M. B., & Fine, M. J. (2015). Racial differences in satisfaction with VA healthcare: 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 healthcare patient experience between African Americans and Whites.	▪ African Americans are less satisfied with some aspects of their VA healthcare 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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Study	Objective	Conclusion
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 healthcare 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.

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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 the 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.

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Study	Objective	Conclusion
Collins, R. L., Haas, A., Haviland, A. M., & Elliott, M. N. (2017). What matters most to whom: Racial, ethnic, and language differences in the healthcare experiences most important to patients, *Medical Care, 55*(11), 940-947.	To determine whether the aspects of healthcare 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 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 healthcare 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 is 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.

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Study	Objective	Conclusion
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.
[*] Stoneking, L. R., Waterbrook, A. L., Garst Orozco, J., Johnston, D., Bellafiore, A., Davies, C., Nuño, T., Fatás-Cabeza, J., Beita, O., Ng, V., Grall, K. H., & 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.

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		▪ 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 Healthcare, 24*(4), 183-189.	To compare the 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., the surgeon not listening carefully) and with both the time spent in the waiting room and the time the surgeon spent with them.
[*] 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 a higher risk for obstetric trauma than English-speaking White patients. ▪ Spanish-speaking Hispanic patients have more obstetric trauma than English-speaking Hispanic patients.