Eight Critical Reasons to Address the Language Barrier in Healthcare
Introduction

Approximately one in every eight individuals in the United States is limited-English proficient (LEP). Unfortunately, only a small fraction of those patients receive the necessary language assistance services (LAS) due to limited resources and inadequate tools. The linguistic and cultural barrier in healthcare presents a critical issue for patients, providers, and health facilities: patients receive inferior care, providers are hamstrung, and health systems carry significant cost burden. In this ebook, we’ve examined the language barrier through a number of different lenses, introducing you to eight reasons why it is vital to prioritize solutions to this issue.

“Communication — with everything in life — is paramount. Especially in medicine. It’s the most important tool that one has. When there is a barrier — a communication barrier — and commonly, in medicine, it will be a language barrier, I feel handcuffed. I don’t feel as though I can get all of the information that I really need to have in order to provide the best patient care.”

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SCOPE & GROWTH

The scope of the language barrier is massive and future projections indicate LEP population growth at increasing rates.
The Scope of the Barrier

The global demographic makeup is becoming increasingly diverse and intermingled, accompanied by widening health disparities attributable to race, ethnicity, income, and socioeconomic factors that hinder the quality of care for language-minority communities. The LEP population has surpassed 26 million individuals speaking more than 350 languages and dialects across the US. In the New York metro area alone, over one third of the population speaks a language other than English at home; almost 200 different languages are spoken.

LEP individuals are among the most vulnerable in the population, as they are often immigrants who are uninsured or lack the cultural familiarity to effectively seek social services and healthcare resources.
Projections: The U.S. Population is Becoming Increasingly Diverse

The last two censuses show that in the last 30 years, the LEP population increased by 80%. Between 2000 and 2010, the total LEP population in the US grew by 28.8%, and the Hispanic population alone increased by 43%. In fact, the Pew Research Center reports that immigration will account for a full 82% of US population growth through 2050.

Enormous Deficit in Coverage

Only a small fraction of LEP patient encounters are adequately supported by LAS.
Reason 2

THE PATIENT

The language barrier negatively impacts the patient: one misinterpretation mistake can be deadly
“Intoxicado”

Communication barriers can have detrimental (and potentially fatal) consequences for the patient even with the misinterpretation of just one word. The tragically famous case of Willie Ramirez is indicative of this. Willie, an 18-year-old boy, was out with friends and experienced a sharp headache. Vision impaired, he drove to his girlfriend’s house and collapsed reporting that he was “intoxicado”. Upon arrival to the ED, Willie’s mother, his younger sister, girlfriend, and girlfriend’s mother communicated at different points in Spanish that Willie was “intoxicado”. The emergency room physician misinterpreted “intoxicado” to mean “intoxicated”. With the lack of understanding of medical history, Willie was misdiagnosed: the ED physician erroneously believed Willie had suffered a drug overdose, so he treated him accordingly.

“Among Cubans, “intoxicado” is kind of an all encompassing word that means there’s something wrong with you because of something you ate or drank. I ate something and now I have hives or an allergic reaction to the food or I’m nauseous...[Willie’s] mother and his girlfriend’s mother assumed that the severe headache he experienced that night was related to eating a bad hamburger at Wendy’s – that Willie was “intoxicado.” (Price-Wise, 2008)

In fact, Willie was suffering from an intracerebellar hemorrhage (which would have called for a neurosurgeon) that continued to bleed for two days. The misunderstanding of this one word and the subsequent course of action resulted in quadriplegia for the patient, and in a $71 million malpractice settlement.
The LEP Patient vs. the English-Speaking Patient

Most medical interpretation errors have clinical consequences, and errors committed by ad hoc interpreters are significantly more likely to have clinical consequences than those committed by hospital approved interpreters.

Substandard clinical dialogue between linguistically discordant patients and providers can lead to numerous negative outcomes for LEP patients, including:

- Higher readmission rates
- Misdiagnosis
- Drug complications
- Incorrect treatment
- Longer hospital stays
Reason 3

THE TOOLS

Providers feel that they cannot rely on current LAS systems and tools to successfully navigate the barrier.
Current Offerings

For many, live, in-person interpretation is not available for every LEP encounter. Providers are forced to most heavily rely on other interpretation options that are unideal. This leads to serious consequences for the patient, provider, and facility. Current offerings are:

Expensive
live interpretation can cost $1.00-2.50/min and study suggests that providers spend an average of 40.5 minutes per encounter with an LEP patient

Antiquated
current tools built on shared phone handsets, pagers, legacy video rigs

Low quality and uncoordinated
providers are dissatisfied and overwhelmingly report subpar interpretation services

Scattered and opaque
for the hospital system and language services department, silo-ed tools provide virtually zero visibility into usage and tracking

Time consuming
there's the prospect of tracking down equipment, and then interpreter
Dr. Lopez on the Challenges of Current Tools

Providers working with diverse patient populations are familiar with the challenges in accessing LAS due to inefficiencies in systems and antiquated technology. Remote phone or video interpretation is critical. With approximately 30 million LEP patients and roughly 3,000 nationally certified medical interpreters, that’s 10 thousand LEP patients per every certified medical interpreter. OPI and VRI offer solutions that scale, however, seemingly small logistical details are impactful, reducing the usefulness of these tools. Dr. Lopez sums up the cumbersome dual-handset phone process:

“Our emergency department is a square city block. So, if the translator phone is in Room 1 and I need it in Room 51, that’s a whole block that somebody has to travel: they have to find it, bring it over, plug it in.”

Dr. Bernard Lopez
Improper Practices

Insufficient tools lead to improper interpreting behavior such as using family and ad hoc interpreters. An article published in the New York Times in 2005, discussed some particularly harrowing cases of children acting as interpreters for their parents' maladies. Dr. Alice Chen, the chief medical officer for the San Francisco Health Network, stated:

“If they are the ones telling their mom she has cervical cancer, that’s a problem...I've seen kids who walk away thinking they caused it.” (California Seeks to Stop the Use of Child Medical Interpreters, 2005)

As a child, Canopy’s founder was pulled out of school by family members to interpret in medical scenarios. Recently, interviews with a group of emergency medicine (EM) residents — who rotate between hospitals in Manhattan and Queens, NY — as part of a Canopy pilot, revealed that 87% of EM residents report to rely frequently on family member or other ad hoc interpreters when working with LEP patients. This practice of using ad hoc, unqualified, staff due to resource scarcity is indicative of a system in distress, the ramifications of which are adverse events for the patient.
Reason 4

THE LAW

Language parity is the law: provision of LAS to LEP persons is regulated by federal laws and policy recommendations
Relevant Legislation Concerning LAS

To deny an LEP patient of LAS is seen as discrimination in the eyes of the law. Providers and facilities are on the hook to ensure patients receive language assistance. There are many federal laws and policy recommendations relevant to LEP patients’ rights in healthcare. Relevant legislation includes:

- Title VI of the Civil Rights Act of 1964
- HHS Policy Guidance on the Prohibition against National Origin Discrimination for LEP persons
- Dept. of Justice Guidance Regarding Prohibition against National Origin Discrimination for LEP persons
- Culturally and Linguistically Appropriate Services (CLAS) Standards for Healthcare
- Executive Order 13166
- Strategic Plan to Improve Access to HHS Programs and Activities by LEP persons
- Affordable Care Act (ACA), Section 1557
CLAS Standards

HHS's Office of Minority Health published CLAS, providing guidance to organizations for how to improve quality of care, access to care, and ultimately elevate patient health outcomes. Standards 4, 5, 6, and 7 are mandates. CLAS Standard 4 stipulates:

“Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/customer with LEP at all points of contact, in a timely manner during all hours of operation.”

Many Facilities Are Not Abiding by CLAS Standards:

A CLAS compliance survey of 135 US hospitals revealed that 13% of hospitals met all four standards, 44% met three, 16% met two, and 7% met one. That leaves 19% that did not meet a single requirement.

Despite the availability of interpreters in some hospitals, their services are often underutilized or misallocated which renders interpretation assistance difficult to find, particularly for less frequently encountered languages. The implications of this? Providers are in desperate need of tools and skills to better communicate with their patients. Facilities find themselves unable to provide the required support.
Reason 5

THE FACILITY

The language barrier negativity impacts the health facility: LEP patients represent liability and increased costs
The LEP Experience

Studies show that the LEP patient is more costly for the health facility than the English-speaking patient (by no fault of their own).

**Longer Stays**
- + 28 min in the ED (165 vs 137 min stay)
- + 4.3 days in the hospital
- 2X duration of hospitalization with an adverse event (26 vs 12.7 days)

**Increased Readmission**
- 60% more ED visits (841 vs 620)
- 50% more hospitalizations (408 vs 343)
- 24% more likely to have unplanned ED revisit within 72 hours

**Decreased Satisfaction**
- 19% less satisfied with ED care (52% vs 71% satisfied)
- 14% would not want to return to the same facility for care (vs 9.5%)

**Increased Testing**
- + $41 more tests ($145 vs $104)
Liability

Due to the complexities of providing care for LEP populations, hospitals and providers are exposed to significant risks and liabilities. For example, a study published in Annals of Emergency Medicine reported that of 57 LEP-provider interactions at two large EDs in Massachusetts, there were 1,884 documented errors, of which 18 percent had potential clinical consequences. Error types were broken down into five categories: word omissions, additions and substitutions as well as editorial comments and instances of false fluency (making up a term, “ear-o” instead of “oreja”). According to The Joint Commission, communication is consistently in the top three most frequently identified root causes of sentinel events. 80% of pediatrician respondents to a 2012 survey reported that they saw LEP patients, but a majority reported using a family member rather than a professional interpreter, despite the fact that using family members as interpreters is correlated with medical error.

UC Berkeley & the National Health Law Program (NHeLP) analyzed medical malpractice claims to identify when language barriers may have resulted in harm to the patient. In 35 claims, the Carrier paid upwards of 2 million dollars in damages or settlements and almost 3 million in legal fees.
Reason 6

DISPARITIES

The language barrier furthers health disparities for the LEP population and compromises cultural competence in care delivery
Health Disparities

Myriad factors contribute to furthering disparities in health and healthcare among different ethnicities and races. Social determinants such as low socioeconomic status, lack of access to education and lack of health insurance lead to such barriers. Sociocultural differences between patients, providers, and the system are also considered by experts to cause health disparities. These differences can influence the decision-making of the provider, impact the patient’s ability to interact effectively with the system, their recognition or understanding of clinical symptoms, their expectations from care, their threshold from seeking care, etc. In the presence of a language barrier, encounters between patient and provider that are unsupported by LAS perpetuate these disparities.
Cultural Competence

Cultural differences can cause impairment in patient provider communications. These communications are directly linked to patient satisfaction, adherence, and health outcomes. The goal of cultural competence is to improve healthcare providers’ ability to communicate effectively with patients of diverse sociocultural backgrounds to deliver equivalent quality healthcare. Effective communication across cultures is integral to providing quality care to diverse patient populations and is important to the successful transformation of the U.S. healthcare system to be patient-centered, equitable, and of high quality.

The AHRQ conducted a meta-analysis of 91 articles measuring the impact of cultural competence training on quality of care for minority patients, finding improvements in patient satisfaction in addition to providers’ attitudes, knowledge and skills. Addressing the systemic obstacles that lead to language discordant patient and provider encounters that are unsupported by LAS, is a first step towards culturally competent, patient-centered care.
The Necessity of Fostering Linguistically and Culturally Competent Physicians

With a population that is becoming increasingly linguistically and culturally diverse, it is important that academic institutions provide their scholars with the support and tools necessary to work effectively with language-minority patients. The Spanish-speaking population currently numbers 41 million in the United States. Dr. O’Dea has spearheaded the medical Spanish elective at the University of Cincinnati College of Medicine. We had the pleasure of speaking with her about the inception of the program and her perspective on the pertinence of this issue to all medical students.

Christine O’Dea, MD

Dr. Christine O’Dea is an Assistant Professor in the Department of Family and Community Medicine at the University of Cincinnati College of Medicine and the Director of Global Health Education at the Christ Hospital/University of Cincinnati Family Medicine Residency program. She is also the course director for the Medical Spanish/Latino Health Elective at the College of Medicine. Dr. O’Dea worked for two years in rural Honduras with Shoulder to Shoulder, a non-profit NGO that works in alliance with the Ministries of Health and Education and is a primary implementer of government health and education services.
An Interview with Dr. Christine O’Dea

Christine O’Dea makes a point to disseminate the pertinence of the language issue to all of her medical students:

[O’Dea]: The Spanish speaking population in the U.S. is growing. It is extremely important that we have providers that are competent both linguistically and culturally to work with Latino populations.

Q [Canopy]: How relevant is this issue if I’m a practitioner outside of a major metropolitan area?

A [O’Dea]: One point I often mention is that there are Spanish speaking people in every corner of the United States, and so if you think this is something that you don’t need because you’re going to Iowa or someplace where you think there is no one who speaks Spanish, you’re wrong. When I worked in Northern Wisconsin, we had a large group of Spanish speaking patients — immigrants from Mexico — and there were no providers that spoke Spanish. So, it’s really in the issue that is affecting all of us not just providers in certain states and certain border areas - it’s really all of us that need to be prepared for this.

Q [Canopy]: How do you address this issue with your students?

A [O’Dea]: Our providers have learned Spanish in other ways. Either through college or just through picking it up working with our patients. There’s varying levels of Spanish proficiency amongst our providers, but one thing I think that is really helpful is not all of our providers are completely proficient. But, many of our providers make an effort to know some Spanish. And, so, what I tell my students is that even if you can just say “Hello, my name is..” in the patient’s language I think that really helps put patients at ease. Even if you know a few words, and then you turn it over to your interpreter to help you out - I think just setting that tone really helps patients feel at ease. For instance, there’s one provider, she actually knows quite a bit of Spanish, and she’ll use an interpreter but she also will use what Spanish she knows, and I think patients really appreciate that.
Reason 7

THE PROVIDER

The language barrier negatively impacts the provider: without communication, care delivery is compromised.
Workplace Stress

Medical personnel are negatively affected by language discordant encounters. One study examining a tertiary care medical center found that 97% of nurses and 78% of physicians reported workplace stress as a direct result of language barriers in caring for their LEP patients.

Without adequate language support and appropriate tools and systems, providers have a very difficult time practicing safe and effective medicine. In a Canopy research pilot, interviews with EM residents revealed that when working with a patient who doesn’t speak English, 30% of residents “feel powerless”, 43% of residents “do more guesswork”, 77% of residents “feel frustrated” and 50% “do more testing” and “omit conversations.”

For first encounters: “Someone comes into triage and we don’t know which language they’re speaking”

For a rare dialect: “It’s pretty much a veterinarian visit at that point”

If the language barrier is not addressed, providers will burnout at increasing rates
Reason 8

QUANTITY ➔ QUALITY

The shift in focus from quantity to quality of care delivery and advances in technology make this issue pressing yet addressable if you’re motivated.
Reimbursement Incentives and Penalties

Performance-based measures link patient-provider communication and patient satisfaction to hospital reimbursement incentives and penalties around patient satisfaction, communication, readmission, adherence, etc. Health facilities now have — and will continue to have — a greater pressure to prioritize this issue and are more likely to support efforts to champion the issue. An Agency for Healthcare Research and Quality (AHRQ) report states:

“As our health care systems move toward improving quality and controlling costs, particular focus needs to be placed on how to prevent medical errors for all patients in general and for vulnerable patients in particular.” (Chapter 1: Background on Patient Safety and LEP Populations)

For example, 25% of a hospital’s Total Performance Score (TPS) for the Center for Medicare & Medicaid Services’ (CMS’) 2017 Hospital Value Based Purchasing (VBP) program is comprised of eight dimensions related to communication and patient experience.
Missed Opportunity for Cost Savings

Federal funds are available through Medicaid and SCHIP to help states and providers pay for language services, creating an enormous incentive for healthcare facilities to prioritize systems and processes that enable LAS reimbursement. However, unfamiliarity with the reimbursement landscape and process results in facilities either not claiming reimbursement for LAS to full capacity or failing to capture reimbursement entirely.

Systematic collection and assessment of language service delivery data remains lacking. As such, facilities are hard-pressed to produce meaningful reports regarding comprehensive deployment of multilingual resources. Even in instances where LAS usage data is collected, it is scattered and in various formats — i.e. EMR, monthly OPI or VRI billing statements, practice management systems, and Revenue Cycle Management (RCM) systems — rendering analysis of usage for the purposes of reimbursement submission challenging, as a uniform, normalized set of data does not exist. Further, without standardized tracking of LAS delivery, there is no evidence-base to encourage the adoption of reimbursement models in additional states.

With performance-based reimbursement schemes taking hold and with unprecedented financial pressures on the health facility, operational efforts are now under intense scrutiny to ensure maximum cost effectiveness. Hospital executives will increasingly need to consider LAS not strictly as a necessary cost center, but also as an opportunity for measurably improving operational efficiency, reimbursement capture, and quality of care.
What Can Be Done?

Tackling the issue from multiple angles will help to assure success; here is some food for thought for a multipronged approach.

1. Are you in charge of Diversity and Inclusion? Language Assistance Services? Patient Relations? Major obstacles blocking the improvement of LAS provision arise from difficulties in optimization and efficient use of inadequate resources, opacity into LAS utilization, scattered, non-standardized data collection and documentation, lack of comprehensive reimbursement claims... Forward movement will come from collaboration. Be inquisitive and open to novel solutions.

2. Are you an administrator at an academic institution? How you can help activate various stakeholder to create programs and systems to better support current and future generations to be able to work effectively with limited-English proficient populations?

3. Are you a provider? Self awareness is paramount: prioritize the development of skills that will enable you to work effectively with your patients and assure you are qualified by your facility to communicate in that language safely and appropriately. A friendly and confident ‘hello’, some assurance or explanation, recognition that an interpreter is on the way, — in your patient’s language — can break the ice and set patients at ease, improving rapport, experience, and satisfaction. However, a common cause of adverse events for the LEP patient is the clinician’s attempts try to “get by” or “make do” with basic language skills for clinical conversations. Be conscious of your abilities and be an advocate for the improvement of LAS provision at your facility so you have the requisite support systems in place to communicate. Be savvy about all qualified interpretation resources at your fingertips; remind and encourage colleagues to utilize approved services.

4. Embrace technology
Embrace Technology

Embrace technology that strives to improve systems and processes and helps to unite individuals. The communication barrier presents a truly complex problem, that to effectively address, will need activism and collaboration between people from different spheres. At Canopy, we focus on working in conjunction with individuals and facilities to create technological solutions to the language barrier: whether you’re a Patient Relations administrator, clinician, executive, or interpreter, your input is critical to the successful development of appropriate tools. It is within the community’s capacity to help significantly improve the status quo. Awareness and compassion coupled with scalable and practical technology approaches can enable the provision of appropriate LAS at the point of care.
About the Author - Who are we?

Canopy Innovations is an NYC-based digital health company whose technologies focus specifically on bridging the language barrier between providers and their LEP patients. With support from the National Institutes of Health (NIH), Canopy has developed a suite of technologies that take unique approaches to reduce the myriad health disparities that result from poor communication. We work with hospitals, health systems and other health facilities to implement enterprise technology that optimizes the provision, documentation and reimbursement potential of LAS. We also work with academic medical and nursing institutions, incorporating digital medical language learning technology into an institution’s medical Spanish curricula, fostering a community of clinicians who can provide more effective care to their Spanish-speaking patients.

To learn more about Canopy:

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