



Language Access: A case study in healthcare disparities

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Importance of language access

- 26 million individuals in the US speak English less than “very well” >>>LEP
- 13 million speak English “not at all” or “not well”
- ~4% of population: equivalent to
 - patients with schizophrenia: 1%
 - patients with rheumatoid arthritis: ~1%
 - patients with HCV: 1%
 - patients with cirrhosis: 0.27%
 - patients with ESRD: 0.3%

Language barriers difficult care

Language barriers:

- Poorer comprehension of medical diagnosis and treatment
- Less satisfaction with physician and encounter
- Less trust in physician
- Worse clinical outcomes (glycemic control in diabetes)
- Increased safety issues with medications and in hospitals
- ED return visits

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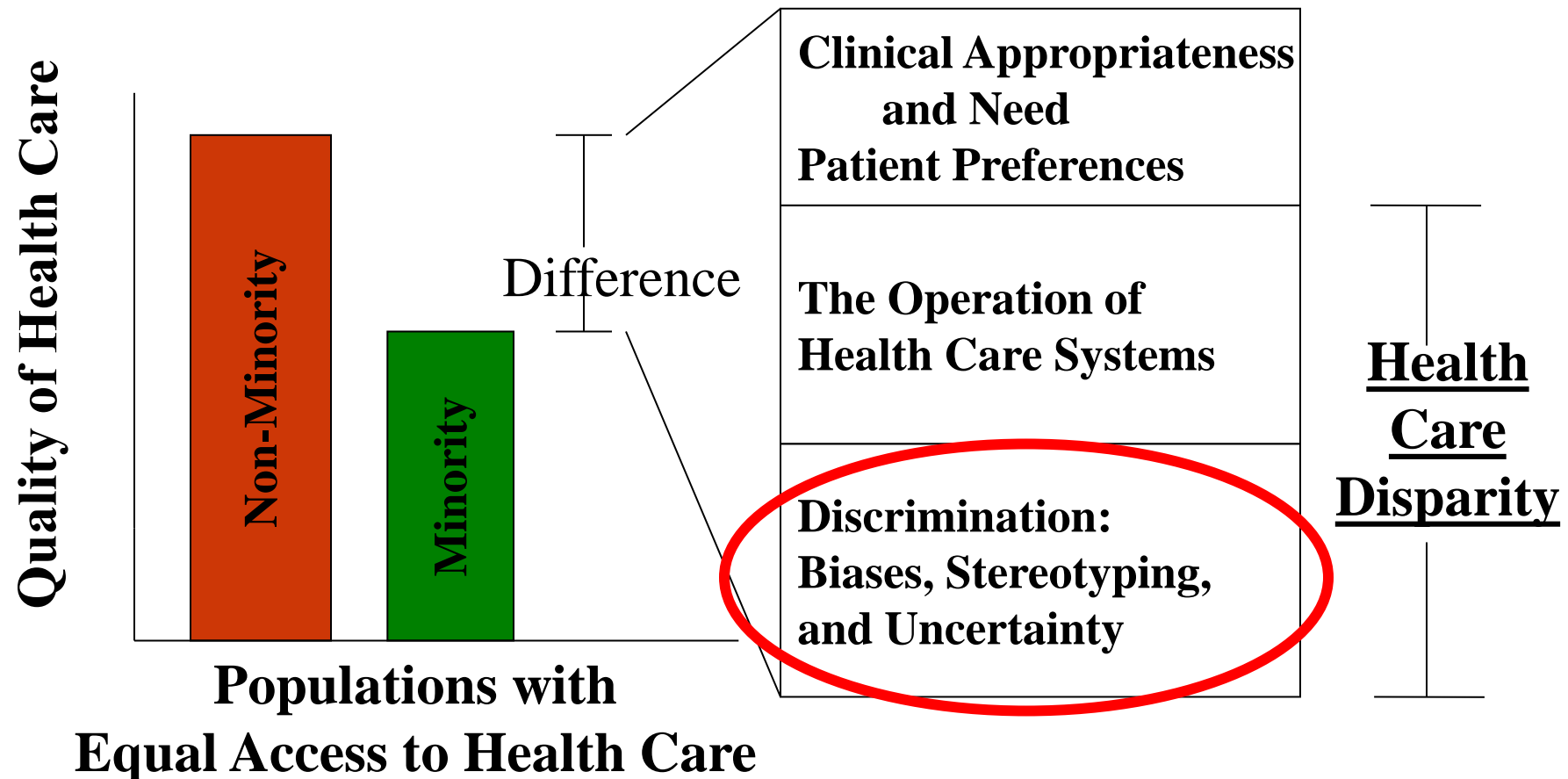
Language access services crucial to equity

- Language concordant physicians are best
- Professional interpreters improve patient reported and clinical outcomes: decades of evidence
- Mandated by federal statutory requirements (Title VI Civil Rights Act). Unfunded
- Often not employed despite some technological advances e.g. video interpretation

Substantial underuse of interpreters

- No national data
- In one study, only 70% of hospitals offered language services
- Studies of qualified interpreter use document low rates
 - 18% of ED patients (4 hospitals in Boston, 2008)
 - 54% of patients undergoing inpatient informed consent (1 hospital in San Francisco, 2017)
 - 29% of office based MDs reported using professional interpreters “often”; 40% reported “never” (National data, 273,000 MDs)
- Multiple patient studies reports underuse of qualified interpreters

What explains healthcare disparities?



Bias against immigrants

- Clinicians are forthcoming about not using interpreters
 - ‘hassle factor’
 - “not crucial to advance care”
 - “probably not fair”
 - “use in important situations”

- “Getting by” is acceptable shortcut. Premised implicitly on patients being less valued

- Lack of interpreter access/infrastructure >>> **structural racism in healthcare**

The New York Times

DOCTOR AND PATIENT
When the Patient Gets Lost in Translation

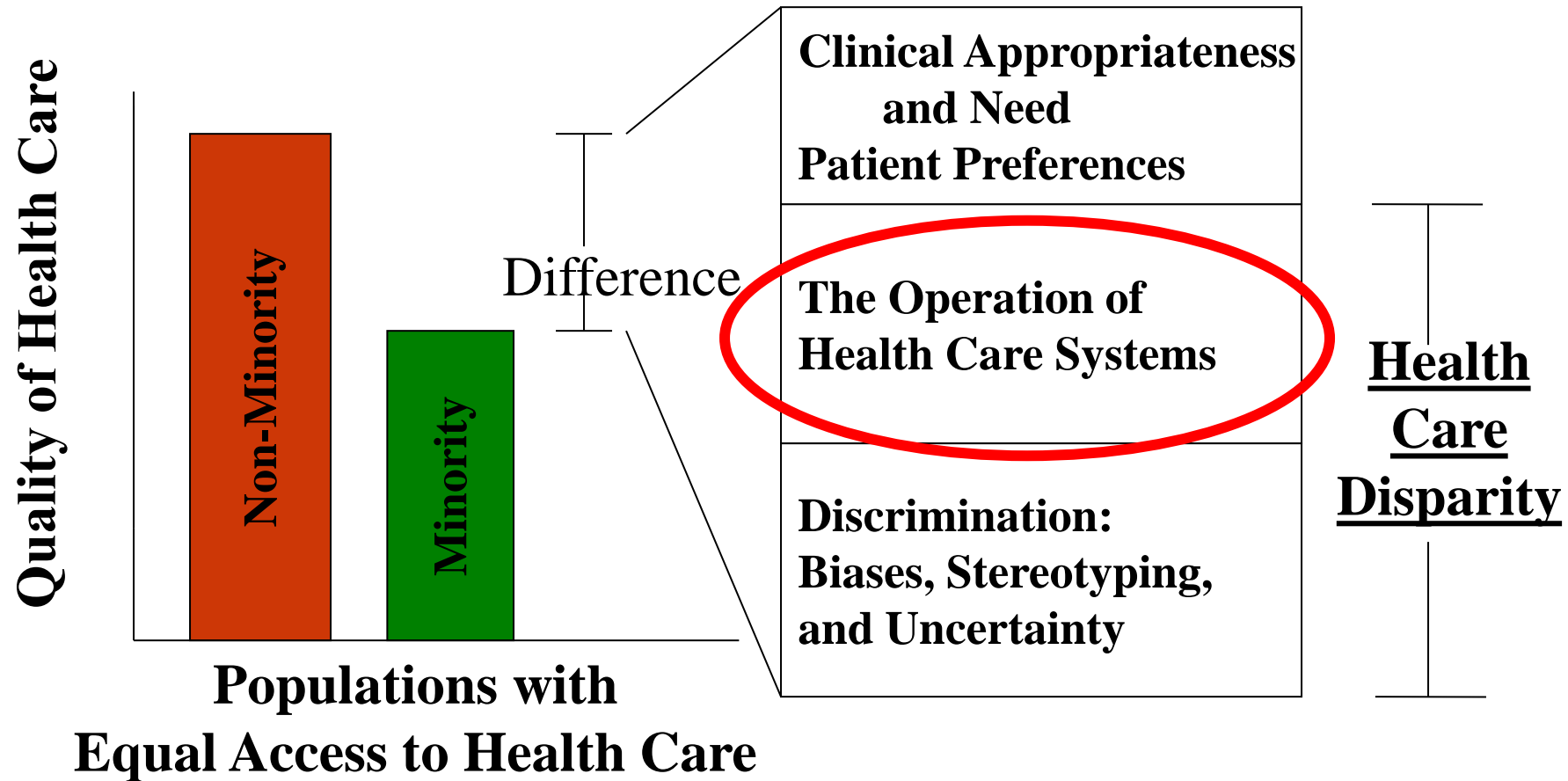


Sean Justice/Getty Images

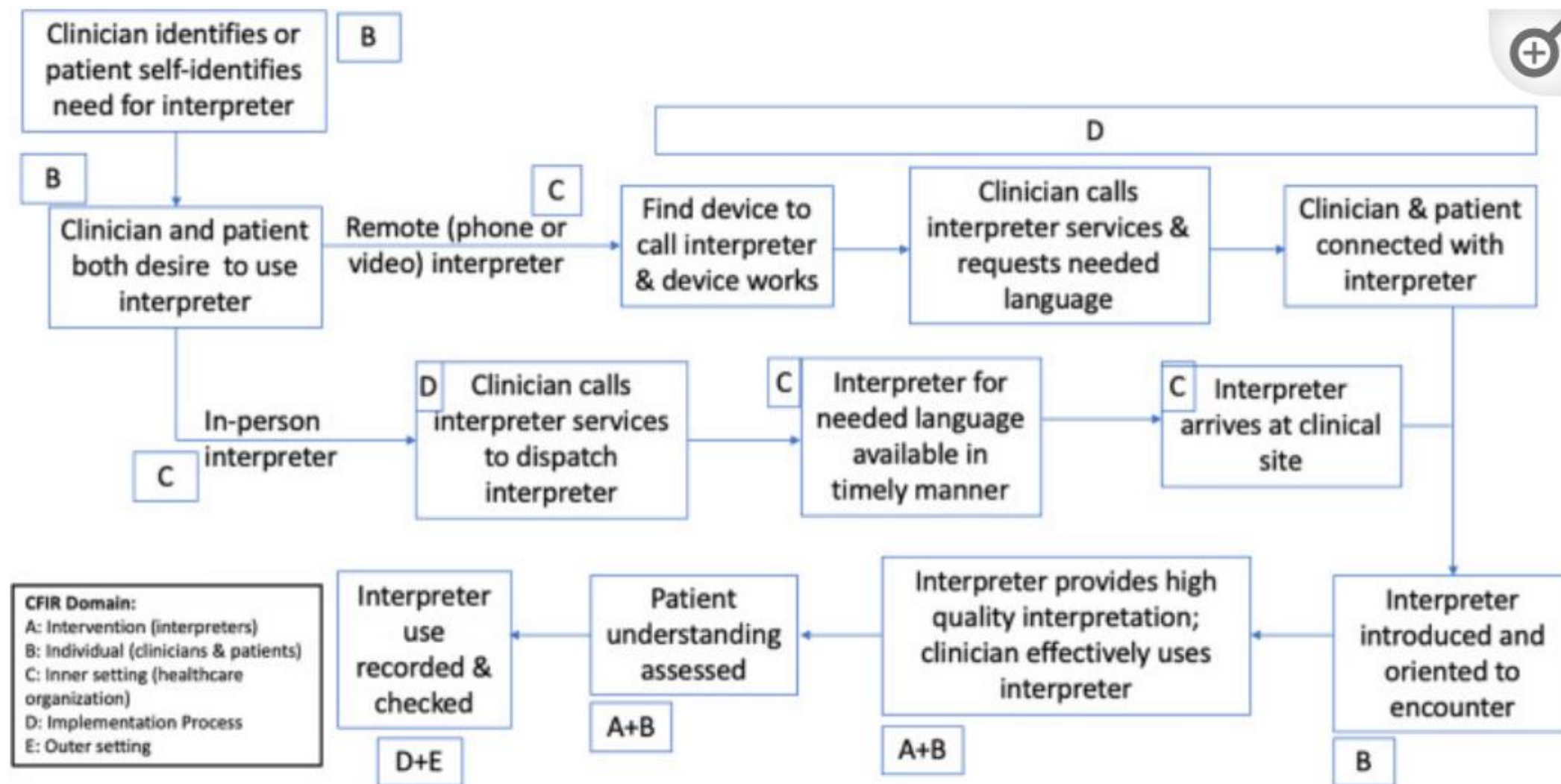
By PAULINE W. CHEN, M.D.
Published: April 23, 2009

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What explains healthcare disparities?



Journey map of pathway to using an interpreter with an LEP patient

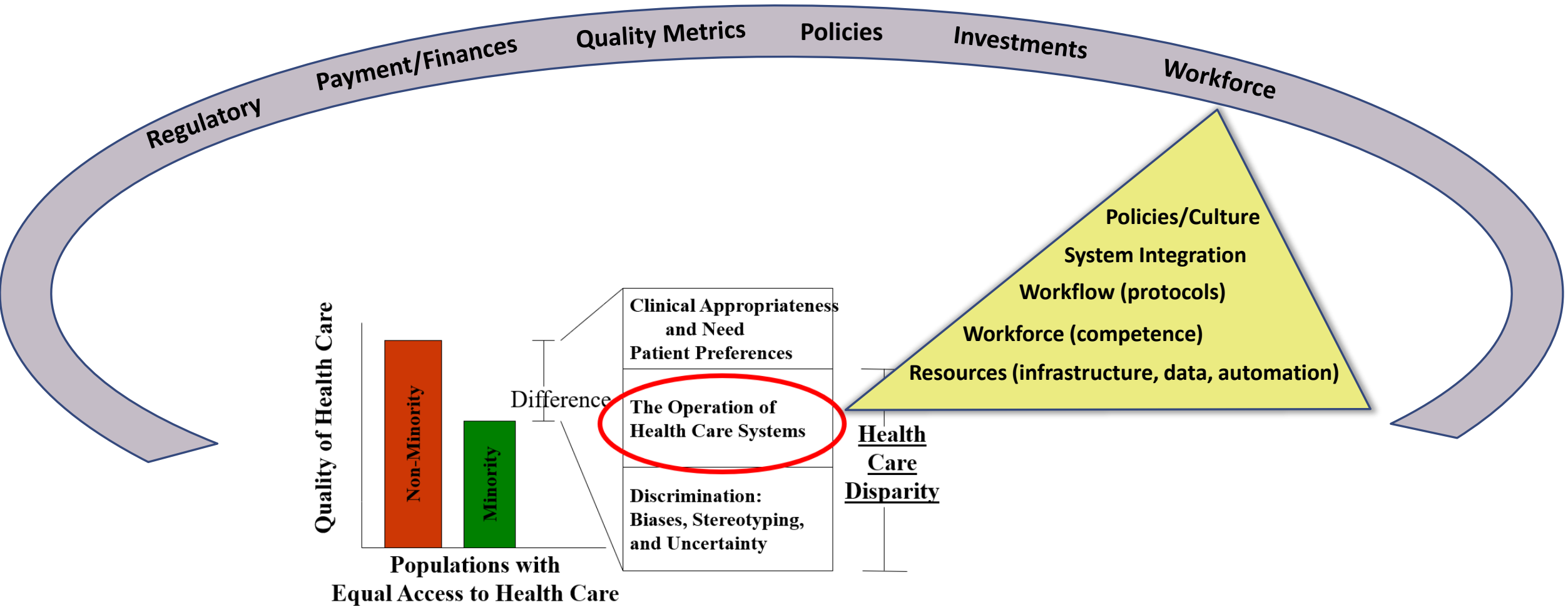


The operations of the healthcare system

- Multiple factors: Interpreters / Clinicians and Patients / Healthcare organizations / Process for implementing interpreters / External influencers
- Interventions that focus solely on educating clinicians to use interpreters have failed
- Interventions that have substantially increased interpreter use are multimodal
 - EMR data on patient language preference
 - Capturing interpreter use in clinical record
 - Improving access to language concordant clinicians
 - Ease of access to interpretation infrastructure (phone, video, in-person)
 - Adequate leadership and funding
 - Clear policies

External to healthcare organization

- Regulatory policies
- Regulatory audits
- Development of digital tools that ease interpreter access, request, documentation
- Digital tools that automate auditing of adherence to policies
- Financial incentives (or sticks) for appropriate use (failure)
- Infrastructure funding akin to EMR funding
- Educational requirements/certification of skills
- Linguistically and culturally diverse workforce



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