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Crossing The Language Chasm:

An in-depth analysis of what language-assistance programs look like in practice

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Abstract

The quality of communication between patients and clinicians can have a major impact on health outcomes, and limited English proficiency can interfere with effective communication. More than ten million U.S. residents speak English poorly or not at all, constituting a language chasm in the health care system. This paper reviews the evidence on the link between linguistic competence and health care quality and the impact of particular language-assistance strategies. Drawing on the experiences of fourteen health plans that have been at the forefront of linguistic competence efforts, we identify lessons for plans, purchasers, policymakers, and researchers on ways to improve the availability and quality of interpreter services.

Communication between patients and caregivers presents a large and growing problem in U.S. health care. Nineteen percent of all Americans with a health care visit in the past two years say they had one or more problems communicating with physicians. The proportion rises to 23 percent for African Americans, 27 percent for Asian Americans, and 33 percent for Hispanics.[1]

Communication barriers take many forms, but one severe impediment is lack of a common language. More than ten million U.S. residents speak English poorly or not at all, constituting a language chasm in health care.[2] This chasm can have a sizable impact on health care outcomes.[3] In this paper, using published and unpublished literature and a qualitative study of health plans, we review the evidence on the link between linguistic competence and health care quality and the impact of particular strategies for achieving linguistic competence. Drawing on the experiences of fourteen health plans that have been at the forefront of these efforts and the broader literature, we identify some implications for plans, purchasers, policymakers, and researchers.

Why Linguistic Competence Matters

The literature shows that language barriers have a demonstrable negative impact on access, quality, patient satisfaction, and sometimes cost.[4] Compared with proficient English speakers, people with limited English proficiency (LEP) are less likely to seek care and to receive needed services when they do. They have fewer physician visits and receive fewer preventive services, even after such factors as literacy, health status, health insurance, regular source of care, economic indicators, or ethnicity are controlled for. Language barriers are associated with poor quality of care in emergency departments (EDs); inadequate communication of diagnosis, treatment, and prescribed medication; and medical errors. Patients with language barriers have lower satisfaction with care, even when compared with patients of the same ethnicity who have good English skills.

Language barriers can also create additional costs, called by Lou Hampers and Jennifer McNulty "language barrier premiums."[5] LEP patients have more diagnostic tests, presumably because of physicians' attempts to compensate for communication difficulties, and are more likely to be admitted to the hospital from the ED.[6] Furthermore, failure to address language barriers can result in other costs, including loss of business from minority consumers and from the private purchasers that buy health coverage for them, and loss of business from public purchasers that increasingly impose linguistic competence requirements.[7]

Which Strategies Work?

Although many gaps remain in the literature, evidence is mounting that use of language assistance can improve care.

Bilingual physicians

Spanish-speaking patients attended by native Spanish–speaking physicians have reported better well-being and functioning, improved adherence to medical regimens, and lower ED use than their peers who were not attended by bilingual physicians.[8]

Interpreters

Studies also show that LEP patients with interpreter services have more physician office visits and prescriptions, use more preventive services, and have higher satisfaction with care than comparable patients without interpreters.[9] One study even found that LEP diabetic patients who used interpreters achieved similar health outcomes to those who had no need of interpreters—an elimination of language barrier disparities.[10]

The effect of interpreter services on health care costs is less clear. Interpreter services have been found to lower costs by decreasing the use of diagnostic testing, lowering the probability of hospital admission and receipt of IV fluids, and reducing post–ED visit charges.[11] On the other hand, professional interpreter services are not free, and use of interpreter services or other efforts to reduce language barriers can also add costs in the short term by increasing use of primary and preventive services.[12] Those increases, however, may lead to lower health care costs in the long run.

In sum, the research suggests that use of interpreters and providers skilled in a patient's language can improve health care quality and satisfaction with care. However, as is often the case, there is a gap between what the research shows can work and what gets implemented. As a next step in our inquiry, therefore, we identify what some models of language-assistance strategies might look like in practice.

What Health Plans Are Doing

Direct providers of services, such as hospitals and physician practices, have traditionally assumed responsibility for providing language assistance to their patients. As health plans have developed language-assistance programs, they also have begun to assume a greater role in facilitating, organizing, and financing language assistance in clinical settings. To describe the cutting-edge approaches taken by health plans, we identified and interviewed trailblazers in the area of linguistic competence. To be considered for inclusion in our study, a health plan had to engage in activities designed to promote both culturally and linguistically appropriate services. Purposeful sampling was used to select plans that were leaders in the field.[13] The sample was stratified on several characteristics, shown in Exhibit 1. The first wave of data collection (semistructured telephone interviews and collection of supporting materials) took place in 2000 and 2001, followed by a second wave in 2002, which obtained updated information and expanded the number of plans included in the study.

Although each of the plans operated in a somewhat different way, most performed four critical functions: collecting data on members' languages, recruiting and identifying bilingual staff and physicians, organizing and financing interpreter services, and educating members and physicians about interpreter services. The experiences of these plan leaders illustrate the potential for addressing the needs of plan members with limited English proficiency.

Collecting data on members' languages

The first step in developing a language-assistance program is usually to assess members' language needs. In contrast to health plans generally, most of the plans in our study possessed data on members' languages.[14] These plans either received data from the state's public insurance programs or collected the data themselves from members. The plans generally used these data for two purposes: (1) aggregate planning (for example, assessing the language adequacy of staff and the physician network or planning for interpreter services), and (2) conducting plan business with that member (for example, making welcome calls in the appropriate language or assigning members who did not make a selection of a primary care provider to a bilingual provider). Language data could also be used for planning clinical visits, but few plans that possessed language data shared them with physicians.

Plans reported that members sometimes questioned the plans' collection of language data. One of the study plans responded by training staff on how to explain to members why language information is needed. This plan collected three distinct data elements: preferred language for written communications, preferred language for oral communications, and the need for interpreter services.

Recruiting and identifying bilingual staff and physicians

To communicate with LEP members, most plans had bilingual staff in positions that interacted extensively with members, such as customer service representatives and health educators. Use of bilingual staff was limited to the most commonly spoken languages.

Few plans actively recruited bilingual physicians. Many plans, however, surveyed physician offices on their language capabilities, to report language capabilities in provider directories (to aid members in selecting their physicians) and to assess the plan's complement of bilingual physicians and the need for interpreter services. Plans have become more sophisticated in conducting their assessments in recent years. Increasingly they ask about the language capabilities of clinical staff rather than asking about the language capabilities of the physicians' offices overall, and ask physicians to rate their proficiency in the foreign language.

Organizing and financing interpreter services

No plan had sufficient bilingual staff or physicians to adequately serve its LEP membership, so all had some need of interpreter services.

Using existing interpreter services—Many of the plans relied, for at least some of their language-assistance services, on physicians whose offices historically served LEP populations and had interpreter services programs in place. This policy required contracting with health clinics or solo practitioners who are often left out of commercial networks. This was some plans' only approach to providing members with access to interpreter services.

> "Some physicians are not aware of the need for an interpreter, believing that their own language skills are sufficient."

Facilitating provision of interpreter services—Health plans' strategies included (1) compiling resource directories of interpreters in the area and distributing the directory to their physician network; (2) negotiating a discount for telephone interpreter services for physicians in their networks; (3) scheduling interpreters to appear at physicians' offices for patients' appointments; (4) and training people, including network physicians' support staffs, as medical interpreters, to increase the supply of medical interpreters in the area.

Providing and paying for interpreter services—In the most activist approach, sometimes used in combination with other strategies identified above, plans provided and paid for interpreter services. This strategy was used primarily by plans that served Medicaid participants. The approaches ranged from the "gold standard" of using professional medical interpreters to using telephone interpreters and ad hoc staff arrangements. None of the plans relied heavily on patients' family and friends to interpret. Plans that financed in-person professional interpreter services tended to actively discourage physicians' use of family and friends as ad hoc interpreters.

When using professional interpreters, most plans used language banks or freelance interpreters. Health plans generally required that interpreters be trained and credentialed, either by the plan itself or by the language bank with which the plan contracted. Because of the difficulty in verifying quality, use of freelance interpreters was generally less popular than using a language bank.

Use of ad hoc staff interpreters was not uncommon for conducting nonclinical plan business with LEP members. Plans surveyed their staff on language capabilities and then circulated a list of staff who could serve as interpreters. These staff members were usually not trained as interpreters, and only two of the plans we interviewed tested ad hoc interpreters for their proficiency in the language and in medical terminology. Plans using this approach expressed some concerns with the quality of ad hoc interpretation. Plans also reported organizational difficulties in running ad hoc interpreter services programs, such as unavailability of staff members when their interpreter services are needed. Plans did not collect data on the use of ad hoc interpreters by physicians in their networks, but the practice was believed to be widespread.

Plans also reported that telephone interpreter services were a relatively inexpensive way to provide coverage for a wide array of languages. But implementation problems, such as examining rooms' not being wired for telephone use, long waiting times, and lack of proficiency with medical terminology, were common. Although a few plans used telephone interpreter services as their sole method of interpreter services, others used telephone language lines for rarely spoken languages and as a backup when the need for interpreter services was not anticipated or interpreters were not available.

Although health plans viewed interpreter services as key to providing high-quality health services to their LEP members, few plans formally evaluated the impact of interpreter services. Interpreter services evaluations conducted by three plans found that after an interpreter services program was implemented, LEP members were more satisfied with their care, and disparities between English-speaking and LEP members in the receipt of preventive services were greatly reduced.

Educating members and physicians

Three methods were most commonly used to notify members and physicians of the availability of language assistance and provide them with instructions for accessing interpreter services: newsletters, provider manuals/member handbooks, and orientations. Innovative methods were sometimes used, such as one plan's giving physicians a Rolodex card with the toll-free number to obtain interpreter services printed on it, and an "I speak [language]" card with the same information for patients to present to physicians. Plans that did not finance or provide interpreter services still tried to educate physicians about professional interpreter services and the plan's facilitation strategies. Several plans conducted training, either as part of provider orientation sessions or as a stand-alone course, to teach physicians how to work with telephone and in-person interpreters. However, most plans believed that more physician education about interpreter services is needed.

Moreover, education may not be enough. Physicians are sometimes reluctant to use interpreter services. For example, physicians vetoed one plan's proposal to provide interpreter services and have not availed themselves of another plan's offer of extra pay when they use an interpreter. An exploration of why physicians were not using plan-provided interpreter services revealed that physicians have many knowledge gaps and misperceptions about interpreter services. It found that some physicians are not aware of the need for an interpreter, believing that their own language skills are sufficient or that use of family or friends as interpreters is appropriate. Other physicians did recognize a need but did not know how to use interpreter services or that the plan paid for them.[15]

Lessons And Implications

Our literature review and discussions with the plans suggest that health plans, providers, policymakers, and researchers can take steps to facilitate, expand, and build on early efforts to cross the language chasm.

What can health plans do?

Evidence from the fourteen trailblazer plans suggests six priority activities that plans can initiate to improve linguistic competence.

Develop a language-assistance plan—Plans often begin providing language assistance ad hoc without having developed a consistent, comprehensive approach. Plans that want to take a systematic approach to language assistance can follow the step-by-step process outlined in *Providing Oral Linguistic Services*, which is based on the experiences of plans in this study.[16]

> "By developing cost estimates, plans can demonstrate to purchasers that the short-run costs of interpreter services are not exorbitant."

Collect and use language data—To create a language-assistance plan, health plans need to know the number of LEP members and which languages they speak. Although some data may be available for publicly insured members and community data can also provide valuable information, these data are not substitutes for plans' collection of member-specific data. For language data to help at the clinical level, the data must also be transmitted to physicians and their staff—a step that most plans omit.

Don't rely exclusively on physicians who historically have served LEP populations—The availability of bilingual physicians and physicians with language-assistance programs in place can be a tremendous asset to a plan. Not having interpreter services to augment these traditional providers, however, confines members with limited English proficiency to these providers. With some evidence demonstrating that providers serving minority communities deliver poorer-quality health care, plans' failure to pay for interpreter services would allow health care disparities that result from current market segmentation to persist.[17]

Educate physicians and hold them accountable—The experience of most of the fourteen plans we studied is that physicians have not been embracing plans' language-assistance initiatives, even when plans have paid for interpreter services. Plans that pay for these services can follow the example of one study plan by not only educating physicians about the benefits of interpreter services and how to access them, but also requiring physicians to document patients' refusal of interpreter services. Plans that do not pay for interpreter services can also educate physicians and use some of the facilitation strategies described earlier to encourage the use of interpreter services.

Recognize language assistance as an integral part of quality—Health plans interviewed for this study overwhelmingly felt that access to interpreter services is an important component of providing high-quality services to LEP plan members, but some had concerns about costs and maintaining competitiveness with other health plans that made them reluctant to invest in language-assistance programs. It is important to recognize that providing language assistance carries no more risk that returns on investments will be realized by others than other quality improvement efforts.

Negotiate with purchasers—Purchasers have an interest in increasing primary and preventive care to LEP people and reducing unnecessary testing that can result from communication failures. By developing cost estimates—using data on the number of LEP members, the projected number of interpreted encounters, and the average cost of interpreter services—plans can demonstrate to purchasers that the short-run costs of interpreter services, even without cost offsets, are not exorbitant.[18]

What can purchasers do?

Public and private purchasers also can have a major impact on the availability of language assistance because they largely control the “business case.” While many plans and providers have an interest in providing language assistance to help them meet both patients’ needs and legal requirements, many are also struggling to cope in very competitive markets. At least in the short run, investing in language assistance can raise costs. But purchasers can do several things to make plans and providers willing to incur such costs.

Pay for interpreter services—Public and private purchasers can instruct their actuaries to include the cost of interpreter services in constructing capitation payment and allow for reimbursement of interpreter services in fee-for-service arrangements. States can amend their state Medicaid plans to access the federal matching funds for interpreter services for Medicaid and State Children’s Health Insurance Program (SCHIP) participants. To date, ten states have done so.[19]

Make expectations explicit—Purchasers are often vague about what they expect from health plans in terms of cultural and linguistic competence.[20] Communicating requirements clearly, as California has done in its Medicaid and SCHIP programs, can promote extensive health plan linguistic competence activity. Private purchasers can also affect plan services for LEP members. One health plan in this study had cultivated small employers, many with Spanish-speaking LEP employees, as its market niche. Employers’ desire for effective communication between employees and health care providers prompted the plan to provide language assistance even before public purchasers were requiring such services.

Require reporting on language assistance—Information on plans’ language-assistance programs not only can be used as a factor in selecting plans to contract with, but also can be shared with consumers to inform their plan selections. For example, California’s HMO Report Card, created by the Office of the Patient Advocate, lists health maintenance organization(HMO) services relevant to LEP and deaf patients, such as the availability of free interpreter services, translated lists of bilingual physicians, and monitoring the satisfaction with care of non-English speakers.[21]

What can policymakers do?

Federal and state laws and regulations requiring that plans and providers address the language needs of LEP populations have provided much of the impetus for linguistic competence efforts.[22] Continued attention by policymakers and accrediting organizations could speed the trajectory and success of these efforts.

Encourage and support health plan collection of language data—A major role the federal government can play is to increase awareness that collection of race, ethnicity, and language data is not only legal, but also vital for enforcing nondiscrimination requirements and addressing health care disparities. The National Committee on Vital and Health Statistics (NCVHS) has recommended that the U.S. Department of Health and Human Services (HHS) strongly encourage and provide support for accurate and complete collection of such data by health plans, and that HHS improve its collection of data on language and LEP populations.[23]

Medicare and Medicaid have a particularly great potential to affect language data collection. Medicare collects and shares with health plans data on race and ethnicity but not language. Proposed Medicaid managed care regulations require states to provide language data to managed care plans. These federal programs can also promote linguistic competence as part of their required quality improvement activities. For example, improvement of culturally and linguistically appropriate services was one of two choices for Medicare mandatory quality assessment and performance improvement projects in 2003.[24]

States also have major roles to play in encouraging health plans to collect language data. This can range from improving the accuracy of language data on publicly insured members that they collect and share with health plans, to requiring that health plans collect language data, as does Texas.[25]

Develop national measures and standards—There are no national measures of the adequacy of language assistance for health plans. In 2004 the National Committee for Quality Assurance (NCQA) retired its measure, “Availability of Language Interpretation Services,” and is now conducting a feasibility study to determine how to assess health plans’ provision of culturally and linguistically appropriate services. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is also exploring standards and measures that address hospitals’ capability to address language and cultural issues.[26] Health plans in our study also reflected that there is a need for national standards for certifying medical interpreters. Only two states credential medical interpreters, and standards have been developed in two other states.

What can researchers do?

As noted earlier, there is a growing body of evidence to show that better communication means better care and that language assistance can improve such communication. On the other hand, the evidence is less clear on the types of interventions that can be most effective and cost-effective and how to implement them in various settings. The Office of Minority Health and the Agency for Healthcare Research and Quality recently published *Setting the*

Agenda for Research on Cultural Competence in Health Care, which identifies unanswered questions on the impact of cultural and linguistic competence on health care delivery and health outcomes.[27] Researchers can partner with health care providers to produce rigorous answers to these questions.

Providing linguistically competent health care is a complex undertaking. Fortunately, the activity of plans such as those interviewed for this study can provide guidance, and many resources and tools are available to those who pursue linguistic competence.[28]

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EXHIBIT 1

Characteristics Of Sampled Health Plans, Study Of Language Assistance In Health Plans, 2000–2002

Geographic service area	Tax status	Model type	Number of members in 2000/2001	Percent ethnic members	Percent public enrollment
California	FP	Network HMO	2,200,000	—[a]	20
California	NP	Group-model HMO	6,000,000	32	2
Eastern city	NP	Network HMO	91,000	90	100
Midwest	NP	Group-model HMO	6,000,000	—[a]	2
Midwest, Atlantic, and southern cities	FP	Network	269,000	>70	100
Minnesota	NP	Network	360,000	48	100
Minnesota	NP	Mixed model	660,000	—[a]	11.5
New England	NP	Network HMO	1,000,000	—[a]	10–20
Northern California city	NP	Group-model HMO	14,000	—[a]	8
Northern California county	NP	Network HMO	78,000	66	100
Southern California	FP	Network	—[a]	—[a]	—[a]
Southern California	FP	Mixed model	337,000	50% of Medi-Cal members, 30% of commercial members	50
Southern California suburban county	NP	Mixed model (subcontract to staff-model HMO)	250,000	61	100
Southern California urban county	NP	Network	780,000	85	100

SOURCE: Authors' tabulation of data provided by study health plans.

NOTES: FP is for profit. NP is not-for-profit. HMO is health maintenance organization.

[a] Not available.