WHY ARE LANGUAGE SERVICES IMPORTANT IN HEALTH CARE?
A CASE FOR NEW ORLEANS

Barriers to quality care are significant for all uninsured and underinsured residents of New Orleans. Individuals with limited English proficiency (LEP) face the added difficulty of poor communication. Communication is a critical element of patient safety and quality care.[i] Communication barriers between provider and patient lead to decreased use of preventive services, misuse of services, and higher rates of hospitalization and drug complications.[ii iii iv] **The Louisiana Language Access Coalition Health Committee seeks to address issue of access to quality health care and health disparities for LEP individuals by eliminating barriers to effective communication.**

DEMOGRAPHICS & NEED

- In 2007, more than 55 million people in the U.S. (19.7% of the population) spoke a language other than English at home. Of those, almost half reported that they spoke English less than 'very well'.[v]
  - Within Louisiana, 9.2% of the population speaks a language other than English at home.[vi]
  - As of 2007, 6% (270,000) of Louisiana's residents were Hispanic.[vii]
  - Of the 6,148 people Vietnamese community in New Orleans East, 98% has returned after Hurricane Katrina.[viii] Among this population, English proficiency levels are at: 1/3 speaks little to no English, 1/3 moderate, 1/3 advanced.[ix]
- New Orleans also has a significant population of Arabic-speaking and Haitian Creole-speaking residents. Many of these people require healthcare services in a language other than English.

Making high quality language appropriate health services broadly available in Louisiana is of critical importance to ensuring the wellbeing of non-English speakers across the State. Why is that?

ACCESS TO CARE

- Adults with limited English proficiency and their children are much less likely to have insurance and a usual source of care, have fewer physician visits, and receive less preventive care than those who only speak English.[x] [xi] [xii] [xiii]

TRAINED INTERPRETERS REDUCE RISK & IMPROVE CARE, SATISFACTION & OUTCOMES

- "Use of professional interpreters is associated with improved clinical care as compared to the use of ad hoc interpreters. Professional interpreters appear to raise the quality of care for LEP patients to approach or equal that of patients without language barriers."[xiv]
- Ad hoc interpreters are much more likely than professionally trained interpreters to make errors that lead to serious medical problems.[xv] [xvi] [xvii] [xviii]
- It is risky to rely on family, friends and minors to interpret medical or health information for multiple reasons including:
  - The individual may not be proficient in medical terminology.
  - They may not possess the necessary skills to interpret.
  - They may unintentionally or intentionally omit or alter important information.
  - The patient may chose to withhold or change important health information due to not wanting family, friends or children to know.
  - Using such individuals to interpret may raise privacy issues protected by the Health Insurance
  - Portability and Accountability Act of 1996 (HIPAA).
  - In the case of children, they may not be emotionally mature enough to handle the information being conveyed.[xix]

NOT HAVING LANGUAGE ACCESS SERVICES CAN BE EXPENSIVE

- "Without a comprehensive strategy for assisting LEP individuals, the risks of missed diagnosis, delay of care, and concomitant malpractice exposure increase for hospitals and health care providers."[xx]
- A lack of effective communication effects patient safety, results in inappropriate use of prescribed medications or the patient's inability to comply with follow-up instructions, increasing the probability of adverse medication reactions.[xxi]

LAWS & STANDARDS

- Three national laws and regulations mandate language access: 1) *Title VI of the Civil Rights Act* (1964); 2) *Executive Order 13166* (2000): "Improving Access to Services for Persons with Limited English Proficiency;" and 3) *HHS Office of Civil Rights Guidance* (2003). These three documents outline the following:
  - Discrimination by recipients of federal financial assistance based on race, color or national origin (i.e. failure to provide language services for LEP clients) is prohibited.
  - Federal financial assistance includes: cash, direct grants, Medicare and Medicaid, equipment, federal land use, grants, economic stimulus money, federal training, etc.[xxii]
  - Language services include: interpretation services, translated vital documents and bilingual signage.
  - HHS Office of Civil Rights Guidance recommends that organizations use a four-factor analysis to determine *meaningful access* to their programs and activities as required by federal law.[xxiii]
  - Based on the four-factor analysis, organizations should develop an implementation plan to address the identified needs of the LEP populations they serve.
  - Organizations are prohibited from requiring LEP persons to use family, friends or minors as interpreters and their voluntary assistance is discouraged.
- The Joint Commission produced a new set of standards for hospital accreditation in 2010, to be implemented in 2011, specific to language access and interpreter services.[xxiv]

*Despite being mandated by law and regulations, language access services are **not** currently funded or reimbursable in the State of Louisiana. Louisiana could choose to reimburse for medical interpreter services through Medicaid and LACHIP. If it were to do so, most of the cost would be reimbursed by the federal government (70% for Medicaid and 75% for LACHIP).* [xxv]

[i] Schyve, P. "Language differences as a barrier to quality and safety in health care: The Joint Commission perspective." IN *Journal of General Internal Medicine*. Suppl. 2: 360-1. Nov. 22, 2007.

[ii] The Joint Commission. "What did the Doctor Say? Improving Health Literacy to Protect Patient Safety." 2007.

[iii] Hampers, L. C., McNulty, J. E. "Professional interpreters and bilingual physicians in a pediatric emergency department: Effect on resource utilization." IN *Arch Pediatric Adolescent Medicine*. 156(11): 1108-1113. 2002.

[iv] Bard, M. R., et al. "Language barrier leads to the unnecessary intubation of trauma patients." IN *American Surgeon*. 70(9): 783-6. 2004.

[v] U.S. Census Bureau, American Community Survey 2007, Table S 1601, "Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over" Available online at http://factfinder.census.gov.

[vi] http://www.census.gov/popest/estimates.html & http:/quickfacts.census.gov/qfd/states/22000.html

[vii] 2007 Census estimates

[viii] Methodist Hospital & MQVN/CDC Feasibility Study

[ix] MQVN/CDC study with the Dept of Health

[x] Ponce, N., Hays, R. D. & Cunningham, W. E. "Linguistic disparities in health care access and health status among older adults." IN *Journal of General Internal Medicine.* 21(7): 786-791. 2006.

[xi] DeRose, K. P. & Baker, D. W. "Limited English proficiency and Latinos' use of physician services." IN *Medical Care Research and Reveiew.* 57(1): 76-91. 2000.

[xii] Yu, S. M., et al. "Parental English proficiency and children's health services access." IN *American Journal of Public Health.* 96(8): 1449-1455. 2006.

[xiii] Jacobs, E. A., et al. "Limited English proficiency and breast and cervical cancer screening in a multiethnic population." IN *American Journal of Public Health.* 95(8): 1410-1416. 2005.

[xiv] Karliner, L. S., et al. "Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature." IN *Health Services Research.* 42(2): 727-54. Apr. 2007.

[xv] Schyve, P. "Language differences as a barrier to quality and safety in health care: The Joint Commission perspective." IN *Journal of General Internal Medicine*. Suppl. 2: 360-1. Nov. 22, 2007.

[xvi] Wilson-Stronks, A., Galvez, E. "Hospitals, language, and culture: A snapshot of the nation. Exploring cultural and linguistic services in the nation's hospitals: A report of findings." The Joint Commission. 2007.

[xvii] The Joint Commission. "What did the Doctor Say?: Improving Health Literacy to Protect Patient Safety." 2007.

[xviii] Groman, R., Ginsburg, J. "American College of Physicians. Racial and Ethnic Disparities in Health Care: A Position Paper of the American College of Physicians." IN *Annals of Internal Medicine*. 3; 141(3): 26-32. Aug., 2004.

[xix] Joint Commission on Accreditation of Healthcare Organizations. "Promoting effective communication – Language access services in health care." IN *Joint Commission Perspectives*. 28(2). 2008.

[xx] Boswell, J., Miller, K., Joiner, J. "Words will never hurt me: the risks in treating a linguistically diverse population." IN *Health Lawyers News*. 11(10): 10-5. Oct., 2007.

[xxi] Andrulis, D., Goodman, N., Pryor, C. "What a difference an interpreter can make: Health care experiences of uninsured with limited English proficiency." IN *The Access Project*. Boston, MA. 2002.

[xxii] Adelson, Bruce. *Title VI of the Civil Rights Act of 1964: A compliance primer for health care providers.* CCH Health Care Compliance Letter. May 19, 2009.

[xxiii] Office of Civil Rights, U.S. Department of Health and Human Services. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311. http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.html. 2003.

[xxiv] Standard IM.6.20 The Joint Commission.

[xxv] Perry, S., et al. "Improving Language Access: CHIPRA Provides Increased Funding for Language Services." Families USA. Feb. 2010.