

CONCEPTS

Health Policy

Breaking through barriers: the need for effective research to promote language-concordant communication as a facilitator of equitable emergency care

Colleen K. Gutman MD¹  | K. Casey Lion MD, MPH^{2,3} | Carla L. Fisher PhD^{4,5} |
Paul L. Aronson MD, MHS^{6,7} | Mary Patterson MD, MEd^{1,8} | Rosemarie Fernandez MD^{1,8}

¹ Department of Emergency Medicine, University of Florida College of Medicine, Gainesville, Florida, USA

² Department of Pediatrics, University of Washington School of Medicine, Seattle, Washington, USA

³ Center for Child Health, Behavior, and Development, Seattle Children's Research Institute, Seattle, Washington, USA

⁴ STEM Translational Communication Center, University of Florida College of Journalism and Communication, Gainesville, Florida, USA

⁵ UF Health Cancer Center, Center for Arts in Medicine, University of Florida, Gainesville, Florida, USA

⁶ Department of Pediatrics, Yale School of Medicine, New Haven, Connecticut, USA

⁷ Department of Emergency Medicine, Yale School of Medicine, New Haven, Connecticut, USA

⁸ Center for Experiential Learning and Simulation, University of Florida College of Medicine, Gainesville, Florida, USA

Correspondence

Colleen K. Gutman MD, Assistant Professor, Pediatric Emergency Medicine, Department of Emergency Medicine, University of Florida, Gainesville, FL 32610, USA.
Email: ckays21@ufl.edu

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Abstract

Individuals with limited English proficiency (LEP) are at high risk for adverse outcomes in the US health care system. This is particularly true for patients with LEP seeking care in the emergency department (ED). Although professional language interpretation improves the quality of care for these patients, it remains underused. The dynamic, discontinuous nature of an ED visit poses distinct challenges and opportunities for providing equitable, high-quality care for patients with LEP. Evidence-based best practices for identifying patients with LEP and using professional interpretation are well described but inadequately implemented. There are few examples in the literature of rigorous interventions to improve quality of care and outcomes for patients with LEP. There is an urgent need for high-quality research to improve communication with patients with LEP along the continuum of emergency care in order to achieve equity in outcomes.

KEYWORDS

communication, health equity, limited English proficiency, research

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1 | INTRODUCTION

Effective communication with patients improves health outcomes, including patient satisfaction, treatment adherence, and clinical measures such as blood pressure and blood glucose management.¹ Communication with patients is also a critical driver of health disparities.² For the 8% of the US population with limited English proficiency (LEP, defined as those individuals who self-identify as speaking English less than very well),³ language-concordant communication is of particular importance.^{4,3} Compared to English proficient patients, patients with LEP have decreased access to primary health care and increased risk for adverse outcomes, including serious medical errors, medication complications, and physical harm.⁵⁻¹² Health professionals without proficient bilingual language skills often rely on ad hoc interpreters, including bilingual staff members and patient family and friends, who frequently make clinically significant errors and omissions in interpretation.¹³ In contrast, professional interpreters are specifically trained and certified individuals who effectively, accurately, and impartially render spoken communication from one language to another, either in person or through remote video or audio modalities.¹⁴ Professional interpretation and language-concordant communication are essential facilitators of high-quality care and improve outcomes for patients with LEP (Figure 1).^{6,7,15} However, despite legislation mandating language access,^{16,17} only 10% to 30% of patients with LEP receive professional interpretation.¹⁸⁻²⁰

2 | LEP IN THE ED

The emergency department is a particularly high-risk setting for communication errors.²¹ It is therefore essential to thoroughly understand the setting-specific barriers and facilitators to effective communication with patients and families with LEP. ED visits are unique in that they (1) are usually unplanned, and professional interpretation cannot be scheduled in advance; (2) feature multiple discrete, discontinuous communication events between the patient and various clinicians rather than one predetermined communication episode; and (3) occur in a setting in which high acuity, volume, and crowding can negatively affect equitable care provision.²² The decision to use professional interpretation reflects consideration of limited time and resource capacity for emergency clinicians.^{23,24} Emergency care is high

risk for adverse events among patients with LEP and is a focus for national quality and safety efforts.²⁵ This is of particular importance given the high rate of ED use by patients with LEP.²⁶ EDs have an ethical obligation to provide high-quality and equitable care to patients with LEP.²⁷

3 | RESEARCH GAPS

There are 3 foundational reasons for the large gaps in evidence to support the emergency care of patients with LEP. First, patients and families with LEP are frequently excluded from clinical trials.²⁸ Recruitment of research participants with LEP carries additional costs and regulatory burden. In some cases, institutional review boards may discourage the inclusion of participants with LEP because of concerns of autonomy, vulnerability, and coercion. Although it is essential to ensure adequate protections are in place to guard against coercion, it is also important that patients and families with LEP are not unduly excluded from research opportunities that may afford individual and population benefit.

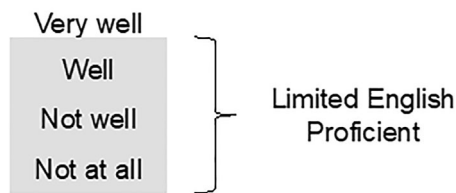
Second, data related to language proficiency and interpreter use is often of poor quality. LEP is often inadequately defined. Healthcare systems and researchers may rely on “primary language,” “language spoken at home,” or subjective observer assessment as a proxy for language proficiency.²⁹⁻³¹ The use of imprecise markers of language proficiency introduces misclassification bias.³¹ Documentation of interpreter use is rarely standardized and is difficult to ascertain from medical record data. To address these concerns, the Agency for Healthcare Research and Quality issued a call in 2010 for improved collection of language proficiency data, including rigorous assessment of patient spoken language proficiency (Figure 2).³ Despite validation,³² these best practices are infrequently implemented and it remains difficult to accurately assess language proficiency in retrospective and database research. Additionally, the term “LEP” has recently gained attention as deficit focused, which may worsen stigmatization.³³ Although careful scrutiny of the term and the use of patient-centered language is warranted, we must also ensure that new terminology is adopted in a standard format that facilitates accurate assessment and documentation of patient language needs.³⁰

Finally, there are few examples in the literature of rigorous interventions to improve quality of care and outcomes specifically aimed

- Use validated strategies to identify patient language needs (Figure 2)
- Provide professional interpretation (in-person, telephone, or video) for each episode of communication with patients with LEP
- Avoid the use of ad-hoc interpreters, such as family members, friends, and bilingual staff who are not professional interpreters
- Implement standardized, accessible methods to accurately record language proficiency and the use of professional interpretation in the electronic medical record

FIGURE 1 Best practices for providing language-concordant emergency care. Abbreviation: LEP, limited English proficiency

How well do you speak English?



What is your preferred spoken language?

FIGURE 2 Best practices for assessing spoken language need. Adapted from *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Accessed September 5, 2020. <http://www.ahrq.gov/research/findings/final-reports/iomracereport/index.html>
Abbreviations: ED, emergency department; EMS, emergency medical services

toward patients with LEP.³⁴ The research approach for improving outcomes for patients with LEP in the ED is multifaceted. Quantitative investigations must be partnered with qualitative scholarship that centers the patient experience while providing insight regarding clinician-identified barriers to language concordant communication. The National Institute for Minority Health and Health Disparities Research Framework highlights the multilevel influences of individual, interpersonal, community, and societal factors that contribute to inequitable health outcomes.² These factors influence communication with patients in multiple settings across the continuum of emergency care and serve as a model to guide research efforts to improve care for patients with LEP (Figure 3). The specific areas in which research is needed across these phases of emergency care are outlined next.

3.1 | Prehospital services

There is little evidence to guide emergency dispatchers and prehospital professionals in providing timely language-concordant care. Professional interpretation is infrequently used by emergency call centers.³⁵ Not only is this an identified barrier for individuals with LEP using the 911 system,^{36,37} it also contributes to inaccuracies and delays in triage.³⁸ In the setting of out-of-hospital cardiac arrest, callers with LEP experience delayed recognition of arrest by the phone dispatcher and subsequent delayed dispatcher-assisted cardiopulmonary resuscitation.³⁹ Conversely, use of professional interpretation during emergency calls may increase delays in medical dispatch, although it is not known if these delays are clinically significant.^{36,38} There is no evidence to guide dispatchers, who must balance the risk of delay in critically time-sensitive care against that of inaccurate triage. Once on scene, emergency medical service professionals responding to high-acuity needs have limited access to professional interpretation and often use ad hoc interpreters (eg, family members and

friends) and/or rely on non-verbal communication and simplified language. These lapses in high quality language-concordant care can result in serious medical errors,^{40,41} and it is not known how this affects triage, transportation, and intervention decisions by prehospital professionals.

3.2 | ED intake and triage

Misidentification of LEP is common.⁴² There is a need for the rigorous development of processes that facilitate the accurate identification of patients with LEP in order to support high-quality clinical care and disparities research. There also may be conflict between the clinician's and patient's assessment of need for interpretation, and there is little research to inform communication with the patient with LEP who declines professional interpretation in the emergency setting.^{43–45}

There is evidence that bias effects ED triage: minority patients are more likely to receive lower acuity triage scores than non-Hispanic white patients despite similar presenting symptoms and vital signs.^{46–49} There is no similar research to explore the impact of language proficiency on triage assignment. Patients with LEP who are admitted are more likely to have an unanticipated transfer to an ICU within the first 24 hours of hospitalization, suggesting failure to recognize illness severity.⁵⁰ Not only may undertriage influence clinical care, but triage scores are also often used as a proxy for illness severity. Triage scores may be used to determine study eligibility or as covariates in research analyses, which may introduce additional bias into research efforts to evaluate quality of care for patients with LEP. Given this influence on research design, it is critical that there be ongoing efforts to evaluate biases and limitations to these designations and seek to improve equity in triage processes.

3.3 | Clinical ED care

The time-pressured ED environment presents unique considerations for patient-centered interactions. Interventions to improve communication with patients in outpatient settings have been demonstrated to improve health outcomes, including quality of life, pain relief, weight loss, and blood pressure.⁵¹ These have not been translated to emergency care, and they warrant study in populations with LEP.

Shared decision-making (SDM), which actively engages patients in knowledge-sharing, deliberation, recommendation, and decision-making, has been endorsed as a priority topic for research in emergency medicine.^{52–54} In outpatient settings, individuals with LEP receive lower quality communication and face barriers to SDM because of physician mistrust and miscommunication even in the setting of professional interpretation.^{55,56} SDM in the ED can be facilitated with the use of decision aids, few of which have been studied with patients with LEP.⁵⁷ Best practices to engage patients with LEP in SDM in the ED have not been explored.⁵⁸

Even when readily available, professional interpretation is not consistently used throughout the ED visit.^{59,60} ED physicians acknowl-

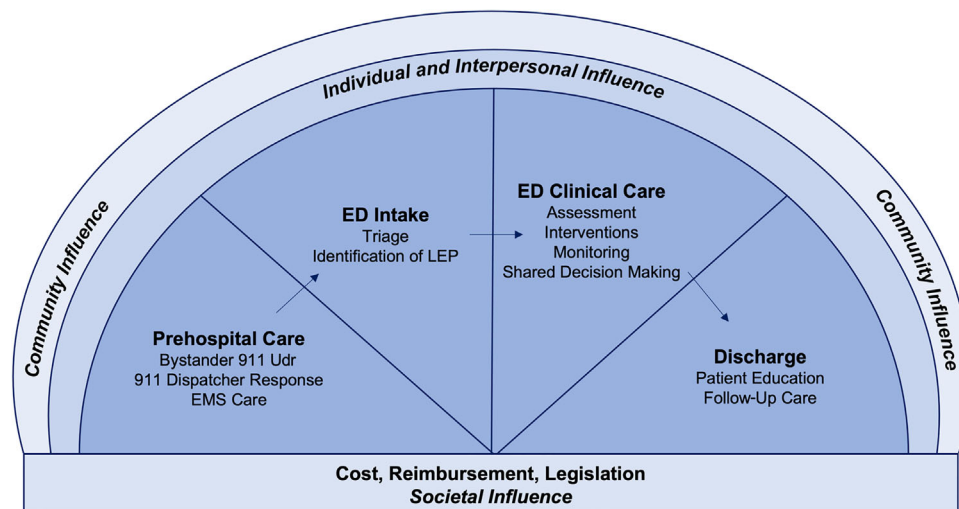


FIGURE 3 Levels of influence on communication with patients throughout the continuum of emergency care. Adapted from the National Institute of Minority Health and Health Disparities Research Framework²

edge frequent lapses in use even when professional interpretation is readily available.⁶¹ Interpreter use is highest during initial evaluation but less frequent for interactions with nurses and consultants and rare for reevaluation, procedures, and medication administration.^{59,60} These interactions, though brief, are at high risk for serious safety events in which bidirectional communication opportunities with patients and families may be essential for prevention of harm. Remote interpretation may increase access to professional interpreters but requires reconnection at each communication encounter. Given the multidisciplinary and discontinuous nature of ED care, there is a need for high-quality research to identify and develop methods to facilitate the inclusion of professional interpreters as essential members of the health care team through all patient interactions.^{62,63}

3.4 | ED discharge

Discharge from the ED is a critical point of transition. Effective, safe discharge requires that patients understand the ED course of treatment and subsequent plan of care. Patients with LEP have lower rates of diagnosis comprehension, higher rates of ED return visits and medication dosing errors, and are more likely to miss follow-up appointments.^{3,64} Effective discharge communication has been shown to improve quality in these areas,⁶⁴ yet patients with LEP often receive suboptimal verbal discharge education.^{65,66} There are multiple modalities for effective discharge communication, but there are substantial gaps in how these are implemented for patients with LEP. Although these gaps are well described, there is paucity of evidence to overcome these barriers for patients with LEP. For example, language-concordant written discharge instructions are preferred by patients with LEP. These are infrequently used, however, and, when available, often consist of generic handouts limited only to the most frequently encountered languages.⁶⁷ Certified translation services, if available,

could provide written translation for personalized instructions, but this time-intensive process may not be well suited to a busy ED.^{68,69} Machine translation can occur in the moment, but current technologies still carry significant risk for error and harm.⁷⁰ Teach-back is an effective method for assessing patient comprehension that is well received by ED patients⁷¹ but the implementation and clinical use of teach-back has not been well studied with patients with LEP. Audio and video technologies show significant promise for improving discharge communication for patients with LEP. Language-concordant, disease-specific video discharge instructions can improve comprehension,⁷² and novel approaches for audio-recording in-the-moment, language-concordant spoken discharge instructions are well received by patients.⁷³ Both warrant further study in the ED. Postdischarge text messaging is another effective communication tool that should be further studied in populations with LEP.⁷⁴

3.5 | Cost, reimbursement, and legislation

Title VI of the Civil Rights Act of 1964, which prohibits discrimination in programs receiving federal funding, provides the foundation for the legal requirement for language-concordant care for patients with LEP.⁷⁵ State legislation requiring language services is limited and enforcement is variable.^{75,76} Large, high-profile lawsuits involving serious or fatal medical errors resulting from inadequate use of professional interpreters may cause local change but, to our knowledge, have not catalyzed widespread policy changes.^{41,75} Unlike legislation requiring language access, reimbursement has been shown to be a powerful incentive for increasing use of interpreter services. However, reimbursement remains infrequent despite relatively low associated costs, and professional interpretation remains underfunded.^{41,77,78} Professional interpretation is cost effective, minimizes unnecessary resource use, and improves population health outcomes.^{20,41} Additional research is necessary in the development and evaluation of novel

payment models to provide reimbursement for language-concordant care.

4 | CONCLUSIONS

Providing high-quality equitable care to patients with LEP in the ED is a complex process. Although there remain gaps in describing the extent of inequities faced by this population, it is clear that patients with LEP have increased risk for medical errors, adverse effects, and patient harm.³ There is an urgent need for research to improve communication across the continuum of emergency care in order to achieve equity in outcomes. Emergency care systems must have reliable processes for identifying and documenting LEP. In addition to quantitative efforts to further define the magnitude and effects of inequity and to prospectively evaluate equity-focused interventions, qualitative research can expand understanding of contributing factors to inequity and identify points of intervention. Qualitative scholarship brings the patients' voice to the forefront of care.^{24,79} By capturing patients', families', and interdisciplinary care team members' authentic lived accounts, these narratives can also serve as behavioral modeling tools in both patient interventions as well as clinician training.^{80,81} Through these rigorous research efforts, providing language-concordant communication should become a facilitator of, rather than barrier to, equitable emergency care.

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PRESENTATIONS

None

CONFLICT OF INTEREST

CKG, KCL, CLF, PLA, and MP report no conflict of interest.

ORCID

Colleen K. Gutman MD  <https://orcid.org/0000-0002-6113-5799>

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