OVERCOMING LANGUAGE BARRIERS IN PRIMARY CARE

By

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Abstract

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Language barriers in health care is a growing problem in the United States. According to the U.S Census Bureau, over 47 million Americans do not speak English very well; it is also estimated that nearly twenty three million speak little or no English. Hence, health care providers often find themselves caring for patients who have limited or no English proficiency. The purpose of this paper is to educate primary care providers about issues that accompany language barriers between the providers and patients with limited English proficiency and propose strategies to decrease the barriers while providing safe patient care.
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Overcoming Language Barriers in Primary Care

Over the past several decades, progress in healthcare, medical practices and medical technology in the United States (U.S.) has been unprecedented. At the same time, the nation has become culturally, linguistically and economically rich. It is estimated that over 47 million people in the U.S. speak a language other than English at home. Almost half of these 47 million speak English less than "very well" by the U.S Census definition (Shin & Bruno 2003). Many linguistically and culturally diverse patients will experience less than adequate access to care, lower qualities of care and poorer health status (Russell, 2009) because of their inability to communicate with providers.

Unfortunately, in some cases diversity has translated into health disparity. Healthcare providers often find it difficult providing care for patients with limited or no English proficiency due to language barriers. In the absence of effective communication, simple nursing care activities such as meeting the basic needs of a patient may be difficult or impossible. Clinically, care such as diagnosis, assessment, and treatment may be inadequately or inappropriately provided. Thus, language barriers can have deleterious effects in the health care context (Flores 2005).

Purpose

The standards for culturally and linguistically appropriate services (CLAS) issued by the U. S. Department of Health and Human Services’ (USDHHS) Office of Minority Health (OMH) were proposed to ensure that healthcare providers offer services that are inclusive, accessible and appropriate to all patients seeking healthcare services (OMH &USDHHS, 2001). Despite the fact that there are about 56 million people without access to healthcare in the U.S. today because they have no or insufficient insurance, providers are still required to
ensure that all healthcare service users who are not fluent in the English language can gain full access to healthcare. Language is not only a communication medium, but has an active role in shaping how people view and experience their health. The purpose of this paper is to educate primary care providers about issues that accompany language barriers between the providers and patients with limited English proficiency and propose strategies to decrease language barriers while providing safe patient care.

**Literature Search Strategies**

A literature search was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, and PubMed. Databases were systematically searched for English language publications. More than 2000 articles relating to language barriers in primary care were identified. The search was then limited to full text, English language, peer-reviewed with publication dates between 2003 and 2010. Articles discussing technology as a barrier to healthcare, barriers to specific health conditions, studies that were conducted in foreign countries and studies that were not reported in English were excluded. Articles identified (N=327) that were research based were screened by title, abstract and relevance and fourteen articles were selected for in depth review. Key words used in the search included *cultural barriers to healthcare, language access in healthcare, multilingualism, diversity in healthcare, language barriers in healthcare, limited English proficiency, cross cultural healthcare, cross cultural communication, English proficiency, nursing communication cultural and linguistic competency and interpreter and quality of healthcare, cost of interpreter service, and methods of interpretation in healthcare.*

The review of the literature resulted in several themes that provided
recommendations for providers. These are: (a) health disparities for people with limited or no English facility; (b) regulatory/legal information; (c) strategies to improve communication between provider and patient; (d) type of available interpretation services; (e) cost of interpreter services and available funding. These consistent themes found in the literature provide a conceptual basis for this paper.

Review of Literature

Health Disparities

Having limited English proficiency is a risk factor for health disparities (Diamond & Jacobs, 2009). These risk factors result in decreased utilization of preventative services, higher usage of unnecessary diagnostic testing and less adherence to healthcare advice and follow up (Gany et al. 2007). In an e-mail conversation with Sobralske (personal communication January 3, 2011) it was noted that even though patients may be reluctant to admit that they do not understand what is being said, language barriers adversely affect a patient’s ability to give an accurate history, comprehension of diagnosis and treatment, adherence to therapy, and the outcome of care. Thus, the language barriers widen the health literacy gap and increases health disparities.

Federal and State Regulations

Clear communication between providers and patient is essential to delivering high quality healthcare. However, interpreters often are not part of the healthcare encounter. Healthcare providers are legally obligated to provide interpretation services to patients who do not understand English. The American with Disability Act (ADA) case law and Title VI Civil Rights Act of 1964 prohibit discrimination by federally funded entities based on race, color, or national origin. When applied to healthcare, the mission of these acts and outcome
case law establish effective communication between providers and members of the community regardless of their level of English proficiency. These bylaws obligate the providers to offer language assistance services at no cost to patients with limited English proficiency (Cheng, Youdelman, & Brooks, 2007).

Federal polices and guidelines on access to language services reflect a growing recognition of the need for language services in healthcare. In 2000, President Clinton’s executive order (Cheng, Youdelman, & Brooks, 2007) reaffirmed Title VI and instructed federal agencies to draft guidance on access to language services for federally funded healthcare services. President George W. Bush subsequently reaffirmed the executive order in October 2001 (Youdelman 2007).

To further patient safety, The Joint Commission (TJC), who accredits healthcare agencies, recognizes language services as an important component of quality of healthcare. Starting in 2007, TJC conducted a research study entitled Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care. The purpose of this study was to investigate methods of how diversity, culture, language, and health literacy issues can be better incorporated into the current TJC standards new requirements. In December 2009, the Patient-centered Communication Standards were approved and released. These standards will be used by TJC to evaluate compliance with the patient-centered communications standards beginning in 2012.

**Strategies for Providers**

A study conducted by Lee, Batal, Maselli, and Kutner (2002) indicated that there are several strategies that could be used to improve communication between a provider and a patient with limited English proficiency (LEP). The strategies identified included, but are
not limited to, professional interpreters, family members and friends used as interpreters, bilingual employees such as clerks (ad hoc), telephone interpretation services, and bilingual providers. The study was conducted at a walk in clinic in Denver Health Medical Center that served more than 3,000 patients annually of which Hispanics accounted for over 50% of the population seen. The results of the study indicated that non-English speaking patients were less satisfied and were less likely to return to the same clinic. Moreover, the authors noted that Spanish speakers who depended on family members or healthcare unit secretaries were 54% and 49% less satisfied respectively than those who were provided AT&T telephone interpreters. Since this study was conducted at a walk in clinic where patients have urgent needs, the authors noted that the study may not be generalized to other practice settings such as primary care despite the fact that effective communication between patient and primary care providers is important in any healthcare setting.

Acknowledging the fact that many studies on language barriers and interpreter services have been conducted among the Spanish-speaking patients, Ngo-Metzger, Sorkin, Phillips, et al. (2007) conducted a cross-sectional survey of 2,746 Chinese and Vietnamese patients receiving care at 11 health centers in eight cities. The authors indicated that patients with limited English proficiency visited their providers less and that they received less health education. Conversely, when both the provider and the patient spoke the same language, patients understood their diagnoses and treatment plan more completely. The study recommended training both interpreters and providers as a means to improve satisfaction of patient care. The authors concluded by emphasizing the importance for the healthcare system/organization to recruit and train additional bilingual providers to meet the healthcare needs of an increasingly diverse population in order to provide high quality care.
for patients with limited English proficiency. Limitations of the study included that the sample studied was comprised of patients who visited primary care within the month of the study and uncertainty as to whether the interpreter was professional trained or an ad hoc staff.

**Types of Available Interpretation Services**

Napoles, Santoyo-Olsson, Karliner, Gregorich, and Perez-Stable (2010) conducted a study that compared the quality rating of in-person, video conferencing and ad hoc interpretation from the clinician’s perspective. After 283 visits, their findings indicated that video conferencing and in—person interpretation were of equal rating. Both video conferencing and in-person interpretation were more appreciated than ad hoc interpretation. The results also indicated that bilingual clinician use for interpretation did not compromise the quality of care, communication, and satisfaction; additionally, according to the clinicians the use of a professional interpreter rendered greater patient satisfaction and fewer interpretation errors. However, since the study results were focused on clinician’s response and not from the patients’ perspective, the study is limited.

Poon, Gray, Franco, Cerruti, Schreck, and Delgado (2003) interviewed 570 Latino patients and families in a pediatric orthopedic practice in California and conducted population census and literature reviews. The findings supported the findings of Napoles et al. (2010) that professional interpreters reduce interpretation errors. Poon et al. (2003) further stated that untrained interpreters could create liability issues when they breach patient confidentiality. The authors also stated that using a family member as an interpreter affects the family hierarchy and the traditional lines of authority. They cautioned against using children as interpreters because this will place “inappropriate burden of responsibility
on the child” (p. 548). Instead, they suggested providers should employ bilingual staff members, interpreters, or interpreter services to provide effective communication that will not violate confidentiality rights or interrupt family hierarchy lines of authority.

Crossman, Wiener, Roosevelt, Bjaja, and Hampers (2008) conducted a study to compare the effectiveness of telephonic, in-person medical interpretation and bilingual providers in an urban pediatric emergency department at which approximately 20% of visits were estimated to be by families with limited English proficiency. During in-person interpretation, a Spanish-speaking interpreter from Peru was available at the appointed time, which may have limited the ability to communicate with non-Peruvian families; additionally, telephonic services were provided for those who spoke Spanish and other languages. A professional interpreter verified the language skills of the bilingual providers. The study indicated that all three-translation services resulted in approximately similar results. However, the researchers further noted that “there was a trend favoring telephonic over in-person interpretation” (p. 631) for reasons unspecified. Crossman et al. (2008) concluded by noting the need for more investigation of manpower allocation issues, duration of interpretation and cost effects of the methods of interpretation.

Gany, Leng, Shapiro, Abramson, Motola, Shield, & Changrani (2007) evaluated the impact of an interpretation method on patient satisfaction in a large New York City municipal hospital. They suggested that telephone interpretation may prevent a potential barriers to patients’ willingness to disclose sensitive information and that this method of interpretation can provide privacy to the patient. It is evident that in areas where the populations of immigrants come from the same country, the networking is so close that patients may know the interpreters. In this kind of setting the use of an in person interpreter
service may bring about failure to maintain patient privacy and may cause patients to be less forthcoming; moreover, patients may not provide accurate information. Thus, considering the ultimate goal of using interpreter service for effective communication, it may be necessary to obtain a telephonic interpreter.

A survey conducted by Sobralske and Moon (2011) encouraged the use of professional interpreters in healthcare facilities for the efficiency and benefit of the healthcare organization. Even though the participants in the study were female Nurse Practitioners (NP), the authors report that the NPs that used professional interpreters were more satisfied with the care they provided than those providers who used non-professional interpreters. However, the study indicates that 56% of the NPs reported that the time allocated for visit with the interpreter was not sufficient.

**Awareness or Lack of Culturally and Linguistically Appropriate Services (CLAS)**

Despite several strategies to improve communication between providers and patients, some providers are either unaware of the interpreter services option, have limited ability to access these services or are reluctant to work with interpreters. A study conducted by Gadon, Balch, and Jacobs (2007) indicated that many primary care physicians are aware of the fact that cultural as well as linguistic barriers need to be addressed in order to provide high quality care. The study indicated that despite considering the availability of interpreter service positively, specialist physicians had concern about liability, extra time, and nonverbal input; on the other hand, the primary care physicians were more concerned about high cost of interpretation. However, in this study few of the office managers and/or the physicians knew exactly how much it would cost to use an interpreter service.
Almost all (n= 41) of the physicians surveyed expressed concerns about the effect of communication barriers on the quality of care. The findings of this study pointed out that due to high levels of frustration with caring for LEP physician and practice managers were considering “abandoning care” of patients with limited English proficiency (Gadon et al., 2007. p. 341). The physicians’ main concern was inability to obtain detailed and accurate medical history, which is the backbone of treatment plans. The authors indicated that due to limited information about how to obtain professional interpreter services, professional interpreters were utilized inadequately. They emphasized the need for sharing resources for language access services.

The first multilingual study that focused on the extent of individual awareness of the language law (Title VI) and its association with language access was conducted by Grubbs, Chen, Bindman, and Fernandez (2006). The authors indicated that only a few individuals with limited English proficiency are aware of the language law. Of the 1,000 people with LEP who participated in this study, only 37% were aware of the language law. And of these 49% had a provider that spoke the same language and 22% reported the use of interpreter. The authors conclude that awareness of the existence of the language law by individuals with limited English proficiency is not sufficient to resolve the language barrier. They recommend that further research be conducted to investigate ways to offer language services to those patients with limited English proficiency.

**Cost of Interpreter Services and Funding**

The studies discussed above have documented the impact of language barriers in the access to quality healthcare. It is also noted that patients who have either an interpreter or a bilingual provider make more outpatient visits and receive and refill more prescriptions.
Nonetheless, Jacobs, Shepard, Suaya, and Stone (2004) reported that many providers do not provide interpreter services because of the financial burden.

Jacobs, Shepard, Suaya and Stone (2004) conducted a study that assessed the impact of interpreter services on the cost and the utilization of health care services among patients with LEP. The study was conducted over a two-year period in four healthcare centers that served about one hundred twenty two thousand patients in Massachusetts. In this study a complete interpreter service was provided for the Spanish and the Portuguese-speaking patients. Of these patients three hundred and eighty patients utilized the interpreter service with the Spanish-speaking patients (n=300) being the dominant group to utilize interpreter services. During the study, there were five full time interpreters that provided interpretation services, which was available 24 hours a day either by telephone or in person. The study indicated that there is indeed an increase in cost due to the utilization of an interpreter. However, the authors stated that despite the increase in cost of providing interpreter service, it is a financially feasible method to enhance the delivery of quality healthcare to patients with LEP.

The authors estimated cost of using interpreter services to be $279 per person per year in 2004; according to the National Health Law Program (2010), it is estimated that the pay rate for an interpreter varies from $12-190 per hour currently. The findings of the Massachusetts study indicated that emergency department costs decreased when patients used interpreter services and increased when no interpreter was utilized. Despite the fact that there was an increase in the overall cost of providing primary care, patients visited their provider frequently for preventative services and were able to refill prescriptions that reduced costly medical complications. The study postulated that the increased cost in
preventive services may lower the cost of care overall. The small sample size of the interpreter service group and the settings of study at a well-established staff model health maintenance organization (HMO) limit the study from being generalized.

According to the National Health Law Program in Washington State, language assistance is required for LEP patients who wish it. Even though soon to be unfunded, the state pays interpreters an hourly fee of approximately $22.50. The state estimates that it will spend $24 million over two years for oral interpretation with an estimated 26,000 encounters per month (or 624,000 encounters in two years). Similarly, according to Oregon healthcare workforce institute, the hourly wage for an interpreter is approximately $22.70 with an average annual salary of $47,200 in 2009. Due to the nation’s ever changing demographics, healthcare reform and law that requires the federally funded providers and organization to provide and arrange for interpreters for LEP at no cost, the demand for healthcare interpretation is continually increasing.

**Implications**

The U.S. population is diverse and faces substantial communication problems at almost every level of the health care delivery system. It can be challenging to assess patient preference in the presence of language barriers. By not offering an interpreter service to the patient, healthcare professionals are denying patients an opportunity to speak in their own language within the context of their culture and are violating patients’ right and Title IV of the Civil Rights Act of 1964. By utilizing unqualified interpreter services such as a bilingual relative of the patient, the patient is placed at risk for increased medical error and there is a risk of poor adherence to clinical instructions as well as potential disruption of the family structural unit.
Rendering safe and quality healthcare is the ultimate goal of every provider. Communication failure can result in inaccurate health histories, uninformed diagnoses, misunderstanding of prescription drugs or other treatment instructions; it can also lead to higher costs, lower satisfaction, preventable complications and higher mortality rates and malpractice law suits.

Understanding that communication is a critical aspect of safe, quality patient care and that patients with LEP may require alternative communication methods, the provider needs to find an alternate means of communication that best suits the healthcare organization. It is convenient to use unskilled interpreters like employee, family members, and even children in the absence of professional interpreters. Sadly, there are times when children are asked to interpret for their parents. However, this practice is neither safe nor accurate.

Optimum options available to bridge language barriers are the use of in person interpreter, telephonic interpreter services, video interpreter services, and bilingual provider. As much as healthcare providers recognize the importance of overcoming language barriers, the barriers to implementing cost-effective interpreter service is high. Despite the cost, providers are required by law to practice safe medicine.

As non dominant and perhaps non-English fluent populations become an increasing percentage of the constantly changing American population, their health status will in part define the nation’s health. Hence, failing to tackle language barriers in primary care will result in higher total healthcare spending. Thus, the practice guidelines derived from the above described research to overcome language barriers in primary care settings includes the following:
• Interpreter service options include telephonic, video remote interpretation and in person or face-to-face interpretation.

• Useful resources for interpreter services may be accessed at www.seattlelanguages.com/interpretation.php http://languageline.com or 1800-752-6096, www.pacificinterpreters.com located in Portland, OR or 800-311-1232

• Bilingual employees such as clerks should be used only if they are trained in appropriate medical terminology.

• Use of family members unless requested by the patient is discouraged and the use of minor as an interpreter is not acceptable as it may disrupt the family hierarchy.

• Each provider needs to be aware that the law requires providers to use an interpreter for all LEP and thus the provider should adhere to this regulation to provide safe and quality care.

• It is challenging to increase the number of bilingual/cultural Nurse practitioners (NPs). The process begins with encouragement and mentoring at early educational levels. It can be furthered by nurse educators in undergraduate programs who play a great role. It might be difficult for an underrepresented/minority nurse student to attempt to find a mentor. However, as nurse educators continue to be academic role models by encouraging minority leadership development, more bilingual/bicultural students may further their education to become NPs.
Conclusion

Improving the quality of health care for diverse populations is not about serving anyone’s special interest. It is simply about making sure that we bridge the chasm for all patients despite culture, religion, ethnicity or language. A western Kenya proverb states “you only make a bridge where there is a river” (All Things Kenyan. N.D.). The river in this situation is the language barrier. Language, the big gap in healthcare, can only be overcome by using trained interpretation services. The greatest challenge with the revolving unpredictable economy is the financial aspect of interpreter services. Little has been studied on how cost has influenced language in the primary care setting; thus, the call for more study is imperative. It is evident that when interpreter services are used there is a need for extra time during medical history taking. To assess the extra cost, there is a need to study for how much additional time a provider will require to see a patient with LEP. Increased diversity and bilingual/bicultural providers could improve care for specific practices particularly where there are cultural and linguistic matches between providers and patients. The feasibility of obtaining bilingual providers for every primary care office needs more investigation. Finally, what factors or incentives would influence providers and healthcare organizations to offer language services would need additional investigation.

For many LEP’s the difference between quality care and affordable care is whether or not an interpreter is available. Subsequently, the ability for a provider to clearly communicate with LEP is an essential step in providing safe and high quality care service. Finally, the question to ask is what steps should providers take to effectively handle the problem of language barriers? Purchasing interpreter service is not enough. There is a need for collaboration between the minority ethnic communities surrounding the healthcare and
healthcare providers to work together to foster a world in which all people can have long and healthy lives no matter what their cultural background, the color of their skin or the language that they speak.
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