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Limited English Proficiency in Older Adults Referred to the Cardiovascular Team

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PG receives personal fees for medicolegal consulting related to heart failure; and has received honoraria from Akcea Inc. and Bionest Inc. MSM reports consulting income from Pfizer, GSK, EIdos, Prothena, Akcea, and Alnylam, and the institution received clinical trial funding from Pfizer, Prothena, Eidos, and Alnylam. All others have no disclosures.

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Abstract

Limited English proficiency (LEP) is defined as individuals in whom English is not the primary language and who have limited ability to read, speak, write, or understand the English language. Cardiovascular (CV) team members routinely encounter language barriers in their practice. These barriers have a significant impact on the quality of CV care that patients with LEP receive. Despite evidence demonstrating the negative association between language barriers and health disparities, the impact on CV care is insufficiently known. In addition, older adults with CV disease and LEP are facing increasing risk of adverse events when complex medical information is not optimally delivered. Overcoming language barriers in CV care will need a thoughtful approach. Although well recognized, the initial step will be to continue to highlight the importance of language needs identification and appropriate use of professional interpreter services. In parallel, a health system-level approach is essential that describes initiatives and key policies to ensure a high-level quality of care for a growing LEP population. This review aims to present the topic of LEP during the CV care of older adults, for continued awareness along with practical considerations for clinical use and directions for future research.

Keywords

Cardiovascular disease; Geriatrics; Language barriers; Language interpreter services; Limited English proficiency; Older adults; Technology

INTRODUCTION

Mr. L is an 82-year-old Spanish-speaking man with type 2 diabetes mellitus, hypertension, chronic kidney disease, hearing impairment, decreased physical functioning, and limited English proficiency (LEP), who was admitted to an urban university hospital with progressive dyspnea. Upon discharge, with a new diagnosis of heart failure with preserved ejection fraction, a medical assistant who was not a certified interpreter aided a nurse in conducting medication reconciliation and delivering discharge instructions written in English. Mr. L was readmitted 10 days later for heart failure exacerbation requiring assisted ventilation after self-discontinuation of diuretics due to polyuria and a self-reported minimal understanding of the rationale for recently prescribed heart failure medications. This clinical vignette highlights how older adults with LEP, with or without sensory (hearing or visual) impairments, are at increased risk for adverse events when complex medical information is not appropriately delivered.

LIMITED ENGLISH PROFICIENCY AND DISPARITIES IN CARDIOVASCULAR CARE

In 2015, approximately 70 million US residents were reported to speak a language other than English at home.[1] Of those, 25.1 million (≈41%) had LEP, defined as individuals who report speaking English less than “very well.”[2] Although most individuals with LEP are

immigrants, 4.7 million (≈19%) are born in the United States. The majority (80%) of the LEP population speak either Spanish (≈16.2 million, 64%) or Asian languages (Chinese, Vietnamese, Korean and Tagalog, ≈13%). On average, adults with LEP have less education and are more likely to live in a low socioeconomic state than English-proficient adults. Older adults (≥65 years of age) constituted 15% of the LEP population.[1]

Over the last 2 decades, the association of LEP to higher incidences of adverse events and suboptimal quality of care have been well described. In patients with heart failure, those with LEP have been associated with lower medical understanding and higher hospital readmissions when compared with English-proficient patients.[3,4] This was attributed to a higher chronological age and greater burden of multiple chronic conditions.[5] Utilizing interpreter services and structured interviews in patients with LEP and heart failure, the challenges to bidirectional complex medical information transmission were recently highlighted.[6] This review focuses on older adults with LEP who present to the cardiovascular team—to increase awareness, interest, and future research in this important area—where, unfortunately, substantial data deserts are present.[7]

SPECIAL CONSIDERATIONS FOR OLDER ADULTS WITH LEP

The demographic shift in the United States has resulted in a higher prevalence of older adults living with complex geriatric conditions and cardiovascular diseases.[8,9] LEP adds an additional incremental layer of complexity, expanding disparities in cardiovascular clinical care.[7] Notably, older adults with LEP are more likely to have limited overall health literacy, and specifically, digital health literacy leading to suboptimal outcomes (ie, in comparison with younger adults, older adults may not optimally utilize currently available digital health tools).

Although digital tools are available on standard Apple and Android platforms, they have been principally marketed for persons with a specific disability.[10] Older adults often have multiple associated geriatric conditions that render currently available tools difficult to use. These include physical limitations (eg, motor skills, hand−eye coordination, visual and auditory acuity), cognitive limitations (eg, processing speed, attention, reasoning), and other age-related barriers (eg, privacy, technology anxiety, burden and intrusion).[10] These barriers and the associated time and effort to involve professional interpreters for communication optimization may result in cardiovascular health inequity.

KEY DEFINITIONS IN LANGUAGE EQUITY

The goal of language equity is to ensure high-quality care by implementing interventions to overcome language barriers and to facilitate effective and patient-centered clinical care. Limited English proficiency individuals are those who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English. Further definitions and descriptions of best practices when working with professional interpreter services are shown in Tables 1 and 2, respectively.

HEALTH CARE DISPARITIES WITH NONPROFESSIONAL INTERPRETATION

The act of “getting by,” characterized by the use of nonprofessional interpreters or noncertified bilingual personnel, and by using ad hoc interpreters (family members, friends), has been associated with lower patient satisfaction, self-efficacy, medication adherence, self-care, and reduced understanding of medical conditions.[11] Poor verbal communication increases the risk of patient safety errors, and is associated with suboptimal clinical decision-making, misdiagnoses, delays in medical care, lower rates of inclusion in clinical trials, medication errors, and adverse drug events.[12]

LANGUAGE-CONCORDANT CARDIOVASCULAR CARE

Providing language-concordant cardiovascular care (ie, cardiovascular team member[s] who speak the patient’s language) can build rapport and break down barriers to limited health literacy and low acculturation that impact the relationship between the patient and the cardiovascular team. Compared with a reliance on professional interpreters, language-concordant care is associated with increased patient satisfaction, improved chronic disease management, and fewer emergency department visits.[12]

It is important to recognize that the best care provided through an interpreter is inferior to language-concordant care for patient comprehension and satisfaction.[13] Patients who switched from a language-discordant physician to a language-concordant physician experienced significantly improved glycemic control.[14] The national Culturally and Linguistically Appropriate Services standards encourages cardiovascular team members who self-identify as fluent in a language other than English to determine their language proficiency and seek bilingual certification.[15] The Clinician Cultural and Linguistic Assessment offers validated oral proficiency tests in multiple languages. It is important to clarify that even if a cardiovascular team member passes the Clinician Cultural and Linguistic Assessment examination, they should be careful to not function as an interpreter due to the varying skills sets needed for optimal job performance.

BENEFITS OF PROFESSIONAL INTERPRETER SERVICES

When language-concordant care is not available, the use of professional interpreters is superior to nonprofessional interpreters. Benefits include fewer errors in communication, higher patient and clinician satisfaction, lower malpractice risk, and fulfillment of legal requirements of Title IV of the Civil Rights Act.[16] Conversely, the use of nonqualified interpreters is associated with higher risk of prolonged hospitalizations and 30-day readmissions.[17] Therefore, health care systems and cardiovascular team members should offer professional interpreter services to patients with LEP, regardless of their English language proficiency.

CARDIOVASCULAR TEAM MEMBERS FACE BARRIERS TO ACCESS OF LANGUAGE SERVICES

Despite the demonstration of the positive impact of language access on quality of care and health outcomes,[16] current federal reimbursement models have inconsistently provided funding for interpreter services, leading to health care organizations often being unable to meet Culturally and Linguistically Appropriate Services standards. Additional limitations include inadequate access to remote interpretation equipment (phone, video, stable Internet connectivity) and insufficient availability of in-person interpreters. Even when interpreter services are available, factors related to time constraints, clinical urgency, geriatric conditions, and therapeutic and ethical considerations can influence the use of professional interpreters.[18]

HIGH-RISK SCENARIOS IN GERIATRIC CARDIOVASCULAR CARE

Most studies of older adults with geriatric conditions and LEP or family members with LEP demonstrate a greater risk of complex shared decision-making during high-risk scenarios such as catheter-based or surgical procedures, device implantation, advanced heart failure therapies, anti-coagulation for atrial fibrillation, hospital discharge, after-clinic visits, and advanced care planning discussions.[11] However, there are mixed data in this area.

An Australian study of physician–patient language discordance noted that in patients undergoing primary percutaneous coronary intervention for ST-elevation myocardial infarction, LEP was an independent predictor of longer door-to-balloon times with similar 30-day mortality when compared with English-proficient patients.[19] However, a small study, conducted in Australia and New Zealand, failed to demonstrate disparities in the receipt of percutaneous or surgical coronary intervention or major adverse cardiovascular events in patients admitted after an acute coronary syndrome.[20] Moreover, using the National Health and Nutrition Examination Survey, patients with LEP were noted more likely to not report having cardiovascular disease despite having concomitant anginal symptoms.[21] A study of cardiopulmonary resuscitation delivery instructions to LEP callers demonstrated poor resuscitation quality and an additional 2 minutes to resuscitation in LEP callers who witnessed a sudden cardiac death.[22] When possible, these clinical scenarios should always include documentation of professional interpretation for patients with non-English language preference.

HIGH-RISK SCENARIOS IN ADVANCED CARE PLANNING

Advanced care planning (ACP) is a process that prepares patients and their designated surrogate decision-makers for medical decision-making and allows patients to share their personal values, life goals, and preferences regarding current and future medical care.[23] Unfortunately, ACP rates are low (~11%) among Spanish-speaking patients with LEP, and, until recently, easy-to-use ACP tools for patients with LEP and limited health literacy were not available. The cardiovascular team can play an important role in engaging adults with LEP by providing easy-to-use ACP tools in their preferred language.

PREPAREforYourCare.org[24] has evidenced-based ACP materials in Spanish and other languages.

PATIENT INFORMATION AND EDUCATION ACCESS

Choosing effective educational resources is imperative to optimizing cardiovascular care. Patients should be asked about their preferred language for written medical information. The cardiovascular team should be aware of the limitations in providing written instruction using web-based translations like Google translate, where there is a risk of inaccurate or mischaracterized translations with complicated and long sentence structures.[25] Vetted and appropriately created print and audiovisual non-English materials are available at the American College of Cardiology's website (www.cardiosmart.org) in Spanish, Portuguese, Chinese, French, Arabic, and Italian. Moreover, the federal Department of Health and Human Services has established a "HELP" line for those with LEP.[26]

PATIENT-LEVEL INTERVENTIONS

To efficiently address language barriers in older adults with LEP, patient-level and system-level interventions could be implemented through a coordinated team (eg, health care administrators, cardiovascular team members, medical assistants, social worker) approach. However, the efficacy and the cost-effectiveness of this is not fully known.

Identification of Language Preference

Screening, identifying, and documenting patients' language preferences can optimize care. Cardiovascular team members should assess patients' language preference for their health care management by asking whether English is the primary language spoken at home and the willingness to utilize a professional interpreter. If the answer is anything other than English, an interpreter should be used and the language of preference should be documented in the health record (Figure).

Proactive collection of language data can allow cardiovascular teams to tailor interventions to their LEP patient population. Data validation requires standardization of screening questions (as noted above) to identify language of preference and interpreter service use documentation. Large registries such as the American College of Cardiology's National Cardiovascular Data Registries provide health care systems with measures of quality of care that incorporate race and ethnicity. However, data on language preference and English proficiency are not currently collected. The systematic collection and analysis of language data should provide further insights into the impact of LEP on cardiovascular care and outcomes.

Appropriate Use of Interpreter Services

During face-to-face interactions, language-concordant care should be prioritized. The use of professional interpreters during any encounter should be documented. Moreover, face-to-face interpretation can assist in enhancing trust and rapport. For older adults with sensory impairment, in-person patient-facing interpreters will allow lip reading and affords

the interpreter an opportunity to read nonverbal communication. Reminding patients and families to bring/wear their hearing aids, glasses, or other devices is invaluable.[27]

Compared with in-person services, remote interpretation through video or telephone has the advantage of 24-hour availability in a broad range of languages that is easily accessible with a lower cost. If remote interpretation is needed, video is preferred, as phone interpretation does not afford the visual elements often needed for high-quality communication (Figure). Table 1 provides recommendations for best practices when working with interpreter services.

SYSTEM-LEVEL INTERVENTIONS

Quality improvement initiatives by health care organizations focused on achieving high standards of cardiovascular care for patients with LEP should:

- Inform patients of their rights to access to language services.
- Facilitate screening and tracking of language preference and documentation of provision of interpreter services in electronic health records.
- Provide easy access to high-quality interpreter services staff and equipment.
- Increase availability of in-person interpreters.
- Train cardiovascular team members on appropriate use of interpreter services.
- Ensure availability of high-quality language-concordant health educational materials.
- Ensure that language appropriate medication labeling is provided.
- Ensure support of the older adult patient and caregiver by having easy to read/understand instructions and ensure HELP-line availability (in person and virtually).
- Increase recruitment and training of health care professionals that can provide language and cultural concordant care.
- Facilitate certification of cardiovascular team members in second language use.

CONCLUSIONS

Health care organizations and cardiovascular team members will need to adapt to the growing population of older adults with limited English proficiency. This can be done during daily practice by ensuring the use of high-quality interpreter services and language-concordant providers along with educational resources when addressing language barriers. Clinician–patient language-concordant care should be the gold standard. In its absence, in-person professional interpretation is preferred followed by video and telephone interpretation. Family members or nonprofessional interpreter services should be avoided, if possible.

It is important to recognize that nationwide strategies to implement linguistically and culturally diverse cardiovascular workforce are critically needed. Federal and state policies should continue to encourage enhanced reimbursement support for language services, including reimbursement for the additional time needed to effectively converse with patients with LEP. Moreover, local registries of patients with LEP and bilingual and trained health care workers that stimulate additional research is still needed. These registries can aid the exploration of associations between LEP, interpretation modalities, language-concordant communication, and cardiovascular care and outcomes.

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CLINICAL SIGNIFICANCE

- Optimal cardiovascular care in older adults should include language needs identification, and appropriate use of professional interpreter services.
- Health systems should attempt to initiate policies to ensure a high level quality of care for a growing limited English proficiency population

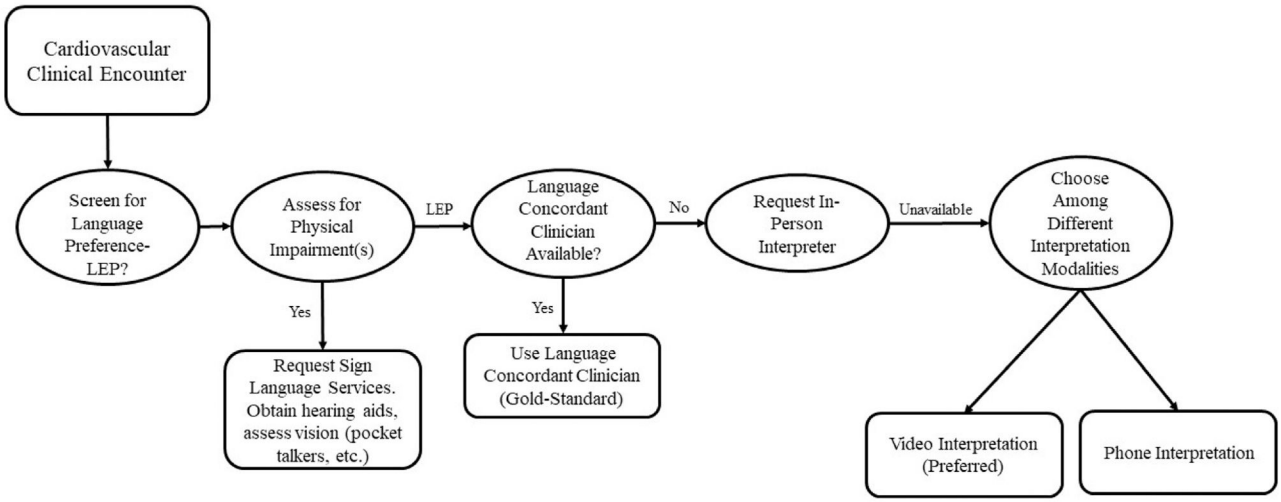

Figure.

Stepwise approach to patients with limited English proficiency (LEP) who present to the Cardiovascular team.

Table 1

Key Definitions of Language Equity

• Professional Medical Interpreter: A person who renders a message spoken in one language into a second language, and who abides by a code of professional ethics.
• Professional Translator: A person specially trained to convert written text from one language to another.
• Ad Hoc Interpreter: An untrained person who is called upon to interpret (family member interpreting for their parents, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual in a hospital waitingroom who volunteers to interpret).
• Certified Bilingual Healthcare Professional: A health care professional who has been formally assessed for a high level of proficiency in at least 2 languages.
• Language-Concordant Care: Care provided by a health care professional who is highly fluent in the patient's preferred language.
• High-Risk Scenario: Clinical encounter when sensitive information is exchanged, such as during history and physical examination, discharge instructions, advance care planning, and goals of care conversations, obtaining informed consent, medication reconciliation discussions.

Table 2

Best Practices and Practices to Avoid When Working with Professional Interpreter Services

Best Practices	Practices to Avoid
• Utilize a pre-patient encounter huddle with interpreter if possible.	• Avoid framing a discussion using a third-person manner, eg, “he said,” “tell her.”
• Use first-person statements.	• Avoid addressing the interpreter instead of the patient.
• Use short sentences.	• Avoid side conversations with the interpreter.
• Insist on sentence-by-sentence interpretation.	
• Speak directly to the patient and maintain eye contact.	
• Avoid having the phone/video equipment or the interpreter staff in between you and the patient.	
• Prioritize key points of conversation.	
• Discussion of complex medical issues should be in a serial (vs parallel) manner.	
• Elicit patients’ perspective to enhance patient centered care.	