

# The Missing Strategy in Addressing Language Barriers

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**C**oronavirus disease 2019 (COVID-19) mortality data show that Latinxs are disproportionately dying in the United States.<sup>1</sup> These findings parallel known health disparities for Latinxs, which can be attributed in part to language barriers. More than 25 million individuals in the United States have limited English proficiency (LEP), including 16 million Spanish speakers, and they are more likely to receive worse health care and experience poorer outcomes.<sup>2</sup> COVID-19 is now magnifying these disparities that continue to persist in part because current language interventions, such as interpreter services and linguistically tailored health information, offer limited solutions to a more upstream, overlooked, and modifiable factor: a patient's access to improving their English proficiency and health literacy.

When patients and their clinicians do not speak the same language, patients receive less health education and experience more testing, more readmissions, and longer lengths of stay, resulting in higher health care utilization.<sup>3</sup> Beyond the clinical setting, language, like other social determinants of health, affects patients' lived environments, including their ability to understand food labels, apply for public housing services, and access reliable community health information. This reality puts them at increased risk of downstream consequences such as mental health problems and chronic health conditions. When language barriers are present, patients suffer, clinicians fail to effectively deliver care, and the health care system faces increased costs.

Traditionally, language barriers have been addressed only by interpreters at the point of care. Interpreters improve patient satisfaction and clinical outcomes.<sup>4</sup> However, interpreter use has been hampered by variable clinician use, patient disenfranchisement, limited availability in rural geographies, and absent or insufficient reimbursement.<sup>5</sup> The increasing demand on clinician time during COVID-19 has likely only decreased interpreter use. Furthermore, the financial impact of COVID-19 on places with already strained financial budgets could lead to the deimplementation of poorly reimbursed interpreter services.<sup>6</sup> Interpreters are essential, but their services are now constrained more than ever. They also do not directly modify the patient's primary risk factor for poor outcomes—namely, having LEP.

## ABSTRACT

The coronavirus disease 2019 pandemic is magnifying preexisting health disparities whereby patients with limited English proficiency receive lower-quality health care and experience poorer outcomes. To address these realities, language interventions to date have focused on interpreter services and linguistically tailored health information. But these limited solutions fail to target a more upstream, overlooked, and modifiable factor: a patient's access to improving their English proficiency and health literacy. We present recommendations for addressing language as a social determinant of health by improving access to English as a Second Language programs. This article outlines steps that health systems and policy makers can take to more directly treat upstream causes of language disparities.

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## TAKEAWAY POINTS

We introduce how English as a Second Language (ESL) courses can address inequities in access to care and health outcomes—many of which have been magnified during the coronavirus disease 2019 pandemic. Further, we present solutions that health systems and policy makers can adopt to improve access to these programs. We anticipate that this article will catalyze debate and quality improvement work for patients with limited English proficiency (LEP). We also believe that our piece is of critical importance to health care administrators, clinicians, and other health professionals who affect the care trajectory of these patients, especially during a pandemic that has disproportionately affected communities of color.

The pandemic has further highlighted the importance of mitigating language-based disparities. By following the 3 points below, health care leaders can improve their health care delivery practices for patients with LEP:

- ▶ improve health care delivery for populations with LEP,
- ▶ partner with community-based organizations that teach ESL, and
- ▶ leverage Medicaid and work with insurers to better manage the care of non-English-speaking patients.

Driven by risk-bearing payment structures, provider organizations are recognizing the relationship between an upstream cause of disease and patient well-being. But such systems largely overlook a critical opportunity to address language barriers and health literacy by increasing adoption of English as a Second Language (ESL) programs.

### Access to ESL Programs

ESL programs are interactive didactic courses that teach non-English speakers the basics of the English language. By the end of the course, learners have higher reading comprehension and improved English-speaking skills. More germane to health professionals, however, is the courses' ability to improve health literacy and, subsequently, patient health. Individuals enrolled in ESL courses that focus on health experience improved understanding of their illnesses (eg, diabetes, hepatitis B) and general nutrition. After course completion, many participants change their diets to avoid unhealthy foods and increase fruit and vegetable intake.<sup>7</sup> Benefits even go beyond the individual, as participants report sharing preventive health content with their community. Improvements in clinical outcomes, including hyperlipidemia and blood pressure control, have also been linked with health-focused ESL programs. For individuals with some English proficiency, one 3-hour session improves general health knowledge. Those with more limited English skills typically require a few months.<sup>7</sup>

Despite current policies in support of ESL programs, access to free ESL courses is limited; individuals can wait years for a spot. Demand is so high that almost 3 in 5 ESL providers have waiting lists, and some have discontinued classes due to lack of funding.<sup>8</sup> The limited supply also damages the learning quality for those who do get a spot—programs are forced to combine learners with different levels of proficiency, creating challenges for instructors to teach effectively. As health care leaders and policy makers focus on social determinants of health and language services in the postpandemic era, access to health-focused ESL courses should be part of the conversation.

### Addressing Language as a Social Determinant of Health

The provision of health-focused ESL courses can mitigate adverse health effects in the LEP population. We present recommendations for expanding the role of the health care system in addressing language as a social determinant of health and reducing language disparities that arise from patient-clinician interactions.

Hospitals can honor their role as anchor institutions by partnering with existing community-based ESL organizations. Expanding ESL health literacy resources through capital investments could allow for more classes and teachers to expand student capacity for high-risk patients. Funding could also be sought through the reintroduction of an Obama administration

federal proposal that supported partnerships among states, adult education providers, higher education institutions, and private organizations.<sup>9</sup> Bolstering language services with health-focused ESL courses may ultimately reduce health care spending and satisfy mandatory community health needs assessment implementation strategies. Currently, many hospitals prioritize “language” on their community health needs assessment, yet it is likely that none target the upstream opportunity of extending language resources.

More feasibly, hospitals can leverage Medicaid Section 1115 waivers—tickets that allow states to implement new health care delivery programs—to target language as a social determinant of health. For instance, North Carolina recently received \$650 million from CMS to address housing instability, transportation security, food insecurity, interpersonal violence, and toxic stress.<sup>10</sup> Language barriers could be added to that list for North Carolina and other states that utilize a waiver. Additionally, given the significant portion of privately insured Spanish speakers, insurers could provide vouchers for their LEP population to attend payable ESL courses that are often in lower demand because of their cost. This program could build from wellness initiatives, such as gym reimbursement programs, that provide financial incentives. Health systems can then evaluate the effectiveness of their courses internally or by partnering with the Department of Education, which provides funds for evaluation of adult education programs.<sup>11</sup>

Access to health-focused ESL classes can be improved, but participation can still be hindered by day-to-day patient barriers, such as working multiple jobs and lacking transportation. Thus, ESL programs should not be implemented in isolation but rather as part of a larger infrastructure focused on addressing patients' social needs. There may also be opportunities to harness virtual classes to meet patients' varying daily challenges. Once these systems are in place, health care institutions should continue expanding linguistically diverse staff, clinicians should continue practicing culturally competent care, and hospitals should continue offering language assistance at the point of care. ESL programs that patients can opt into should not replace these services but instead augment them.

During this public health emergency, health systems may appropriately focus on clinical operations, but they need to soon turn their attention to addressing the upstream causes of language barriers. This strategy could better prepare us for the next pandemic by minimizing language discordance between a patient and their clinician or public health system. Clinical leaders can begin by partnering with existing community-based ESL organizations, leveraging Medicaid Section 1115 waivers, and providing voluntary at-risk patients with ESL course vouchers. Patient health and institutional financial sustainability could both be positively affected if language is treated like all other social determinants of health. ■

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