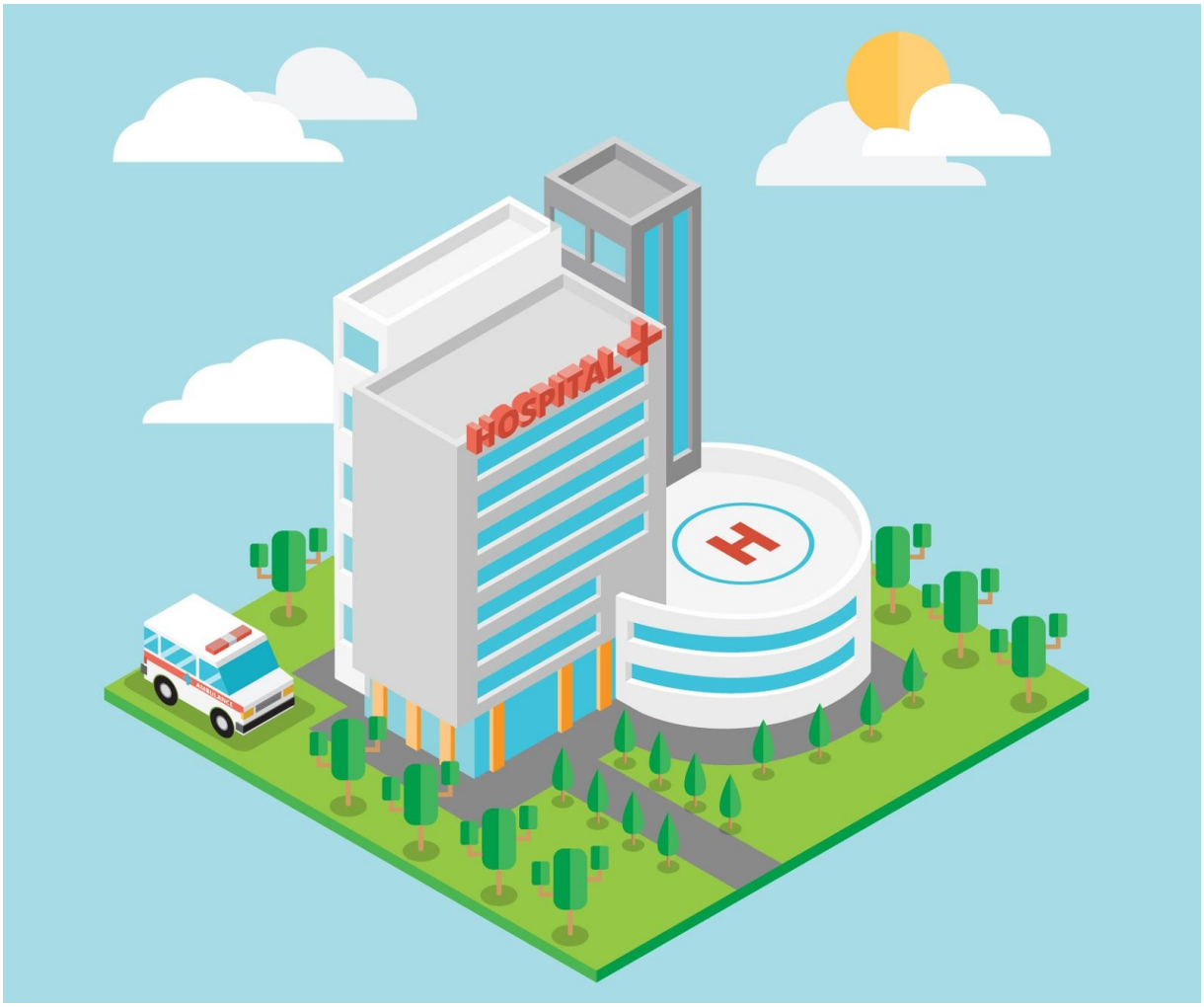
Language Barriers and Hospital Readmission Rates: An Overview



LUNA | Language Services

Introduction: The Cost Implications of Hospital Readmissions

Each year, approximately 2 million Medicare beneficiaries are readmitted to the hospital within 30 days of discharge, costing the federal health insurance program $26 billion.[1] Of this figure, an estimated $17 billion results from potentially avoidable readmissions.[2]

Preventing needless hospital readmissions has become a major target of cost control for healthcare providers in recent years—an objective due in no small part to the *Hospital Readmissions Reduction Program* (HRRP). Established under Section 3025 of the Affordable Care Act, the HRRP penalizes hospitals with Medicare readmission rates that exceed national averages.[3] In short, the HRRP aims is to cut excessive healthcare spending while improving patient safety and quality of care.[4]

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[1] Am. Hosp. Ass'n, *Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care*, Trend Watch (Sep. 2011), http://www.aha.org/research/reports/tw/11sep-tw-readmissions.pdf;; Joseph R. Betancourt et al., Ctrs. for Medicare & Medicaid Servs., Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries 1 (2015), *available at* https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf.

[2] Betancourt et al., Guide to Preventing Readmissions, *supra*, at 2.

[3] Pub. L. No. 111–148 § 3025(a), 124 Stat. 119, 408 (2010). *See also* Ctrs. for Medicare & Medicaid Servs., *Readmissions Reduction Program (HRRP)*, https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html (last updated Apr. 18, 2016); *and* Cristina Boccuti & Giselle Casillas, Kaiser Family Health, *Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program: Issues Brief* (Mar. 10, 2017), http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program.

[4] Am. Hosp. Ass'n, *Examining the Drivers of Readmissions*, *supra*.

While not all readmissions are preventable, hospitals can preempt a number of them by addressing certain barriers patients face before, during, and after admission and discharge.[5] Several studies have shown that demographic and socioeconomic factors—such as a patient's race, ethnicity, language proficiency, age, socioeconomic status, place of residence, and disability—may be predictors of readmission risk.[6] Given today's increasingly diverse patient population, these factors present a daunting challenge for hospitals delivering high-quality care while addressing the persistent cost implications of readmissions.

The Effect of Language Barriers

Approximately 64.7 million individuals—both foreign and native born—speak a language other than English at home, according to the U.S. Census Bureau.[7] While the majority of these individuals also speak English either fluently or very well, nearly 40 percent (25.9 million) are considered Limited English Proficient (LEP).[8] Limited English proficiency refers to anyone above the age of 5 who reported speaking English less than "very well," as classified by the Census Bureau.[9]

Approximately 4 million or 8% of the more than 52 million Medicare beneficiaries are limited English proficient.

In a 2006 survey, 63% of hospitals nationwide reported encountering LEP patients either daily or weekly.[10] Moreover, the LEP population accounts for approximately 4 million or 8% of the more than 52 million Medicare beneficiaries, raising significant cost

[5] Betancourt et al., Guide to Preventing Readmissions, *supra*, at 1.

[6] *Id*. (citing various studies for each of these factors); *see also* Am. Hosp. Ass'n, *Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care*, Trend Watch (Sep. 2011) (same).

[7] Migration Policy Instit., *Language Diversity and English Proficiency in the United States* (Nov. 11, 2016) (citing U.S. Census Bureau, American Community Survey Data), http://www.migrationpolicy.org/article/language-diversity-and-english-proficiency-united-states.

[8] *Id*.

[9] *Id*.

[10] Romana Hasnain-Wynia et al., Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey i (2006), *available at* http://www.hret.org/quality/projects/resources/languageservicesfr.pdf.

implications for hospitals that ignore the potential impact language barriers have on readmissions.[11] According to the Centers for Medicare and Medicaid Services, "Limited English proficiency is associated with several factors that contribute to avoidable readmissions, including lower rates of outpatient follow up and use of preventive services, medication adherence, and understanding discharge diagnosis and instructions."[12] Research has also shown that language barriers—reinforced by the absence of a qualified interpreter—often result in extended hospital stays.[13] Several peer-reviewed, physician-led studies affirm these general observations. Specific findings include the following:

- The **length of stay for** LEP patients with certain medical and surgical conditions is approximately **0.5 days longer** than English-proficient (EP) patients with similar conditions.[14]
- The **length of stay** for LEP patients ***without* access to an interpreter** on both admission and discharge days is about **1.5 days longer** than LEP patients *with* access to interpreters on both days.[15]
- **Readmission rates** for LEP patients ***without* access to an interpreter** on both admission and discharge days are **9.4% higher** than LEP patients *with* access to interpreters on both days.[16]

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[11] Ctrs. for Medicaid & Medicare Servs., Off. of Minority Health, Understanding Communication and Language Needs of Medicare Beneficiaries (2017).

[12] Joseph R. Betancourt et al., Ctrs. for Medicare & Medicaid Servs., Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries 5 (2015), *available at* https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf. *See also* Joseph R. Betancourt et al., Agency for Healthcare Research and Quality, Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide for Hospitals 3 (2012).

[13] Leah S. Karliner et al., *Language Barriers and Understanding of Hospital Discharge Instructions*, 50 Med. Care 283 (Apr. 2012), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3311126; Mary Lindholm et al., *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates*, 27 J. Gen. Intern. Med. 1294 (Apr. 2012), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680.

[14] A. John-Baptiste et al., *The Effect of English Language Proficiency on Length of Stay and In-Hospital Mortality*, 19 J. Gen. Internal Med. 221 (2004).

[15] Lindholm et al., *Professional Language Interpretation*, *supra*, at 1296.

[16] *Id*. at 1297.

- A 2017 study reported a **4.4% decrease** in hospital readmission rates among LEP patients with 24-hour access to remote (phone) interpreter services during an 8-month period, resulting in an estimated total savings of **$1.3 million** *after* accounting for interpreter service costs.[17]

- Non-professional, ad hoc interpreters—who may include family members, friends, nonclinical hospital employees, or others with no formal training—can **misinterpret or omit up to half** of physicians' questions, are less likely to note medication side effects or other information of clinical significance, and have a higher risk of ignoring embarrassing issues (especially when children or other family members are used to interpret).[18]

- LEP patients are **40% more likely** than EP patients to experience physical harm associated with an adverse event, a result due in large part to communication errors.[19]

Recommendations

Effective communication is essential for providing quality care to LEP patients. The following measures, when combined with other strategies, are likely to reduce readmission rates and hospital stays among the LEP patient population:

- Confirm that LEP patients are aware of, and have access to, a qualified medical interpreter during inpatient stays, discharge, and when accessing post-hospital care.

- Ensure that discharge instructions, both oral and written, are communicated in the patient's preferred language.

- Avoid using a patient's family members or friends as interpreters. These persons may

[17] Leah S. Karliner et al., *Convenient Access to Professional Interpreters in the Hospital Decreases Readmission Rates and Estimated Hospital Expenditures for Patients With Limited English Proficiency*, 55 Med. Care 199, 203 (Mar. 2017).

[18] Lindholm et al., *Professional Language Interpretation*, *supra*, at 1294; Glen Flores, MD et al., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, 111 Pediatrics 6 (Jan. 2003), *available at* https://www.unige.ch/presse/archives/unes/2007/pdf/Pediatrics_Interpreter_Errors_%20Article.pdf.

[19] Chandrika Divi et al., *Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study*, 19 Int'l J. Qual. Health Care 60 (2007).

not be trained to understand medical terminology and issues of confidentiality may prevent them from disclosing critical health information.

- Reduce the complexity of discharge and self-care instructions provided to patients by using terminology the patient understands (i.e., avoid use of medical jargon). Health literacy refers to a patient's ability "to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[20] Barriers to health literacy are more common among minority adults and those who speak English as a second language.[21]

- Facilitate trust with patients by demonstrating respect for cultural practices and beliefs that may impact understanding of their medical condition, treatment, possible outcomes, risks, and patient self-management.

Resources

Agency for Healthcare Research and Quality, Re-Engineered Discharge (RED) Toolkit.

The RED Toolkit includes a series of tools that provide implementation guidance with a focus on language barriers, cross-cultural care, and communication and trust with diverse patient populations. Addressing these factors is critical to ensuring patients' understanding of their diagnosis, care, and discharge instructions. Tool four specifically addresses the role of culture, language, and health literacy in readmissions and walks the user through the preparation required to provide RED to diverse populations. The tool also provides detailed examples of culturally appropriate approaches to implementing the RED. Key issues when working with diverse populations are highlighted, including: assessing communication needs; working with professional interpreters; communicating across differences;

[20] U.S. Dep't of Health & Human Servs., *Quick Guide to Health Literacy*, https://health.gov/communication/literacy/quickguide/factsbasic.htm (last visited Jun. 2, 2017).

[21] U.S. Dep't of Health & Human Servs., *America's Health Literacy: Why We Need Accessible Health Information* (2008), www.health.gov/communication/literacy/issuebrief. *See also* David W. Baker, MD et al., *Functional Health Literacy and the Risk of Hospital Admission Among Medicare Managed Care Enrollees*, 92 Am. J. Pub. Health 1278 (2002) (indicating that limited health literacy is linked to more frequent hospitalization and readmissions).

understanding how culture informs health beliefs, attitudes, and behaviors; and understanding the role of family and community.

Centers for Medicare & Medicaid Services, Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries (2015).

Developed for the CMS Office of Minority Health and "all hospital leaders such as CEOs, VPs, and others, who focus on quality, safety, and care redesign," this guide presents (1) an overview of key issues related to readmissions for racially and ethnically diverse Medicare beneficiaries; (2) a set of activities that can help hospital leaders take action to address readmissions in this population; and (3) case studies of strategies and initiatives aimed at reducing readmissions in diverse populations. Several key issues focus on language barriers and access to interpreter services, health literacy, and culturally-competent patient education.

U.S. Department of Health & Human Services, *National CLAS Standards*.

First issued in 2000 by the Health and Human Services Office of Minority Health (OMH), the National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) establish a blueprint for healthcare organizations to "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs."

Three of the CLAS Standards relate to communication and language assistance: (1) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources; (2) recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area; and (3) educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

With implementation of the Affordable Care Act in full swing, these standards—while not legally binding—serve as a critical guide to developing policies and strategies that improve the quality of health care services and meet the needs of an increasingly diverse patient population.

Last Updated: June 13, 2017.

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