

Caring for Children and Families With Limited English Proficiency: Current Challenges and an Agenda for the Future

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This month's issue of *Hospital Pediatrics* features 2 articles addressing quality of care for children and families with limited English proficiency (LEP),^{1,2} highlighting an important area of growing concern for clinicians and researchers. Children from LEP families make up a large and expanding proportion of the US population,³ but as these 2 articles show, we continue to face substantial challenges both in providing these children with high-quality, equitable care and in studying them, which is an important prerequisite to developing effective interventions to improve care.

A primary challenge in both caring for and studying LEP patients and families lies in correctly identifying them. Many institutions do not consistently collect language data, and those that do often record the primary language spoken at home, which does not adequately identify the presence of a language barrier or the need for interpretation.^{4,5} This situation leads to clinicians being unable to rely on the language information captured in the medical record to determine interpreter need, which then encourages many to assess the family's English ability with each communication and "get by" without an interpreter if they can.^{6,7} The collection of less helpful or inconsistent language information also makes it very difficult to study language barriers within large databases such as the Pediatric Health Information System, given the variability in the institution-level data.

In pediatrics, we face the additional challenge of trying to determine whose English proficiency or interpreter need to document, because different caregivers' needs may differ and not all caregivers are always present. For the purposes of clinical care, it would be ideal to assess and document the English proficiency or interpreter need for each caregiver individually, although the question of how to handle multiprofile families for research purposes would remain. These challenges are all evident in the definition of the LEP group in the article by Ju et al,¹ in which the authors used a combination of non-English primary language, documentation of interpreter use, and/or having a language barrier documented during the initial nursing assessment. This approach reflects the current limitations of the data collected at most institutions, but resulted in a somewhat counterintuitive LEP group that was larger than the population recorded as speaking a non-English primary language (26.3% LEP but only 18.5% recorded as a non-English primary language). This result may reflect failure to assess and record language for many families, incorrectly assigning families to English, or differences in the proficiency of caregivers present at different times (eg, the English-proficient mom was present at the initial assessment, but the grandmother with LEP

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has requested an interpreter for updates). Regardless of the reasons, such inconsistencies result in poorly defined populations at risk and may account for the lack of an overall association between LEP and readmissions in their study. Until these challenges are addressed, our ability to effectively understand the current state and to improve care for children and families with LEP will be limited by inconsistent findings across different institutions and data sets.

Another important issue to consider in improving care for LEP children and families that the article by Ju et al highlights is the importance of effect modification and the additive impact of multiple barriers to engagement with care. The authors found that income and race/ethnicity were important effect modifiers of the relationship between LEP and readmissions, which they hypothesized might be related to the availability and use of professional interpretation (with lower availability of non-Spanish interpretation) for the former and additional socioeconomic status-related barriers for the latter. One could imagine low literacy, difficulty filling or understanding prescriptions, difficulty obtaining follow-up care, or competing priorities as important additional barriers that might be more common among the lowest income LEP populations and that contribute to increased readmissions.^{5,8} Improving our ability to measure both actual interpreter use and these additional barriers to care will greatly improve our ability to understand current care delivery and improve outcomes for these vulnerable children.

A third important challenge to effectively studying children and families with LEP lies in the difficulties of translating survey measures across languages and cultures. The article by Zurca et al² highlights 1 approach to this problem, in which they developed their survey measures de novo and reviewed them with both English- and Spanish-speaking focus groups. The use of survey-based outcomes is appealing, given both the critical importance of understanding care from the family's perspective and the sample-size challenges

attendant on trying to study administrative measures that are either uncommon (eg, readmissions) or highly variable (eg, costs). However, relatively few relevant validated survey measures exist in Spanish, and even fewer exist in other languages. More importantly, the majority of measures that do exist in Spanish were translated or adapted from English and were not developed or refined with the use of input from the cultural groups in which we now seek to use them. This situation can lead to response patterns that differ in important ways across groups and complicate interpretation of results.⁹ This situation puts researchers in a difficult bind. Either they can choose to use survey measures that have not been fully validated in their target population (whether they develop new ones or translate/adapt existing ones) and run the risk of obtaining confusing, inaccurate, or invalid results or they can exclude populations for whom validated survey measures do not exist, which is ethically problematic, because it systematically excludes vulnerable groups from the possibility of benefitting from research. In the long term, researchers and funding agencies need to recognize the importance of developing culturally and linguistically appropriate survey measures and be willing to invest the time and money required to do it in a rigorous fashion.

Unfortunately, as both featured articles show, many children from families with LEP continue to receive lower quality, less equitable care compared with children from English-proficient families. In the article by Zurca et al, only 73% of families reported receiving any interpretation at admission to the PICU, which is a time of critical illness for the child and high stress for the parents, and of those, 7% reported reliance on a family member or friend to interpret, a practice we know is associated with a high risk of error.¹⁰ Over the course of the PICU stay, only 53% of families reported that the medical team used an interpreter most or all of the time, and 14% reported rarely or never receiving one.² Given that professional interpretation is necessary but not sufficient to achieve effective communication with LEP families and that effective communication is critical to

providing high-quality, family-centered care, we have a long way to go in pursuit of equitable care delivery for LEP families. And although Ju et al were not able to explore precisely what factors led to the higher readmission rates among some groups of LEP families in their study, it seems clear that we are similarly falling short in achieving equitable outcomes.

If we are going to make progress on improving the quality of care for this population, institutions, clinicians, funders, and researchers will need to come together to recognize the importance of the current inequity and commit to finding solutions. Specifically, we need to expand and standardize what language data are collected and shared by institutions; fund and engage in rigorous survey measure development and validation for specific, less-common language and culture groups; think comprehensively about risk factors for worse care or outcomes and how they might interact with one another; change medical culture so that infrequent, broken, batched communication is not considered acceptable; and develop, test, and implement interventions to address the many barriers these families face to full engagement. The articles in this issue of *Hospital Pediatrics* make important additions to the large and growing body of evidence that shows deficits in the care provided to LEP patients and families, but until larger change occurs in the system we will be doomed to keep reporting the same kinds of inequities, without moving substantially closer to effectively addressing them.

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