

Navigating Telehealth in Limited English Proficiency Populations

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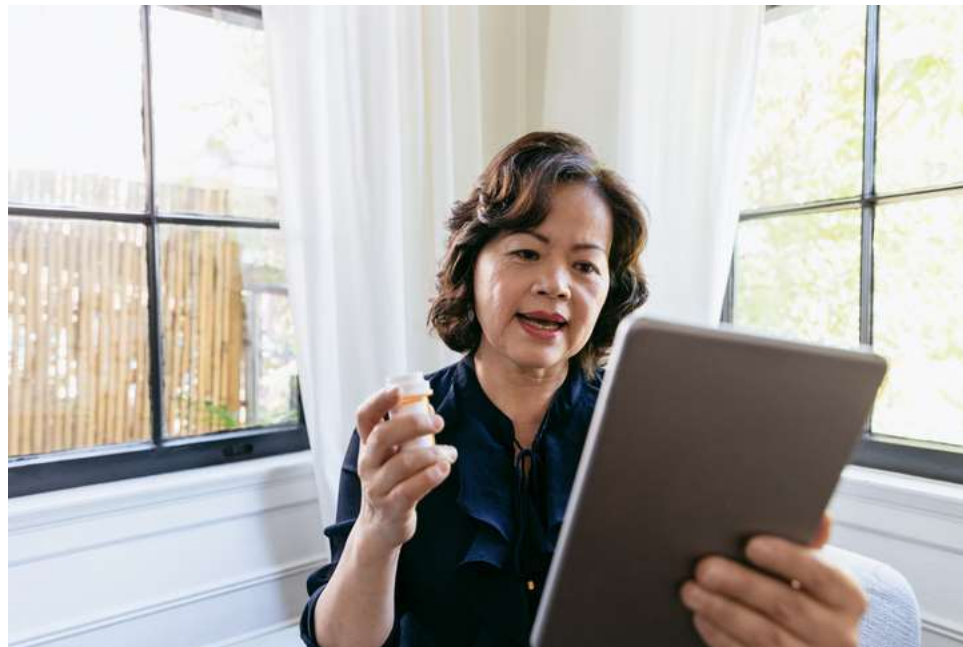
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Background

During the novel coronavirus crisis, many clinics across the country have rapidly converted in-person visits to Telehealth/Telemedicine. This allows for patients to still meet with providers virtually and discuss important aspects of their health, while limiting exposure to health systems. The movement towards Telehealth raises questions about access for patients with limited English proficiency (LEP). For members of marginalized populations, the switch to Telehealth may exacerbate health disparities, including limited access to technology. For instance, studies have shown that use of live video communication was used less frequently by patients with lower incomes, in rural settings, and on Medicaid (Park et al., 2018). In addition, users of a direct-to-consumer telehealth platform were more likely to be employed, living in an urban setting, have a higher education level and have greater access to internet and devices (Liaw et al., 2019).

We acknowledge that this topic is very new, and new data is emerging every day. Through 27 interviews with primary care providers (19), social workers (2), and medical interpreter/caseworker cultural mediators (CCMs) (6) at various clinic sites in

Seattle, WA, we created a rudimentary guide on how to navigate Telehealth for LEP populations.



Woman discusses her prescription medication with a doctor via video conference.

Summary

Telehealth is an important new tool in medicine that is quickly gaining traction. However, LEP populations face specific barriers to care. This article aims to accomplish the following:

- 1) Explore the challenges that LEP patients face with Telehealth
- 2) Offer suggested Telehealth focused practice models for providers

Although Telehealth can be optimized at all levels, the focus of this piece is at the **provider** level.

Barriers to Care

We have identified six main factors that impact LEP populations in Telehealth encounters. Of note, many of these items are closely intertwined with **socioeconomic status**. In 2018, approximately 1 in 8 Americans were living below the poverty line (Semega et al. 2019). When comparing a household income of <\$30,000 and a household income of >\$75,000, poor socioeconomic status is associated with lower rates of smartphone ownership (71% vs 95%), home broadband access (59% vs. 92%), and Internet use (82% vs 98%) (Pew Research Center, 2018, 2019; Nouri et al., 2020). These numbers shed light on the important connection between digital access and socioeconomic status.

1. **Digital literacy:** Almost all providers reported a frequent need to teach their patients how to use Zoom. This troubleshooting can be time-consuming. In addition, some patients have expressed distrust in video encounters, due to lack of experience with using digital platforms of communication.
2. **Lack of equipment:** Telehealth requires a device (smartphone or computer) AND Internet access.

DEVICE ACCESS: Some families are sharing a single device. One CCM described a family where the kids could not do schoolwork until Dad returned from work, because Dad had the only smartphone in the family.

ACCESS TO INTERNET: Internet can be expensive. Even if families have Wi-Fi, it can be unreliable. In addition, those who rely on cellphone data may quickly use up their available data. For instance, one CCM mentioned that many patients use WhatsApp to VideoChat with family members abroad. It may be pertinent for them to save data for this communication, rather than a Telehealth visit.

3. **Private space:** Many patients live in multigenerational households and share bedrooms and living areas. There is little

space for privacy in these circumstances. This is often a concern for adolescent mental health visits. Even if the patient has a good relationship with the provider, the patient may not be forthcoming if there is a chance that they are overheard.

In addition, some patients feel comforted by the private, supportive, physical space of the clinic. One provider reports, “[There is] a sense that the physical space of [the clinic] is a space and experience that’s important for them. You know they come in here and it’s an indoor space where...they have some ownership of it. That’s a loss for them that can’t be recreated with telemedicine. There’s patients who get foot care or dry socks or whatever that we just don’t have a way to provide for them via telemedicine.” (Bollinger, 2020).

4. **Language:** Some providers are concerned that they are seeing fewer LEP patients than usual. Factors contributing to this decline include the following:

- Instructions for Telemedicine platform are not available in all languages
- Interpreting generally works well IF the language is easily available via a video or telephonic interpreter

Special consideration for the deaf and hard of hearing community:

Sign language is a three-dimensional language. When it is reduced to a two-dimensional screen, much is lost in translation. Care must be taken to maximize the appropriate windows on-screen to ensure that hand movements are visualized clearly.

In addition, deaf patients may need *two* interpreters. For instance, a Deaf Vietnamese patient may communicate in Vietnamese sign language, which American Sign Language (ASL) interpreters cannot understand. These patients need a Certified Deaf Interpreter to translate non-ASL languages to ASL. A hearing ASL interpreter will then translate this to the provider. This is a complex process that requires collaboration with Audiology and Language services.

5. **Age:** Most successful telehealth visits with elderly patients have been set up by adult children. In addition, vision and hearing difficulties are contributing factors for a geriatric population

6. **Personal Preference:** Patients may prefer in-person or phone conversations due to familiarity. In addition, they may not want to show providers their home, be embarrassed to be on camera, and have other personal preferences.

Benefits of Telemedicine

- Families with multiple children can be seen together.
- Patients who live far away and have barriers to physically coming to clinic may have easier access to care.
- There is an ability to screen share and share resources online (e.g. visit birth control counseling websites).

Encounters That Work Well for Telemedicine

- Mental/behavioral health
- Stable, chronic disease
- Ex: Diabetes (if provider can visualize glucometer or list of readings)
- Ex: HTN (if provider can visualize list of blood pressure readings)
- Medication reconciliation and refills
- Anticipatory guidance/counseling
- Parenting support, infant/early childhood support
- Minor acute complaints

Encounters That Are Less Successful for Telemedicine

- Wellness exams (especially those that require immunizations and labs)
- Acute complaints that are reliant on careful physical exam
- Encounters for patients who are hard of hearing or require significant body language may require additional coordination,

but can be very successful. See “Special considerations for the deaf and hard of hearing community” above.

Please note that there are task forces dedicated to researching which encounters work best for Telemedicine. The information provided in this article is based on limited survey data.

Suggested Practices for Providers

(UW Patient Experience Committee, 2020)

Before the encounter:

- As a provider, if this is your first time with Telehealth (either in English or with an Interpreter) or your first time using an interpreter, feel free to *practice* beforehand. This is only applicable if you have a non-tethered Telehealth platform that does not require an embedded scheduled visit.
- Identify patients that may need additional resources with navigating Telehealth. Huddle with your clinic staff and have them contact the patient several days ahead of time to make sure appropriate links are sent, questions are answered, etc.
- Work with your MA/clinic to determine the clinic flow. (Ex: who will do the patient rooming, Telemedicine coaching, etc.)
- Telehealth instructions should be given to patients in their preferred language as well as English. (Sometimes family members who read English can help provide troubleshooting.)
- Mock visits can be helpful for patients, especially those with limited digital literacy.
- Identify which patients need interpreters in languages that are not accessible on the Telehealth system, so that you are prepared.
 - If an embedded video interpreter is not available, have preparations for a telephone (audio only) interpreter to join the visit.
- Consider hands-on teaching for Telehealth for patients at their next in-person visit.
- If a patient does not want to show their home, give them the option of sitting in front of a blank wall, or turning off their video for the history portion of the visit.

Introducing the encounter:

- **Always use an interpreter when needed.**
- As an example, when using Zoom at the University of Washington (including UW Neighborhood Clinics and Harborview Medical Center) there is an integrated interpreter service for 35 languages. You can “Call out” to connect an interpreter to the Zoom call. The interpreter will appear as a conference call participant.
- At UW, if the language needed is not available, you may be able to contact **Telephonic Interpreter services** and have them call into the Zoom encounter
- [Click here for more details about interpretation, with instructional screenshots.](#) This applies only to UW facilities.
- **Conduct a “pre-session” with the patient and interpreter.** Remember, if this is a telephonic interpreter, the interpreter *cannot* see what is going on in the room.
- Discuss with the *patient* the role of the interpreter, context of session, people in the room, etc. Include the interpreter’s commitment to maintain confidentiality.
- Discuss with the *interpreter* the context of the room. “Ex: Our patient is Ms. B, an Amharic speaking woman presenting with abdominal pain. She is here with her husband, Mr. B, who is very concerned that this may be cancer.”
- **Even when the LEP patient speaks some English, advise the patient to allow the interpreter time to interpret everything the provider is saying.** This is to ensure that the patient has the complete and accurate understanding of the provider’s message. Sometimes the LEP patient believes that he or she understands the message in English and does not want to wait for the interpreter to interpret, but actually misunderstands the message.
- **If the family member is present and insists on interpreting for the patient:**
 - The provider should explain the reasoning behind using trained interpreters. Use of family members or other untrained ad hoc interpreters increases the chance of medical error due to inconsistent medical terminology, false fluency, and editorialization. Please explain to the patient and family that from a patient safety perspective, it is imperative that we use an objective, outside interpreter whenever possible.
- **If the family member is present and insists to speak directly to the provider on the behalf of the patient in English:**
 - With the patient’s consent when conversing with the family member, the provider should summarize the conversation and allow the interpreter time to interpret that summary. This is to allow the patient to actively engage in the appointment and make informed decisions.

- Give the patient a brief overview of Telemedicine. **Inform the patient that the encounter will not be recorded and is HIPAA secure.**
- Be sure your face is well lit and is about the same size of the patient's face on the screen.
- Your credentials badge should be visible to the patient.
- To maintain eye contact with patients, look *directly at the camera*. Shrink the zoom image of the patient down and move it directly below the camera to improve your view.
- Open with a warm greeting: "It is good to see you. I am sorry that we cannot meet in person."
- State "I also like to acknowledge up front that my eyes may be darting around during our encounter as I look at your chart and take notes. I just wanted to make sure you didn't think I was distracted when looking around."
- If you or your MA is wearing a mask for safety, please explain why to the patient on camera
- Small talk can help put the patient at ease ("How are you and your family doing?")

During the encounter:

- Ask open-ended questions. Ask one question at a time.
- Speak in complete sentences, but not run-on paragraphs.
- Grammar differs for different languages. Not all languages are structured in the same way as English, and the full sentence (including subject and verb) is sometimes needed for translation.
- Interpreters have great memory and often take notes, but it will be helpful to ask one question at a time.
- Allow the interpreter to ask questions to you for clarification.
- Use "teach-back" techniques. This helps double check that interpretation was accurate and can open a space for clarification.
 - Patients may be embarrassed to report that they did not understand part of the encounter, and "teach back" offers an opportunity for question and answering. Teach-back is a way to ensure that the provider explained information clearly. Clarify to the patient that this is NOT meant to be a quiz for the patient.
- The physical exam can be challenging. Often, we are teaching patients to perform physical exam maneuvers without being able to offer hands-on guidance.
 - Demonstrate for your patient to the best of your ability. Ex: For musculoskeletal exams, raise your own arms to show your patient via video what maneuvers you would like them to emulate.
 - Be specific and give verbal cues to help the interpreter. Remember, Telephonic interpreters cannot see what is going on. Ex: Instead of raising your own arms and saying, "Please move your arms *like this*," say, "Please raise both of your arms *above your head, like this*."
 - If there is a Video Interpreter, turn the camera off for more sensitive exams.

After the encounter:

- Take time to reflect on the session. Questions to ask:
 - What went well?
 - What did not go well?
 - What specific challenges did you face? Were they on the patient end or on the provider/clinic end?
 - How can these challenges be troubleshooted before the next visit?
 - Is this a patient that is a good candidate for Telehealth? What are the risks vs. benefits of having the patient come in for an in-person visit?
 - Can this encounter be improved with in-person Telehealth training? Is this a patient who may need to be seen in-person for optimal patient care and safety?

Specific cultural considerations:

- Jewish patients who strictly observe Shabbat (the Sabbath) refrain from using electrical devices during this time.
- Muslim women may feel uncomfortable with male provider or male interpreter via Telemedicine. Even if the male provider is not physically in the room, the screen creates proximity and discomfort. The patient may be more comfortable with turning her video off, or better yet, with speaking to a female interpreter.
- Older Vietnamese patients may depend on their children or other family members to make decisions for them. In addition, they may be responsible for management of medications and appointments. It would be beneficial to remind the patients

beforehand to have these family members present during the visit. If family members are unable to attend, the provider may have to call the family member separately at a later time to make sure the patient receives the needed support.

This section is a work in progress, given the preliminary nature of our findings.

Accessibility Requirements for Remote Interpreting

- Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry or grainy images, or irregular pauses in communication.
- A sharply delineated image that is large enough to display the interpreter's face, arms, hands and fingers, and the participating individual's face, arms, hands and fingers, regardless of his or her body position.
- A clear, audible transmission of voices.
- Adequate training for staff.
- Remote interpreters must be qualified.

Conclusion

Telehealth is a rapidly growing field of medicine, a movement expedited by the 2020 COVID-19 pandemic. It is a powerful tool that allows for patients to be seen in the comfort of their own home. Unfortunately, barriers exist for underserved populations, specifically patients with limited English proficiency. This article acts as a skeleton guide for suggested best practices when pursuing Telemedicine for LEP populations. Because limited data exists regarding Telemedicine best practices, we anticipate that this article will be a living document that will be regularly updated as we continue to learn from our patients and our experiences.

Resources for Providers

- [Resource Round-up: Multilingual Tutorials on Zoom and Other Online Platforms](#)
- [Academy of Communication in Healthcare: COVID-19 Telehealth Communication](#)
- [Staying Connected In The COVID-19 Pandemic: Telehealth At The Largest Safety-Net System In The United States](#)
- Telehealth Training & Professional Development: [The Northwest Regional Telehealth Resource Center](#)
- [Washington State Telehealth Collaborative](#)
- [Center for Connected Health Policy](#)
- [TTAC Telehealth Technology Center](#)
- [The National Consortium Of Telehealth Resource Centers](#)
- [Podcast: Examining The Telehealth Digital Divide For Patients With Limited English Proficiency.](#)

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