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One in Four Spanish-Speaking Hispanic Adults Have Difficulty Finding Language-Concordant Health Care Providers

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Navigating health care in English can be daunting for those who prefer communicating in another language, and adverse health consequences can occur when language barriers arise (Haldar, Pillai, and Artiga 2023; Youdelman 2013a).[1] Many regulations are in place to protect the rights of and expand health care access for people with limited English proficiency (LEP), such as prohibitions against discrimination based on national origin and primary language in programs and activities that receive federal funding under Title VI of the Civil Rights Act of 1964 and efforts to improve quality of care through the National Standards for Culturally and Linguistically Appropriate Services (Youdelman 2013b).[2] Section 1557 of the Affordable Care Act (ACA) also includes protections against discrimination because of primary language specific to health care, and a 2024 Department of Health and Human Services rule clarified and strengthened those protections (Youdelman 2024). As of publication, the 2024 Section 1557 rule is still in place, and it remains unclear whether or how it could change. In March 2025, the new administration made English the official language of the US through an executive order (EO) and rescinded a Clinton-era EO that required federal agencies to take "reasonable steps to ensure meaningful access to their programs and activities" for people with LEP.[3] However, the current EO does not overturn federally funded entities' responsibilities to comply with language access requirements under Title VI of the Civil Rights Act or Section 1557 of the ACA.[4]

An estimated 26 million people ages 5 and older in the US are characterized as having "limited English proficiency," which is defined as speaking a language other than English at home and speaking English "well," "not well," or "not at all" (as opposed to "very well") (Haldar, Pillai, and Artiga 2023).[5] People with LEP are more likely than those who are proficient in English to be uninsured and to lack a health care provider or usual source of care, which can lead to differential access to preventive services and ongoing care for chronic conditions for people with LEP (Twersky et al. 2024). Systemic issues also impede access for patients with LEP—for example, some providers and health care systems do not provide language access services to their patients because they lack awareness of their language access responsibilities or lack training on how to use interpretation services with patients. Provider time constraints and the cost of providing these services are also barriers. Additionally, the large number of health care entities subject to language access requirements makes it difficult for the federal government to monitor and enforce language access laws, leading to uneven implementation (Chen, Youdelman, and Brooks 2007; Diamond, Wilson-Stronks, and Jacobs 2010; Hofstetter and McHugh 2024; Schiaffino, Nara, and Mao 2016; Shah, Velasquez, and Song 2020).

Improving language concordance between providers and patients, which for this brief we define as access to interpretation services or providers who speak patients' preferred languages, is an important step toward mitigating language barriers and their associated health inequities for people with LEP. This paper provides a high-level overview of findings from studies that examine how language concordance affects health care and health outcomes and presents national findings on language concordance, the difficulty of finding language-concordant providers, and preferences for language-concordant providers among Spanish-speaking Hispanic nonelderly adults, drawing on the Urban Institute's June 2022 Health Reform Monitoring Survey (HRMS). We focused on Hispanic adults who took the survey in Spanish (henceforth "Spanish-speaking Hispanic adults"). Because the survey was only conducted in English and Spanish, we did not assess the experiences and preferences of people whose primary language is not English or Spanish. Our key findings include the following:

- Most studies we reviewed found a positive association between patient-provider language concordance or interpretation services and health care and health outcomes; some found no association, and a few found a negative association.
- One in 10 Spanish-speaking Hispanic adults did not have a language-concordant provider, and 1 in 4 reported difficulties finding a language-concordant provider in 2022.
- About 4 in 5 (83 percent) Spanish-speaking Hispanic adults said it was very or somewhat important for their health care provider to speak the same language or provide translation services.
- Spanish-speaking Hispanic adults who were concerned about future unfair treatment in health care were more likely than those without such concerns to prefer a language-concordant provider (90 percent versus 78 percent, respectively).

Failing to provide language-concordant care can negatively impact patients' lives and health (Youdelman 2013a). Changes in policy and practice that could reduce the extent of language

discordance in health care settings include increasing the availability of multilingual providers, improving provider language competency and the availability and quality of interpretation services in health care, and promoting provider and health care system accountability for appropriate linguistic services.

Background

How Does Language Concordance—or Lack Thereof—Affect Access to and Experiences in Health Care?

Most studies we reviewed found a positive association between patient-provider language concordance or interpretation services and health care and health outcomes; however, some found no association, and a few found a negative association (Diamond et al. 2019; Hsueh et al. 2019; Karliner et al. 2007). As detailed below, the studies we assessed could only document associations and not causal impacts and did not always capture potentially relevant information, such as providers' language proficiency. Studies showing positive results predominantly focused on the relationship between language concordance and patient ratings of and communication with providers. Studies demonstrating positive associations include the following.

- ***Patient experience and communication with providers:*** Several studies demonstrated positive benefits of language concordance on patient experiences and communication with providers. For example, researchers found that language concordance is positively associated with patients' satisfaction with their physician (Detz et al. 2014; Dunlap 2015; Eskes et al. 2013; Jacobs, Sadowski, and Rathouz 2007), positive patient ratings of their physicians (Ngo-Metzger et al. 2007), and better patient ratings of providers' responsiveness to their health concerns (Fernandez 2004). Language concordance was positively associated with patients' comprehension of their health care encounters and understanding of prescribed medications (Wilson et al. 2005), and with reports of better interpersonal aspects of care, higher levels of trust in physicians (Ngo-Metzger et al. 2007; Schenker et al. 2010), and increased comfort in discussing sensitive information in health care encounters (Lopez Vera et al. 2023).
- ***Health care receipt, medication adherence, and clinical outcomes:*** Some studies also found a link between language concordance and improvements in glycemic control, medication adherence, timely follow-up care following abnormal cervical cancer screenings, and fewer bad reactions from medication use (Charlot et al. 2015; Fernandez et al. 2011; Parker et al. 2017; Traylor et al. 2010; Wilson et al. 2005). A retrospective cohort study of select health centers in New England found that implementing a professional interpretation program was associated with increased uptake of rectal exams in men and flu immunization among patients who received professional interpretation services (Jacobs et al. 2001). A few studies showed that language concordance was positively associated with receiving health care education, such as diet and exercise counseling (Eamranond et al. 2009; Ngo-Metzger et al. 2007). One study found that

language concordance was associated with fewer emergency department visits (Jacobs et al. 2007).

Some studies found null associations between language concordance and health care, and relatively few found negative associations. For example, Jih and colleagues' 2015 study in California found that language concordance was associated with lower mammography screenings among Latinas and lower uptake of colorectal cancer screening among Asians, which is consistent with other studies showing negative or no association between concordance and colorectal cancer screenings (Walsh et al. 2009; Sentell et al. 2013). Also, some studies did not find an association between language concordance and medication adherence, particularly for patients with diabetes (Detz et al. 2014; Fernandez et al. 2017; Traylor et al. 2010). August and colleagues (2011) found that Spanish-speaking Hispanic adults with Spanish-speaking health care providers in California were just as likely to discuss their mental health needs with their physicians as their English language-concordant counterparts.

As noted above, the field lacks studies that evaluate causal impacts associated with having or not having language-concordant health care providers. In addition, studies we reviewed typically did not include provider language competency, which could shape how effective or ineffective a language-concordant provider might be, and studies may not be generalizable beyond the geography or population studied. In addition, decreased use of more invasive or uncomfortable forms of preventive care (such as colorectal cancer screening and mammography screenings) among patients with language-concordant providers may reflect a deeper understanding of the procedure and its associated risks because these were explained in their preferred language (Jih et al. 2015). Moreover, studies often rely on varied definitions of patients' "limited English proficiency." For example, some studies may use self-reported data for this measure, while others may use electronic health data to define people with LEP as those who requested interpretation for an encounter (Lor and Martinez 2020). This latter definition may undercount patients with LEP, given that not all patients who need an interpreter will request one (Twersky et al. 2024).

Furthermore, some studies showed variation in outcomes depending on whether patients had access to a language-concordant provider, professional interpreters, or untrained interpreters. Access to professional interpreters and language-concordant providers generally affords benefits to patients, with language-concordant providers appearing to provide the greatest benefits (Seible et al. 2021); in contrast, having untrained interpreters is associated with negative consequences for patients (Bauer and Alegria 2010; Flores 2005; Silva et al. 2016). Some studies also showed that patients prefer professional interpreters over untrained interpreters, including family members (Ngo-Metzger et al. 2003), and that having ad hoc interpreters is associated with lower patient satisfaction with care (Lee et al. 2002). Additional research addressing the limitations noted above could help provide a clearer picture of how language concordance is associated with patient health and satisfaction with care.

Findings from the June 2022 HRMS

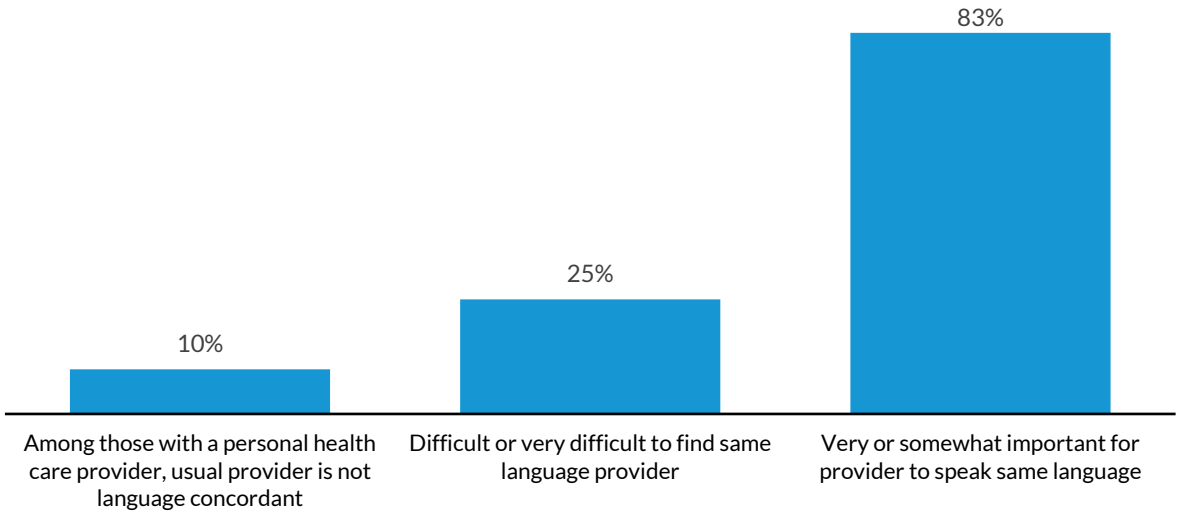
This section draws on the June 2022 HRMS findings on patient-provider language concordance, language concordance preferences, and the difficulty of finding language-concordant providers for Spanish-speaking Hispanic adults.

One in 10 Spanish-speaking Hispanic adults did not have a language-concordant provider, and 1 in 4 reported difficulties finding a language-concordant provider in 2022.

Overall, 54 percent of Spanish-speaking Hispanic adults reported having a personal health care provider at their usual source of care (data not shown). Among adults with a personal health care provider and usual source of care, 1 in 10 (10 percent) reported that they do not have a language-concordant provider (figure 1).[6] Spanish-speaking Hispanic adults with a personal health care provider and usual source of care also reported higher levels of English proficiency compared with Spanish-speaking Hispanic adults *without* such care, who were not asked about language concordance with providers (data not shown).[7] As such, our measure of language concordance does not capture experiences of Spanish speakers who may have more severe language access challenges.

FIGURE 1

Share of Spanish-Speaking Hispanic Adults Reporting Language Concordance with Their Health Care Providers, Share Reporting That It Is Very/Somewhat Important to Have a Language-Concordant Provider, and Share Reporting It Is Difficult/Very Difficult to Find a Language-Concordant Provider, June 2022



URBAN INSTITUTE

Source: Health Reform Monitoring Survey, June 2022.
Notes: Adults are ages 18 to 64. Spanish-speaking adults are defined as those who took the survey in Spanish. Estimate for the share who do not have a language-concordant provider is limited to adults who reported having a personal health care provider at their usual source of care. Language concordance refers to respondents having a provider who speaks to them in their preferred language or provides translation services.

Additionally, 25 percent of all Spanish-speaking Hispanic adults reported that finding a language-concordant provider was difficult or very difficult. At the same time, over 4 in 5 (83 percent) of Spanish-speaking Hispanic adults reported that they would prefer a language-concordant provider. Among the subset of Spanish speakers who reported speaking English "not well" or "not at all," 9 percent reported that their usual provider does not speak their same language or provide translation services, 30 percent reported it was difficult or very difficult to find a language-concordant provider, and 90 percent reported it was very or somewhat important for providers to speak their same language or provide translation services (data not shown).

Spanish-speaking Hispanic adults who were concerned about future unfair treatment in health care were more likely than those without such concerns to prefer a language-concordant provider.

Spanish-speaking Hispanic adults reported that having a language-concordant provider is important, a preference that was highest among those concerned about future unfair treatment in health care, meaning they reported being very or somewhat concerned that they or a family member will be treated or judged unfairly at a doctor's office, clinic, or hospital because of their racial or ethnic background or primary language. Nine in 10 (90 percent) Spanish-speaking Hispanic adults who were concerned about future unfair treatment in health care settings reported that having a language-concordant provider is very or somewhat important (table 1). This share was lower among Spanish-speaking Hispanic adults who did not have such concerns (78 percent).

TABLE 1

Share of Spanish-Speaking Hispanic Adults Reporting That Having a Language-Concordant Provider Is Very/Somewhat Important, by Concerns About Future Unfair Treatment in Health Care Settings Because of Race, Ethnicity, or Primary Language, June 2022

	Among adults who are not concerned about future unfair treatment	Among adults who are concerned about future unfair treatment
Share reporting that having a language-concordant provider is very/somewhat important	78%	90%***

Source: Health Reform Monitoring Survey, June 2022.

Notes: Adults are ages 18 to 64. Spanish-speaking adults are defined as those who took the survey in Spanish. Language concordance refers to respondents having a provider who speaks to them in their preferred language or provides translation services.

***Estimate differs significantly from adults reporting they are not concerned about being treated or judged unfairly in health care settings in the future at the 0.01 level, using a two-tailed test.

Discussion

Although many Spanish-speaking Hispanic adults would prefer having a language-concordant provider, about 1 in 10 of these adults with a usual provider said that provider is not language-concordant, and 1 in 4 said they faced challenges accessing such providers. A limitation of our language concordance

measure is that it only captures whether language services are available to patients and does not tell us anything about the quality of those language services. For example, patients may have access to bilingual, nonmedical staff, but those staff may not be qualified to interpret medical terminology; providers may speak basic Spanish but not enough to communicate complex medical terminology; or patients may need to wait a long time for a visit to have an interpreter available when they see a provider. Further, because of limitations in the HRMS, we could not capture the language access experiences of people who do not speak English or Spanish. Further research on language access quality and preferences is warranted.

Given the body of evidence showing that language concordance may improve patient experiences and outcomes, ensuring that patients have access to multilingual providers or interpretation services may be critical to reducing health inequities for people with LEP. Below, we outline steps that could complement federal actions to reinforce language access protections.

Increase the Availability of Multilingual Providers and Improve Provider Language Competency

A recent study found that, although about 4 in 10 practicing physicians speak a language other than English, only about 1 in 10 of those frequently use a non-English language with their patients (Ortega et al. 2022). A mismatch in languages spoken among providers and their patients may be at least partly to blame for the underutilization of multilingual capacity among providers. Top languages spoken among multilingual physicians include Spanish, Hindi, French, Chinese, and Russian, of which only Spanish and Chinese rank in the top languages spoken by US populations with LEP (Ortega et al. 2022; Hildar, Pillai, and Artiga 2023). Increasing racial and ethnic diversity of students in US health professions training institutions, with a focus on increasing the number of students who speak languages with the highest need in health care, could at least partly improve the diversity of languages spoken by health care providers (Gonzalez, Smedley, and Nelson 2025).

Drawing on international medical graduates could be another way to increase the pool of multilingual providers. About 1 in 4 practicing physicians are international medical graduates, and these international medical graduates include substantial proportions of people with Hispanic and Asian backgrounds (Ahmed et al. 2018; Norcini et al. 2008). However, international graduates face barriers to practicing in the US, including additional licensing and credentialing requirements, immigrant admissions barriers, and challenges with getting into US residency programs (McElvaney and McMahon 2024). Facilitating recruitment and retention pathways for international medical graduates could help diversify the physician workforce along language, cultural, and racial/ethnic identities and could also reduce general health care shortages because international medical graduates represent large shares of key specialties, such as psychiatry and pediatrics, and they tend to practice in medically underserved areas (Ahmed et al. 2018).

On its own, increasing the number of multilingual providers may be insufficient to address language issues; not all providers will speak languages other than English at a level necessary to communicate

complex health terminology (Chiauzzi et al. 2010). As such, ensuring that physicians' language competency is adequate to deliver crucial health information will also be important. Clinics and health systems could regularly monitor multilingual providers for language competency, offer multilingual providers opportunities for training to communicate medical terms, and require professional interpreters when providers do not have adequate language competency.

Increase the Availability and Quality of Interpretation Services in Health Care

For patients without access to a multilingual provider, access to high-quality, professional interpretation services can bridge language gaps. However, not all health care providers offer professional interpretation services, instead relying on ad hoc interpreters such as bilingual staff, including front office staff, or patients' family members to interpret (Ogunnnaike, Hyde, and Somanadhan 2022). The reasons for underutilization of professional interpretation are many, but addressing some of the major factors, such as cost, time required, and training, could be beneficial to health care systems (Chen et al. 2007; Diamond et al. 2010; Ogunnaike et al. 2022; Squires 2018).

With no current formal requirements for interpreter training, the quality of interpretation services available to patients varies (Squires 2018). Prior research suggests that interpreters with more hours of training commit significantly fewer interpretation errors than interpreters with fewer training hours (Flores et al. 2012). To help standardize quality and ensure that interpreters can communicate complex health information to patients adequately, it may be necessary to require certification requirements for medical interpreters, such as formalizing minimum requirements recommended by the National Council on Interpreting in Health Care, requiring interpreters to become board certified, and setting a minimum number of required training hours for medical interpreters (Squires 2018). On the provider side, implementing training to help providers understand how to work with interpreters and when to call them, and streamlining the process for requesting interpretation during a health care encounter, could help reduce barriers to using interpreters (Ogunnnaike et al. 2022; Squires 2018).

Promote Provider and Health Care System Accountability

Section 1557 of the ACA bans virtually all health care providers and health insurance plans that receive any financial assistance from the federal government from discriminating against patients. A Department of Health and Human Services rule finalized in 2024 helps clarify who is protected under existing law and which providers are accountable to existing law (Youdelman 2024). Notable new guidance in this rule includes an explicit definition of a "qualified interpreter," which clarifies that minors cannot be used as interpreters except in very limited emergency circumstances and that relying on bilingual staff whose language abilities are not vetted is insufficient to meet standards for providing culturally and linguistically appropriate service. For example, interpreters must be familiar with specialized medical terms. Additionally, providers who use machine translation for medical documents must have these translations vetted by a qualified human interpreter.

In addition, the Department of Health and Human Services rule reinforces federal requirements that providers communicate to patients about their language access rights, including by creating language access plans, posting notices about patients' rights to interpretation and translation, and increasing patient awareness of their right to file civil rights complaints if they have been discriminated against because of language (Youdelman 2024). It remains unclear whether the new federal administration will move to undo the rule beyond recent actions that would erode protections for LGBTQ+ people.[8] In addition, the Trump administration issued an EO in early 2025, making English the official language of the US.[9] The EO also rescinded a 2000 policy that reiterated federal agencies' responsibilities to address the language needs of people with limited English proficiency.[10] The new EO does not change federally funded entities' existing responsibilities to provide language access—the EO cannot overturn statutes under Title VI of the Civil Rights Act or the ACA.[11] Because the current EO does not change language access laws, it is unclear what its effect on language access will ultimately be.

Guidelines such as those in the 2024 Section 1557 rule provide guardrails to prevent providers from engaging in practices that reduce language access or provide subpar language access, but even if fully implemented, on their own, these would not fully address language access issues. Additional progress may entail requiring providers to routinely collect preferred language data from patients, monitoring language access gaps, regularly assessing language competency for providers and nonmedical staff to ensure competency is adequate, and filling in with interpreters when that is not the case.[12]

Data and Methods

We used data from the June 2022 HRMS for our quantitative analyses. The HRMS was conducted by the Urban Institute and is a nationally representative, internet-based survey of adults ages 18 to 64. The HRMS sample was drawn from Ipsos' KnowledgePanel, the nation's largest probability-based online research panel comprising about 60,000 members. Panel members are recruited from an address-based sampling frame covering approximately 97 percent of US households, including those without internet access. Panel members are given internet access and web-enabled devices if needed to facilitate participation. The HRMS was fielded in English and Spanish from June 17 to July 5, 2022, with a sample size of 9,484 adults.

We focused on the sample of 639 Spanish-speaking Hispanic adults, where "Spanish-speaking" was defined as adults who took the survey in Spanish. We estimated the share of these adults with a usual provider who reported that their provider speaks to them in the language they prefer or provides interpretation services. We also estimated the share of adults who reported that having a language-concordant provider is "very" or "somewhat" difficult for them and the share of adults who reported it was "very" or "somewhat" important to have providers who are language-concordant. Finally, we determined how concern about being treated unfairly because of race, ethnicity, or primary language in health care settings in the future was related to preferring a language-concordant provider.

Measures

Measures of language concordance, preferences for language-concordant providers, and difficulty finding language-concordant providers were only asked of adults who took the survey in Spanish or who speak English "not well" or "not at all." Twenty-five respondents who took the survey in English and reported speaking English "not well" or "not at all" were excluded from our analysis. Only adults who reported having a usual source of care and a personal health care provider were asked about language concordance. The measure of concern about future unfair treatment in health care was asked of all survey respondents.

LANGUAGE CONCORDANCE

Adults with a usual health care provider were considered language-concordant with their providers if they selected "yes" to the following question:

- Does your personal health care provider/the personal health care provider that you see most often speak to you in the language you prefer or provide translator services?

Our measure of language concordance was based on a similar measure from the Medical Expenditure Panel Survey. In this survey, respondents who reported speaking a language other than English at home, reported speaking English "not well" or "not at all," and reported having a usual source of care were asked whether their provider or someone at their providers' office offers services in the languages they prefer or provides translation services. The HRMS also asked adults who reported having a personal health care provider and speaking English "not well" or "not at all" about language concordance, but unlike the Medical Expenditure Panel Survey, HRMS respondents who took the survey in Spanish, regardless of their English proficiency, were also asked questions about language concordance.

PREFERENCES FOR LANGUAGE-CONCORDANT PROVIDERS

Adults who selected "very" or "somewhat" important for the following question were considered to prefer language-concordant providers:

- When you see or talk to doctors or health care providers about your own health, how important is it to you for the doctors or health care providers to speak to you in the language you prefer or provide translator services? (response options: very important, somewhat important, not too important, not at all important)

DIFFICULTY FINDING LANGUAGE-CONCORDANT PROVIDERS

Adults are considered to have difficulty finding language-concordant providers if they selected "very difficult" or "difficult" in the following question:

- When you are sick or need advice about your health, is it easy or difficult to find doctors or health care providers who speak to you in the language you prefer or provide translator services? (response options: very easy, easy, difficult, very difficult, don't know)

CONCERN ABOUT FUTURE UNFAIR TREATMENT IN HEALTH CARE

Adults selecting "very" or "somewhat" concerned for the following question were considered to be concerned about future unfair treatment in health care, and those who selected "not too" or "not at all" were considered to be not concerned:

- Thinking about the future, how concerned are you that you or a family member will be treated or judged unfairly at a doctor's office, clinic, or hospital because of your or their racial or ethnic background or primary language? (response options: very concerned, somewhat concerned, not too concerned, not at all concerned)

Limitations

The HRMS is subject to sources of error, including a low cumulative response rate and nonresponse bias. Because the HRMS is fielded only in English and Spanish, it does not fully capture the experiences of adults who speak other languages. Additionally, we cannot verify providers' proficiency in respondents' preferred languages to assess the quality of the language access available to patients; it is possible, for instance, that patients have access to providers who speak their preferred languages but not with the fluency required to communicate health information. As such, these patients may still face language barriers not captured in our data. Further, questions about the ease or difficulty of finding a language-concordant provider are only people's perceptions of how difficult this process is; we do not know from the data how much of an effort respondents made to look for a concordant provider.

Notes

[1] Steven Rascón, "Navigating Language and Cultural Barriers to Access Health Care," WHYY, December 11, 2023, https://whyy.org/segments/navigating-language-and-cultural-barriers-to-access-health-care/.

[2] US Department of Health and Human Services, "National CLAS Standards," accessed December 2, 2024, https://thinkculturalhealth.hhs.gov/clas.

[3] The White House, "Designating English as the Official Language of the United States," March 1, 2025, https://www.whitehouse.gov/presidential-actions/2025/03/designating-english-as-the-official-language-of-the-united-states/.

[4] Mara Youdelman, "Despite New Executive Order, Language Access Is Still the Law!," National Health Law Program, March 3, 2025, https://healthlaw.org/despite-new-executive-order-language-access-is-still-the-law/.

[5] Throughout this brief, we use the term "people with limited-English proficiency." Although "people with limited-English proficiency" is the term commonly used to refer to people who speak a language other than English and speak English less than "very well," we acknowledge that it is also a term that is deficit-oriented and does not account for the high-degree of skill needed to acquire a second (or more) language. For a broader discussion on this topic, see Ortega, Shin, and Martinez (2021).

[6] This estimate is slightly lower than tabulations from the Medical Expenditure Panel Survey (MEPS). In the MEPS, about 96 percent of Hispanic adults ages 18 to 64 with a usual source of care who speak English "not well" or "not at all" reported having a provider who speaks to them in the language they prefer or provides translator services.

[7] Overall, about 34 percent of Hispanic adults who took the survey in Spanish reported speaking English "well" or "very well."

[8] Lindsey Dawson and Jennifer Kates, "Overview of President Trump's Executive Actions Impacting LGBTQ+ Health," *KFF*, March 18, 2025, https://www.kff.org/other/fact-sheet/overview-of-president-trumps-executive-actions-impacting-lgbtq-health/.

[9] Elena Moore, "Trump Signs Executive Order Making English the Official Language of the U.S.," *NPR*, March 1, 2025, https://www.npr.org/2025/03/01/nx-s1-5313883/trump-english-official-language-executive-order.

[10] The White House, "Designating English as the Official Language of The United States," March 1, 2025, https://www.whitehouse.gov/presidential-actions/2025/03/designating-english-as-the-official-language-of-the-united-states/.

[11] Youdelman, "Despite New Executive Order, Language Access Is Still the Law!."

[12] Pilar Ortega and Tiffany M. Shin, "Language Is Not a Barrier—It Is an Opportunity to Improve Health Equity Through Education," *Health Affairs,* July 30, 2021, https://www.healthaffairs.org/content/forefront/language-not-barrier-opportunity-improve-health-equity-through-education.

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