

BREAKING THE LANGUAGE BARRIER:

Health Care Quality, Efficiency and Savings
through Professional Medical Interpretation



Louis F. Provenzano, Jr.
President and Chief Operating Officer
Language Line Services

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INTRODUCTION

The growing linguistic diversity of the United States is having a dramatic impact on the delivery of essential social services, particularly health care services. Each day, thousands of patients arrive at hospitals, urgent care centers and primary care medical offices, and before their temperature is taken or their blood pressure is gauged, they face a potentially devastating barrier that could affect the quality of care they receive, the outcome of their visit, and their future health. These patients have limited English proficiency (LEP), defined as speaking English less than very well or not at all, and the language barrier they face has a detrimental effect on their care and overall health.

Here is an example of the scenario that LEP patients encounter: an individual arrives at a hospital with shooting pain in the abdomen, but is unable to tell physicians and nurses what he is experiencing, or how it relates to his personal medical history. He tries to explain his symptoms, but his description is misunderstood, leading to a delay in treatment and unnecessary tests. For those with limited English skills, this hypothetical example is all too real.

Hospitals and medical centers offer medical interpretation services in order to avoid the type of situation described above (“interpretation” is the spoken form of language translation). In fact, any facility that receives federal funds is required by law to provide access to competent language services, but the reality is that some offer medical interpretation services in name only, relying on untrained administrative staff or a patient’s family members – even young children – to help with communication. While medical interpretation by trained, qualified professionals has a documented positive impact on health care efficiency and effectiveness, it is simply not consistently available.

The reasons why quality interpretation services are not readily available are varied, but almost always involve the question of cost and responsibility for payment. Private insurers do not generally reimburse for language services, and only a handful of states provide Medicaid reimbursement. Medicare does not provide coverage. In addition, there are no national standards that define competent medical interpretation although many professionals and organizations are working toward the goal of national certification including standards for training, testing and on-going education.

There is perhaps no greater step that can be taken to improve health outcomes for LEP patients, reduce unnecessary medical costs as they relate to these patients, and standardize the availability and quality of medical interpretation, than to provide reimbursement for language access services. This white paper examines the growing impact of language diversity, the role of quality medical interpretation, and the importance of reimbursement for language services by Medicaid, Medicare and private insurers.

THE CHANGING LINGUISTIC LANDSCAPE

Statistics clearly demonstrate that the ethnic and linguistic make up of the United States is changing rapidly. Across the country, in urban and rural areas, an increasing number of languages are spoken by a growing number of residents. According to U.S. Census data, over 47 million people in the country speak a language other than English at home, and nearly 24 million are considered LEP. The number of foreign-born individuals in the country has now reached an all-time high of 38.1 million, according to the Census Bureau’s 2007 American Community Survey.¹ The Bureau has also predicted that minorities will comprise the majority of the country’s population by 2042, with the demographic shift being driven by greater diversity and increases in immigration.

Census information also clearly maps the rate and nature of linguistic change. Between 1990 and 2000, for instance, the percentage of American residents speaking a language other than English at home rose from 13.8 percent to 17.8 percent, and the LEP population increased from 6.1 percent to 8.1 percent.² In addition, evidence shows that LEP speakers come from all age and income groups.

Today, more than 176 languages and various dialects are spoken across the country. Languages once considered rare in certain parts of the U.S. are now heard more frequently. For example, in Arlington, Virginia, there is a need for Krio language interpreters; Krio is the language of Sierra Leone, Africa. Denver needs Karen speakers; Karen is spoken in Myanmar. In the Seattle area, interpreters are needed for Oromo, a language of Ethiopia. In Phoenix, Dari is spoken; Dari is a language of Afghanistan.³

The linguistic diversity trend is predicted to continue, with marked effects on many key social functions, from the operation of the judiciary to the delivery of emergency services. Perhaps no other segment of our economy, however, is experiencing as dramatic an impact as the health care arena.

THE IMPACT OF LANGUAGE ON HEALTH CARE AND THE ROLE OF TITLE VI

In hospital emergency rooms and urgent care clinics, the reality of our nation's linguistic situation is perhaps most notable and obvious. As more LEP patients arrive for care and consultation, there is a vital need for high quality medical interpretation and translation to ensure that diagnoses and treatments can be delivered quickly and accurately. Patients arriving for care must be able to communicate their symptoms, medical histories, and the circumstances of their illness to their care givers, and without quality interpretation, they simply cannot do so. While the effect is clear in emergency settings, it is also obvious in other medical circumstances, including regular physician visits and outpatient testing.

As health care administrators are well aware, Title VI of the Civil Rights Act has long required those who receive federal funding to provide the same level of access to services for limited English speaking patients as they do for those who speak English. This requirement represents a protection against discrimination based on national origin. An Executive Order "Improving Access to Services for Persons with Limited English Proficiency," issued in 2000,⁴ attempted to clarify and strengthen the language access implications of Title VI, but it has left gaps in structure and enforcement.

Without guidance or consistent enforcement, hospitals and other medical facilities have responded to the federal language access requirement in dramatically different ways, with some offering in-house interpreters combined with over-the-phone language interpreting services, and others offering much less. Even among those with formal interpreting services, the level of quality varies greatly.

Given the growing LEP population and the widening inconsistency in patient communication, state and federal requirements that govern how hospitals communicate with a diverse patient population are certain to become more stringent and strictly enforced in years to come. In fact, many new laws and regulations have already come into effect in recent years. In California, for instance, a 2003 law that took effect on January 1, 2009 requires all health plans to offer the same access to language services as enrollees in government plans. Hawaii requires language services in all state programs, with the mandate that oral and written interpreting must be provided to LEP individuals. Similarly, the State of Maryland requires the provision of oral language assistance by hospitals and agencies receiving federal funds. And in Washington, a State Cultural Competence requirement mandates cultural competency training for physicians. In New York, regulations require hospitals to develop language assistance programs to ensure "meaningful access" to medical services, as well as accommodation for all patients who require language assistance.

More legislative and regulatory changes are on the horizon. Federal and state legislation has been proposed to extend language access requirements to all health care organizations, and to define more carefully the nature and content of these programs. Washington, California, New Jersey and New Mexico are all considering or have implemented cultural competency requirements.

While federal and state lawmakers and regulators work to implement new requirements, The Joint Commission has undertaken a comprehensive research project that provides important support for government action on a number of fronts. The study, entitled *Hospitals, Language, and Culture: A Snapshot of the Nation*,⁵ investigates how hospitals offer care to diverse populations, and clearly demonstrates the challenges that hospitals face as well as the need for financial support. At the same time, The Joint Commission has added a language services component to its assessment criteria.

THE IMPORTANCE OF PROVIDING MEDICAL INTERPRETATION

As mentioned, while most medical care givers are required to provide language access services, the manner in which they do so is widely inconsistent. Many medical facilities have formal medical interpretation programs, but many others are less formal. Anecdotal evidence shows that facilities often rely on family members of patients to provide medical interpretation; others rely on untrained administrative staff. The consequences of this approach can be deadly - and costly.

Statistics show that language is a major factor in cases of misdiagnosis and instances of poor treatment at hospitals, and delays in service or access to preventive care. Medical error in general is a troubling issue, but patients with limited English proficiency are almost twice as likely to suffer adverse events in U.S. hospitals, resulting in temporary harm or death, according to a pilot study by The Joint Commission entitled *Language Proficiency and Adverse Events in U.S. Hospitals*.⁶

In addition, LEP patients are more likely to report poor health, defer medical care, leave hospitals against medical advice, miss follow-up appointments and experience complications from medications.⁷ Whether LEP patients are delaying care because they expect to face a difficult medical encounter due to language issues, or whether they are receiving substandard care due to

miscommunication and delays caused by language gaps, the end result is the same: language barriers are clearly resulting in the unequal delivery of medical care, and in physical harm.

LANGUAGE BARRIERS: PERSONAL STORIES

Take the high-profile case of William Ramirez. Twenty years ago, paramedics in Miami defined his word “intoxicado” as “high on drugs” instead of “food poisoning.” His care was delayed as a result of a series of related emergency room miscommunications, and now a quadriplegic, he has been awarded a \$71 million malpractice settlement.

Other cases are equally tragic. A three year-old girl arrived at an emergency room with her parents. The girl suffered from abdominal pain, but this was not clearly communicated to medical staff, delaying a diagnosis of appendicitis, resulting in a 30-day hospitalization, and infections.

While the toll on the health and well-being of LEP patients is disconcerting, there is also a financial toll on health care organizations, and state and federal agencies. Language barriers can result in inefficient, and therefore more expensive care. Often, without proper medical interpretation, care givers cannot accurately gauge the symptoms or medical histories of their patients, and therefore must perform additional, costly tests and otherwise unnecessary invasive procedures. These costs are ultimately born by patients and insurers, including Medicaid and Medicare.

Providing quality, trained medical interpreters can therefore not only improve medical outcomes, it can save health care dollars by ensuring faster results, fewer unnecessary medical procedures, and reduced legal expenses. By making LEP patients more comfortable with health care encounters, interpretation can also encourage preventive care and overall improved health care habits. According to studies, patients with limited English skills who are provided with interpreters “make more outpatient visits, receive and fill more prescriptions, do not differ from English-proficient patients in test costs or receipt of intravenous hydration, have outcomes among those with diabetes that are superior or equivalent to those of English-proficient patients, and have high satisfaction with care.”⁸ Medical interpreters are an essential link between LEP patients and needed care.

THE ROLE OF THE TRAINED MEDICAL INTERPRETER

Nationally, there are more than 41,000 trained interpreters, many of whom work in the health care field in more than 176 languages. An interpreter who is specially trained in medical interpretation has a deeper knowledge of medical issues and terminology, understands privacy issues surrounding HIPAA, and has a clear understanding of the role that interpreters play in the relay of information between medical staff and patients.

Medical facilities can employ the services of professional interpreters in a variety or combination of ways:

1. *In-House Staff Interpreters:* Facilities can employ trained bilingual clinical staff and bilingual employees who are dedicated to providing medical interpretation.
2. *Independent Contractors:* Facilities may engage individuals who are contractors who provide interpretation on an as-needed or part-time basis.
3. *Telephone Interpretation Services:* Facilities may contract with telephone interpretation services that provide on-call interpretation in any language via a three-way call, typically involving a dual handset used by the patient and medical staff, with the interpreter on the line remotely.
4. *Video Interpretation Services:* Facilities may supplement their language services offerings with video interpretation, a service used primarily for the deaf and hard of hearing.

Whether relying on in-house staff or telephone and video interpretation services, medical providers can only be assured of quality and accuracy if they employ interpreters that are trained and tested. Since standards for training and certification generally are not in place, as discussed in the next section, facilities must make special efforts to gauge the quality of the services they employ.

THE NEED FOR REIMBURSEMENT FOR LANGUAGE ACCESS SERVICES

Medical and social research studies, along with accepted legal interpretations, are clear on three important matters:

1. Medical providers receiving any federal funds have a legal responsibility to provide language access services.
2. Language barriers lead to inefficient care and poor outcomes for those with limited English skills.
3. Trained medical interpreters can help improve outcomes, which in turn results in better care and reduced medical expenses.

Given the facts and data, it is reasonable to assume that all medical providers would provide quality medical interpretation according to an agreed-upon set of standards, and on a consistent basis. But because there is no clear funding to accompany the Title VI requirement, and because there are no specific guidelines or standards set for medical providers, medical interpretation is in fact not consistently available.

THE STATE OF REIMBURSEMENT TODAY

Many incidents of miscommunication in hospitals, emergency rooms and doctor's offices could be avoided if state and federal health agencies, along with private insurers, paid for qualified or certified medical interpreters to be available for those with limited English skills. Facing budgetary restrictions, medical facilities often make decisions regarding the depth and breadth of their language access services based on a quick and anecdotal assessment of general needs: hospitals that see a high number of Spanish-speaking patients, for instance, may decide to hire a trained in-house Spanish interpreter staff, while hospitals that see fewer such patients may rely on untrained staff who may or may not be truly competent interpreters. For languages that are spoken less frequently at a given medical facility, administrators may simply believe that it is more cost-effective to rely on a patient's family members.

Ultimately, LEP patients may receive different kinds of interpretation assistance, and therefore a different quality of care, depending upon what hospital or physician they visit, what the local population of limited English speakers might be, and the extent of that facility's language assistance program. The decision regarding the type of interpretation services that a medical facility will provide is driven most clearly by cost, and so, by offering reimbursement for interpretation according to set standards, Medicaid, Medicare, and private insurers can not only solve a financial problem, they can improve medical outcomes and efficiency in the long run.

Under Medicaid and CHIP (Children's Health Insurance Program), states can pay for interpretation services, and they will be eligible for federal matching funds of up to 75 percent. Currently, 12 states and the District of Columbia have implemented programs to utilize these federal matching funds, and these states have developed mechanisms for reimbursement, along with qualifications and standards for interpretation and translation services that are eligible.⁹ States that authorize Medicaid reimbursement are able to take a significant step toward improving care for their Medicaid populations. At the same time, states can keep their health care institutions in top working order, by easing the financial challenge that LEP patients pose to hospitals and other medical facilities. Federal matching funds ensure that states can achieve these goals in a way that is cost-effective for their own fiscal health.

Available data suggest that private insurers do not generally provide reimbursement for language services, although some, like Kaiser Permanente and Group Health Cooperative, provide a level of direct interpretation services for their members.¹⁰ Like Medicaid, however, private insurers can encourage better health care decisions, improve outcomes and reduce unnecessary tests and procedures, and therefore costs, by agreeing to reimburse for language services. In fact, the argument in favor of Medicare, Medicaid and private insurance coverage for language interpretation is very similar to the argument for coverage of preventive care, something that insurance companies are beginning to actively promote and embrace. Communication with medical providers is the first rule of preventive care, since communication can lead to better outcomes and prevent mistakes, all while making patients feel comfortable enough to seek care at the first sign of trouble. Language assistance, like preventive care, saves money and lives in the long run.

REIMBURSEMENT AS THE FIRST STEP TOWARD UNIVERSALLY AVAILABLE, QUALITY MEDICAL INTERPRETATION

The federal government does not set clear guidelines for states that opt to accept matching funds to provide Medicaid reimbursement for language services. Just as the federal government requires hospitals and other entities that receive federal

funds to provide language access, but does not provide thorough guidelines on how this should be accomplished, the federal CHIP Reauthorization Act of 2009 provides funds for Medicaid reimbursement for language services, but leaves it to the states to determine the methodology.

In some cases, policy makers have expressed concern regarding standards of eligibility for interpretation and translation providers. They have asked, rightly, how to determine the qualifications of interpreters, the quality of interpreting services, and how to ensure ongoing quality monitoring. If interpreters are to be reimbursed by Medicaid for services in the same way that medical testing facilities are reimbursed for their services, how can state officials be certain that the interpreters, whether working in-house or by means of a telephone interpretation service, are qualified?

By giving states latitude to develop the method for reimbursement, the federal government has provided them with an opportunity to ensure quality, but it has also created the strong possibility that standards will vary greatly from state to state, causing confusion for interpreters. States that offer Medicaid reimbursement must develop a method for structuring their payments, and in doing so can develop regulations that specify standards of eligibility and quality for medical interpreters and translators.

In developing these standards, states will find an abundance of data and information on the issue of quality and standards, since many language interpretation professionals have been working to develop certification programs for medical interpreters. In fact, across the health care interpretation profession, the issue of developing a program of certification, including training, testing and continuing education, has been a priority for many years. A certified medical interpreter, like a licensed nurse, certified medical technician or certified medical assistant, would demonstrate measurable skills, appropriate understanding of medical terminology, and an ongoing commitment to their profession.

Recently, the International Medical Interpreters Association (IMIA) and Language Line Services signed an agreement to join forces in an effort to work toward swift implementation of a national medical certification program. This unified effort is aimed at achieving a consistent methodology that will ensure the quality of language services in every state. If adopted, national certification will bring clear and tested procedures for measuring the overall quality of a facility's language services offerings. It also promises to aid a more streamlined process of hiring, compensating, and verifying the up-to-date credentials of medical interpreters. With national certification, Medicare, Medicaid and private insurers will have a clear path toward setting universal quality and eligibility standards for the reimbursement of medical interpreters.

Today, only Washington State has implemented a program of certification. And so, in the absence of national certification, states are left to create regulatory standards for quality interpretation as they implement Medicaid reimbursement for translation and interpretation. In this way, they can ensure that they will pay for services that are verifiably valuable and achieve the desired outcomes of efficient and effective care.

CONCLUSION

Today, the doors of our nation's medical facilities are opening to a changing world defined by cultural and linguistic diversity. With more than 24 million U.S. residents having limited English proficiency, nearly every emergency room, urgent care clinic, hospital admitting department, and physician's office in the nation will experience first-hand the way in which language barriers can delay care, create confusion and errors, and strain budgets. While Title VI requires equal access to care and the provision of language assistance services, widespread inconsistency in the way that this requirement is implemented has led to a serious disparity in care between those who speak English very well and those who do not.

Evidence clearly demonstrates that trained, qualified medical interpreters make the delivery of health care more efficient and effective for LEP patients. But while Medicare, Medicaid and private insurers reimburse for a variety of medical services that are deemed essential, they do not consistently reimburse for language assistance services. Twelve states and the District of Columbia do offer Medicaid reimbursement for interpretation services, but in order for health care delivery to be truly consistent, reimbursement must become the standard. The federal government should provide payment for medical interpretation for Medicare patients. All states must offer Medicaid and CHIP reimbursement for language services, and federal matching funds make this approach very cost-effective. Private insurers must also recognize the clear benefits of medical interpretation to both patients and the bottom line.

For patients with limited English skills, language services can be as important as medical diagnostic equipment, such as an MRI. Only with good communication can patients explain their symptoms, elaborate on their medical histories, and understand the care that is being offered. Like an MRI, accurate communication can lead to efficient diagnoses and effective treatment. Language access is also closely related to preventive care for LEP patients – making them comfortable with the services they receive, encouraging them to seek care early and continue with medications, and helping to avoid errors and future complications.

Ensuring quality is a critical part of the equation when it comes to laws and regulations related to language access. Reimbursement for language services by Medicare, Medicaid, and private insurers is one of the most important social and health issues facing policy makers today, as it involves not only questions related to determining just how vital medical interpretation is, but also questions related to determining what constitutes successful, quality interpretation. States that allow Medicaid reimbursement for interpretation and translation, for instance, have wide authority to determine who is eligible to receive payment and what quality standards should apply to their work.

Many state and federal policy makers and organizations are working to implement programs of certification for medical interpreters. States should demand a comprehensive, national approach to the issue of quality in language services, but until a truly national certification program is in place, they can greatly accelerate the move toward quality medical interpretation through the Medicaid reimbursement process. Reimbursement will not only require standards of eligibility, it will lead to an entirely higher standard of quality by allowing more medical facilities to improve their approach to language services. Given the evidence and data, this consistency and quality must be the goal.

¹ U.S. Census Bureau, “American Community Survey,” <http://www.census.gov/acs/www/index.html>.

² L. Ku and G. Flores, “Pay Now or Pay Later: Providing Interpreter Services in Health Care,” *Health Affairs*, Volume 24, No. 2 (2005).

³ Source: LanguageTrak® by Language Line Services.

⁴ Presidential Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency,” *Federal Register* 65, no. 159 (2000).

⁵ The Joint Commission, the California Endowment, “Hospitals, Language and Culture: A Snapshot of the Nation,” http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf (2007).

⁶ Chandrika Divi, Richard G. Koss, Stephen P. Schmaltz and Jerod M. Loeb, “Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study,” *International Journal for Quality in Health Care* (April, 2007)

⁷ Ku and Flores, “Pay Now or Pay Later: Providing Interpreter Services in Health Care,” *Health Affairs*, Volume 24, No. 2 (2005): p. 436.

⁸ Ku and Flores, “Pay Now or Pay Later: Providing Interpreter Services in Health Care,” *Health Affairs*, Volume 24, No. 2 (2005): p. 437.

⁹ “Medicaid and SCHIP Reimbursement Models for Language Services,” National Health Law Program (2007).

¹⁰ Ku and Flores, “Pay Now or Pay Later: Providing Interpreter Services in Health Care,” *Health Affairs*, Volume 24, No. 2 (2005): p. 438.

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World Headquarters
1 Lower Ragsdale Drive, Bldg. 2
Monterey, CA 93940
1 800 752-6096
www.LanguageLine.com