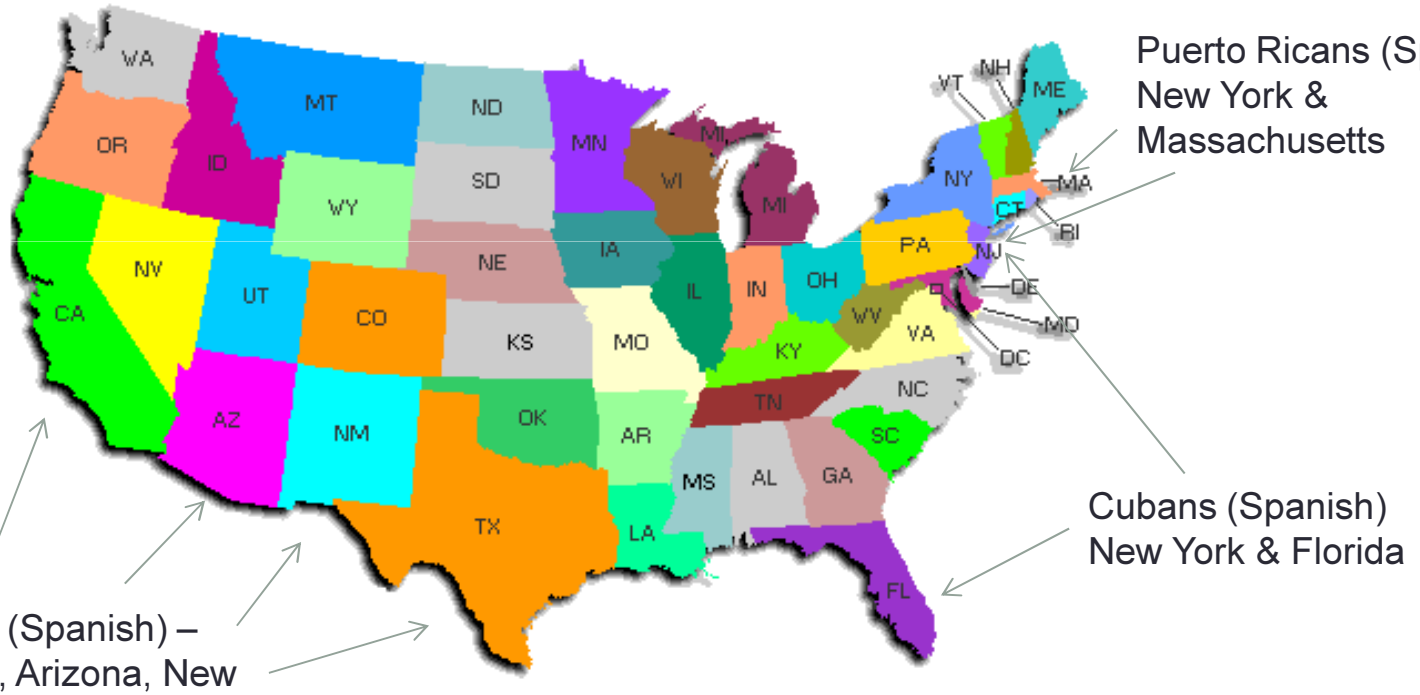
HEALTHCARE INTERPRETING IN THE USA

On the rise: interpreting services in healthcare settings

Lourdes Sanchez, MS, CMI
New York, NY

The Beginning – Migration

Groups that influenced healthcare interpreting



Puerto Ricans (Spanish)
New York &
Massachusetts

Cubans (Spanish)
New York & Florida

Mexicans (Spanish) –
California, Arizona, New
Mexico & Texas

The Beginning – Healthcare Interpreting

Any bilingual individual

- Family members/Friend
  - Adults/children
- Volunteers from the community
- Volunteers from the hospital
- Hospital staff (at any level)

Challenges that started to surface
-No structure on how to interpret
-Unreliable resources
-Questions on level of bilingualism
-Questions on impact on family/friends
-Lack of trust

The Evolution – Language Diversity

- Census Data 2011
- 60.6 million people peaks a language other than English at home
  - Almost two-thirds (37.6 million) spoke Spanish.
  - Chinese (2.9 million)
  - Tagalog (1.6 million)
  - Vietnamese (1.4 million)
  - French (1.3 million)
  - German (1.1 million)
  - Korean (1.1 million).

The Evolution – Language Diversity

Creation of Interpreting Services Programs

Examples

- Boston Medical Center 1968
  - Hired Spanish interpreters
- Beth Israel Deaconess Hospital 1978
  - Started with volunteers, for Russian
- Massachusetts General Hospital 1979
  - Started with volunteers, for Italian

The Evolution – Driven by Patient Safety

1964 Legal Foundation for Language Access - Title VI of the Civil Rights Act of 1964

- "prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance."

1982 Creation of first Over-the-phone Interpreting Company (LLS)

1986 Creation of the Massachusetts Medical Interpreter Association (MMIA)

1987 MMIA creates the Code of Ethics for Interpreters

1995 MMIA & Education Development Center, publishes first the Standards of Practice and states that certification of interpreters is the next step

2000 President Clinton signed Executive Order 13166

- "Improving Access to Services for Persons with Limited English Proficiency"

As of January 2006, at least 43 states had enacted 1 or more laws addressing language access in healthcare settings.

- More than half of these states had between 1 and 4 laws, whereas most others had between 5 and 10 laws. A smaller number had more than 10.
- California continues to have more laws addressing language access in health settings than any other state—over 70 to date

The Evolution – Driven by Patient Safety

2009 1st National Certification for Medical Interpreters, created (20 years in the making)

2011 The Joint Commission revised their standards related to effective communication and for language access

- Addressing qualifications for language interpreters and translators
- Identifying patient communication needs
- Addressing patient communication needs
- Collecting language data

The biggest barrier to language access is the lack of widespread reimbursement for healthcare interpreting and translation services.

Medicaid and the State Children's Health Insurance Program (SCHIP) have indicated that language services are eligible for federal matching funds.

However, each state determines whether and how its Medicaid program will provide reimbursement for interpreting, and providers cannot receive payments for these services unless the state chooses to provide them.

The importance of creating awareness

- Limited English Proficiency (LEP) has been associated with:
  - Making fewer preventive visits (mammograms, Pap smears)
  - High utilization of unneccesary diagnostic tests in the Emergency Rooms
  - Low rates of follow-up visits
  - Low overall health status scores
  - Poor adherence to prescribed medication regimens
  - Poor understanding of diagnosis and treatment
  - Low satisfaction with their care

Some consequences to the organization
Higher liability
Higher overall cost
Delays in treatments
Delays in discharges

Challenges still being faced in the U.S.

- Inconsistencies from organization to organization as to which department should be in charge of languages access
  - Sample of current placement: Volunteers, Telecom, Patient Access, Security, Food and Services, Operations, Risk Management, etc.
- Organizations complain that language services is an unfunded mandate therefore they view the services as an expense to the organization instead of seeing it as a program to mitigate risk, ensure patient safety and access to care
- The resistance from some hospital staff to offer the services to the limited English proficient (LEP) individuals
- The vast majority of LEP don't know that the provision of language services is their right

What needs to be done in the U.S.

- Organizations need to come to a consensus as to the best placement for language services to increase its importance and ensure a standard way of providing services
- Organizations should press for a reimbursement mechanism for language assistance services across payors including Medicaid /Medicare in every state.
- Organizations should require standard training so all healthcare providers understand the harmful effects of language barriers
- Organization should make sure that every LEP patient understands about their legal rights to receive language services.

Recommendations to ensure the provision of language access outside the U.S.

- Use the U.S. experience as a base to move forward
- Learn from the U.S. challenges, mistakes and successes
- Concentrate on the key factors that will make language access successful
  1. Make sure that language services is overseen by a department that works with patient safety and quality of care
  2. Advocate for reimbursement countrywide
  3. Develop mechanisms for on-going training on the importance of language services
  4. Make sure that organizations have proper signage, literature, materials for patients to know about their rights so they can advocate for themselves
- Once the key factors have been accomplish then move into the details related to the actual management of the services