

The Need for National Policy on Medical Translators

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Introduction

In 2013, the United States immigrant population grew by 1.4 million people, making the overall immigrant population over 41 million people¹. Not only is the immigrant population growing, but immigrants come from an increasingly diverse set of countries. As of 2007 there were over 200 languages spoken within the United States². Linguistic barriers can inhibit immigrants' use of basic public services, such as health care. Without a robust understanding of English, each step, from finding a hospital to filling out paperwork to communicating symptoms and understanding treatment options becomes difficult or impossible for immigrants. Confusion in the medical setting is a reality for the over 25 million immigrants having limited English proficiency³.

Hospitals that do not provide translation services to LEP patients have observed lower preventive service uses, such as mammogram, vaccines as well as higher admittance to emergency departments amongst LEP patients⁴. Preventive services are not only beneficial to the patient, they are also lower overall cost of care, while emergency department visits raise cost⁵. Therefore the lack of interpretation services not only is detrimental to immigrants' health, but is also costing the United States health care system a great deal. Further emphasizing the need for medical translators were the study's same finding with well-trained

medical translators the disparities between LEP and English proficient patients shrank starkly⁶.

The goals of this brief are to explain hospital's current approach to providing translation services, legislative action to date, as well as provide feasible policy options for addressing the need for medical translators.

Background

Current Approaches

When hospitals have patients with LEP they often rely on either bilingual staff or family members to translate. There are many problems with these approaches. Many bilingual staff do not have the necessary training nor the time to effectively translate medical topics. This is not only frustrating for the patient, but also for the translators themselves. In one study interviewing over 25 medical translators, a bilingual staff stated that, "sometimes [doctors] think 'cause you're bilingual, you're supposed to know everything in every single area of medicine, and it's kind of unfair. . . [but] they don't understand the...The whole stack of decisions you have to make when you're interpreting."⁷ Due to the lack of training and time the use of bilingual staff is therefore not a viable solution long term solution for providing medical interpretation services.

The other popular route of using family members as translators is equally problematic. Similarly to bilingual staff, they do not have proper training and often patients can be uncomfortable relaying health information through them. One study found that women were particularly uncomfortable talking about gynecological symptoms with their male relatives as translators, resulting in them not discussing potential problems with their physicians⁸.

The lack of consistent and viable translation has negative consequences on patients. One poignant example is the death of thirteen year old Gricelda Zamora who died of a ruptured appendix in Phoenix, Arizona. In an ER visit the two days prior to her death the medical staff had not provided a translator to her parents who spoke poor English, resulting in her parents mistakenly believing they were only to return in three days for a follow up visit⁷.

Action to date

It is due to tragic cases like Gricelda Zamora that there has been federal and executive action on the need for translators in health care. Based on the requirement that no person be denied benefits or discriminated based on national origin written into the 1964 Civil Rights Act, medical institutions receiving federal funding are required to provide translation services. Augmenting federal requirements in 2000, President Bill Clinton issued Executive Order 13166 mandating equal access to healthcare for LEP individuals⁹. A primary result of this executive order was the expansion and strengthening of the Office of Civil Rights (OCR) action on cases involving claims of discrimination due to linguistic barriers.

Complaints brought to the OCR by LEP persons have consistently resulted in increased translation services by hospital. For example, in August of 2014 Mee Memorial Hospital (MMH) in rural California agreed to expand their LEP programs for their five clinics and approximately 50,000 patients¹⁰. Their agreement included a commitment by MMH to provide translation services for the indigenous Mexican language Triqui Bajo. In this situation the OCR was able to enhance language services in rural area, which are typically underserved, and for a language spoken by a small percentage of the population.

The MMH case, while laudable, also illustrates the lack of voluntary adoption of translation programs by hospitals. This can be seen at the state level where many states have legislation that is specific to the need for translation services for one language or a specific condition. A typical example can be found in New Jersey, which requires breast cancer information be translated in both English and Spanish, but not for other common forms of cancer or in other languages¹¹. Successes like the case in Mee Memorial Hospital should be praised, but it is important to recognize them in the broader national medical translation services. Ultimately vast discrepancies exist in the translation services that are provided not only state by state but also hospital by hospital.

Barriers to Further Action

Hospitals that have attempted to provide translation services, either through hiring full time translators, contracting phone translation or video conferencing services have run into two common road blocks. One surrounds reimbursement for translation services, particularly from federal programs like Medicaid, CHIP, and Medicare. The second major concern is about defining and finding qualified medical interpreters. Particularly as hospitals contract translation services out there is a need to guarantee that medical interpreters are indeed qualified. It is within the area of reimbursement and training that there is the most potential for policy to spur growth.

Policy Options

Option One: Ensuring Federal Reimbursement

One study found that one of the single largest barriers to comprehensive translation services was the lack of reimbursement¹². With the

federal government paying for over a quarter of all health care¹³, federal changes in medical interrupter reimbursement rates has the potential to positively impact language interpretation services offered nationally. Ideally, such legislative action would provide a number of realistic options for hospitals, such as allowing hospitals to contract out medical document translations, as well as paying for phone or video call interpreter services in addition to reimbursing on site translators. Providing for each of these options would allow hospitals to hire the translation services that are appropriate for their size and population needs.

Option Two: Creation of National Medical Interpreter Certificate Program

Another policy option is to facilitate the creation of a federally recognized medical interpreter certificate program. By facilitating the growth of well qualified professionals, the federal government could encourage the growth of the medical interpreter field. The proposed certificate program could be based off of Washington states' certificate program, which has been run by the state's Department of Health and Human Services since 2010¹⁴. An option would be for the government to use the Washington state curriculum and commence running certification programs in federally owned space throughout the country. To contain program costs, parts of the curriculum could be held online. By building off of the Washington state program, the federal government would help fill the need for qualified medical interpreters.

Option Three: Combine Funding with Certification

One of the barriers to medical translation services reimbursement is the lack of qualified professionals. A cause of the lack of qualified medical interpreters is the lack of payment for translation services. By combining option one and option two, this policy could help alleviate both barriers to a more robust medical translation service. Here, the government would enact the legislation making medical translation services reimbursable. In combination with the funding change, the Department of Health and Human Services would publish a best practice guidelines for medical interpreter services, which in turn could be adopted by states as they see fit. The benefit of this approach is that it directly addresses the problems with federal reimbursement, while encouraging states to start and run their own certificate program.

Conclusion and Policy Recommendation

In conclusion, while the need for medical translation services is evident, there are many viable options for filling the need. Based on both feasibility and reach, I would recommend policy option three. By addressing both the financial problems hospital face providing interpretation services as well as creating a framework for addressing the skills vacuum, this policy tackles the two largest barriers facing medical interpretation services. Through its broad reach, policy option three will help to foster the 25 million LEP individuals receiving care they can understand.

Additional Resources

1. Office of Civil

Rights <http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html>

2. Agency for Health Care Research and Quality: Guidelines for Serving Patients who are LEP

<http://www.ahrq.gov/professionals/systems/hospital/lepguide/>

3. Washington State Language Testing and Certification Program

<https://www.dshs.wa.gov/fsa/language-testing-and-certification-program>

4. Journal Article: "Impact of Medical Interpreter Services on Quality of Care"

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