AN ARIZONA POLICY PRIMER

Struggle to Communicate: Medical Interpretation in Arizona

ARIZONA HEALTH FUTURES

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Policy Primers: *a nonpartisan guide to a better understanding of key terms and issues in the Arizona health policy landscape.*

Struggle to Communicate: Medical Interpretation in Arizona A Mexican immigrant enters an emergency room in so much pain that he can't walk. Doctors diagnose him with kidney stones and prescribe pain medication. The man fills the prescription at a nearby pharmacy, taking his sister along to interpret. Over the next two days, he continues to suffer. Finally, the emergency department follow-up coordinator discovers the man hasn't been taking the medication. His sister, who speaks limited English, thought her brother should take pills every 46 hours instead of "every four to six hours" as printed on the bottle's label.

St. Luke's Health Initiatives
A Catalyst for Community Health

Miscommunication between patient and provider can lead to misdiagnosis and inadequate – even fatal – medical care. Fortunately, such instances are becoming less common as hospitals and other providers recognize and respond to the need to increase their capacity to provide qualified medical interpretation services for a growing population of patients who don't understand or speak English. In this emerging and important field, Arizona is a leader.

In this *Arizona Health Futures* Policy Primer, we review the state of language interpretation services in the medical setting. We describe an emerging profession with a discrete set of qualifications and multidisciplinary training; provide a general overview of federal requirements and hospital compliance measures; focus on the needs of both Arizona providers and their patients who are of limited English proficiency; and discuss alternative financing structures. Finally, we look to the future of medical interpreting and suggest possible steps to institutionalize language services as part of a seamless delivery system.

About 25 percent of Arizona's population — roughly 1.4 million people — speak a language other than English at home.[1]

A Struggle to Communicate

Not surprisingly, professional health care interpreting is emerging as a discipline in Arizona, and growing rapidly in response to immigration patterns and legal requirements. About 25 percent of Arizona's population — roughly 1.4 million people — speak a language other than English at home[1] With safety and health at stake, patients who cannot describe symptoms or understand a diagnosis are at risk of receiving inadequate care. Medical interpreting takes place in hospitals, physician offices, clinics and home health visits – any setting where there is a conversation between a patient and provider such as a nurse, doctor, lab technician or pharmacist.

Federal law requires providers to pay for qualified interpreters for all patients who are of limited English proficiency (LEP). But hospitals and other providers, which are struggling with workforce shortages and a myriad of financial and regulatory pressures, are often hard pressed to take on a new responsibility that can be both costly and complicated to administer.

Physicians also bear an additional burden when providing care for patients with limited English proficiency. They risk malpractice liability if they are unable to ascertain a patient's symptoms, medical history or consent. They might also be held responsible if a patient misunderstands a diagnosis or instructions. Such lack of communication can conceivably lead to government sanctions for discrimination.

Although this struggle to communicate and a lack of readily available funding for qualified interpreters represent significant challenges, they do not necessarily prevent Arizona health care leaders from working together to test creative solutions while maximizing existing resources.

Terminology

A common set of terms is used in the field of medical interpretation to distinguish types of services and functions:

- **AD HOC INTERPRETER** An untrained person called upon to interpret, such as a patient's bilingual family member, a physician's staff member who is pulled away from other duties to interpret, or a self-declared bilingual bystander in a waiting room who volunteers. Also called a *chance interpreter* or *lay interpreter*.[2]
- **ADVOCACY** Any intervention by an interpreter that does not relate directly to the interpreting process, based on an imbalance of power or unmet need. Advocacy furthers the interests of the patient, care provider or another party whose words and actions are being converted. Experts disagree on the degree of advocacy that is acceptable. See *transparency*.[3]
- **CONSECUTIVE INTERPRETING** The participants in the conversation pause to give the interpreter time to convert their words. The interpreter must be able to retain in memory lengthy questions and responses. This is different than *simultaneous interpreting*, defined below.[4]
- **CULTURAL BROKERING** Action taken by an interpreter that provides cultural information in addition to straight linguistic interpretation of the given message.[5]
- **SIGHT TRANSLATION** Reading documents and interpreting them verbally into another language.[6]
- **SIMULTANEOUS INTERPRETING** Required in situations where several participants in a conversation are speaking rapidly. Their words are converted in real time, with no pauses for interpretation. The interpreter must maintain speeds as high as 160 words per minute.[7]
- **TRANSLATION** Written conversion of text into a different language. In the language professions, the term 'interpretation' refers only to verbal communications, while 'translation' refers to written texts.[8]
- **TRANSPARENCY** The principal that everything said by any party during the conversation should be interpreted into the other language. This way, everything said is understood by all parties present. If the interpreter engages in conversation by speaking directly to one party, the interpreter must subsequently convert his or her own speech as well as that of the other party. Transparency is maintained when everything said by all parties, including the interpreter, is converted into another language.[9]

TYPES OF INTERPRETERS

AD HOC: Most commonly used. Bilingual individuals who are not trained in interpreting skills or medical terminology. They are often hospital employees or the patient's friends and family members.

VOLUNTEER: They may or may not be trained. Some donate time directly to the hospital, while others volunteer for a community group that "donates" them to the hospital.

TRAINED: Bilingual individuals who have completed an educational program with courses on interpreting skills and medical terms. They may interpret in a dual-role capacity, or may work full-time as medical interpreters.

CERTIFIED: Currently, there is no certification for medical interpreters in Arizona. However, the industry is moving toward creating a curriculum and exam for this purpose.

THE ROLE OF A MEDICAL INTERPRETER

The professional skills required of a medical interpreter are complex. Quality interpreting requires more than makeshift conversion of words from one language into another.

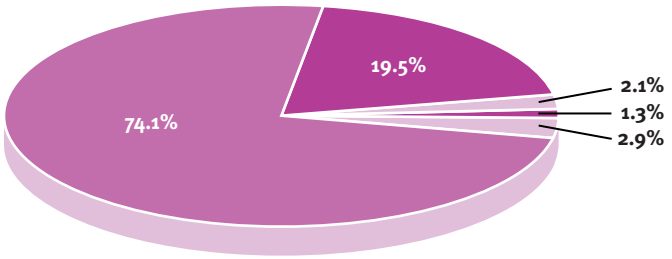
It is first and foremost a process of understanding a spoken message and expressing it accurately and objectively in another language while taking into account the cultural and social context.[10] Interpreters encounter everything from slang and idioms to specialized Latin or scientific terms. They facilitate access to health care while helping to prevent medical errors.[11]

A Growing **Need**

With an increasing number of persons in Arizona and other states speaking a language other than English, there is a growing need for medical interpreters.

The federal government defines individuals of "limited English proficiency," or LEP, as those who "cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers."[12] For example, language barriers have caused one in five Spanish speakers to refrain from seeking needed medical care.[13] Language is the most frequently cited obstacle to care for LEP individuals.[14]

Language Spoken at Home for Arizonans 5+ Years



74.1%	19.5%	2.1%	1.3%	2.9%
English Only	Spanish	Indo-European Languages	Asian and Pacific Island Languages	Other

Source: Compiled by the Language Policy Research Unit, Education Policy Studies Laboratory, Arizona State University.

More interpreters are needed to service the growing number of LEP individuals in the health care system. But even when they are available, their skills vary widely. Unlike services for the hearing impaired or for criminal defendants in court, those in the medical setting have no centralized standards or national exam. As a result, physicians and hospitals have difficulty ascertaining whether an interpreter is qualified. This forces most health care providers to rely on a patchwork of untrained staffers, telephonic services, and patients' friends or family members.

In short, there is a growing need for trained medical interpreters because of pressures from both the demand and supply sides of the issue.

Putting Words to Work:

A Capsule History of Medical Interpretation in Arizona

- **ROOTS OF THE PROBLEM** Traditionally, medical providers had few options for communicating with LEP patients. They pulled bilingual hospital staffers from other job duties or relied on a patient's friend or relative to interpret. Such ad hoc recruits were untrained in the skills of interpreting and unfamiliar with medical terminology. Some patients withheld information from physicians because they were embarrassed to describe personal symptoms to the ad hoc interpreter. Especially in cases where the interpreter was of a different gender or generation, patients were reluctant to compromise their privacy and talk freely to the interpreter about their problem.

- **A TRAGIC CONSEQUENCE** A preventable death in 1999 proved to be a seminal event for health care interpreting in Arizona . When a 13-year-old girl suffered an appendicitis attack, nobody was available to interpret for her. Despite physicians' best attempts, she was misdiagnosed until it was too late to save her. Her death vividly demonstrated the dangers of inadequate medical interpreting services.

- **IN RESPONSE** Community leaders gathered to prevent such a tragedy from recurring. The Arizona Hospital and Healthcare Association and the Arizona Latino Health Association formed a task force and advocated for competent language services.

- **GETTING ORGANIZED** A group of Arizona hospital employees, linguists and academics came together in 2001 to form the *Maricopa County Medical Interpreter Project (MCMIP)*. They focused their efforts on increasing the quality and quantity of medical interpreters in the greater Phoenix area by providing training programs and networking opportunities. The *Arizona Interpreters and Translators Association (AITA)* is a newer project that grew from MCMIP. Goals include establishing core competencies for language services, expanding access to such services and educating interpreters.

- **REFINING A CURRICULUM** MCMIP assembled a panel of national experts in 2003 to determine best practices for training and testing medical interpreters in Arizona. Their backgrounds included linguistics, public health, government policy, pedagogy and medicine.[15] MCMIP's Spanish Bilingual Assistant (SBA) certificate program is a 16-week, 60-hour course for students who are fluent in Spanish and English. It covers basic anatomy, physiology, disease, culture, ethics, legal issues and the interpreter's role.

- **ARIZONA AT THE FOREFRONT** Arizona is a leading state in terms of generating policy and standards for health care interpreters. MCMIP hosted a national conference of industry leaders and created a model program that is research-based and can be implemented in hospitals efficiently and cost-effectively.

- **QUALITY CONTROL** While Arizona has helped to pave the way, several national groups and those in other states have also formed in recent years. The National Council on Interpreting in Health Care has members across the country. The Office of Minority Health of the U.S. Department of Health and Human Services created standards known as CLAS – or Culturally and Linguistically Appropriate Services – that reflect federal laws governing language services in health care.

- **NEXT STEPS** Untrained, ad hoc interpreters are still the most common scenario in Arizona hospitals, and indeed, all across the country. But this is changing as AITA moves toward attaining state standards and certification for interpreters and translators.[16] AITA reports that an increasing number of colleges and universities are offering courses and certificate programs. Language-based businesses are growing. More physicians are relying on trained, qualified interpreters.[17]

Untrained, ad hoc interpreters are still the most common scenario in Arizona hospitals, and indeed, all across the country – but this is changing.

The State of
Medical Interpreting in Arizona[18]

Seventeen Arizona hospitals recently described their interpreter programs as part of an informal survey conducted by St. Luke's Health Initiatives in conjunction with the Arizona Hospital and Healthcare Association. While this is hardly an exhaustive survey, it does suggest some key trends:

HOSPITALS USE A COMBINATION OF INTERPRETING SERVICES

94%
Use Telephonic Services

88%
Use an Ad Hoc System

35%
Employ Full-Time Staff Interpreters

24%
Employ External On-Call Contractors

24%
Employ Part-Time Staff Interpreters

- **CAPACITY HAS INCREASED** 59% of respondents have added to their interpreter capacity in the past two years, while 41% report that interpreter capacity has remained the same. None has reduced interpreter capacity.
- **MORE INCREASES ARE ON THE WAY** 47% of respondents plan to increase interpreter capacity in the next two years, while 53% have no plans to alter interpreter capacity. None has plans to reduce interpreter capacity.
- **THE NUMBER OF PATIENTS SERVED VARIES WIDELY** When asked how many patients are of limited English proficiency, Arizona hospitals report as few as "less than 1%" to as much as 40%. As one might expect, this varies by location and size.
- **THE COST VARIES WIDELY** When asked how much the hospital or system would have to spend annually to fully accommodate all patients who are of limited English proficiency – including verbal communication and translation of forms and signage – hospitals estimated the cost to be as little as $10,000 per year to as high as $1 million per year.
- **HOSPITALS USE A COMBINATION OF INTERPRETING SERVICES** The most commonly utilized method of interpreting is telephonic, with 94% of respondents using this service. Next is the ad hoc system, employed by 88% of respondents. In addition, 35% of hospitals report employing full-time staff interpreters. Finally, 24% of respondents use external contractors who are on-call, and 24% employ part-time staff interpreters.
- **ADMINISTRATION OF LANGUAGE SERVICES IS NOT UNIFORM** Reflecting the fact that interpreting is a new service within medicine, the hospital industry has yet to set standards for managing it. When asked which department oversees medical interpretation, half of the respondents listed "human resources." Just over one-fifth reported "administrative." The rest listed a range of departments including education, case management, nursing, community outreach, service excellence, material services and quality management.
- **HOSPITALS MUST BALANCE LANGUAGE SERVICES WITH OTHER CRITICAL ISSUES** When asked about other issues that might be of concern, every respondent cited the nursing shortage. Fully 94% cited shrinking insurance reimbursement rates, while 76% listed the cost of caring for uninsured or underinsured patients. The issues of crowded emergency departments, rising malpractice premiums, and regulatory compliance with HIPAA, EMTALA and other laws each were listed by 65% of respondents. Over 45% cited a physician shortage.
- **SOME ADMINISTRATORS WELCOME GOVERNMENT ASSISTANCE** When asked how policy-makers could help hospitals provide language services, 59% of respondents said policy-makers should provide *financial expertise* that shows hospitals how to offset costs of paying interpreters and translators. Next, 47% said policy-makers should provide guidelines for *industry standards* or core competencies, and 35% want training and knowledge on how hospitals can best accommodate patients of limited English proficiency. Finally, 29% would like to see more flexible regulations that allow for creative funding mechanisms.[19]

A Range of Viewpoints

Hospitals express varying attitudes toward language services, ranging from a legal burden to a marketing opportunity. A sample of responses:

> *"Although Spanish-English bilingual personnel are plentiful, there is actually a shortage of bilingual persons with high-level language skills. That means even with training in terminology, ethics, protocols, etc., we are challenged to achieve the level of proficiency we would like."*

> *"Provide a tax exemption on a tiered scale offered to employers on the basis of the number of employees who have completed a basic conversational language class. As the number increases, so, too, would the exemption. Investigate class curriculum setup, monitored through the Hospital Association or Nursing Home Association, etc. relative to healthcare practice."*

> *"We do not recruit a lot of care providers who are bilingual – 4% of nursing and less than 15% of line staff overall. This decreases flexibility to provide interpretation training and have more extensive coverage."*

> *"We are using interpreter staff more heavily because they are trained, skilled, predictable resources."*

> *"All facilities should be required to have around-the-clock, full-time interpretation services in person, in Spanish."*

> *"An issue for appropriate medical interpretation in our hospital is the language competency, or lack of competency, of professionals who can do their job in a second language. Another issue is accurate, timely use of interpreters by medical staff. Many do not use an interpreter – rather they make a 'quick' use of family members. The understanding of the role of interpreters by some care providers needs development."*

Culture Transcends Language

Health care interpretation requires more than mere word-to-word conversion. Interpreters must also take cultural nuances into account.

Literal Translation

The term *literal translation* refers to the process of converting every word in exact sequence, with no regard to how the message would normally be expressed in the other language. For example, the French sentence "Il y avait beaucoup de gens" is literally, "It had there many people." The intended message is, "Many people were there." The professional interpreting community considers literal interpreting to be unsuitable.[20] Without supplying the cultural context and "reading between the lines," the chances for miscommunication, misunderstanding and misdiagnosis increase.

Folklore and Home Remedies

Ideas about the cause of an illness are often culturally based, and so are health practices. Information about fever, for example, should take into account the Latino perspective that illnesses are either "hot" or "cold," and the practice of avoiding cold foods when there is a fever. Instead of recommending popsicles and gelatin to maintain hydration, culturally adapted material would recommend broth or hot tea in this particular cultural setting. When health information is translated, medical interpreters review the materials for relevance to the cultural practices of the parties and adapt the information accordingly.

"It [medical interpretation] is a concern due to the potential liability in addressing our patients' needs."

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"We actually see this as a service rather than a burden. We actively market to patients in Mexico to come here for care. This is part of our comprehensive care delivery to international patients."

CHILDREN AS INTERPRETERS

Although many immigrant children speak fluent English and seem like a convenient interpreter, this practice is controversial. Children are prone to omissions and guessing, which can result in misdiagnosis, incorrect medicine and lack of informed consent. In some cases, providers have told youngsters to break tragic news regarding ill relatives. Other times, they have described graphic or sexual information that disturbed the young interpreter. Parents may have questions they are not willing to ask through a child. For all these reasons, the industry hopes to reduce the incidence of children being used as interpreters.[22]

All Medicine is Cross-cultural

Medicine can be characterized as a culture within itself, including its own jargon and practices. Physicians share beliefs based on their training and work settings, and their common medical terminology often functions as a mini-language. Since most patients do not share the experience of medical school or speak medical jargon, they find themselves in a cross-cultural experience. In the U.S., this is especially true for persons who may be from cultures farther removed from western, allopathic traditions. Any group that shares a set of beliefs, behaviors, and language is said to share a culture. Good medical interpretation has to "translate" one set of beliefs and expectations into another set for understanding between the parties to occur.

Who is a Medical Interpreter?

Medical interpreters in Maricopa County generally earn $11 to $15 per hour. Most worked in some other capacity in a health care setting before becoming an interpreter. Some grew up interpreting for family and friends. They work all hours and shifts, since the hospital is always open and taking patients.[21] In their own words, here are how some people describe what inspired them to become medical interpreters:

A Nurse's Story

As an obstetrics nurse in another state, I helped women birth their babies knowing only three words in their language – "breathe," "push," and the vernacular for "have you had a bowel movement?" Eye contact, touch, and good nursing skills can only go so far. I was at risk, the doctor was at risk, the hospital was at risk, but most seriously, the mothers, babies and their families were at risk.

A Childhood Memory

I began interpreting at the age of seven for my mother. I had just learned a little bit of English the year before. I was probably 15 years old the first time I interpreted in a hospital. I was interpreting for my mother, who was having a gall bladder attack. She was screaming, "Me muero! Me muero!" (I'm dying! I'm dying!) Well, I did not become an orphan as I had feared that day. By the time I graduated from high school, I made multiple visits to the doctor with my siblings for stitches, neurological workups, adolescent developmental evaluations and some medical visits that I often found embarrassing.

A New Recruit

I interpreted for a screaming child having a lumbar puncture. My knees grew weak. I held my breath, and then I fainted in the nursing station. I got teased in a kind way, and they said, "Okay, when will you be back?" My thoughts were, "Are they nuts?" My next encounter was with a young, single Salvadoran woman who was pregnant. She had never been to a hospital or been examined, much less by a male physician. I could tell that having a Spanish interpreter made the situation more bearable. I was hooked. I could not wait to return to help once more.

Legal Requirements

Authority

The Civil Rights Act of 1964 prohibits any entity that receives federal money from denying benefits to individuals based on their national origin.[23] In this context, the Department of Justice and several courts have linked language to national origin.[24] Physicians and hospitals are subject to the Act because they receive federal dollars in the form of Medicare and Medicaid payments. Many also receive federal grants, tax breaks, and government stipends for programs including medical education and hospital construction. In all, public dollars account for almost 45 percent of health care expenditures.[25] Such pervasive federal funding of health care obligates providers to observe Title VI of the Civil Rights Act. As a result, they must supply interpreters as a condition of receiving public funding.

The Civil Rights Act is interpreted broadly to include not only intentional discrimination, but any action that has the effect of discrimination or causes a disparate impact against certain individuals.[26] Accordingly, the Act requires hospitals and physicians to provide interpretation services.[27]

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Compliance

- **ELEMENTS** The U.S. Department of Health and Human Services issued a 2000 policy guide that outlines how medical providers can comply with the language sections of the Civil Rights Act. The four key elements of compliance are:

  1. **ASSESSMENT** The hospital, or other entity such as a nursing home, must thoroughly assess the language needs of the population served.
  2. **WRITTEN POLICY** The entity must implement a comprehensive written policy that ensures meaningful communication.
  3. **STAFF TRAINING** The entity must take steps to ensure that staff understand the policy and are able to implement it.
  4. **VIGILANT MONITORING** The entity must oversee the language program to ensure that LEP patients have meaningful access to services.

- **FACTORS** The above elements are not intended to apply equally to all entities and are not one-size-fits-all. The government takes several factors into account when judging the level of compliance:

  1. **SIZE OF THE ENTITY**
  2. **RESOURCES AVAILABLE TO THE ENTITY**
  3. **SIZE OF THE LEP POPULATION**
  4. **NATURE AND OBJECTIVES OF THE PROGRAM**
  5. **FREQUENCY OF THE ENTITY'S CONTACT WITH LEP INDIVIDUALS**

Remedy

LEP patients who are denied language services may file a complaint to be investigated by the U.S. Office of Civil Rights (OCR).[28] OCR has conducted thousands of such investigations over the past 30 years, many of which resulted in voluntary compliance agreements and consent decrees.[29]

INTERPRETATION SERVICES: MORE THAN JUST HEALTH

"The duty to provide appropriate language assistance to LEP individuals is not limited to the health and human service context. Numerous federal laws require the provision of language assistance to LEP individuals seeking to access critical services and activities. For instance, the Voting Rights Act bans English-only elections in certain circumstances and outlines specific measures that must be taken to ensure that language minorities can participate in elections. Similarly, the Food Stamp Act of 1977 requires states to provide written and oral language assistance to LEP persons under certain circumstances. These and other provisions reflect the sound judgment that providers of critical services and benefits bear the responsibility for ensuring that LEP individuals can meaningfully access their programs and services."

From the U.S. Department of Health and Human Services[31]

A resolution agreement between OCR and an Arizona hospital calls on the hospital to implement a number of significant steps. Under the agreement, the hospital must:

- Provide interpreters for LEP patients.
- Avoid using untrained interpreters such as family members or friends.
- Prohibit the use of minors as interpreters.
- Post multilingual signs stating the availability of free interpreters.
- Have contracts in place with professional interpreters.
- Create a multilingual card or other tool that allows LEP individuals to identify themselves and their language.
- Conduct annual assessments of its LEP needs.
- Train staff and volunteers to respond to LEP patients.
- Translate such documents as consent forms, discharge instructions, billing information, grievance procedures, pharmaceutical instructions and patient's rights notices.

In cases where the parties do not reach a voluntary compliance agreement, OCR may hold a hearing, refer the case to the Department of Justice or even revoke federal funding.[30]

Other Sources of Regulation

Although the Civil Rights Act is the broadest and most powerful regulator of linguistic services, several other sources call upon health care providers to ensure meaningful access to care.[32]

- **MANAGED CARE AGREEMENTS** Some contracts require providers to assess their language capability or schedule appointments with staff interpreters included.[33]
- **ACCREDITATION ORGANIZATIONS** Private entities set standards for health care facilities. For example, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other institutions, has enacted standards that require language access.
- **MALPRACTICE LIABILITY** An injured patient could sue for damages, arguing that communication problems led to a medical error. Failure to provide an interpreter might constitute negligence on the provider's part and may lead to improper care. It may also constitute an absence of informed consent to treatment or a breach of the duty to warn of treatment risks. Inappropriate use of ad hoc interpreters may violate a patient's privacy rights. Finally, it may amount to a breach of professional standards of care.
- **STATE REGULATIONS** California, Massachusetts and New York have passed laws guiding health care facilities on communicating with limited English patients. Generally, these laws simply mirror federal standards. Arizona does not currently have such a law.[34]

Getting Creative:
Funding Medical Interpretation

- **AN EXPENSIVE MANDATE** More than half of providers point to cost as the principal barrier to providing language services.[35] Most types of private and public insurance provide no reimbursement.[36] The White House Office for Management and Budget estimates that interpreting services cost the health care industry $267.6 million annually.[37]

- **HELP FROM WASHINGTON** Federal matching grants are available to assist state programs that cover residents living at or near poverty levels. In an August 2000 letter to the states, the U.S. Medicaid director wrote, "…under both the SCHIP and Medicaid programs, Federal matching funds are available for States' expenditures related to the provision of oral and written translation administrative activities and services provided for SCHIP or Medicaid recipients. Federal financial participation is available in State expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service."[38] Only eight states are participating in the matching program. Unfortunately, budget deficits have rendered most states unable to pay for their share of language services, despite the fact that doing so would free up federal dollars to cover the remainder.[39] Locally, the Arizona Health Care Cost Containment System (AHCCCS) is moving toward taking advantage of this funding source.

- **BUSINESS STRATEGIES** Providing interpreters can yield benefits as a marketing advantage with the Hispanic market. As this group's purchasing power continues to grow, hospitals and other businesses want to attract and retain Hispanic patients. Language services increase patient satisfaction and loyalty. This leads to referrals and repeat business. Furthermore, language services are a risk-reduction technique because they mitigate malpractice liability and fines associated with a lack of regulatory compliance. In addition, proper communication can save hospital and clinic money by avoiding unnecessary diagnostic tests, follow-up calls, follow-up visits and misdiagnoses. Physician time, which is particularly costly, is saved when a patient visit runs more quickly and smoothly due to language services.

- **SHARING THE BURDEN** Some immigrant advocacy groups have trained volunteer interpreters and dispatched them to providers at no cost or for a nominal fee.[40] These "language banks" exist in New York, Virginia and Illinois.[41] One California managed care organization, the Alameda Alliance for Health, offers stipends to providers who use interpreters.[42]

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Rates for Interpreter Services[43]

PROGRAM	RATE
Hawaii Medicaid (fee for service)	$25-$45/hour
Maine Medicaid (fee for service)	$30-$40/hour
Minnesota Medicaid (fee for service)	$50/hour
Utah Medicaid (fee for service)	$35/hour
Washington Medicaid (fee for service)	$34-$39/hour
Alameda Alliance for Health (private managed care)	$90-$100/hour, two-hour minimum (offers a $30 stipend)
Multicultural Association of Medical Interpreters, Oneida, New York (private community foundation)	$45-$60/hour (offers discounted rates with contracts)

Several companies sell a telephonic interpretation service that makes multilingual operators available around the clock for about $150 per hour.

Telephonic Language Services

Several companies sell a telephonic interpretation service that makes multilingual operators available around the clock. Dozens of hospitals across Arizona have registered with such a service. At about $2.50 per minute, telephonic interpreting costs about $150 per hour – much more than face-to-face interpreting. It is also limited by the inability to see body language or hand gestures. Further, telephonic interpreters are unable to read informed consent forms and do sight translation. Nevertheless, in many cases these operators are the most qualified interpreters available, and their service delivery methods are effective in certain controlled circumstances.

Providers Face Administrative Challenges

With rising demand for language services and low availability of trained individuals, health care administrators face difficulties by simply attempting to locate and hire interpreters. Further, the absence of national and state standards leaves administrators wondering how to judge the effectiveness or qualification of potential interpreters.[44]

Even some hospital staff members hide the fact that they are bilingual for fear that they will be expected to serve double duty, being forced to take on a greater workload with no additional compensation.

Some emergency room physicians worry that expanding language services could actually exacerbate the situation in Arizona's overcrowded emergency departments. They believe that limited English individuals are more apt to seek primary care in an emergency department if hospitals provide interpreters while physicians' clinics do not.[45]

If necessity is the mother of invention, such challenges will produce creative solutions. One such example is of two hospitals that partnered in acquiring interpreter services, which both needed but neither could afford alone. The challenges of finding and paying interpreters should not prevent us from tapping into the rich human resource that Arizona's growing multicultural population represents.

Physician Perspective on Serving Limited English Patients

51% of respondents reported that cultural and language barriers prevent their patients from adhering to treatments.

92% said cultural and language issues are important or very important in the delivery of care.

82% would use translated material if it were available.

58% would absolutely use interpreters if available to them; another 17% would most likely use them.

49% would be interested in having their staff trained as professional interpreters.

Source: 2001 survey conducted by L.A. Health Care Plan, a public health maintenance organization serving California's Medicaid and State Children's Health Insurance programs.[46]

Policy Considerations

With another major wave of immigration to America's shores and rising numbers of people with limited English proficiency, the ability to provide accurate and timely interpretation between patients and providers in the medical setting will prove critical to the delivery of high quality services free from errors resulting from miscommunication. This is especially true for a border state like Arizona, with large numbers of Hispanic residents and 25 percent of the total population that speak a language other than English at home.

The demonstrated need for medical interpreters is high, and will likely remain so for the foreseeable future. In that context, we offer the following policy considerations in the areas of workforce development, financing and implementation:

Workforce Development

- The medical interpreting industry should consider the development of centralized standards and a certificate program that identifies an interpreter as having certain core competencies and qualifications. This would promulgate a common set of practice expectations and allow employers to make educated hiring decisions.
- The incorporation of medical interpretation practices and issues in the continuing education curriculum for existing health professional provides a transition strategy that complements the longer-term strategy of recruitment of minorities into the health professions over time.
- The best sources for future medical interpreters are usually those close to home. Providers and policy leaders should consider close collaboration with various immigrant groups to assist with the identification and training of high quality medical interpreters. Instead of continuing to rely on ad hoc interpreters, providers might also focus efforts on the training of existing staff who wish to work as professional interpreters – and pay them for the additional services. This may prove to be more cost effective in the long run.
- Medical interpretation often occurs within a value-laden, emotionally charged atmosphere of patient vulnerability and fast-paced decision making. Practitioners should consider adopting one set of standards for the *ethics* of health care interpreting within the growing profession of medical interpreters.
- Because of well documented practical and ethical issues, providers should consider adopting a policy of never using children as interpreters, save for unavoidable emergency situations.

Financing

- Policy leaders should consider supporting the efforts of Arizona's AHCCCS (Medicaid) program – and all state Medicaid programs – to apply for federal matching funds for language services. In addition to leveraging federal funds, it legitimates what is already a strong de facto need for qualified medical interpreter services.
- Immigrant advocacy and service groups are a logical and practical conduit for trained medical interpreters. Both private and public funding sources might consider investing in increasing the capacity of these organizations to develop medical interpreter programs through effective business and fund development strategies.
- Physician offices and other outpatient settings need high quality medical interpretation services too. While financing such services is always a challenge, it might be effectively addressed through support for translator consortiums or other types of partnerships that can be applied across a spectrum of private providers.

The medical interpreting industry should consider the development of centralized standards and a certificate program that identify an interpreter as having certain core competencies and qualifications.

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Immigrant advocacy and service groups are a logical and practical conduit for trained medical interpreters.

The recent development of the Arizona Interpreters and Translators Association (AITA) provides a focal point in Arizona to establish core competencies for language services, expanding access to such services, training interpreters and placing them in medical settings.

Implementation

- If the federal government mandates language interpretation services, it ought to be prepared to support their implementation. For example, financial and other technical consultants could be funded to assist in upgrading programs through the developing marketing and training strategies, streamlining operations to prevent waste, and reducing liability risk. There is a possible state role here as well.
- The recent development of the *Arizona Interpreters and Translators Association (AITA)* provides a focal point in Arizona to establish core competencies for language services, expanding access to such services, training interpreters and placing them in medical settings. Support for strengthening relationships between AITA and the myriad of provider organizations that need interpreter services should be encouraged.
- As medical interpreter services grow in scope and demand, advocates and program designers might look for implementation strategies in the court interpreter program and sign language interpreter program for the hearing impaired. These long-established industries have high standards and could serve as a model for elevating the profession of medical interpreting.

For More Information

Arizona Resources

Arizona Interpreters and Translators Association — contactAITA@yahoo.com

Arizona State University Translator Certificate Program — www.asu.edu/clas/dll/spa/

Maricopa County Medical Interpreter Project — (602) 631-6575

Phoenix Children's Hospital Language and Cultural Services — www.phoenixchildrens.com

University of Arizona Health Sciences Center, Phoenix Campus — www.ahsc.arizona.edu/phoenix/

National Resources

National Council on Interpreting in Health Care — www.ncihc.org

Hablamos Juntos (Robert Wood Johnson Foundation) — www.hablamosjuntos.org

American Translators Association — www.atanet.org

The Cross Cultural Health Care Program — www.xculture.org/index.cfm

Other States

California Healthcare Interpreters Association — www.chia.ws/

Massachusetts Medical Interpreter Association — www.mmia.org

Telephonic

CyraCom International — www.cyracom.net

Language Line - www.languageline.com

World Wide Interpreters — www.e-wwi.com

Interpretalk Language Services Associates — www.lsaweb.com

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16 Ibid., p. 8.

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18 Survey conducted Jan. 2004 by St. Luke's Health Initiatives and the Arizona Hospital and Healthcare Association.

19 For more on this topic, see José L. Calderón, M.D. and Robert A. Beltrán, M.D., op. cit. ("However, a major pitfall in the structure of care germane to these mandates is the lack of tools and methods for complying with them. Beyond directives to improve health communication aimed at improving health status, nothing has been offered by federal, organizational, or healthcare quality oversight committees that would help healthcare delivery systems comply with these mandates.")

20 National Council on Interpreting in Health Care, op. cit., note 12.

21 Interview with Barbara Rayes, president of Arizona Interpreters and Translators Association, Feb. 16, 2004.

22 Ibid.

23 Title VI of the Civil Rights Act of 1964, § 601; 42 United States Code § 2000 et. al. ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.")

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To improve the health of people and their communities in Arizona, with an emphasis on helping people in need and building the capacity of communities to help themselves.

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