What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency

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1. Mark Rukavina, Executive Director
The Access Project

Hello, I'm Mark Rukavina, director of The Access Project of Brandeis University.

I'd like to welcome everyone to today's press conference for the release our report: **What a Difference an Interpreter Can Make: The Health Care Experiences of Uninsured with Limited English Proficiency.**

The Access Project is a resource center for organizations and coalitions seeking to expand or improve access to health care in their communities. With funding from The Robert Wood Johnson Foundation, The Access Project conducted a survey of more than 4,000 people with no health insurance to better understand their experiences and perceptions of health care in their communities. Today's report is based on this survey data.

According to the U.S. Census, 22 states have seen their Hispanic population double in the last 10 years. Over 30 million people – more than 11 percent of the total US population – are foreign-born. Many having limited English proficiency. Through our survey, we wanted to learn how the tremendous growth of people not able to speak English well, was affecting the US health care system.

The stories we heard from people were of hospitals with no interpreters or translated information. Hospital housekeeping staff, with no training in medical interpretation, translating complicated health information. Children being forced to interpret, being exposed to their parents' confidential medical conditions. Patients who leave doctor visits with no understanding of their medical orders. And successful lawsuits won because of negative outcomes due to blatant miscommunication.
This costs money, and it may cost lives.

We hope this report will be a call to action for health policymakers.

First, interpreters should be more widely available. Hospitals and doctors must work together to ensure interpreter services are there for patients who don't speak English well.

Patients should be offered interpreter services at no cost. This is required by the Civil Rights Act of 1964. And these services should be funded. The federal government provides funding to states for interpreters through the Medicaid and SCHIP programs, but only five states have used this funding source.

Second, standards are needed. Health professionals should not use family members as interpreters for their patients. States should follow the lead of California and Massachusetts in requiring health care institutions to provide qualified interpreters for patients who don't speak English well. National standards developed by the US Department of Health and Human Services' Office of Minority Health could serve as the standard for health care providers.

And finally, we must research the relationship between language barriers and medical errors. There has been little research done in this area to date. Hablamos Juntos hopes to build that body of knowledge. We feel that this is a critical research topic for NIH and other research organizations.

I would like to remind everyone that the full report, in both English and Spanish, is available on our website: www.accessproject.org, along with personal stories, contact information for national experts and local spokespeople, links to related immigration and health issues websites, and state data.

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2. Dennis P. Andrulis

Department of Preventive Medicine at the State University of New York/Downstate Medical Center in Brooklyn

Good afternoon. My name is Dennis Andrulis. I am a research professor in the Department of Preventive Medicine at the State University of New York/Downstate Medical Center in Brooklyn and lead author of this report. I also want to acknowledge my coauthors, Nanette Goodman and Carol Pryor.

The report we are releasing today is based on one of the only multi-site surveys documenting the hospital experiences of people limited in their ability to speak or understand English. As seen through their eyes, it suggests that language barriers for patients could have significant consequences for the health of patients and for the financial well being of providers.

Our results focus on survey responses from about 600 uninsured Spanish-speaking individuals who used urban area hospitals during the year 2000 and stated they needed language assistance. 46% said that the hospital provided language assistance, while 54% said that this assistance was not very available or unavailable. All 600 were part of our larger urban area hospital survey of almost 4200 uninsured who used 23 hospitals in 16 cities.

We found from our review of their responses that patients who did not get needed language assistance reported problems or poor experiences that touched almost all aspects of their care. Three key findings provide important evidence of just how these problems affect patient and providers alike.

First, hospital patients who needed but did not get language help were much more likely to say they could not understand directions for taking their prescription drugs --27% did not understand their medications compared with just 2% for those who received assistance.

Second, of those who said they needed help paying their medical bill, hospital staff were much less likely to discuss ways for them to pay for their care—over half of patients who didn't get language assistance stated they were never asked if such help was needed, compared with 36% for those who received language assistance. Those needing language assistance and help in paying for medications fared even worse: more than three in four (76%) said staff "never" asked if they needed assistance paying for their prescriptions, which contrasted sharply with 54% for the comparison group.

And third, while many patients were in debt for their hospital care, those who needed but did not get language help were more likely to say they would not use that hospital again--over one in five compared with 12% for individuals receiving needed language assistance. If they became insured in the future, one third of patients without needed language help said they would not use the hospital again compared with only 9% who got such help.

The reported experiences of these patients provide persuasive, consistent evidence on the importance of effective communication across language differences. Perhaps most troubling is that these findings do not bode well for the physical health of patients and the financial health of hospitals. For example, understanding medications is critical to improving health. But it is also essential for avoiding medical errors with potentially significant human and monetary costs. In addition, uninsured patients not getting needed language help were primarily using hospitals that care for the poor. If they say they will not use these facilities again, just where will they go? Finally, hospitals that do not rectify these communications problems may very well lose insured patients with better reimbursement rates. Providers, the federal government and state governments are increasingly recognizing these potential costs. This study offers further evidence to support these efforts.

I will be happy to answer any questions. For other details on the project, including its design and other significant results, I refer you to the full report.

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3. Joseph R. Betancourt, MD, MPH
Senior Scientist, Institute for Health Policy
Director for Multicultural Education, Multicultural Affairs Office
Massachusetts General Hospital-Harvard Medical School

Good afternoon, and thank you for joining us. As Mr. Rukavina mentioned, my name is Joseph Betancourt and I am a researcher, educator, and practicing Internist at the Massachusetts General Hospital and Harvard Medical School.

The fact that patients with limited English proficiency receive poorer quality health care is undeniable and indisputable. Research is just now beginning to highlight what practicing health care professionals have known all along—it is impossible to obtain an accurate medical history—or be assured that your patient is educated about their condition—or understands your instructions—in the presence of a language barrier. This should come as no surprise, as health care providers first and most critical tool is their ability to communicate effectively with the patients they care for.

Findings from this Access Project survey further shed light on how language barriers impact quality—with patients claiming they cannot get financial assistance for care when it is available, or stating that they cannot understand how to take the medications they've been prescribed. Having experience in this research field, I assure you that this is just the tip of the iceberg. The further we dig, and the more we study, the greater our understanding will be of this problem and its incredible depth. Language barriers between the patient and the health care system impact all levels of our ability to provide quality care to any and all patients we see.

Two recent Institute of Medicine Reports provide a blueprint for how and why we should address this issue—and they also demonstrate that in fact addressing language barriers in health care should not be marginalized, but instead an integral part of improving the quality of care of our health care system. The Institute of Medicine, or IOM, is a non-profit organization that is part of the National Academy of Sciences that is charged by Congress to convene experts to study key questions in health care, education, and research, and then provide findings and recommendations.

The IOM's "Quality Chasm" report lists improved patient centeredness, patient safety, and equity as three of its six major pillars of quality improvement needed to advance our health care system. Patient centeredness focuses on the need for our system to be respectful and responsive to individual patient health beliefs, values and needs; patient safety focuses on the need to eliminate any potential medical errors; and equity centers on the need to assure that health outcomes don't vary by race/ethnicity, gender, class, location or language proficiency. It quickly becomes apparent that if we don't address language barriers, we cannot be responsive to individual patient health beliefs, values and needs; we cannot eliminate any potential medical errors; and we cannot guarantee that our health outcomes won't vary by race/ethnicity, gender, class, location or language proficiency; and ultimately, that we cannot achieve a health care system that provides the highest quality to all Americans.

Similarly, the IOM's "Unequal Treatment" report confirms that there are disparities in the health care system based on race/ethnicity and language proficiency, and encourages the use of interpreters in the medical encounter and support for the Office of Civil Rights to enforce current anti-discrimination legislation.

4._Jose Gomez, Resident of Alexandria, VA
as translated and read by Suyapa Hernandez, Interpreter

My name is Jose Gomez

I am from El Salvador, and I have been here in this country for about 25 years. About a year and a half ago I went to Alexandria Hospital because I was suffering from a muscular pain. When I arrived at the hospital, I had another problem. I could not speak English, therefore, I could not explain why I was there. There was not an interpreter to help me.

I was admitted, but I had difficulty communicating with the doctor. I was not given an explanation of my problem. If the doctor tried to explain it, I did not understand. However, the doctor gave me a prescription. The same day at the hospital, I bought the medicine prescribed by the doctor. Within a few days, I ended up at the emergency room at the hospital because I was intoxicated by the medication. There was not an interpreter at this time. I was treated with an intravenous IV and I was told not to continue taking any medications. I still do not know why I became intoxicated, if it was because I was taking other medications in conjunction with the one I was prescribed with, or if I was allergic to that medication itself.

I attribute my problem to the language barrier. The doctor may have asked me if I was taking another medications or if I was allergic to any type of medications. But I would not have been able to understand what he was asking me. I may have given him the wrong answer.

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5. Mara Youdelman
National Health Law Program

First, I would like to provide the legal background for ensuring linguistic access in health care. Since 1964, Federal law has required that organizations receiving federal funding to provide language assistance to persons with limited English proficiency (LEP). The law ensures LEP individuals have equal access to federally funded programs and services.

While the federal law has been in effect since 1964, the federal government has recently recommitted itself to ensuring linguistic access.

This attention has started discussion on methods of providing linguistic assistance. NHeLP has just completed a report on "promising practices" that I'm going to discuss. This report was funded by The Commonwealth Fund and will be released on April 30th.

The purpose of the report is to identify models of – and funding for – providing linguistic access in health care. Our primary conclusion finds that providing linguistic access can be done in an effective and cost-efficient manner. The organizations we examined include health maintenance organizations, hospitals, state and local governments, educators, and provider and community based organizations.

Let me highlight three models that can be used effectively:

1. Statewide Medicaid/SCHIP reimbursement
2. Hospitals
3. MCOs

First, Statewide Medicaid/SCHIP Programs.

- *States can receive federal reimbursement for interpreters provided to Medicaid and SCHIP enrollees. Five states currently obtain these reimbursements.*

  - *WA, HI and UT – the states contracts with language service organizations (similar to WA)*

  - *ME and MN – the state reimburses fee-for service provider who provides language interpreter services via phone or in person*

Regarding the second model, we looked at four hospital-based programs

- *Massachusetts state law requires emergency rooms and in-patient psychiatric facilities to provide interpreters at no cost to patients*

- *Gouverneur Hospital in New York City provides simultaneous translation for patients and cultural competency training for providers.*

The third model identifies programs operated by managed care organizations

- *Alameda Alliance for Health in California pays for interpreters and provides stipends to providers for the appropriate use of interpreters*

- *LA Care Health Plan in Los Angeles provides training to bilingual staff as medical interpreters*

Other models and funding sources are outlined in the report itself

Conclusions

Overall, providing linguistic access can be done in an effective and cost-efficient manner. A variety of methods exist for ensuring linguistic access that can be easily replicated. This report includes a number of conclusions and future steps including research, funding, and education by the HHS Office for Civil Rights and Centers for Medicare and Medicaid Services.

Copies of the report will be available from our website, www.healthlaw.org and www.cmwf.org after April 30th.