

Practice Management

Language Interpretation Services in the Urgent Care Center

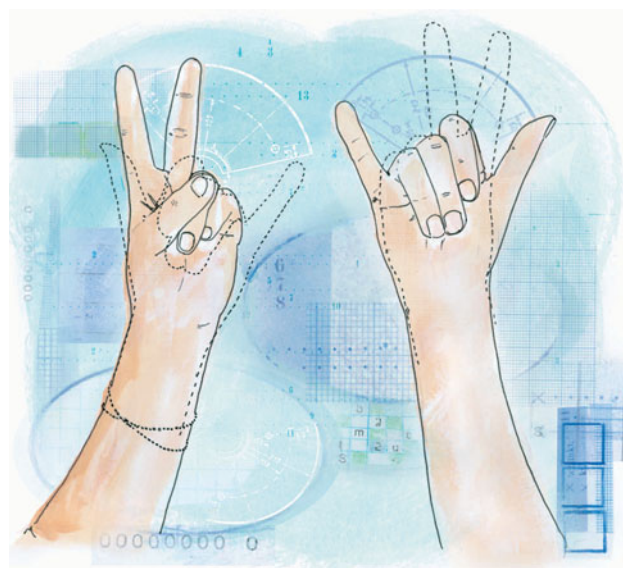
Urgent message: Cultivating trust requires good communication and if a language barrier stands between patient and provider, not only are clinical outcomes jeopardized, but the urgent care operation can be subject to legal liability.

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The demographics of the United States are rapidly changing. Today a language other than English is spoken in 55 million households, 67% of which speak Spanish, and an estimated 19% of Americans have Limited English Proficiency (LEP).^{1,2} In places like Southern California, over 200 languages are spoken and nationally, 1 in every 10 business transactions occurs in a language other than English.³ Over 1.2 million immigrants, both documented and undocumented, move into the United States each year, and children born to immigrants account for over 70% of population increases.⁴ Considering the proliferation of non-English speakers who require healthcare in the United States, it should come as no surprise that the availability of medical interpretation services is required by law.⁵

Legal Considerations for Urgent Care Operators

While medical interpretation services have been shown to enhance patient compliance and follow-up while significantly reducing chances for misdiagnosis, two federal regulations affect how urgent care centers treat patients with limited English proficiency or who have



hearing or sight difficulties:

- Title VI of the Civil Rights Act; and
- Title III of the Americans with Disabilities Act (ADA).

If an urgent care center receives any funds from Medicare, Medicaid, Tricare or any other federal health program, Title VI of the Civil Rights Act of 1964 requires that center to provide “equal access to treatment” in a way that is “meaningfully understood by patients”—

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both of which have been defined as including accommodation for limited English proficiency as well as for physical impairment.

Executive Order 13166, issued by President Clinton in 2000, stipulates, “Any health facility that receives federal monies must provide competent interpreter services for all limited English proficient patients. In case of refusal to provide this service, federal monies can be denied the facility.”⁶

In 2000, then President Bill Clinton emphasized the importance of “meaningful understanding” in medical settings when his Executive Order 13166 expanded the protections of Title VI to people with limited ability to understand English. In 2002, the Department of Health and Human Services (HHS) followed up with its own guidance regarding “meaningful access”⁷ that considers it discriminatory to deny services in a healthcare setting to beneficiaries of federal health care programs. “Effective communication is critical for necessary health and human services,” said HHS, and “in many cases, LEP individuals form a substantial portion of those encountered in federally assisted programs.”

Further, according to Title III of the ADA,⁸ “no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations...and that discrimination includes a failure to make reasonable modifications in policies, practices, or procedures when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modification would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations.” The definition of public accommodation *specifically* includes the “professional office of a health care professional,” 42 U.S.C. §12181(7)(F).⁹ Under the ADA, urgent care centers must provide *equal access* to their services and one must assume that *includes patient communication*.

Steps to Offering Medical Interpretation Services

Urgent care operators have several options for meeting the requirement to communicate with patients in a way they understand. If a center sees a large number of patients speaking the same non-English language, the most convenient and perhaps most cost-effective is to use the center’s staff to translate. This requires hiring bilingual receptionists, technicians and medical assistants but even better are bilingual nurses and doctors who can

treat patients without using a mediator. According to the International Medical Interpreters Association (IMIA), bilingual staff are an *investment* in the patient experience with “language discordant” patients 61 percent more likely to rate their providers as “fair” or “poor” compared with language-concordant patients.¹⁰

However, bilingual clinicians are often difficult to find and a full-time medical interpreter can earn \$40,000 or more per year—a heavy expense burden, even if also supporting the center as a receptionist or medical assistant. And what happens when, say, a clinic in South Florida that employs providers and staff who are fluent in Spanish encounters a French-, Portuguese-, or Russian-speaking patient, which is common in Miami?

Because the interpreter will be speaking back and forth between two communicators, the most important skill is to have fluency in both languages.

As a substitute for bilingual providers and staff, most large cities have companies that can provide on-site face-to-face medical interpretation services in any number of languages. A trained medical interpreter is someone who has been formally educated in medical interpretation and is not only sensitive to cultural nuances but also educated in medical terminology. More often than not, medical interpreters are native speakers. The advantages of an in-person, experienced medical interpreter include patient satisfaction, assurance that truthful information is being conveyed, better understanding on behalf of both the patient and caregiver, decreased costs of diagnostic testing, and fewer preventable medical errors.¹¹

Sign language interpreters help their clients a bit differently than do spoken language interpreters. They have fluency in both English and American Sign Language (ASL), which has its own grammar. ASL is composed of signing, finger spelling, and specific body language. People with hearing difficulties may read speakers lips. Interpreters help lip-readers use oral interpretation, which is mouthing the words carefully and distinctly so that the person who is lip reading can understand more easily. They may use “cued speech” – hand shapes near their mouth to give lip readers more information. They can also use body language and facial expressions to communicate. For patients who are both sight- and hearing-impaired, the interpreter will use “tactical signing”—signing into the patient’s hand so that he/she can feel the communication.¹²

When an On-Site Interpreter Isn’t Possible

While the advantages of using “professional interpreters” cannot be disputed, the on-demand nature of

urgent care and ebbs and flows in walk-in volume make it impractical to have an interpreter physically present. And when family members and other non-professionals (such as community activists or church representatives who arrive with the patient) are relied upon, there can be an inherent lack of familiarity with medical terminology, word substitution or editing, or emotions added by the interpreter, which contribute to confusion, miscommunication, and medical mistakes.¹³ Introducing non-professionals to the patient encounter can also jeopardize patient privacy.

Depending on an urgent care center's location, it may see limited English proficiency patients several times a day, once or twice a week, or once or twice a year. The frequency with which a center encounters the need for medical translation plays a large role in determining which translation options balance demand, cost, and efficacy.

Given the impossibility of having bilingual staff to meet every need that could arise at an urgent care center, the most practical methods of interpretation are flash cards containing common signs, telephonic, and video services.

First off, research casts doubt on the efficacy of flash cards for medical interpretation purposes. The odds of miscommunication using flash cards are high because pointing to images lacks the specificity of spoken language and can convey any number of meanings. Based on studies that trained interpreters are 70% less likely to err than untrained interpreters,¹⁴ the most effective solution is the use of technology to "bring" a trained interpreter into the clinic.

Telephonic medical interpretation has been the fastest growing, and according to the IMIA,¹⁵ this method was touted for use in facilities that dealt with many languages, had infrequent need for translation services, or that were located in outlying areas. Because encounters can be conducted in an exam room with the clinician, patient and a speakerphone—telephonic translation preserves patient confidentiality. Service providers are available 24 hours a day, 7 days a week, and support almost every language and dialect.

Telephone interpretation can be useful with patients who speak uncommon languages or in emergencies when an in-person interpreter cannot be arranged. But the telephone interpreter cannot monitor and evaluate the patient's body language and facial expressions. Communication is more than words; patients lack medical lexicon so consider someone pointing to a body part to indicate where their pain originates or how it trav-

els.¹⁶ Using Internet technology, telephonic interpretation can be coupled with a video feed, providing both words and gestures to the interpreter. Allowing for visual cues not only improves the accuracy of translation, but it can accommodate communication for the deaf and hearing-impaired patients because sign language is easily communicated via video connection.

For most urgent care centers, a subscription to a telephonic or video medical interpretation service is a low cost way to ensure compliance and preparedness, should a non-English-speaking or hearing-impaired patient show up and require services.

Conclusion

Urgent care centers are required to offer interpretation for patients who are using federally funded programs to pay for health care services as well as those who are hearing- or vision-impaired. To identify the best interpretation method for your center, consider the frequency or likelihood of non-English-speaking patients, the diversity of languages presenting, and the language skills and training of providers and staff. ■

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