



**Incentive to Improve Care: Paying  
Healthcare Organizations to Provide  
Interpreter Services**

White Paper

Neighborhood Health Plan of Rhode Island  
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## Introduction

Clear communication between doctors and patients is essential to delivering high quality health care. Communicating and understanding diagnoses, treatment advice, or directions from health care providers is arguably the most critical part of the health care service encounter for patients. Understanding and processing medical and treatment information can be challenging for many patients, but for people with limited English proficiency (LEP) it is a nearly impossible task. For nearly 21 million adults and school-age children in the United States who do not speak English as their primary language and who are limited in their ability to read, write, speak or understand English, an encounter with the health care system is a potentially more anxious, costly and dangerous encounter.<sup>1</sup>

Research has shown that language barriers are linked with less care-seeking and diminished access to health care services.<sup>2,3</sup> Language barriers are also associated with poor quality of care in emergency departments, medical errors and with inadequate communication of diagnosis, treatment and medications.<sup>4</sup> LEP patients also have lower levels of patient satisfaction and studies show that costs of health care services are higher for LEP patients who don't have interpretative services.<sup>5</sup> Meanwhile, trained interpreters or bilingual health care providers have a positive impact on the health care of LEP patients. Such patients with interpreter services see doctors more often, use more preventive services and have higher satisfaction with care.<sup>6</sup>

But trained interpreters too often are not part of the health care encounter. This is the reality even though laws and other requirements exist to help ensure that individuals with limited English proficiency get appropriate language services when seeking health care services. Title VI of the federal Civil Rights Act prohibits health care providers enrolled in Medicare, Medicaid and other federal programs from discriminating against individuals with limited English proficiency.<sup>7</sup> The provision of interpreter services is recognized as a way to meet compliance. In order to meet accreditation standards, the Joint Commission on Accreditation of Healthcare Organizations expects hospitals and other health care facilities to meet language need of patients, and a growing number of state laws require interpreter services be provided to LEP patients. Despite the medical research and legal policies in place supporting interpretation services, many insurers and health care payers do not pay for language services.

Neighborhood Health Plan of Rhode Island (NHPRI), however, is trying to change that. Under a grant from The Robert Wood Johnson Foundation's *Hablamos Juntos*, an initiative designed to break down communication barriers between health care providers and Spanish-speaking patients, NHPRI and five partners launched the *Su Salud* program. The purpose of *Su Salud* is to create a medical interpreter reimbursement model that can be used by other health plans and payers nationwide. This is the first such effort to create a claims reimbursement mechanism for interpreter services in the nation. In its effort to create such a payment mechanism, *Su Salud* has established community standards for medical interpreters that have raised the bar for language and interpretation services in Rhode Island. As of June 2004, *Su Salud* has trained 60 medical interpreters, overseen the hiring of trained medical interpreters by area hospitals and community health centers, and established a standard for training and qualifying interpreters that other health care organizations in Rhode Island and elsewhere can follow.

For health plans, hospitals, physicians and other health care providers, the ability to clearly communicate with patients with limited English proficiency is a critical step in properly treating patients, reducing medical errors, improving patient safety, narrowing the well-documented health care disparities gap that leads to ethnic and minority groups receiving inferior care, and delivering effective, high-quality health care services. Health care organizations that want to remain competitive from both a cost and quality standpoint must adapt to the needs of their increasingly diverse communities.

This White Paper highlights NHPRI's effort to establish the nation's first fee-for-service claims reimbursement mechanism for language and interpretation services. With few insurers or payers covering interpretation services, the federal policies imposing language services are viewed as unfunded mandates. NHPRI believes reimbursing providers for language and interpretation services is an important element in helping to ensure that LEP patients receive quality health care. Baseline data provides potential cost benefit in the emergency department and neo-natal intensive care unit from interpreter services. The business case evaluation was unable to provide evidence of cost-savings during the limited period studied. Results suggest that the null result may be due to low *intervention*

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*dosage*, meaning that a small percentage of the study population is reported to have received the intervention of *Su Salud* interpreter service. NHPRI has decided to move towards an incentive/pay-for-performance initiative under *Su Salud* due to design problems in the Fee for Service program that need to be tweaked. Such problems include but are not limited to using an additional encounter form to submit for reimbursement.

## The Need for Su Salud

Providence, R.I., has experienced the powerful demographic shift that has greeted other communities around the nation in recent years, the dynamic growth of the foreign-born population. Providence's Latino population, which comprises more than 30 percent of the city's total population, increased 108 percent between 1990 and 2000.<sup>8</sup> Many of these new immigrants speak or understand little English. According to the 2000 U.S. Census, 47 million people, or 18% of the U.S. population, speak a language other than English, compared to 31 million individuals in 1990. The number of individuals with LEP was 21 million in 2000, about one-third more individuals than in 1990.<sup>9</sup> Some of these minority groups, such as Latinos, experience a poorer overall health status and face a disproportionate burden of chronic and infectious illnesses compared to white Americans.<sup>10</sup>

NHPRI, a non-profit health plan that primarily enrolls non-English speaking women and children eligible for the state-sponsored Rite Care program—which serves beneficiaries eligible for Medicaid or the State Children's Health Insurance Program—began to see the impact of this demographic shift when more and more of its members sought care in emergency and urgent care settings. These unsettling trends were associated with NHPRI members who speak little or no English. Latino children, for example, increasingly were seeking care at emergency rooms for ambulatory conditions, and more NHPRI patients were returning to the emergency room within 36 to 48 hours of initial ER treatment. What's more, health plan members who sought treatment in the emergency room weren't following up with primary care physicians afterwards. The consistent theme in these undesirable and unnecessary utilization patterns—both decreasing the quality of care patients receive while driving up costs—came to communication-associated problems with LEP patients. Another troubling trend NHPRI spotted: newborns of LEP parents were staying consistently longer in the neo-natal intensive care unit than were other babies. Doctors were more reluctant to release NICU babies when their parents spoke little English. At one hospital, NHPRI-covered newborns with LEP parents spent an average of 1.5 days longer than infants with English-speaking parents. One patient day in the NICU in 2002 cost an average of \$5,116.

### What is Hablamos Juntos?

Meaning "we speak together" in Spanish, Hablamos Juntos is an initiative of the Robert Wood Johnson Foundation (RWJF) to develop affordable language service models that are shown to improve the quality of health care for Latinos, the largest ethnic minority group in the U.S.

For many of the 14 million Latino people in this country who speak or understand little or no English, a visit to the hospital or doctor's office can be overwhelming. Appointments can be difficult to schedule, health problems may not be discussed, and treatment information may not be understood or misunderstood. Language barriers can increase the likelihood of unnecessary hospital admissions and diagnostic tests. Language barriers also are linked to negative health impacts, as they can lead to confusion over diagnosis, instructions for medication and follow-up procedures.

Clear communication between doctor and patient is essential to providing quality health care. To help develop effective language services models that can be adopted as best practices by health care organizations nationwide, RWJF has invested \$10 million in 10 demonstration health care sites that will develop and test innovative solutions to break down communication barriers that can compromise care.

Hablamos Juntos is focusing on three priority language services: 1) increasing availability and quality of interpreter services for Spanish-speaking patients in health care facilities; 2) providing useful health care-related material in Spanish; and 3) Developing easy-to-understand ways for non-English speaking patients to navigate health care facilities. To learn more about this effort, visit: <http://www.hablamosjuntos.org>

While NHPRI had worked hard over the years with providers and Rite Care enrollees on accessing care in appropriate places, health plan officials were spotting trends that more closely resembled populations seeking care in an unmanaged system. These patterns were occurring even while hospitals, community health clinics and some other providers employed interpreters or otherwise made interpreter services available.

Most health care payers consider the costs of language services the responsibility of providers and expect hospitals, physicians, and other health care providers to cover the cost of such services as part of their overhead. As a result, there's been little incentive for health care providers—even in the face of laws and JCAHO accreditation

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requirements—to invest money and energy in providing such services. As a result, the availability and the proficiency of interpreter services in health care settings vary widely.

A number of state Medicaid programs, however, have been in the vanguard when it comes to including language services as an optional benefit and covering some portion of the costs of interpreter services.<sup>11</sup> While this is indeed a step in the right direction and helps raise awareness of on the need for interpreter services while spurring health care organizations to provide language services to the Medicaid population, gaps continue to exist.

Under the RIte Care program, for example, participating health plans and providers are under contractual obligations to provide interpreter services for scheduled member visits, but not for emergency, urgent or unexpected care visits. While hospitals and other provider organizations employ interpreters, often these interpreters are available only

## Neighborhood Health Plan of Rhode Island

*Mission:* NHPRI, an innovative health plan in partnership with Community Health Centers (CHC), is a catalyst for improved access and better health in Rhode Island, especially for vulnerable populations.

*Organization:* Not-for-profit HMO

*Established:* 1993 by Rhode Island community health centers

*Members:* 75,000 enrollees, largely from the state's RIte Care program, the managed care program for State Children's Health Insurance Program and certain Medicaid beneficiaries

*Enrollee profile:* Largely children (enrolls about half of all children in Providence and nearly 20% of all kids in Rhode Island) and non-English-speaking populations (24% of members speak Spanish as their primary language).

*Provider Network:* Nearly 600 primary care physicians, with most members seeking care at 11 CHCs; 1,700 specialists; and all Rhode Island hospitals

*Performance:* First CHC-affiliated health plan in the nation to gain the National Committee for Quality Assurance's "Excellent" accreditation.

during typical business hours, not around the clock. Providers also have relied heavily on outside language service agencies and telephone interpreter services, which may be a suitable option. However, at times getting timely access to off-site interpreters and scheduling them around patient appointment times proved less than ideal and costly. NHPRI learned that half of visits it paid contracted interpreters for either never took place or not completed because of patients no show or provider or patient delays.

Providing interpreter services in emergency and urgent care setting can be even more problematic. Even when interpreters are on staff, wait times can be long. As a result, health care provider organizations resort to relying on bilingual staff—ranging from clinicians to front-office staff—many of whom are not trained in the nuances of language services, never mind in medical interpretation. Bilingual staff as interpreters may be a viable option if skills in language proficiency and content knowledge of medical interpreting are present. Front-office staff with conversational language skills can and should be used to meet language needs in administrative encounters, but not in clinical encounters without the proper medical interpreter training and experience. Too often, a patient's family members (including young children), friends or other untrained interpreters are left to fill the void. Significant problems arise

when ad hoc interpreters are used inappropriately in place of trained interpreters. Limited English Proficient (LEP) patients may not fully understand diagnoses and treatment. Untrained interpreters are prone to making mistakes, omitting, adding, and substituting information. Providing a medical interpreter ensures the transmission of accurate and complete information.<sup>12</sup> Even with the RIte Care program covering language services, RIte Care patients still were not consistently getting language services.

It was against this backdrop that Rhode Island's legislature in 2001 passed a law that required every hospital in the state by July 2002 to provide qualified interpreters and/or bilingual clinicians for LEP patients and other language-related requirements, such as banning the use of children under age 16 for interpretation. This law has gotten the attention of Rhode Island's provider community. It was at this time that NHPRI joined forces with other organizations—Rhode Island Hasbro Children's Hospital, Woman & Infant's Hospital, St. Joseph's Hospital for Specialty Care, Providence Community Health Center, and advocacy organization Ocean State Action Fund—to try to change the status quo in the area of health care interpreter and language services in state. The group applied for the Hablamos Juntos grant and began the Su Salud initiative in October 2002.

## Implementing a Reimbursement Code for Interpreter Services

The Su Salud project's primary purpose is to create a claims reimbursement mechanism for interpreter services, with the goals of increasing access to care and the quality of care for LEP patients while demonstrating a positive

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financial outcome for health care organizations providing linguistic and culturally competent care. Reducing liability, improving the delivery of patient care, and the development of a reimbursement mechanism creates an incentive for providers to include interpreter services in the routine delivery of care and at no cost to the patient. NHPRI officials believe that health care services need to be paid for in order to be valued in the current health care delivery system, otherwise such services won't be performed effectively.

While participating Su Salud provider organizations provided interpreter services to all LEP patients, the project only reimbursed for interpreter services that occurred in the context of a medical encounter for NHPRI's Spanish-speaking members. While the demonstration's focus was specific, NHPRI officials believe that interpreters should be present throughout the entire delivery of care from access to discharge. Making trained and experienced interpreters available is a patient safety and quality of care issue. RWJF funded Su Salud because there was a clear recognition that medical interpreters play a big role in delivering safe and effective care to a large portion of the populations. In Rhode Island, at the time, several events were taking place, including:

- The passage of a state law requiring Rhode Island hospitals to provide interpreters throughout their facilities;
- Increased momentum by key providers and NHPRI to collaborate on how to meet the new law without breaking the bank;
- A recognition by NHPRI that it has a contractual responsibility to ensure all patients in RIte Care get the same level of care;
- An awareness among health plan officials that language barriers mean patients don't get the care they need and are likely to cost the plan more, as these members use more services trying to get well in a system that mismanages them or their conditions will worsen and their care will cost more; and
- An understanding by NHPRI officials that working jointly with providers on a solution helps to forge a stronger relationship with hospitals.

By providing fee-for-service reimbursement for interpreter services within a clinical encounter, Su Salud also allows for the building of an appropriate infrastructure—including the creation of a floor or basic standards in which provider organizations can assess, train and qualified interpreters—needed in order to receive health plan reimbursement for providing language services. Currently, nationally there are no standards by which interpreter assessments and testing are done, resulting in wide variation of verbal and written interpreting skills. Fee-for-service reimbursement and the accompanying claims process also allows NHPRI to collect data on language services, while tracking and monitoring outcomes in the project's targeted areas. This was used toward determining the cost-benefit analysis of the project.

*Code Development:* The development of the reimbursement code was among the easiest steps in the Su Salud effort. Health plans can't create their own reimbursement codes; instead this process must be done in concert with purveyors of nationally used medical coding systems. Luckily, Su Salud participants did not have to go through this process, and neither do other health care payers and providers.

Su Salud program staff talked with internal credentialing and claims department officials, who discovered a little-used code for oral interpretation and sign language, T1013, under the Health Care Common Procedure Coding System. The configuration of systems and activation of the T1013 code can be replicated throughout a state, region or country. While any provider can submit claims using procedure code T1013, it doesn't mean that reimbursement will be involved. Under the Su Salud initiative, the code is being used by the provider partners with reimbursement for "clinical" interpreter services at each partner site. The Su Salud team, along with NHPRI's provider relations and claims department, oriented billing department staff at each provider site on how to use the code, properly assign a provider identification numbers to "qualified" interpreters, and in developing a database of trained interpreters and dual-role staff.

With Rhode Island's newly enacted state law, getting buy-in from executives at the provider partners did not present a challenge. However, organizational leadership is paramount under such an effort, and only when top leaders understand the importance of interpreter services to their organization and patients can they make a commitment do things differently. While leaders at the provider partner organizations were willing to make strides toward organizational change it nonetheless took a tireless effort by Su Salud staff and Su Salud liaisons at each partner site

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to talk, encourage, educate and train executives, managers and frontline clinicians and workers on the importance of trained interpreters on the delivery of health care for LEP patients, as well as on the process for reimbursement under the initiative.

Su Salud staff and representatives at each provider site initially decided that it would not be feasible to develop and implement language services interventions throughout an entire organization. It was decided that each provider organization would focus on a specific area under Su Salud. Rhode Island Hospital/Hasbro Children's Hospitals focused on providing interpreter services in the children's and adult emergency rooms, while Women and Infants' Hospital concentrated on the neo-natal intensive care unit and triage areas. Meanwhile, St. Joseph Hospital for Specialty Care focused its Su Salud efforts on walk-in and urgent care patients, with Providence Community Health Centers concentrating on prenatal primary care patients.

Reimbursement for interpreter services initially was to be based on the start-stop model used for anesthesia services billing. However, providers quickly reported their internal systems could not incorporate that model. As a result, it was agreed by all parties that reimbursement would be based on 15 minute increments of clinical interpreter services time. Each 15 minutes constitutes one unit. Within the provider partner sites, the information technology staff needed to make adjustments to the computer systems so that departments that had never been revenue-generating areas, such as interpreter services, could bill for reimbursement. Staffers in these areas were trained to file clean claims that would be accepted by NHPRI for interpreter services reimbursement. Adjusting to the new workload and getting the interpreters to complete the proper forms for reimbursement have been some of the bigger challenges from the standpoint of provider partners.

*Getting Paid:* Under Su Salud, claims submitted by partner sites for eligible services provided between Feb.1, 2004 and Dec. 30, 2005 would be reimbursed. NHPRI provided 25 percent of the match toward interpreter services reimbursement under the initiative, with Hablamos Juntos funding providing the rest. The revenue generated through the reimbursement code is designed to help cover the costs of incorporating interpreter services at each demonstration site. The reimbursement rate under Su Salud is \$28.50 for each clinical encounter hour. A clinical encounter is linked to a diagnosis code involving a face-to-face service, such as triangular (interpreter. Patient and clinician) or dual role/self (assessed bilingual clinician performing a job-related function in primary language of patient) encounter. An exception includes mental health services.

Under Su Salud, provider partners were required to hire additional interpreters and pay for their training under the initiative. NHPRI and each Su Salud partner contributed 25 percent of the upfront costs of the demonstration through in-kind space, staff time, and trainings, for example. Only services provided by interpreters who had completed a new interpreter education, training and qualification program established under Su Salud were eligible for reimbursement. Both dual role and dedicated interpreters (including new hires and existing interpreters) were eligible to participate in the Su Salud interpreter training and qualification program. Interpreters who were not employed full-time or part-time by the Su Salud partner organizations weren't eligible, although NHPRI and the provider sites still utilize outside interpreter agencies.

Once an interpreter received a certificate of completion of training, the provider's information would be sent to the health plan's credentialing department and the interpreter would be assigned a provider number for reimbursement purposes under the demonstration. Su Salud partner sites can submit a claim only for clinical interpreter services—social work and other non-clinical interpreter services are not eligible under the initiative—given to a NHPRI Rite Care member in need of language services and who sought care in one of the pre-designated areas under the initiative. Under Su Salud, it was determined early on that the demonstration would focus initially on critical areas in different provider sites to determine whether or not the approach made sense to expand throughout an entire hospital or to other departments. Access in the initial target areas was deemed as some of the areas of highest importance in how they would affect access and quality. To get reimbursed under the initiative, providers must submit within 90 days of services a signed encounter form and either a UB92 or HCFA-1500 form for interpreter services provided to NHPRI members who sought care. The encounter forms act as back-up to the claim.

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*Observations:* Enjoying a reputation as a provider-friendly health plan, NHPRI was cognizant of not overburdening provider partners with numerous system changes. However, at least one provider organization discovered its claims were not getting reimbursed part way through the demonstration. The reason, NHPRI officials discovered, was that an incorrect place of service code was cited on the provider's claims forms. For each claim submitted for reimbursement, providers must choose from more than 70 places where that service was provided. Since the Su Salud demonstration was very specific about what types of care would be reimbursed, a code designating an inpatient visit (21) would not be reimbursed if that provider was only eligible, for instance, to be paid for such services for emergency room patients (23).

## Research Spotlight: Making the Case for Interpreter Services

Research shows the important role trained medical interpreters have on the delivery of health care services to patients with limited English proficiency (LEP), including:

- Non-English speakers are less likely to get preventive health services. (13)
- One in five Latino patients who speak limited or no English fail to seek care when they need it. (14)
- Latino patients cite language barriers as the reason for misdiagnosis, poor medical care and inappropriate medications and hospitalizations of their children. (15)
- LEP patients receive less detailed inform about rehabilitation therapy, and understand less of medication-related instructions. (16)
- Spanish-speaking patients discharged from the ER without interpreters are less likely to understand diagnoses, prescribed medications, special instructions or plans for follow-up care. (17)
- More than 25% of surveyed patients who did not have an interpreter and who needed medications didn't understand the instructions for taking their medications, compared to just 2% of those who has an interpreter or who did not need one.(18)
- Low-income Latino parents did not enroll their children in health programs because of limited English proficiency and little experience in navigating the insurance system. (19)
- LEP can lead to inefficient care as clinicians are unable to understand LEP patients' symptoms and end up using more diagnostic resources or invasive procedures. (20)
- Untrained or ad hoc interpreters commit more errors of potential clinical consequence compared to professional interpreters. (21)
- Patients who confronted a language barrier during a medical encounter were significantly less likely to be discharged from the ER with a follow-up appointment than other patients. (22)
- LEP patients who are provided with professional interpreters make more outpatient visits, get and fill more prescriptions and have high satisfaction with care. (23)

Moreover, NHPRI initially was greeted with an internal challenge to configure its claims payment system so it would flag and deny claims from institutions that were not part of the Su Salud project, and claims made for a clinical encounter outside a focus area within a partner site. The latter meant NHPRI had to reconfigure its computer systems to deny this service. The challenge for information technology staff was to ensure that other covered services would not be denied.

Meanwhile, trying to initiate change to an organization's culture is not easy, especially when it's another organization's culture you are trying to change. While NHPRI largely had buy-in of leaders at Su Salud provider organizations to the enhance interpreter services, a tremendous amount of work was required to help turn that vision into reality. Getting managers and frontline clinicians to accept the changes Su Salud was introducing and to change behaviors in delivering care to LEP patients required dedicated staff members—at both the health plan and within each provider organization—who champion the cause. These champions have to be dedicated and believe in the mission, be willing to work long hours and available at odd hours, and be present on the frontlines in order to help people in these organizations actually make changes to the status quo.

One key step Su Salud stakeholders took that helped achieve buy-in at the different organizations was the

formation of a Su Salud workgroup, which included officials from each partner site. Regular meetings kept the ball moving forward, and the relationships individuals developed also meant they could call on each other, whether to help facilitate change within one of the organizations or to exchange ideas informally. NHPRI and Su Salud officials also talked with lawmakers, state health officials and other key stakeholders in the community, who became excited about the program and wanted to see it succeed.

## Achievements in Creating a Community-based Medical Interpreter Infrastructure

Creating what's believed to be the nation's first fee-for-service reimbursement mechanism for interpreter services, Su Salud is showing that fee-for-service payment for language services is a model that can be replicated by other health care organizations and payers in order to improve that patient-provider encounter for individuals with limited English proficiency and as a way to help providers better meet federal and state laws, as well as JCAHO accreditation requirements in the area of language services and cultural competency. Su Salud has also shown that

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interpreter service reimbursement is an avenue to raise awareness among providers about the importance of language services and that trained interpreters are a linchpin in an organization's ability to deliver high quality care to a large and growing segment of the population. This has important business ramifications too, as payers look to reimburse providers on a pay-for-performance basis.

Su Salud has not only led to the hiring of 10 additional interpreters by the four provider partners, but the initiative has also helped create a floor for interpreter services in Rhode Island. Moreover, the program has helped to increased momentum toward setting a national standard for clinical interpretation services. Without a common standard for such services, provider organizations are left on their own to negotiate this tricky and unfamiliar terrain. To date, this has proved to be a failing strategy. Each institution does things differently in their attempt to meet federal, state and accreditation requirements. Many organizations depend on interpreters with little or no training. Other Su Salud achievements include:

*Providing increased resources dedicated to language services and for the first time reimbursing provider organizations for providing patients with trained and qualified interpreters.* The Su Salud project pumped \$1 million into Rhode Island health care organizations for the purpose of improving language services to the growing Latino population. The effort raised the awareness of the importance of and the role interpreters play in providing quality health care services to patients with limited English proficiency, while increasing the value of such services by reimbursing health care provider organizations for providing trained interpreters.

*Training of 60 dedicated or dual-role interpreters at four provider organizations.* Su Salud brought medical interpreter training within the reach of local health providers and set an expectation that interpreters should be trained. In order to become a "qualified" interpreter under the initiative, participants were given a new Spanish Language & Interpreter Skills Assessment. This allowed provider organizations to get a baseline on interpreter skill level and then measure individual skill level post-training. Interpreters also went through a 48-hour intensive medical interpreter training through the University of Massachusetts Medical School. Providers report that the training was beneficial even for interpreters who had already been on staff.

*Helping providers to be able to better meet federal and state laws, as well as JCAHO accreditation requirements around language services.* The demonstration was designed in part to help participating hospitals meet legal and accreditation requirements around language services. Su Salud has allowed Rhode Island Hospital and Hasbro Children's Hospital, for example, to provide around-the-clock interpreter service in the emergency departments. Prior to the initiative, interpreter services were available Monday through Saturday during regular business hours and some extended evening hours. Meanwhile, Women & Infants' Hospital created five positions for dual-role staff (certified nursing assistants/interpreters) in triage and the neo-natal intensive care unit. Before the initiative, the hospital did not have qualified internal staff in those two critical medical areas.

*Improving efficiencies around the delivery of interpreter services.* Having trained medical interpreters on staff is preferable to contracting out as it creates consistent working relationships between clinicians and interpreters. Relying on outside interpreter contractors—who may have limited training—does little to foster a relationship between a clinician and interpreter. By providing trained interpreters and educating clinicians on how to work with an interpreter you foster a direct relationship between the patient and provider. It is also inefficient from a cost perspective. NHPRI is required to pay \$33 to \$40 per hour for contracted interpreters for provider visits scheduled at least 48 hours in advance. NHPRI pays a minimum of one hour each time the language consulting service is used, and pays the agency regardless of whether a patient misses the appointment, or if a provider or patient comes late to a scheduled appointment. NHPRI has found, on average that it is reimbursing two units, or 30 minutes, for each interpreter service claim (and only when the service is actually provided). That translates to a little more than \$16 for each non-emergency room encounter.

*Increasing awareness of importance of interpreter services among frontline staff.* Provider representatives report a higher awareness of the benefits of medical interpretation services brings and a better appreciation of the positive impact it can have on health care quality. Patterns have changed among some providers, who have become less willing to call on a bilingual staff member instead tracking down a trained medical interpreter. Efforts to educate all

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staff at provider organizations have helped promote an awareness and better appreciation of interpreter services, and have translated into staff depending less on bilingual family members.

*Increasing good will among NHPRI, provider partners and other stakeholders.* NHPRI's effort to lead an effort to help local healthcare providers improve their ability to provide legally mandated language services to LEP patients—through technical assistance, financial reimbursement and leadership—has helped to further cement NHPRI's reputation as a trusted and provider-friendly health plan. The goodwill around this initiative has also shown that competing organizations can work collaboratively for the sake of improving the delivery of healthcare services. Furthermore, leaders from partner sites, state government officials and LEP-related advocates were also involved in the planning of Su Salud.

*Establishing a local medical interpreter training program.* Until now, there have been no training opportunities available for medical interpreters within the state of Rhode Island. The 48-hour medical interpreter program through the University of Massachusetts Medical School was used to provide staff interpreters with baseline training. Meanwhile, Hablamos Juntos' national program office has recommended a 300-hour community college curriculum for all its demonstration sites from the Community College of San Francisco. The curriculum provided to Su Salud by Hablamos Juntos was finally implemented within a local community college, Community College of RI. This is the first college based medical interpreter training in Rhode Island, classes for this one-year certificate program started on September 7<sup>th</sup>.

*Collecting data needed to demonstrate the effectiveness of language services.* For the first time, Su Salud partners will be able to collect data on the use of interpretation services. Rhode Island State law mandates that hospitals document and collect language preferences, including whether or not and why an interpreter was provided. Without data, organizations can't measure how well they are doing or highlight problem areas. Until Su Salud, no method existed to evaluate possible cost savings from providing linguistic and culturally competent care. Data collection will be able to demonstrate how effective language services were to the participating partners. Su Salud lessons and data will be used to demonstrate to Rhode Island Medicaid officials the impact interpreter services has on the delivery of care, as it partners urge the state to cover interpreter services as a covered benefit under the state Medicaid program.

### **Conclusion: Is it Worth It?**

The ability for physicians, hospitals and other health care providers to clearly communicate with patients with limited English proficiency is an essential step in providing safe and high-quality health care services to millions of patients in the U.S., and without discriminating against patients who do not speak English as their primary language, or who are limited in their ability to read, speak or understand English. For too many patients the difference between efficient and quality care and costly, even dangerous care is whether or not a medically trained interpreter is available. In addition to a growing body of evidence linking language barriers to quality of health care, the imperative for health care organizations to act is also embedded in law, including Title VI of the federal Civil Rights Act, which prohibits health care providers participating in Medicare, Medicaid and other federal programs from discriminating against individuals with limited English proficiency.

Unfortunately, providing medically trained interpreters for LEP patients occurs too infrequently, putting such patients at risk. Many insurers and health care payers do not pay for language services. As a result, medically trained interpreters often are not available when LEP patients seek health care services. Neither is there an available infrastructure to train and reliably test the competency of interpreters working in the health care arena, putting an even heavier onus, in the form of an unfunded mandate, on health care providers to meet laws, accreditation and other requirements to do so. Under a grant from The Robert Wood Johnson Foundation's Hablamos Juntos initiative, Neighborhood Health Plan of Rhode Island is trying to change the status quo.

As a result of NHPRI's effort to establish the nation's first fee-for-service claims reimbursement mechanism for language and interpretation services under the Su Salud demonstration, Neighborhood Health Plan is showing others that paying for such services is both doable and provides benefits. The cost-effectiveness evaluation was unable to provide evidence of significant cost-savings from interpreter services during the limited period studied, further

## INCENTIVE TO IMPROVE CARE: PAYING HEALTHCARE ORGANIZATIONS TO PROVIDE INTERPRETER SERVICES - WHITE PAPER

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investigation into program implementation suggests that the null result may be due to low *intervention dosage*, meaning that a small percentage of the study population are reported to have received the intervention of *Su Salud* interpreter service. NHPRI believes there is potential to demonstrate cost savings in areas such as NICU & ER. It is believed that if we lengthen the study period we may be able to gather the sufficient data needed to make our business case. We will continue the claims reimbursement and we have also started an incentive/pay- for- performance initiative under Su Salud. The Su Salud effort comes as state Medicaid programs consider fee-for- service models to reimburse for interpreter services.

As a result of effort to establish the nation's first fee-for-service claims reimbursement mechanism for language and interpretation services under the Su Salud demonstration, Neighborhood Health Plan is showing others that paying for such services is both doable and provides benefits. The Su Salud effort comes as state Medicaid programs consider fee-for-service models to reimburse for interpreter services.

The cost-effectiveness evaluation was unable to provide evidence of significant cost-savings from interpreter services during the limited period studied, further investigation into program implementation suggests that the null result may be due to low *intervention dosage*, meaning that a small percentage of the study population are reported to have received the intervention of *Su Salud* interpreter service. NHPRI has decided to move towards an incentive/pay- for- performance initiative under Su Salud due to design problems that need to be tweaked. Such problems include but are not limited to using an additional encounter form to submit for reimbursement.

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<sup>1</sup> Ku, Leighton and Flores, Glenn, Pay Now or Pay Later: Providing Interpreter Services in Health Care, Health Affairs, Vol. 24, Issue 2 (2005): 435-444.

<sup>2</sup> Woloshin S., Schwartz LM, et al, Is Language a Barrier to the Use of Preventive Services? Journal of General Internal Medicine, Vol. 12 (1997): 472-477.

<sup>3</sup> Shapiro J and Saltzer E., Cross-cultural Aspects of Physician-patient Communication Patterns, Urban Health, Vol 10 (1981): 10-15.

<sup>4</sup> Brach, C., Fraser, I. and Paez, K., Crossing the Language Chasm, Health Affairs, Vol.24, No. 2 (2005): 424-434.

<sup>5</sup> Hablamos Juntos Website, June 2005.

<sup>6</sup> Brach, C., Fraser, I. and Paez, K., Crossing the Language Chasm, Health Affairs, Vol.24, No. 2 (2005): 424-434.

<sup>7</sup> Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d et. seq.

<sup>8</sup> Neighborhood Health Plan of Rhode Island, Su Salud Program Executive Summary, April 2002.

<sup>9</sup> U.S. Census Bureau, Language Use and English-Speaking Ability: 2000, Pub. No C2KBR-29 (Washington: U.S. Census Bureau 2003).

<sup>10</sup> The Robert Wood Johnson Foundation website, Tracking Health Plan Enrollees' Race and Ethnicity, <http://www.rwjf.org/newsroom/featureDetail.jsp?featureID=176&type=3>.

<sup>11</sup> National Health Law Program & the Access Project 2003, Language Services Action Kit.

<sup>12</sup> Woloshin S., Schwartz LM, et al, Is Language a Barrier to the Use of Preventive Services? Journal of General Internal Medicine, Vol. 12 (1997): 472-477.

<sup>13</sup> Hablamos Juntos Website, June 2005.

<sup>14</sup> Hablamos Juntos Website, June 2005.

<sup>15</sup> Hablamos Juntos Website, June 2005.

<sup>16</sup> Hablamos Juntos Website, June 2005.

<sup>17</sup> Language Access Advocacy Project California 2004, Presentation: Importance of Language Services.

<sup>18</sup> National Health Law Program & the Access Project 2003, Language Services Action Kit.

<sup>19</sup> Hablamos Juntos Website, June 2005.

<sup>20</sup> Ku, Leighton and Flores, Glenn, Pay Now or Pay Later: Providing Interpreter Services in Health Care, Health Affairs, Vol. 24, Issue 2 (2005): 435-444.

<sup>21</sup> Ku, Leighton and Flores, Glenn, Pay Now or Pay Later: Providing Interpreter Services in Health Care, Health Affairs, Vol. 24, Issue 2 (2005): 435-444.

<sup>22</sup> Language Access Advocacy Project California 2004, Presentation: Importance of Language Services.

<sup>23</sup> Hablamos Juntos Website, June 2005