Language Access Services Translate to High Quality Health Care:

Findings from Interviews on Language Services in Kentucky

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INTRODUCTION

All children need access to high quality health care to grow and become productive adults. The success of Kentucky's communities relies on a supply of healthy and educated young people, ready to take up the workplace demands of the 21st century.

Effective communication between health care professionals and patients is a critical component of high quality health care services. For families learning English, quality care requires specific attention to communicating with patients so that the medical provider understands the patient's needs and the patient understands the provider's recommendations. Providing language access services results in improved delivery of health care, particularly in regards to preventive, routine care and prescription drugs.[1,2] In contrast, the lack of language services has been associated with increased use of expensive diagnostic tests, increased number and duration of emergency room visits, and a greater likelihood of intubation for children with asthma.[3]

Language access services refer to specific efforts of health care professionals to ensure effective communication with patients learning English. These services range from offering documents translated in other languages to providing interpreter services (see Table 1). Research indicates that there may be a net savings produced by providing language services to all patients in the health care setting.[4,5]

Table 1: Options for Providing Language Access Services

Interpretation of Spoken Word	Translating Written Patient Information Materials	Translating Prescription Labels
– Bilingual providers – Trained medical interpreters – Telephone interpreter services – Bilingual staff – Language bank cooperative or group purchasing of interpreter services by practices/clinics – Trained members of community-based organizations – Remote simultaneous interpreters – Trained volunteers from local universities – Telemedicine linkups to interpreters – Foreign language immersion courses for clinicians and staff	– Professional translation – Computer translation software – Computer translation downloads from federal Web sites	– Professional translation – Computer translation software

Source: Pediatrics: Language Barrier. Agency for Healthcare Research and Quality; Morbidity and Mortality Rounds on the Web. Available at http:///webmm.ahrq.gov/.

Title VI of the federal Civil Rights Act guarantees a patient's right to interpretation and translation services in federally-funded activities and programs. Whether immigrants or citizens, some people for whom English is a new language have mastered the language, yet

others do not yet feel comfortable communicating in English about their medical needs. Some health care providers comply with this law and offer language access services to all of their patients. Unfortunately, it remains clear that many families still do not receive language access services, limiting the quality of the health care they receive.

The population of people who are learning English is diverse in income. While approximately half of young children of immigrants live in poverty, the majority of people who are learning English do not.[6] This has important implications for policy development; efforts to increase health care access for all patients cannot focus entirely on low-income populations, as this would exclude more than half of all the individuals who are learning English. For this reason, both the government and private insurers need to become involved in improving patient outcomes.[7]

In 2002, the federal Office of Management and Budget estimated that it would cost the United States $268 million a year to provide interpretation services in hospitals, outpatient physician offices, dentist offices, and emergency departments.[8] The cost of interpreter services has been estimated to represent approximately 0.5 percent of the total cost of a visit, but this small cost can have a large impact on a patients' access to care.[9]

Despite federal laws upholding the right to language access services and a growing understanding in the health policy arena, "many providers are not aware of their responsibility, have not prioritized the issue, or have not been held accountable through consistent enforcement."[10] In an effort to remedy this, many states have adopted policies to increase access to health care for all people.

California, Maryland, and Washington, D.C. enacted comprehensive laws that broadly address language access.[11] Many other states, including Kentucky, have policies in place that target specific programs. For example, 29 states have laws related to language access in the health care setting for children, and 12 of those states have specific requirements regarding notices about Medicaid's Early, Periodic, Screening, Diagnosis, and Treatment program.[12]

Although not comprehensive, Kentucky has six provisions related to language access services in the health care setting.[13] These laws include instruction on providing Spanish-speaking interpreters for HIV/AIDS prevention and treatment, supplying interpreter services for Medicaid applications, and requiring Medicaid managed care organizations to distribute translated marketing materials if more than 10 percent of the members speak a particular language. Early Intervention Services in Kentucky are also required to provide materials in the patient's preferred language, and may be reimbursed for interpretation services as part of an Individual Family Service Plan.[14]

Because of the rise in Kentucky's population of people who are learning English and the value of improving communication between health care providers and patients, Kentucky Youth Advocates conducted interviews to assess current services. Kentucky Youth Advocates interviewed more than 30 people in Kentucky, including community-based advocates working

with people learning English, as well as health care providers, including hospitals, health departments, and clinics. This report summarizes what we heard, presents research on the need for language access services, discusses best practices in the field, and offers recommendations. The main findings from the interviews include:

- Health care providers realized the importance of language access for their patients, but the extent and scope of the policies they developed varied greatly.
- Language access services lack consistency and often do not follow the provider's stated policy.
- Language access services fall short on quality and breadth.
- Information is not readily available to patients to explain the language access services providers are required to offer.

The recommendations include:

- Improve statewide coordination of language access services.
- Evaluate and improve policies to assure quality in language access services.
- Educate patients on what services they should receive and the risks of using untrained interpreters.
- Develop a reimbursement mechanism for language services.

A note about interviewees:
We talked to more than 30 health care providers and advocates throughout Kentucky. The health care providers were generally larger facilities like hospitals and local health departments. The advocates included community-based advocates working with people learning English. We divided the state into 6 regions and spoke with at least two advocates and health providers in each region. We realize the limited scope of the interviews, but highlight the connection between the Kentucky experience and broader research. We sincerely thank the participants for being candid in our discussions. We assured them each of the confidentiality of their responses.

FINDINGS

Health care providers realized the importance of language access for their patients, but the extent and scope of the policies they developed varied greatly.

Creating accessible health care services for all community members starts with placing a value on strong and effective policy development within the health care setting. One advocate reported, “Some places are more than happy to provide ways to accommodate patients, while others don't care one way or another.” The likelihood of accessing language services for health care depends in part on the setting; this is true both nationally and in Kentucky. Our interviews did not include private practice providers, but interviews with advocates revealed that this group of health providers had the longest way to go in terms of being accessible to people learning English. Access to language services in these small health care settings, which tend to provide the majority of preventive health care, could be improved by reviewing and modifying their policies.

During the interviews, it became clear that larger health providers realized the importance of providing language access services for their patients. They described a sense of urgency due to legal obligations, quality of care, and the fact that their patient load consisted of people with varied levels of English language proficiency. The failure to provide quality interpretation and translation services in the medical setting can have negative consequences for providers as well, including: malpractice lawsuits, sanctions, funding cuts, and increased costs of care.[15,16] In one case study, a misunderstanding over one word led to a child’s paralysis and a $71 million malpractice settlement.[17]

Providers recognized that quality of patient care is often compromised due to insufficient quality interpretation and translation services. However, they described having few options because of the cost, number of patients, and/or the lack of resources available locally. Several described a perceived lack of need for the services because of the small number of patients learning English. Another frustration included the inadequacy of resources for services whether it be the need to use several interpreters, for instance English to Spanish to Quiché and back again, or too few certified medical interpreters available. As one health provider stated, “[it is] quite a bit of a challenge for health care facilities to obey the law due to lack of availability [of interpreters].”

Many of the providers interviewed described putting a lot of time, effort and money into policy development and implementation; they were very deliberate in their efforts. Unfortunately, there were others with a much more limited view of the need for strong internal policies. One advocate said, “The bad practices include allowing children to serve as the interpreters, using language lines when not appropriate, not providing trained interpreters, and giving information to the clients in English, not their native language.”

The health providers stated that employing bilingual staff would be helpful, and some did actively recruit, although they acknowledged that there needed to be a separation between

health provision and interpretation. One interesting finding was that none of the health care providers we spoke to claimed to look at adverse health effects and its correlation with language access needs or levels of English proficiency. None of the health providers reported that their bilingual staff members were visually identifiable to patients; meaning that a patient would not be able to seek out the services of a bilingual staff member with a visual cue, such as a name badge with primary language identified.

These findings and current research indicate that for large health care settings like hospitals, or those that care for a high proportion of patients who are learning English, language access services may be more accessible than other types of facilities/providers, and are certainly more accessible than they were even a few years ago.[18] Federally-qualified community health centers also serve an important role in providing health care that meets patients' language needs. Nationally, they care for three times the percentage of patients who are learning English as their percentage in the U.S. population. In 2006, more than 30 percent of the patients seen in these centers were served in a language other than English. Most patients at these centers reported that their care provider spoke their language.[19]

Despite the gains in access, many other providers need to improve their language access services. For instance, a survey of hospitals found that nationally, 82 percent used staff interpreters, while 62 percent in Kentucky used staff interpreters.[20] Private practices trail further in offering language access services. A 2006 national survey of internal medicine physicians found that 65 percent of internists reported having active patients who are learning English, yet "fewer than 10 percent of practices are currently engaged in initiatives to provide or improve language services".[21]

Language access services lack consistency and often do not follow the provider's stated policy.

Language access services provide a critical link to health care for people who are learning English, yet implementation of language access policies show inconsistencies. Many studies identified English proficiency as one of the primary factors determining access to health care.[22] The barriers that lack of language access services pose to health care access overall are as significant as the lack of health insurance.[23] A survey of Latino parents revealed that language issues were cited as the single greatest barrier to health care access for their children.[24] Another study revealed that children of parents learning English are three times more likely to have fair/poor health status and significantly increased odds of not being brought in for needed medical care.[25]

Many of the Kentucky health care providers with whom we spoke were making efforts to provide language access services. Most of the providers, per the requirements of Title VI, had written policies in place and they are made available for staff members to access. They typically trained staff on these policies upon hiring them and subsequently at annual trainings at which attendance was required. Most of the providers also reported documenting in a patient's

record the need for language access services and the services used in order to better serve the patient in future visits.

Despite the efforts of providers to establish and implement language access policies, provider perceptions of language access services differed from the observations of advocates working with people learning English. For example, health care providers reported that they typically make the arrangements for interpreter services when needed by a patient. However, advocates consistently recounted an expectation, stated or perceived, among health care providers that patients bring their own interpreters when they come to receive medical care.

A national study of pediatricians revealed that nearly 70 percent use a patient's relative as an interpreter (a practice that has been associated with potentially fatal errors as well as ethical and legal drawbacks), and only about one-third offer translated written materials.[26] A Kentucky advocate reflected that, "The private doctors tell patients that they have to bring their own interpreter, and often, the interpreter is not proficient in English, which leads to bad information and miscommunication."

Many medical providers agreed with advocates that despite efforts to provide language access services, family and friends often interpret during medical appointments. Research shows this practice increases the risk of medical errors.[27] Some facilities reported that they discourage families from using untrained medical interpreters while others reported that they do not allow children, family, and friends to interpret. Interpretation by adult family members or friends was acceptable to some providers if it made the patient more comfortable. Few facilities required families to sign a form that indicated they refused language access services.

Title VI of the Civil Rights Act of 1964 requires service providers utilizing federal funding to provide information in a language that patients can understand.[28] The federal Office for Civil Rights provides specific guidance on complying with Title VI regarding the use of family and friends as interpreters.[29] It found that "requiring, suggesting, or encouraging a patient to provide their own interpreter, particularly a minor child, infringes on the patient's legal rights (at least when the provider is a recipient of federal funds in the form of Medicaid, Medicare, or SCHIP payments for even one patient in the practice)."[30]

One advocate talked about "people in our parish whose children have to interpret, because there is no one at the doctor's office to interpret." However, interviews with health care providers disclosed a portion of patients offered interpretation services decline in favor of using a friend or relative, even when discouraged by providers. This may be due to patients' distrust of unknown third parties or lack of knowledge of the importance of using a medical interpreter. It also highlights the need to increase families' understanding of the medical risks of using a untrained interpreters.

Using children as interpreters places an undue burden on young people and potentially takes them away from school or other activities. Interpretation can also pose a significant emotional burden. In focus groups conducted with immigrant youth in Kentucky, a young person reported

on her experience having to interpret at the doctor's office: "I had to tell my mom she had cancer. I had to know first. I had to tell her first."[31]

When language access practice does not follow policy, language barriers can contribute to poor health care quality and poor outcomes for children.[32] A 2007 study found that patients not proficient in English experience a higher risk of serious physical harm or death due to communication errors as compared to English-speaking patients (49 percent vs. 30 percent).[33] Likewise, patients with a provider who did not speak their language received less health education compared to patients with a provider who speaks the same language as the patient.[34] Language barriers have also been found to decrease access to primary and preventive care, hinder patient comprehension, decrease adherence to treatment plans, and reduce patient satisfaction.[35]

In addition, the chance of medication errors increases dramatically when patient and health care provider do not speak the same language. In one study, 27 percent of patients who needed an interpreter and did not receive one failed to understand instructions for taking medications, versus 2 percent of those who either received interpretive services or did not need interpretation.[36]

Language access services fall short on quality and breadth.

Although the majority of health care providers throughout the state use some form of basic language access services, the services can be inadequate or of poor quality. The quality of successful language access services depends on trained and competent language access providers. Yet health care providers and advocates throughout Kentucky described deficits that compromise the quality of the health care.[37]

Several inconsistencies exist between the perceptions of health care providers and advocates concerning quality and true access to services. One involves patients' experiences with the discharge process, including billing and instructions for care. According to health care providers, their policies include interpretation and translation of forms at discharge, but advocates state this rarely occurs. An advocate observed that the billing statements their clients receive come in only one language and that language is English. One advocate said, "The billing department sends everything out in English, and while the clients understand the numbers, they do not understand what the rest of the bill means. I know of cases where clients keep making payments, even though the bill already has been paid."

Advocates also claim that instructions for care, including pharmacy information, come solely in English. It becomes difficult for parents to properly administer medication to their children when the information is in a language they cannot comprehend. One advocate exclaimed, "a lot of the time, even if there is an interpreter at discharge, they can't explain the medicines or what they (caregivers) need to do at home to the patient. One mom had a baby with a cleft palate, but they (health care provider) couldn't explain how to clean it or that surgery would be needed or that the child wouldn't have this the rest of their life. The mother was crazy with

worry and came to me, and I looked up information on the internet in Spanish to explain it to her, which helped calm her down."

Advocates and health care providers expressed concern that interpreters are often not trained to do medical translation. In fact, an advocate (referring to health care providers) stated, "they may use interpreters, but the interpreters are not necessarily properly trained to provide medical interpretations." Even though interpreters may be fluent in a given language, that does not mean they possess medical terminology skills or the skills to work as an interpreter. Qualified interpreters are trained not only in medical terminology, but also in how to provide accurate and meaningful interpretation.

The ramifications of not having interpreters robustly versed in language-appropriate medical terminology could be severe enough to threaten the safety of the patient. A rigorous study of Spanish-speaking patients conducted in a hospital emergency department concluded that patients with language concordant providers (providers that speak the patient's language) reported the highest levels of understanding of their diagnoses and treatment plans.[38]

When asked about the biggest challenges they face in offering language access services, the majority of health care providers mentioned "the availability of qualified interpreters" and the "growing number of languages that you need to have available." Our interviews also revealed that many health care providers, absent state guidance, found it difficult to gauge the competency of the interpreters and translated materials that they use. Oftentimes, the contracted agency providing the interpretation services makes the determination of competency. One health care provider raised concerns because the language line with whom her employer contracts is the entity that determines whether a face-to-face interpreter is qualified or if the language line should be used. The provider noted, "I think it might be a conflict of interest because [approving a face-to-face interpreter] is not in their financial interest."

Another issue health providers were asked about was how they assess their patients' level of English proficiency. Providers reported using a range of practices to determine a patient's need for language services. Advocates reported that some providers decide based on the patient's appearance or whether the patient is speaking another language with someone when they enter the facility. Others use a card with languages listed for patients to identify the language they speak. Best practices include asking a two-part question to gauge proficiency, based on questions used by the United States Census. Asking the questions, "Do you speak a language other than English at home?" and "How well do you speak English?" during the intake process gives health care providers a better understanding of patients' needs.[39]

The lack of a formal process creates the possibility of subjectivity that could ultimately compromise the quality of health care the patient receives. For example, a patient might understand enough English to get through the administrative process; however, that does not mean that they understand English well enough to comprehend a medical diagnosis. One advocate claimed that "many providers think that they are being understood by the patients,

when they are not. Some patients will say ‘yes’ when they really don’t understand, just to appease the doctor.”

Even though many health professionals provide Spanish interpretation and translation, they often do not offer services in other languages. Most of the providers did not conduct a community needs assessment to determine what types of services will be needed by their patients. According to a 2007 CyraCom (a company that provides interpretation services) Language Index, the language of Somali ranked second in Kentucky.[40] Advocates in our interviews highlighted Somali, as well as Quiché and Burmese as languages that were underserved in the health care setting.

One advocate expressed that “if the language is Spanish, then there almost always are materials in Spanish. [People who speak] other languages do not have materials provided to them in their native language.” In fact, some areas with a relatively high population of individuals that speak Quiché have neither in-person interpreters nor phone interpreters available; therefore, a patient’s friend or family member is relied upon for interpretation.

Information is not readily available to patients to explain the language access services providers are required to offer.

Individuals have the legal right, under Title VI of the Civil Rights Act, to interpretation and translation services in federally-funded activities and programs. The law requires any entity receiving federal funds (including hospitals, health departments, health plans, social service agencies, nonprofits, clinics, and physicians), to provide language access services to patients. Large organizations like hospitals are almost invariably required to provide interpretation and translation services to their patients.[41] Further guidance was provided in 2000 by President Clinton in the form of Executive Order 13166, which explicitly requires both federally-funded and federally-conducted programs and activities to eliminate language barriers for beneficiaries and participants.[42] In 2003, President Bush affirmed his support for Executive Order 13166.

Title VI of the Civil Rights Act requires the following standards for facilities receiving federal funds:

- offering language access services at no cost to each consumer, at all points of contact, and at all hours of operation;
- providing trained bilingual staff and/or face-to-face interpreters (with options such as telephonic interpretation recommended for use only as a supplemental solution);
- giving translated written notice as well as interpreted verbal notice to consumers in their preferred language regarding their right to no-cost language assistance;
- using hospital signage and written materials translated into the languages most commonly encountered in that area; and
- assuring the competence of interpreters, while discouraging and not relying on ad-hoc translators such as patients’ friends or family members.[43]

A number of other recommended standards have also been developed, such as creating an implementation and assessment plan for developing language access services in the organization and collecting demographic data to guide development of language services.[44]

Despite the fact that language access services are a legal right, we heard repeatedly about patients not receiving these services. Health care providers stated that information on patient rights is distributed to all patients. However, advocates report a lack of awareness among patients about their right to receive health care in their preferred language. Limited understanding of the right to language access services, especially among those who may be very new to the United States, can create confusion and fear among patients. Even when patients understand that health care providers are expected to attempt to communicate with them via interpreters, they may be under the impression that the responsibility to secure an interpreter lies with them rather than the provider.

The use of translated materials, without a verbal explanation could also be a barrier to care, as many patients have reading difficulties, regardless of their preferred language or education level. One advocate relayed that “most of our clients have a 3rd, 4th, or 5th grade level of school.” Limited literacy skills are not unique to patients learning English, and providers need to develop materials or a process for relaying the information in a way that people at many skill levels can understand.

These issues underscore the importance of health care facilities being prepared to verbally communicate the right to language access services to patients in a variety of languages. If a patient has limited reading skills, then written notice of their rights is obviously an ineffective means of communication. As one advocate stated, “The facility may have things translated, but the literacy level of clients is still a huge issue because if they can’t read well then it doesn’t matter what language the forms are in.”

Confusion over a patient’s right to language access services and expectations of health care providers hinder the ability of patients to advocate for themselves and their families to receive those services. Advocates asserted that even among those aware of their rights and with the knowledge of how to file a complaint, relatively few take that action. Some may feel disempowered due to their socioeconomic status or their position as newcomers in this country. These issues place an additional responsibility on agencies serving people learning English to ensure language needs are being met, yet many counties in Kentucky have no agencies that patients can turn to for help in advocacy.

RECOMMENDATIONS

Improve statewide coordination of language access services.

Health providers, state and local government, families, and advocates can work together to improve outcomes by coordinating Kentucky's language access services. It would not only benefit families in Kentucky, but also health care providers and ultimately improve the health and wellness of our residents.

Indiana provides a model for establishing statewide standards for interpreters and translators in the medical field. Indiana passed a law creating the Commission on Health Care Interpreters and Translators to determine to what extent the state should provide oversight of those providing language access services.[45] The Commission tasks also include recommending the level of education needed to be trained in interpretation and translation, and outlining standards of practice for translators and interpreters.[46]

Kentucky should establish a commission to improve services for families and support health care providers that would:

- Develop a statewide training program for certification in medical interpretation that addresses the growing number of languages spoken by patients;
- Maintain a directory of certified medically-trained interpreters and their certified languages to increase provider knowledge of available interpreters;
- Establish a network for providers, advocates, and patients to share resources and ideas; and
- Create an ombudsman position to effectively address negative patient experiences.

Evaluate and improve policies to assure quality in language access services.

Kentucky could develop a universal language access plan informed by policymakers and health care providers, which could be adapted for the needs of each provider. Several comprehensive guides exist that identify national standards in providing culturally and linguistically competent health care services.[47,48,49,50]

Policymakers in Illinois built upon federal requirements under Title VI of the Civil Rights Act and enacted laws with specific language access requirements in all hospitals and long-term care facilities.[51] These include developing a language access plan, reviewing the plan annually, establishing procedures for providing interpreters, conspicuously posting notices of the availability of interpreters, and notifying employees of policy and how to make the services available to patients.[52]

Kentucky's universal plan should draw from best practices and provide model policy language tailored for the Commonwealth. It should also ensure a process for dissemination to provider staff and ongoing training on how to serve all patients.

Educate patients on what services they should receive and the risks of using untrained interpreters.

Health care providers, advocates, government, and patients all have a role to play in improving knowledge and awareness of language access services. Advocates play a critical role in educating patients about the legal obligations of providers, the risks of using non-medically trained interpreters, and how to report bad experiences. To be effective, advocates must educate themselves on these topics as well. Advocates should also empower clients to be proactive in their interactions with providers. Patients can request an interpreter in advance and carry an "I speak…" card that explains to the provider the right to an interpreter and identifies the language they speak.

State government also has a role in educating patients. Kentucky's Cabinet for Health and Family Services, which includes local health departments, set forth policy that states the importance of client education and requires posting of the availability of an interpreter in waiting rooms. State government also can play the role of developing and disseminating educational materials about patient rights and ensuring an effective and trusted process for patients to report experiences that violated their right to services in their language. Health care providers could then contribute to patient education by distributing these materials to all patients.

Develop a reimbursement mechanism for language services.

Cost is a primary factor considered by health care providers in the adoption of appropriate language access services. The health care providers with whom we spoke did not identify any reimbursement system to assist them in covering language access services. They also said that these expenses continue to grow. Yet cost need not be a prohibiting factor; several successful models for funding language access services in health care have been used in other states.[53] These models tend to fund services through one of three entities: the federal government's Medicaid and SCHIP programs, state government, and managed care organizations or private insurers. A few funding models also rely, in part, on community partnerships.

Medicaid and SCHIP are the most significant resources for funding language access services for children and families. As of 2009, fifteen states were receiving federal matching funds for interpreter services (see Table 2).[54,55] Federal matching funds for language access services were increased as part of the SCHIP Reauthorization Act.[56] For Medicaid, the matching rate is 75 percent.[57] For SCHIP the enhanced rate is the higher of 75 percent or the sum of the state's current federal CHIP administrative matching rate plus five percentage points.[58] In Kentucky, this rate would be almost 85 percent.[59]

*Table 2: Program Features of States Receiving Federal-Matching Funds for Interpreter Services***

State	State LEP Population[1]	Federal Match FY 2007	Spending FY 2006[2]	Claim Type	Qualified Providers	Reimbursement Rate	Entity Receiving Reimbursement	Quality Provisions
DC*	38,236	50%	$610[3]	Admin	FFS[4]	$135-$190/hour (in-person) $1.60/min (telephone)	Language agency	Language agency monitors quality
HI	143,505	Medicaid – 57.55% SCHIP – 79.25%	$144,000	Service	FFS	$36/hour (in 15 min. increments)	Language agency	Language agency monitors quality
ID	46,539	Medicaid – 70.36% SCHIP – 79.25%	$87,913	Service	FFS	$12.16/hour	Providers	None
KS	98,207	50%	$46,479	Admin	Managed Care	Spanish - $1.10/min. Other - $2.04/min.	EDS – Medicaid Fiscal Intermediary	Language agency monitors quality
ME	24,603	Medicaid – 63.27% SCHIP – 74.29%	NA	Service	FFS	Reasonable costs	Providers	Privacy standards and code of ethics
MN	167,511	50%	$1,644,400	Admin	FFS	Lesser of $12.50/15 min. or usual & customary fee	Providers	None
MT	12,663	50%	$2,000	Admin	All	Lesser of $6.25/15 min. or usual & customary fee	Interpreters	Providers must arrange for "qualified" interpreter
NH	28,703	50%	$5,870	Admin	FFS	$15/hour $2.25/15 min. after the first hour	Interpreters	None
TX*	2,669,603	Medicaid – 60.78% SCHIP – 72.55%	NA	Admin	FFS	NA	NA	None
UT	105,691	Medicaid – 70.14% SCHIP – 79.10%	$87,500	Service	FFS	$28-$35/hour (in-person) $1.10/min. (telephone)	Language agency	Language agency ensures quality
VA*	303,729	50%	$8,546	Admin	FFS	Reasonable Costs	Area Health Education Center & 3 public health departments	Proficiency standards and interpreter training
VT	9,305	50%	NA	Admin	All	$15/15 min. increments	Language agency	Language agency ensures quality
WA	350,914	50%	$393,414	Admin	All	50% of allowed expenses	Public entities	Certifies interpreters in 7 most common languages, all others must be qualified
			$38,225	Admin	All	Broker – admin fee Interpreters/agencies - $33/hour	Brokers, interpreters, and language agencies	
WY	8,919	50%	NA	Admin	FFS	$45/hour	Language agencies	Interpreters conform to national standards

Source: Table from Connecticut Health Foundation (2007). Seeking Solutions: State Approaches to Covering Medical Interpreter Services in Medicaid and SCHIP Services. Available at http://www.cthealth.org/matriarch/documents/4%2027%2007%20final%20interp%20models%20brief.pdf. Accessed August 2009.

*Notes: ** Iowa began to get reimbursed for interpreter services in June 2009 and this information is not included on the table [1] – based on 2000 Census and LEP means Limited English Proficiency; [2] – or most recently available data; [3] in first 6 months of program; [4] FFS means fee for service, * - pilot projects or recently established programs; NA = information not available*

CONCLUSION

The future of the U.S. economy depends on a healthy workforce. In order to achieve this goal, investments need to be made now in the health and development of our children and their families. A growing number of children live in families in which at least one member is learning English, and research shows their access to health care is significantly lower than that of their English speaking peers. Federal and state laws address these individuals' right to language access services in the health care setting, but more must be done to implement and monitor programs that provide these services. Significant gains may be made in the health and well-being of every child and family with a minimum investment in interpretation and translation services.

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