Service Category Definition - DSHS State Services
September 1, 2017 - August 31, 2018

Local Service Category:	**Linguistics Services**
Amount Available**:**	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to people living with HIV (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between client and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any client seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing impaired HIV+ persons. Services exclude Spanish Translation Services.
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible client.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	people living with HIV in the Houston HSDA

Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/25/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

ARTS AND CULTURE

The Importance of Medical Interpreters

Emily Tonkin, D.O.

While working on the psychiatry consultation-liaison service at a children's hospital, I was asked to see a 12-year-old girl with lymphoma, multiple medical comorbidities, and limited English proficiency. The primary hematology-oncology team was concerned about oppositional and aggressive behaviors interfering with necessary medical care. Upon reviewing the case and doing a behavioral analysis on several major incidents in which the patient became aggressive or otherwise out of control, it was discovered that often staff was not using medical interpreter services. For example, a phlebotomist was witnessed entering the patient's room and attempting to draw blood without speaking a word to the patient. After implementing a behavioral plan and increasing the use of medical interpreters, the patient's behaviors improved.

Executive order 13166 was enacted in April 2000 to improve access to services for people with limited English proficiency in accordance with Title VI of the Civil Rights Act, which prohibits discrimination on the basis of national origin. As such, health care agencies must provide interpreter services to limited English proficiency patients. Data show that professional medical interpreters are underutilized in the health care setting, and multiple barriers to appropriate use have been identified, including limited time and limited access to interpreters (1). Additionally, alternatives to on-site interpreters, including telephone and video interpreters, have demonstrated some deficiencies (e.g., lack of non-verbal communication, less attention to cultural differences) (1).

Communication barriers can lead to a variety of problems, including aggression, hindrance of care, lack of informed consent, and avoidance of the health care system, among other negative outcomes.

As demonstrated by the opening anecdote, communication barriers can lead to a variety of problems, including aggression, hindrance of care, lack of informed consent, and avoidance of the health care system, among other negative outcomes. Conversely, it has been shown that use of an interpreter increases patient satisfaction, decreases adverse outcomes, and improves adherence and positive outcomes (2). Patients with limited English proficiency have expressed preference for professional interpreters over their bilingual family members and friends (3). In addition to providing accurate and informed language interpretation, interpreters often serve as cultural liaisons between patients and medical staff (2). Nevertheless, there are limitations to interpreter services, including variability in skill level, as there is no standardized certification for medical interpreters (4). Further limitations include delays in assessment (e.g., pain level) while waiting for an interpreter (1).

Despite these limitations, it is of the utmost importance to utilize medical interpreters in order to provide the same quality of care to all patients regardless of their preferred language. Medical providers have a professional and ethical obligation to treat all patients according to a standard of care determined by their field. This obligation cannot be fulfilled with regard to limited English proficiency individuals without the use of medical interpreters. Future efforts to improve interpreter services could focus on implementation of a standardized certification process and recruitment to increase the number of available in-person interpreters in the health care system.

At the time this article was accepted for publication, Dr. Tonkin was a fifth-year resident in the Department of Psychiatry, Louisiana State University Health Sciences Center, New Orleans.

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Medical Interpreters in Outpatient Practice

Barb Jacobs, MEd[1]
Anne M. Ryan, JD[2,3]
Katherine S. Henrichs[2,4]
Barry D. Weiss, MD[3,5]

[1]Language Interpreter Center, Alaska Institute for Justice, Anchorage, Alaska

[2]Tucson Family Advocacy Program, Medical Legal Partnership for Health, Tucson, Arizona

[3]Department of Family and Community Medicine, University of Arizona College of Medicine, Tucson, Arizona

[4]University of Arizona James E. Rogers College of Law, Tucson, Arizona

[5]Department of Health Sciences, University of Alaska, Anchorage, Alaska

ABSTRACT

This article provides an overview of the federal requirements related to providing interpreter services for non-English–speaking patients in outpatient practice. Antidiscrimination provisions in federal law require health programs and clinicians receiving federal financial assistance to take reasonable steps to provide meaningful access to individuals with limited English proficiency who are eligible for or likely to be encountered in their health programs or activities. Federal financial assistance includes grants, contracts, loans, tax credits and subsidies, as well as payments through Medicaid, the Children's Health Insurance Program, and most Medicare programs. The only exception is providers whose only federal assistance is through Medicare Part B, an exception that applies to a very small percentage of practicing physicians. All required language assistance services must be free and provided by qualified translators and interpreters. Interpreters must meet specified qualifications and ideally be certified. Although the cost of interpreter services can be considerable, ranging from $45-$150/hour for in-person interpreters, to $1.25-$3.00/minute for telephone interpreters, and $1.95-$3.49/minute for video remote interpreting, it may be reimbursed or covered by a patient's Medicaid or other federally funded medical insurance. Failure to use qualified interpreters can have serious negative consequences for both practitioners and patients. In one study, 1 of every 40 malpractice claims were related, all or in part, to failure to provide appropriate interpreter services. Most importantly, however, the use of qualified interpreters results in better and more efficient patient care.

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MEDICAL INTERPRETERS IN OUTPATIENT PRACTICE

Unless they are traveling and become ill in a non-English–speaking country, it is likely that most English-speaking clinicians in the United States have never had the experience of explaining their illness symptoms to a health professional who didn't speak their language. But, for millions of people with limited English proficiency (LEP) living in the United States, this is an everyday occurrence.

The United States is changing demographically. According to the most recent US Census, from 2010 to 2014, about 62 million people (born in the United States or another country) spoke a language other than English at home.[1] About 41% of these individuals (25 million people) have LEP, defined in the census as individuals older than 5 years who speak English "less than very well."[1] The Census Bureau projects a similar percentage on into 2020.[2]

Medical professionals who work with LEP patients should rely on trained and, ideally, certified, medical interpreters to give them the best comprehension of what a patient is saying. Having a patient try to get by with limited English, using untrained bilingual staff or family members, or having clinicians use their limited language ability (for example, high school Spanish) to communicate in the patient's language, can have dire consequences both for the patient and the clinician. Consider this well-known real-life example:

On his initial medical history, a Spanish-speaking boy aged 18 years, of Cuban descent, presented with abnormal mental status complaining of "intoxicado." An untrained interpreter

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CORRESPONDING AUTHOR

Barry D. Weiss, MD
Department of Family and Community Medicine
University of Arizona College of Medicine
1450 North Cherry
Tucson, AZ 85718
bdweiss@u.arizona.edu

understood this to mean that the boy was intoxicated - though in the Cuban dialect, the boy was actually saying that he was "nauseated." He received care for a drug overdose attributed to substance abuse but developed paraplegia, subsequently found to be due to a ruptured intracranial aneurysm. The case led to malpractice lawsuit with a $71 million award to the plaintiff.[3,4]

Is Providing Interpreter Services a Requirement?

Discrimination on the basis of national origin or other protected categories in programs or activities receiving federal financial assistance has long been prohibited in the United States. To assure compliance with Title VI of the 1964 Civil Rights Act,[5] Executive Order 13166,[6] issued in 2000, required federal agencies to develop systems to improve access to their programs and services for persons with LEP, defined as those "whose primary language for communication is not English" and who have "a limited ability to read, write, speak, or understand English."[7] In 2003 the Department of Health and Human Services (HHS) published guidance about how to meet the provisions of the aforementioned executive order by providing LEP individuals with meaningful access to federal health care programs (HHS LEP Guidance).[8,9] That guidance continues to be used today. In addition, the prohibitions against discrimination in health care programs were further addressed and codified in HHS regulations implementing Section 1557 of the Affordable Care Act (ACA).[10,11]

Consistent with HHS LEP Guidance, the regulations require all covered health care programs and providers to take "reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities."[12] Required language assistance services must be free to patients, accurate and timely, protect patient confidentiality, and be provided by qualified interpreters.[13]

Entities covered by these antidiscrimination provisions include those who meet any of the following criteria: (a) operate a "health program or activity," any part of which receives "federal financial assistance" from HHS (eg, hospitals, health clinics, state Medicaid agencies, health insurance issuers, nursing homes, physician practices, etc); (b) are administered by HHS (eg, Medicare programs, Medicaid programs, the Children's Health Insurance Program [CHIP]); or most recently (c) were established under the Patient Protection and Affordable Care Act (ACA), such as state-based and federally facilitated Health Insurance Marketplaces.[7] Pertinent to item (a), operating a health program or activity includes provision or administration of health-related services as well as health-related insurance coverage. If any part of the health program or activity of the covered entity receives federal financial assistance from HHS, then all of its programs and activities are subject to these antidiscrimination provisions.

The important point for outpatient practices is that receiving federal financial assistance includes submitting claims and receiving payments from federal government programs like Medicaid, most Medicare programs, or CHIP.[14,15] The one exception to this rule is if the only federal financial assistance a clinician or practice receives is Medicare Part B.[16] The Department of Health and Human Services has noted, however, that "almost all practicing physicians in the United States…accept some form of Federal remuneration or reimbursement apart from Medicare Part B" and therefore are subject to these requirements.[16-18]

Determinations of whether covered entities, including physicians and practices that receive federal financial assistance, have taken the required reasonable steps to provide meaningful access to LEP individuals must be made on a case-by-case basis. Factors that will be considered include the "nature and importance of the health program or activity and the particular communication at issue"[19] and other relevant factors including whether the entity has "developed and implemented an effective written language access plan appropriate to its particular circumstances."[20]

Although development and implementation of a language access plan continues to be voluntary, it is a key component in evaluating compliance. Other relevant factors include: (1) the prevalence of LEP individuals in the population eligible to be served or likely to be encountered, (2) the frequency with which they are encountered in the practice, (3) the cost of providing language assistance services, and (4) whether the practice has availed itself of all available opportunities to lower costs.[21-23]

How to Meet the Requirements?

When entities are required to provide interpretation for LEP individuals, they must use the services of "qualified" medical interpreters. Unfortunately, when an interpreter appears in clinic or hospital settings to assist during a clinician-patient encounter, most clinicians assume the interpreter is qualified to interpret. But, that's not always the case.[24]

A qualified interpreter for an individual with LEP is one who "(1) adheres to generally accepted interpreter ethics principles, including client confidentiality; (2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and (3) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology."[25]

Federal regulations and guidance do not require interpreters to be licensed or certified. Use of certified interpreters is required in some states,[26] however, and HHS considers certification helpful to establish competency.[27]

Certified medical interpreters have a high level of fluency in 2 or more languages, have been trained in the ethics and role of a medical interpreter, study medical terminology, and can facilitate the flow of a patient-clinician medical visit—including making clinic visits shorter than when telephonic or uncertified in-person interpreters are used.[28] In contrast to "trained" interpreters, certified interpreters have participated in a formal medical interpreter education program and have passed written and oral examinations in medical interpreting. Just like medical professionals, they have a code of professional standards and ethics among which includes accuracy, confidentiality, and impartiality.

Currently there are only 2 national organizations in the United States that provide formal certification of medical interpreters: The National Board of Certification for Medical Interpreters[29] and the Certification Commission for Healthcare Interpreters.[30] Whenever possible, clinicians and health systems should seek to use the services of interpreters who are certified by these organizations.

It is not appropriate to rely on health care staff to interpret unless they are "qualified bilingual/multilingual staff"—defined as individuals who meet the requirements listed in Table 1.[31] Practices and health systems covered by the regulations cannot require patients to provide their own interpreters.[32] The use of minor children accompanying a patient to serve as interpreters is also prohibited except in emergency situations involving "an imminent threat to the safety or welfare" of the patient when no qualified interpreter is available.[33] In addition, adults accompanying the patient cannot be used as interpreters absent emergency conditions or where the patient specifically requests that the accompanying individual interprets and "reliance on that adult for such assistance is appropriate under the circumstances."[34]

Finally, covered entities are also required to post notices of nondiscrimination and include "taglines" in appropriate languages on specified documents and signs that alert individuals with LEP to the availability of language assistance services.[35] Examples of a sample notice of nondiscrimination and taglines in over 60 languages are available free on the HHS website.[36]

What Are the Options and How Much Do They Cost?

Physicians in small practices often cite cost as a barrier to using trained interpreters[37] and indeed, costs can be considerable—though they vary from state to state.[38,39] They also vary depending on whether a practice uses in-person face-to-face interpreters, telephonic interpreters, or video remote interpreting.

In-Person Interpreters

If using a face-to-face interpreter provided through a language translation service, costs are generally in the range of $45-$150 per hour, often with a minimum time requirement (eg, 2-hour minimum).[39] Costs can vary, however, depending on the language involved. For example, in an area where many Spanish-language interpreters are available, the cost is often lower than in areas where few are available. The costs for an interpreter of languages that are rarely spoken, in contrast, can be more. Costs for an independent interpreter who is not affiliated with a language service provider can also be more.

Telephonic Interpreters

Many medical providers use telephonic language services to provide immediate language assistance, and this approach costs less than face-to-face interpreters. Telephonic interpreters are paid by the minute, but there can be a set-up charge along with volume minimums or monthly minimums that vary between

Table 1. Definition of Qualified Interpreters[25,31]

Qualified Interpreter for an Individual With Limited English Proficiency	Qualified Bilingual/Multilingual Staff
An individual who, via a remote interpreting service or on-site presence: Adheres to generally accepted interpreter ethics principles, including client confidentiality Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology	A member of a covered entity's workforce who is designated by the covered entity to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the covered entity that he or she: Is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology Is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages

services. A typical cost is in the range $1.25-$3.00 per minute,[39] varying between companies and varying with the time of day and language.

While telephonic interpreting is convenient, less costly, and in some situations the only available option (particularly in practices with patients speaking multiple languages), it can sometimes be suboptimal.[40] Problems cited with telephonic interpretation include inadequate clarity of sound, the inability of the interpreter to respond to visual cues from the patient and clinician, and cultural barriers in which some patients are not comfortable speaking with an unknown voice.[41,42] A face-to-face interpreter, rather than telephonic interpreting, is particularly important in mental health settings, for communicating with patients who are hard-of-hearing, for patient education that includes visual components, and when communicating with children.[43]

Video Remote Interpreting

Video remote interpreting (VRI) is a video telecommunication service that uses devices such as web cameras or videophones to provide language services via a remote/off-site interpreter. Video remote interpreting has long been used for sign language interpreter services. Similar to telephonic interpreters, VRI can be used when qualified or certified interpreters are not available for face-to-face interpretation. The Department of Health and Human Services has developed standards for use of VRI that are listed in Table 2.[44]

Costs of VRI involve expenses for equipment and for the interpreter service. Costs for equipment can vary widely, depending on whether a practice simply uses a laptop or desktop computer or a more sophisticated setup using cameras, speakers, and microphones. Commonly cited costs for VRI interpreter services can range from as little as $1.95 per minute to as much as $3.49 per minute, sometimes with a minimum number of minutes (eg, 15 minutes) per session.[45,46]

Table 2. Health and Human Services' Standards for Video Remote Interpreting

Video remote interpreting (VRI) shall be provided with a qualified interpreter for an individual with limited English proficiency. When using VRI, the health program or activity shall provide:
Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication
A sharply delineated image that is large enough to display the interpreter's face and the participating patient's face regardless of the patient's body position
A clear, audible transmission of voices
Adequate training to users of the technology and other involved individuals so that they can quickly and efficiently set up and operate the video remote interpreting[44]

Table 3. States in Which Medicaid/CHIP Programs Will Reimburse Health Care or Language Service Providers for the Cost of Interpreter Services[48]

District of Columbia	New Hampshire
Hawaii	New York
Iowa	Utah
Idaho	Vermont
Kansas	Virginia
Maine	Washington
Minnesota	Wyoming
Montana	

How Can the Cost be Managed?

In some cases the cost of interpreter services will be reimbursed or covered by a patient's federally funded medical insurance. Medicaid and CHIP programs in at least 14 states and the District of Columbia (Table 3) will reimburse providers or language service agencies for the cost of interpreter services involved in a covered patient's care.[47-50] In those states in particular, cost should not be an obstacle to clinicians providing interpreters for Medicaid and CHIP patients, though clinicians in some states must cover the up-front costs and then seek reimbursement from the state program. Using billing code T-1013 along with the CPT code that is appropriate for the clinical encounter is one option for claiming reimbursement for these services.[51] Although not specifically required to do so, states are also permitted to "claim federal matching funds for the costs of….oral interpretation as administrative expenses or as medical assistance-related expense."[47]

In addition to reimbursement, some states have adopted other systems to keep the cost of interpretation from falling on individual health care providers. For example, Arizona's Medicaid program requires each contracted managed care organization to provide free interpretation services.[52] By calling the patient's contracted plan, individual health care providers can then obtain free telephonic interpretation services on an as-needed basis at no cost to the provider or patient.

Additionally, other states and providers have centralized telephonic language services to reduce costs.[53] The Department of Health and Human Services encourages covered entities to work together and with professional associations to develop the most cost-effective delivery programs for language assistance services,[54] suggesting approaches such as use of communication technology and sharing language assistance materials and services (eg, telephonic interpreter services could be shared between Medicaid programs in different states).[54]

Finally, HHS has reminded qualified health insurance issuers of their obligation as a condition of certi-

fication to implement a quality improvement strategy that "provides increased reimbursement or other incentives for the implementation of activities to reduce … health care disparities, including through the use of language services."[55] The Department of Health and Human Services "encourage(s) health insurance issuers to structure their health plan payment structures to consider health providers' expenses in providing language assistant services."[55]

Are the Costs Worth It?

Regardless of the federal and state requirements for language assistance or whether federally funded state programs provide reimbursement, providing appropriate interpretation services is a basic and key component of good patient care for individuals with LEP. Indeed, both the Institute of Medicine and the Joint Commission recognize the need for effective communication as an important aspect of high-quality care.[56,57]

Besides enhancing the quality of care and avoiding poor health outcomes for patients, there are potential negative consequences for health care providers that do not provide appropriate language assistance services. As noted earlier in the case example, malpractice lawsuits can result from adverse patient outcomes due to incorrect language interpretation. In fact, a report in 2010 evaluating 1,373 malpractice claims from 4 states found that 1 of every 40 claims were related, all or in part, to failure to provide appropriate language interpreter services.[58] Some cases resulted in multi-million dollar malpractice settlements.[59] Covered health care providers may also be subject to enforcement actions for failure to provide appropriate interpreter services.[60,61]

Working With An Interpreter

Many health care systems and medical practices provide training to staff on working with an interpreter. Resources are also available in the medical literature[62] and through free online continuing medical education programs.[63] This type of training will give clinicians and staff information on the ethics and role of a trained medical interpreter, how to make the clinical encounter go smoothly to provide the best care to patients, and other tips for working with interpreters.

Furthermore, in addition to helping ensure compliance with federal requirements, having a comprehensive "language access plan" will help a practice provide excellent care to LEP patients in ways other than just providing interpreter services. A language access plan contains policies and procedures to guide staff in providing meaningful access to services for individuals with LEP. Guidance and language access plan models have long been available from HHS and other sources.[64,65] More information on developing a plan that fits the needs of your practice can be found at http://www.lep.gov.

FINAL COMMENT

Providing the best care to patients, complying with legal requirements, and developing and implementing a language access plan will assist clinicians in helping their patients stay safe and healthy. A language access plan that involves professional medical interpreters will provide better health outcomes, ethical patient care, improved patient satisfaction, and reduce costly repeat visits by patients who don't understand what clinicians are asking or telling them about their medical problems.[66,67]

To read or post commentaries in response to this article, see it online at http://www.AnnFamMed.org/content/16/1/70.

Key words: language interpreters; patient-physician communication; health literacy

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Hospitals should figure out how to provide translation services.

By Terena Bell

It's actually much more expensive to not provide translation.

Under the ACA, failure to provide a medical interpreter can be met with a $70,000 fine.

Do you speak a second language fluently? Sort of fluently? Or maybe you partially remember high school Spanish? Well, show up with the right friend at the wrong hospital and you too can be a medical interpreter: Let them know you can say a few words, and the job can be yours.

It sounds insane—that a hospital would give you a job you're not remotely qualified for, especially one that could have serious repercussions for someone's health. But the state of medical translation means that it is too frequently the case. As far back as 1996, research from Emory University School of Medicine showed that 76 percent of Spanish-speaking patients went without an interpreter in the emergency department. Data on the subject is scarce, but anecdotal evidence indicates little has changed. One doctor at Mt. Sinai in New York, a hospital that often sees patients who don't speak English, told me her colleagues frequently ask her to interpret Arabic, a language she doesn't even speak, because she has a Middle Eastern last name (she requested anonymity for professional reasons). This is all part of an ad-hoc system that often means if translation is provided at all, it's likely from a bystander, family member, or friend with no idea how to say things like "mitral valve prolapse" in a foreign language.

Why? You might wonder if it's because ER doctors have to save lives quickly, and finding an interpreter could cause delays. That sounds reasonable, but hospitals have plenty of protocols that help them achieve complicated outcomes quickly—language access ought to be one of them. Nor is it because medical interpreters don't exist or can't be found. Instead, underuse of medical interpreters seems to stem from misunderstanding how proper translation improves medical outcomes, and that it's not only fiscally possible, it's actually fiscally prudent, since it's illegal not to offer.

Medical interpreters are supposed to be certified. Credentials from both the Certification Commission for Healthcare Interpreters and the National Board of Certification for Medical Interpreters are accepted. For additional qualifications, you can pursue a master's in interpreting or a graduate certificate from universities across the country. Like doctors, interpreters are also required to pursue continued education every year. It's in the National Council on Interpreting in Health Care (NCIHC) Code of Ethics: "The interpreter strives to continually further his/her knowledge and skills."

Hospitals would never dream of letting a patient's friend operate just because she can hold a scalpel. But they ask bilingual relatives to interpret all the time, disregarding how critical communication is to patient care. Get one word wrong and the consequences can be life-changing: After staff misunderstood *intoxicado* (Spanish for "poisoned") as "drunk," Florida teen Willie Ramirez received the wrong care and ended up paralyzed. In Oregon, Elidiana Valdez-Lemus died after 911 misinterpreted her address. Lack of proper translation has consequences outside of emergencies, too: Erika Williams, a second-year medical student at Harvard Medical School, summarized research to show that when there's a language barrier, patients "receive less preventative care," don't take medication as prescribed, "and are more likely to leave the hospital against medical advice."

Hospitals would never dream of letting a patient's friend operate just because she can hold a scalpel.

Federal civil rights laws state that hospitals must provide people—all people—with equal access to care, regardless of "race, color, or national origin." That's the phrase used in Title VI, the first law pertaining to professional interpreters. If "national origin" doesn't indicate language as a discriminator clearly enough, in Executive Order 13166, President Bill Clinton implicitly stated any organization receiving federal funds—like Medicaid or Medicare—must provide "meaningful language access." If they don't, facilities are supposed to lose those funds.

But this doesn't always happen. Chris Carter, president of the Association of Language Companies, the U.S. trade organization for translation and interpreting providers, says hospitals rarely become proactively compliant: "Unfortunately, member companies of the ALC have noticed in recent years that healthcare organizations usually wait until they are audited by the [Department of Justice] and found non-compliant with [Affordable Care Act] Section 1557 or other laws before they shift from ad hoc service provision to implementing an organized Language Access Plan."

Is providing interpretation prohibitively expensive? Not in the context of what medical care costs—and how expensive mistakes are. From 2005–2015, I owned an interpreting company. When we opened, an on-site Spanish interpreter cost $25 an hour. If you wanted someone by phone, it was $1.50 a minute. Interpreting services are also reimbursed by certain types of insurance. But the No. 1 sales objection we heard from hospital administrators was that professional interpreting was too expensive.

Under the ACA, failure to provide a medical interpreter can be met with a $70,000 fine—for each encounter with a patient. Which means that the cost of not providing an interpreter, even if it doesn't lead to errors, is astronomically higher than the cost of paying for one.

At least for now. As states file ACA waivers, they aren't just opting out of Obamacare's better-known parts. They're also giving hospitals permission to shortchange limited-English speakers' care. It's true that Title VI is there to fall back

on, but it's rarely and arbitrarily enforced. It's the ACA's hefty fines that have been the impetus forcing hospitals to change: Carter says that since ACA audits began, interpreting companies have seen many hospitals working with professional interpreters for the first time, an improvement he's noticed industrywide.

"The risks are too high to give up and to say quality interpretation for everyone in America just can't be done," Carter says.

The right to understand what doctors are doing to your body is fundamental. The right to know your own diagnosis is basic, to know when surgery is being performed on what, to understand why people are putting needles and tubes inside you. Interpreting isn't too expensive—it's essential to providing accurate medical care. Hospitals' failure to appreciate and act on this is not a failure that we should dismiss for mere budgeting. It's a manifestation of racism that should no longer have a place in our society.

In moments of medical crisis, you need a doctor who can help you navigate uncertainty.

For years, I prowled the medical wards of Bellevue Hospital, the pockets of my white coat stuffed not only with my stethoscope and prescription pad but with poems, essays, and short stories. If I happened upon unsuspecting medical students or interns, I'd press some elevator reading onto them—an Ed Hirsch poem, a Chekhov story, a Sontag essay, something from our own Bellevue Literary Review. If I was feeling less bound by social mores that day, I'd hop on the elevator with them, extolling the virtues of the photocopied literature I'd dispensed to them.

It wasn't always artful, and more than a few students thought I'd sprung a cerebral leak, but I was convinced that our medical trainees needed literature. They were up to their ears in renal tubular acidosis and eosinophilic esophagitis, after all. If there was anyone who needed a stat dose of alliteration, or an emergent infusion of metaphor, it was these medical trainees.

Of course, we in medicine have been burned numerous times doing things that we are convinced are correct, only to be bitten by clinical trials that prove us wrong and then wrong again (think estrogen-replacement therapy). So it's good to see some data supporting the role of humanities in medical education. The studies will never be as grand as the multinational megatrials for cardiac interventions (not much interest in Bulgakov from Big Pharma), but the trickles of evidence that are coming in are heartening.