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ATKINS INTERNATIONAL GLOBAL BUSINESS NEWSLETTER

Educating the Patient: Talk Is Not Always Cheap

The conclusion of a recent study concerning the affordability, availability and acceptability barriers to healthcare for the chronically ill seems to say it all:

“In strengthening the public sector, it is important not only to improve drug supply chains, ambulance services, referral systems and clinical capacity at public clinics, and to address the financial constraints faced by the socially disadvantaged, but also to think through how providers can engage with patients in a way that strengthens the therapeutic alliance.”

In this survey of 1446 individuals from low to middle income areas, 74% of reported health problems were chronic and only 35% were receiving regular treatment. To quote the results of the study:

“Poor provider-patient interaction led to inadequate understanding of illness, inappropriate treatment action, 'healer shopping', and at times, a break down in cooperation, with the patient 'giving up' on the public health system.”

The study found, however, “productive patient-provider interactions not only facilitated appropriate treatment action, but enabled patients to justify their need for financial assistance to family and neighbors. In addition, patients and their families with understanding of a disease became a community resource drawn on to assist others.”

The conclusion of the study was that providers communicating effectively with their patients results in better care for everyone. Communication is the key to good healthcare.

Did we mention this study was done in rural South Africa?

Now, before you discount the above as not pertaining to the United States, consider the plight of roughly 72 million Americans (about 27% of US residents) who speak a language other than English or have limited English proficiency.

These patients receive “poor provider-patient interaction” and flounder in our healthcare system, similar to care in third world countries.

According to a recent article by the New England Journal of Medicine, “Patients who face such (language) barriers are less likely than others to have a usual source of medical care; they receive preventive services at reduced rates; and they have an increased risk of non-adherence to medication.”

“Such patients are less likely than others to return for follow-up appointments after visits to the emergency room, and they have higher rates of hospitalization and drug complications. Greater resources are used in their care, but they have lower levels of patient satisfaction.”

How do help millions of people overcome the language barriers to healthcare in our industrialized nation? The obvious solution is to teach them English. Most people are willing to learn, but it takes time to become fluent (and their appendix may be bursting today.) It also takes resources that some do not have. In the meantime, we can provide them with medical interpreters.

The 1964 Civil Rights Acts forbids discrimination based on national origin. Healthcare providers receiving federal funds are required to offer interpreting services to patients with limited English skills. Forty-three states have passed laws that address language access in healthcare, but few enforce them. The enforcing agency, the Office of Civil Rights (OCR) of the US Department of Health and Human Services is required to



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Who Should Do The Talking?

When language is a barrier to fixing your broken arm and no one wants to be responsible for the cost of providing medical interpreters, what is a non-English speaker to do?

Many recruit a non-medically trained person to accompany them to the hospital or doctor visit. This person may be their child who has learned English in school, a neighbor, or a friend. In an emergency, possibly even a janitor or a nurse who is bilingual may be recruited. Janitors are qualified to relay highly technical information from a CAT scan, right?

Medical miscommunication horror stories are numerous. A verb mix up led to quadriplegia. Lost limbs and malpractice suits result from a lack of informed consent.

Sometimes not using a professional interpreter is your only option, but problems abound. Using a neighbor or friend to interpret means the physician may not get the whole story, or vital information, due to embarrassing details. Would you want your neighbor to parlay your sexual history to your physician?

Often non-English speaking parents look to their children for help. Not being medically trained, they may incorrectly communicate how to administer drugs or therapies. They may also be left with the daunting task of informing their loved ones of a terminal illness. This is not something an 8 year old should have to tell a parent or loved one.

“...no interpreter was used in 46 percent of emergency department cases involving patients with no or limited English proficiency. Most physicians are not a resource either. Only 23% of US teaching hospitals provide non-English language training and for most that do, the training is optional.”

New England Journal of Medicine

Placing the impetus on the healthcare provider is a possibility; however, interpreting requires being fluent in two languages and the ability to conduct a three-way conversation. It is a specialized skill that requires training. Three years of high school Spanish does not mean a healthcare provider, though medically trained, is qualified to interpret.

Interpreters are important in the healthcare setting. Do not discount their value. They speak both English and a second language. They assist patient-provider communication. They are reliable and do not omit, add, condense or alter content in their interpreting. ←

CDC Taking Steps to REACH Latinos

Latinos comprise the largest ethnic group in the United States and have 2 to 3 times the prevalence of type 2 diabetes mellitus as Caucasians.

A study sponsored by the NIH and the University of Massachusetts, the Lawrence Latino Diabetes Prevention Project, was wrapped up in 2008 in Lawrence, the poorest city in MA and 68.7% of its population is Latino, mostly from the Dominican Republic and Puerto Rico.

For Puerto Rican and Dominican adults in Lawrence, the prevalence of diabetes is 11.8%. For non-Hispanic whites in MA, it is 6.4%.

Based on scientific predictions of Latinos with a high risk of developing diabetes over the next 7 years, individuals were identified, screened and randomly selected to continue to receive their usual care or were provided a lifestyle intervention condition for one year. The intervention program was targeted to help patients lose weight through dietary changes and increased physical activity.

This study differed from others in that the intervention was less intensive, delivered in Spanish, and was specifically tailored to the literacy needs and cultural preferences of the target audience. All of the study surveys were orally administered in Spanish. The program was also implemented by trained members of the community who were supervised by a clinical research nutritionist and a behavioral psychologist.

The result was a community and academic partnership that allowed for a successful program. The retention rate for those at risk was 93%.

One in three children born in the US in the year 2000 will develop diabetes. For Hispanic females born in 2000, it is one of two.

US Dept. of Health and Human Services



With such great results, the study has evolved into the Racial and Ethnic Approaches to Community Health (REACH) 2010 Latino Health Project. REACH is a “community-based public health program funded by the CDC to eliminate racial and ethnic health disparities.”

The project provides diabetes outreach information that reflects the local culture and has been successful in increasing the number of Latinos getting help for their diabetes as well as the percentage of people reaching their blood sugar goals.

To sum up the project’s findings: “The keys to lasting change in the Latino community are education, social support and community collaboration.” ←



Talk Is Not Always Cheap (continued)

(Continued from page 1)

obtain “voluntary” compliance. In short this means they wait for a complaint to be filed, investigate it, get an agreement from the offender to offer interpreting and go about their business. They rarely return to see the problem has been resolved and in 40 years has not imposed a fine or withheld federal funds for non-compliance.

The OCR recommends telephone language lines for random languages that walk in the door but how does that work when a person is bleeding to death in the ER or in the middle of birthing a child? In-person interpreting by a trained medical interpreter is the best option but it is also the most expensive.

That begs the next question: Who should pay for this? Hospitals? States? Insurers? The Federal Government?

In a burgeoning healthcare system that has many broken parts, some hospitals are barely able to function and keep their doors open. As they put out fires, having medical interpreters handy is not on their list of priorities, nor is it something many can afford to provide.

Should insurers pay? In California, legislation (SB853) became effective on January 1, 2009 requiring medical interpreting and translation services for insured individuals. Unfortunately there is no way to enforce this requirement. Physician and advocacy groups claim the large chunks of change insurers pay out to shareholders and executives shows they could afford to pay for medical interpreting. The fear that insurers will stop covering populations most in need of these services also comes with that claim.

Should the States have to foot the bill? Indigent healthcare coverage by Medicaid is supposed to cover medical interpreting but it is up to the state to pay providers. Medicaid reimburses providers for claims (at rates lower than those charged by professional interpreters) but only after the expense is incurred. As such, providers consider medical interpreting an “unfunded mandate” and refuse to pay for it up front.

In 2000, before he left office, President Clinton signed an executive order requiring all recipients of federal funds, including government agencies, to provide free verbal interpreting and written translation services for non-English speaking clients. The Association of American Physicians and Surgeons (AAPS) sued to overturn this order. They felt it was wrong to expect doctors to pay for the service and thought the federal government should pony up the dollars. When the Bush administration was elected, they kept the “mandate” in place but softened the language and gave it a more voluntary tone.

There is a federal program currently in place through the Center for Medicare and Medicaid Services (CMS) which offers states federal matching funds for medical interpreting services for Medicaid patients and low income children who are receiving federal assistance funds. It has not been well advertised over the years and, especially in this economic downturn, many states are unable to raise their half of the cash.

“People of diverse race and ethnicity face more barriers to care, greater risk of chronic disease, lower quality of care, and higher mortality than whites. Of Medicaid’s 52 million beneficiaries, as many as half of are members of racial and ethnic minority subgroups, and more than 60% of all these beneficiaries are enrolled in managed care.”

Center for Health Care Strategies, Inc.

In 2002, the federal Office of Management and Budget estimated an annual cost of 268 million dollars to provide professional medical interpreting service in the US.

As “the buck” continues to be passed around, the question remains: Who should pay for medical interpreting services for

non-English speaking patients?

Regardless of who should pay, the bottom line here is pay for it now, or wait and pay later at a compounded cost. The truth is that many of the non-English populations in need of interpreting services are at a higher prevalence for many common diseases than most Americans. Educating them now in their native tongue and providing them with equitable healthcare based on good provider-patient communications means paying less for preventable procedures and hospitalizations, medical errors and lawsuits down the road.



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Atkins International
Associates, Inc.

54 Old Highway 22, Suite 302
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The Gatekeepers of Healthcare

Many women are the healthcare managers for their families. They influence 75-80% of healthcare decisions and control healthcare spending dollars to the tune of 1.2 trillion dollars. In part because they require more reproductive services, women also use more health care services than men.

According to the US Department of Labor, "Women make approximately 80 percent of health care decisions for their families and are more likely to be the caregiver when a family member falls ill."

Women are not just patients and caregivers, however, they are also professionals. One out of every four physicians is a woman and by the year 2025 that number will be one in two. Understanding how women communicate and receive information is the key to effectively reaching them with important medical information.

Unfortunately, most non-native English speaking women are left out of healthcare conversations. With over 63% of members of minority groups in the US speaking only very little English, too many families are missing a fundamental element in their healthcare services – information.

Fortunately, recent studies indicate that people are more receptive and more likely to seek care when provided with medical information in their native language. By recognizing the impact that minority women have as daughters, sisters, wives, mothers and friends, reaching out to them in their native tongue has far reaching ramifications. To improve the health of our nation, it's time to include all women in the healthcare conversation. ←

The mission of CONNECT

With expertise in areas of language, culture and relocation, AIA will use the quarterly newsletter as a tool to unite and educate the global business community on issues of relevance for improving global business communication.

Sherry Dineen, *Editor*

Who we are

Atkins International Associates, Inc. is a global provider of language and cultural support programs including:

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