The Perfect Storm

Cost Analysis Determines
Lack of Reimbursement for Interpreting Services is Unsustainable

Izabel E. T. de V. Souza (Arocha) and
Louis F. Provenzano Jr.

April 2015

The Perfect Storm

Cost Analysis Determines
Lack of Reimbursement for Interpreting Services is Unsustainable

Izabel E. T. de V. Souza (Arocha) and
Louis F. Provenzano Jr.

April 2015

Executive Summary

US citizens and residents who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English are limited English proficient, or LEP. These individuals are entitled language assistance with respect to a particular type or service, benefit, or encounter by Federal law. This includes the Deaf and Hard of Hearing. LEPs and Deaf and Hard of Hearing individuals have been called jointly language minority patients.

Title VI of the Civil Rights Act of 1964 provide that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives federal financial assistance. Under Title VI and the Americans with Disabilities Act (ADA), hospitals must provide effective means of communication for patients, family members, and hospital visitors who are LEP, or Deaf or Hard of Hearing, respectively. Additionally, Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency stipulates that LEP individuals should have meaningful access to federally funded programs and activities.

Factors Leading Towards The Perfect Storm

The number of Limited English Proficient patients (LEPs) is dramatically increasing, and yet many healthcare facilities and organizations are cutting budgets associated with language services for language minority patients. According to the US Census of 2011, there are 25.3 million LEP individuals in the United States, accounting for approximately 9% of the total US population. The LEP population grew 81% from 1990 to 2011. This means it almost doubled in two decades. In addition, according to the National Institute on Deafness and Other Communication Disorders (NIDCD) in 2014, 10% of the general population of the US is Deaf or Hard of Hearing.

Capped hospital departmental budgets and the lack of reimbursement for interpretation services have slowed the incorporation of language access plans in healthcare. There are interpreters available for service, but they are often not available or are even called for healthcare encounters due to financial barriers, among other obstacles. This ever-growing gap is unattainable and poses the possibility of a catastrophic future that endangers the health and safety of language minority patients, the financial stability of healthcare facilities, and the overall quality of care in our ever-diversifying, multi-cultural country.

Few are doing anything about this dangerous course. Only 13 of 50 states reimburse interpretation services and it is for Medicaid patients only. Most private insurers have not reimbursed for language services, although 20% of their insurance dues revenue stream may come from language minority patients. Multi-million dollar lawsuits against hospitals are rising. A report published by The Joint Commission, the organization that accredits hospitals, identified lack of accurate communications as a common root cause to adverse health outcomes.

Interpreting costs must incorporate hard financial data as well as less tangible opportunity benefits in order to obtain a comprehensive perspective on the cost/benefit of interpretation services. Opportunity benefits include enhanced satisfaction, improved patient safety, and lower negative health outcomes caused by miscommunication. The biggest contributors to opportunity cost are the risks associated with lawsuits due to negative health outcomes, loss of accreditation, or loss of federal funds. Medicaid, Medicare and most private insurers do understand the costs related to complications, delays in hospital stay, missed follow-up appointments, and delay of care. These same cost-drainers also affect language minority patients, and that they can be mitigated or eliminated, by requiring the services of a professional interpreter for the 20% of the general population that has a language barrier. One of the highest preventable costs to US healthcare is the 30-day readmission rate. Under the Hospital Readmissions Program Accuracy and Accountability Act of 2014 (HRRP), hospitals can be penalized if their 30-day readmission rate from past years is higher than the national average rate. A study on the cost of hospital readmissions finds that about 1 in 12 adults discharged from a hospital is readmitted within 30 days, adding $16 billion to the cost of healthcare in the United States. Readmission rates are high, as much as 13-30%, with Medicaid and Medicare patients having the highest rates of 30% and 26% respectively. A study by the University of Massachusetts Medical Center has found that professional interpreting services at both admission and discharge reduced a patient's length of stay and reduced 30-day readmission rates. The language minority patient is 20% of the general population; so one can extrapolate that of the $16 billion lost to readmissions, 20% or $3.2 billion might grossly reflect the cost of readmission for language minority patients.

Cost Analysis

The cost of interpretation services varies by modality. The modalities studied were 1) staff 2) per diem 3) contractor 4) telephonic 5) video. While there is data on the current earnings of interpreters, this cost analysis takes into consideration fringe benefits, administrative costs, and other cost expenses or savings opportunities related to the risks and benefits of the usage of the services. Until further compensation data is published, this national cost model for language interpreting in healthcare may be useful: $22.61 per 20-minute healthcare encounter or $67.83 per hour. It is important to note that this figure is a comprehensive figure, and it is not how much interpreters earn, but rather focuses on the actual cost of language services to healthcare organizations.

Conclusion

As seen above, there are several factors that are leading to an unsustainable financial framework for providing language minority patients with quality and cost-effective healthcare services. The size of the language minority patient population is increasing at a faster pace than the rest of the population. The costs involved to remedy negative outcomes and avoid unnecessary costs are much lower than the cost of not providing such services. Without a paradigm shift, we will see the healthcare of language minority patients erode and the costs of this erosion will tax the healthcare system in a significant manner.

It is time for a national effort to reimburse medical interpreting services. Medicaid, Medicare and private insurers pay for diagnostic exams in order to prevent health problems. The certified medical interpreter is a necessary and powerful tool in that diagnostic protocol and should be an integral member of the healthcare team. This will have a direct impact on the patient's level of understanding, compliance, trust and overall success of the desired treatment. If the supply can keep up with the demand via reimbursement, there will be numerous benefits that allow for healthcare services to be provided at a higher quality, and with less risk and cost-drain. All patients will be able to fully communicate their healthcare needs and therefore receive meaningful and accurate services, unencumbered by miscommunication. Providers will be able to diagnose without fear, and rely on the medical or healthcare interpreter as a team member to provide linguistic and cultural services to ensure a culturally and linguistically appropriate care to a growingly diverse population.

"Simple justice requires that public funds, to which all taxpayers of all races [colors, and national origins] contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial [color or national origin] discrimination."

- President John F. Kennedy

Introduction

There is a current and alarming paradox within language access services for healthcare that has all the elements for a *perfect storm*, and while a few minor corrective actions have the potential to yield life and cost saving results, many remain on a direct collision course towards this dangerous tempest. The status quo current paradox is on a rapid path into disaster. There are two major trends colliding and medical interpretation is in the middle of a potential paradigm shift that requires immediate action.

According to the U.S. Census Bureau (2012), the number of Limited English Proficient patients (LEPs) is dramatically increasing. The Hispanic population, for example, will represent the majority of the country in less than 30 years[1]. That being said, many healthcare facilities and organizations are cutting budgets associated with language services for language minority patients. This white paper seeks to explore the elements contributing to this looming storm, discuss recent trends in the industry, and provide a new and safe passageway for review of research in order to propose a cost analysis to avoid the catastrophic consequences associated with our current course.

There are federal laws and regulations requiring language access in healthcare for all organizations that receive federal funding, but it is an unfunded mandate. These laws serve LEPs and also the Deaf and Hard of Hearing: this white paper refers to language minority patients who require qualified medical or healthcare interpreting services.

This white paper will also attempt to answer the following questions:

- What does it truly cost to provide interpreting services, and what impact does it have in providing cost-efficient and patient-safe healthcare services?

- Why is the current situation unsustainable?

- In a country founded upon themes of multiculturalism and equality, what must be done to ensure that all patients across the US have access to meaningful, safe services with measurable impact for a healthier America?

The answers are direct, succinct and logical, but they will take rigor and discipline to promulgate throughout the healthcare system.

1. United States Census Bureau. (2012). *U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation Half a Century from Now* [Press Release]. Retrieved from https://www.census.gov/newsroom/releases/archives/population/cb12-243.html

A Primer on Language Access Federal Laws and Mandates

Title VI of the Civil Rights Act of 1964, and its implementing regulations, provide that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives federal financial assistance. Language can be a barrier for individuals to access important benefits or services, understanding and exercising important rights, complying with applicable responsibilities, or understanding other information provided by federally funded programs and activities. US citizens and residents who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English are limited English proficient, or LEP. These regulations include the Deaf and Hard of Hearing. These individuals are entitled language assistance with respect to a particular type or service, benefit, or encounter by law. For example, based on the 2010 Census, over 35 million individuals speak Spanish, and almost 7 million individuals speak an Asian or Pacific Island language at home. If these individuals have a limited ability to read, write, speak, or understand English, they are LEP.

The Americans with Disabilities Act of 1990 (ADA) established a series of measures to prohibit instances of discrimination because of a person's disability. The ADA requires that the communication needs of the Deaf and Hard of Hearing persons are met, and this frequently demands the professional services of a certified American Sign Language (ASL) interpreter. Sign language interpreting enables Deaf and Hard of Hearing (formerly known as hearing-impaired) individuals to communicate. Under the Americans with Disabilities Act (ADA), hospitals are mandated to provide effective means of communication for patients, family members, and hospital visitors who are deaf or Hard of Hearing. The ADA applies to all hospital programs and services, such as emergency room care, inpatient and outpatient services, surgery, clinics, educational classes, and cafeteria and gift shop services. Wherever patients, their family members, companions, or members of the public are interacting with healthcare staff, the hospital is obligated to provide effective communication.

On August 11, 2000, President Clinton signed *Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency.* The LEP Executive Order (Executive Order 13166) stipulates that LEP individuals should have meaningful access to federally conducted and funded programs and activities. The Executive Order requires federal agencies to examine the services they provide, identify any need for services to LEPs, and develop and implement a system or language access plan to provide those services so LEP persons can have meaningful access to them. It is expected that agency plans will provide for such meaningful access consistent with, and without unduly burdening, the fundamental mission of the agency. The Executive Order also requires that the federal agencies work to ensure that all recipients of federal financial assistance provide meaningful access to their LEP applicants and beneficiaries.

Many individual federal programs, states, and localities also have specific provisions and laws requiring language services for LEP and Deaf and Hard of Hearing individuals. While these ordinances and new state laws cement language access at the local level, national regulations and mandates cover the entire nation.

President John F. Kennedy said in 1963:

"Simple justice requires that public funds, to which all taxpayers of all races [colors, and national origins] contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial [color or national origin] discrimination."

How Big is the Language Minority Population?

There are two categories of individuals who require interpreting services. Limited English Proficient (LEP) individuals are the individuals who do not speak, understand, or read English enough to have meaningful communication. The Deaf and Hard of Hearing are in this category but are usually listed separately in the Census. Together, they have been called language minority patients by the Office of Minority Health of the Human and Health Services Department.

According to the US Census of 2011, there are 25.3 million LEP individuals in the United States, accounting for approximately 9% of the total US population. The Census only reported on individuals who were ages 5 and older in 2011. The most astounding fact is that the LEP population grew 81% from 1990 to 2011. This means, almost doubling in two decades. Although most LEP individuals are foreign born, a sizable share (about 19 percent, or 4.8 million) of this population is native born. Approximately 50 percent of LEP individuals lived in California (6.8 million), followed by Texas (3.4 million), and New York (2.5 million) in 2011. In addition, large LEP populations resided in Florida (2.1 million), Illinois (1.2 million), and New Jersey (1.1 million). California's share of the total LEP population was by far the largest, making up about 27 percent of the nation's LEP population. Altogether, the top six states accounted for 67 percent of the nation's 25.3 million LEP individuals.

According to the National Institute on Deafness and Other Communication Disorders (NIDCD) in 2014, 10% of the general population of the US is Deaf or Hard of Hearing[3,]. About 2 to 3 out of every 1,000 children in the United States are born with a detectable level of hearing loss in one or both ears. More than 90 percent of deaf children are born to hearing parents. One in eight people in the United States (13 percent, or 30 million) aged 12 years or older has hearing loss in both ears, based on standard hearing examinations. Men are more likely than women to report having hearing loss. Last, about 2 percent of adults aged 45 to 54 have disabling hearing loss. The rate increases to 8.5 percent for adults aged 55 to 64. Nearly 25 percent of those aged 65 to 74 and 50 percent of those who are 75 and older have disabling hearing loss.

2. National Institute of Deafness and Communication Disorders. (2014). http://www.nidcd.nih.gov/health/statistics/pages/quick.aspx

Since 10% of the general population is Deaf and Hard of Hearing, and the LEP population is at 9% at this time, but rising sharply, one can extrapolate that almost 20% of the population can be considered language minority patients. This is a significant population size of the total US population whose access to healthcare deserves a closer look. This one of the trends and a current situation that involves many facets that merit further discussion.

If 20% of the US population is represented by language minority patients, it is a size that can no longer be ignored.

An Unfunded Mandate

While the language minority population has grown substantially, this is an unfunded mandate. What has been observed since the Executive Order 13166 of 2000, and the CLAS Standards (*Culturally and Linguistically Appropriate Services in Health Care)* of 2000, revised in 2010, is the very slow and uneven implementation of language access plans in the past 15 years, specifically in the provision of healthcare services. There are various reasons for this phenomenon but the primary one is that it is an unfunded mandate. Although providers are obligated to offer these services to LEP patients, capped departmental budgets and the lack of reimbursement for these services prevent their actual availability. It is not that interpreters are not available for service, as often claimed. Often they do not get called for a needed healthcare encounter due to financial and other barriers.

Only 13 states reimburse interpretation services and only for Medicaid patients currently. Until recently, most private insurers have not reimbursed for language services, although they serve large numbers of language minority beneficiaries who are paying their health insurance premiums. In fact, 20% of their insurance dues revenue stream comes from language minority patients. The majority of healthcare organizations in the US struggle with variances in their annual funding. They are working to provide additional language services out of their own administrative budgets, without any specific language access funding benefits. When services are created, hospital managers have to work within those strict financial constraints. While there are 13 states that reimburse for language services only for Medicaid and SCHIP, it is not substantial number in the national scope.

According to the *Medicaid and SCHIP Reimbursement Models for Language Services Report 2009 Update* by National Health Law Program (NHelp), while only some states currently provide reimbursement, the examples on the report help identify promising ways to evaluate and establish reimbursement mechanisms for language services. Of the 13 states, five treat it as a service cost, while nine treat it as an administrative cost.

Spotty Language Data: Hospital Information and Technology (IT) Departments are Strained

In a 10-hospital language access project, named *Speaking Together: National Language Services Network*, funded by the Robert Wood Johnson Foundation, participating hospitals with large interpreter departments conceded that they were not able to cover all of their language minority patients[3]. When the project started, they could not even provide documentation to showcase the extent of their services, compared to their hospital's entire language minority patient population. While many language service departments have ever improving data on their patient demographics and the language services provided, most language data are not linked to their hospital wide patient population data. Fulfillment rates are still not being documented in most hospitals in the country because they do not have the appropriate IT structure to connect all the language minority services to electronic medical records (EMR). Some hospitals in this country are still moving from paper to electronic medical records. There are few hospitals that have data systems in place to require documentation of how the language need was met for each healthcare encounter in the medical records, Both Meditech and Epic, the largest EMR organizations, have still not standardized language need and language service in their default EMR software packages even though there are mandates for ethnicity and language data for all patients[4]. As a result, the provision of interpreting services is simply not guaranteed to the LEP and Deaf individuals that need it. They will get an interpreter if the hospital can afford one at that moment.

3. Geisz, MB, "Speaking Together: National Language Services Network, An RWJF National Program," April (2011) *Robert Wood Johnson Foundation*

4. Paradise R., Choi, S., Cundiff, L., Khaliif, M., Nevill, L, Arocha, I., Marlin, R., Patel, F. Friedman, E., "Best Practices for Data Collection in Language Services Quality Improvement: Electronic Medical Record Documentation of How Language Needs Were Met During Clinical Encounters." Nov. (2013) *Institute of Community Health.*

Spotty Services: You will Communicate via a Certified Interpreter if One is Available

When administrators are asked why they are not able to cover all their patients, the responses are similar: Lack of reimbursement. The hospitals are paying most of the costs out of their administrative budgets and insurance companies are not reimbursing for the mandated medical interpreter cost to serve patients. These costs are capped and therefore are carefully controlled each month, as they should. Although federal agencies and the organizations receiving federal financial assistance are bound by the laws and regulations cited in the beginning of this article, they remain responsible for an unfunded mandate.

The core of the problem is that hospitals are simply not able to bear the entire burden of language access. Some hospitals cannot afford to hire certified healthcare interpreters during the weekends or evening hours and resort solely to remote (telephone or video) interpreting, which is not adequate or possible in every situation with all patients. Some hospitals do not have a budget to train healthcare personnel on how to utilize these services or even which number to call. Lack of equipment or usage codes is another problem, as a provider cannot use a telephone or video device that is not there. Other hospitals hold providers on the line before passing the phone to a vendor organization in the hopes that an internal hospital interpreter will provide the service. However, with long waits, providers hang up and then complain that the interpreter was not available. Most hospitals are well intentioned and are doing the best they can with the funds they have. Dr. James Rohack, past President of the American Medical Association, was quoted in the ATA publication "Getting it Right" stating, *"Look at the common thread in lawsuits: it's that the patient feels the doctor didn't adequately explain why he did what he did. Inadequate communication means more tests, but there is also a higher risk of lawsuits."*

Increased Regulation

The Joint Commission, an organization that accredits hospitals published language access standards that hospitals need to abide by before accrediting the organization. A seminal report published by The Joint Commission showcased the importance of accurate communication in healthcare was identified as a common root cause to adverse health outcomes[5]. Other studies have come to the same conclusion[6].

[5.] The Joint Commission, "What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety." www.jointcommission.org/assets/1/18/improving_health_literacy.pdf

[6.] Huntington, B., & Kuhn, N. (2003). Communication gaffes: A root cause of mal-practice claims. *Baylor University Medical Center Proceedings*, 16, 157-161.

The Office of Minority Health is also increasing its oversight over this issue of language access in health care, both nationally and locally. The Culturally and Linguistically Appropriate Services (CLAS) Ordinance establishes clearly what hospitals must do in order to provide services to diverse patients that are both linguistically and culturally appropriate. In addition to language interpretation, medical interpreters act as cultural bridges between patients and providers. Many issues of patient non-compliance can be improved with a better understanding and adaptation to the patient's cultural needs. According to Guadalupe Pacheco, President/CEO of the Pacheco Consulting Group in Washington, D. C. and previous Senior Health Advisor to the Deputy Assistant Secretary Director for the Office of Minority Health states *"Cultural competency education has the potential to improve patient-provider interactions, compliance, and patient satisfaction. Through cultural competency education mandates, policy can play a vital role in eliminating health disparities."*

Increased Lawsuits

Lawsuits against hospitals are increasing and one lawsuit alone could pay for hundreds or thousands of interpreted encounters. The most famous lawsuit due to misinterpretation was the Willie Ramirez case of 1980[7]. The lawsuit resulted in a settlement over Willie's lifetime of approximately $71 million, assuming he lived to age 74. Recently there have been other cases, some that have become national news due to the severity of the adverse outcome, one (April 2014) resulting in death due to an error in interpretation of the address of the victim, preventing the ambulance to arrive on time. The $3 million wrongful death lawsuit accuses a 9-1-1 Spanish-language interpreter of making an error in the interpretation of an address, causing the ambulance to the wrong location as a 25-year-old woman was gasping for air.

A total of 26 minutes were lost as medics raced around searching for the woman in distress, finally receiving the correct address and arriving minutes after to find Elidiana Valdez-Lemus unconscious from cardiac arrest. She had not taken a breath in the previous 14 minutes, and doctors declared her brain dead[8].

These lawsuits are caused primarily due to errors by unqualified bilingual individuals or staff asked to provide professional medical interpreting services, or by the denial of the facility to provide an interpreter when needed[9] . Patients are much less likely than Deaf or Hard of Hearing patients to sue hospitals.

7. Price-Wise, Gail Language. *An Intoxicating Error Mistranslation, Medical Malpractice, and Prejudice.* BookBaby. January 2015.

8. Green, Aimee, "Lawsuit: 911 Spanish interpreter botched translation, sent ambulance to wrong address" April (2014) The Gregorian

9. Beckman, H. B., Markakis, K. M., Suchman, A. L., & Frankel, R. M. (1994). The doctor-patient relationship and malpractice. Lessons from plaintiff depositions." Archives of Internal Medicine

There is a much higher amount of lawsuits arising from the Deaf community when compared to the LEP community.[10] According to Bruce Adelson, CEO of Federal Compliance, LLC and former U.S. Department of Justice Senior Trial Attorney notes *"If any hospital, public or private agency, institution, or organization, or other entity, receives Federal funds or Federal Assistance than Title VI requirements would apply across the board."*

To see a list of articles about language access lawsuits, turn to the International Medical Interpreters Association lawsuit page, which lists all the news related to such lawsuits, at www.imiaweb.org/resources/legal.asp

So, What Does an Interpretation Service Cost?

The cost/benefit ratio is the million-dollar question all have been asking. For the purposes of this white paper, several cost categories will be discussed in order to provide a cost framework that is objective and comprehensive[11]. Financial accounting costs are the actual total costs (direct, indirect, and overhead) tangible and incurred by an entity/provider to provide interpreting services. Data varies regarding the rates being paid for the service. According to the Bureau of Labor Statistics (BLS), medical interpreters are within the category of Interpreters and Translators (I&T), and rates the average income for this general category at $45,430 per year, or $21.84 per hour[12]. These are general rates, and are not specific to healthcare interpreters. The Bureau reports that the I&T profession has a job outlook estimated growth of 46% between 2012-2022 due to the increased demand for language services. This is a staggering increase estimate, confirmed by a similar trend in language minority population growth. According to the *Interpreter Marketplace: A Study of Interpreting in North America Commissioned by InterpretAmerica*, published in 2010, interpreters make from $30,400.17 to $35,865.02 a year. Common Sense Advisory does not identify compensation by specialty[13].

10. Beckman, H. B., Markakis, K. M., Suchman, A. L., & Frankel, R. M. (1994). The doctor-patient relationship and malpractice. Lessons from plaintiff depositions." Archives of Internal Medicine, 154 (12) 1365-1370.

11. Blanchfield, B., Gazelle, G. S., Khaliif, M., Arocha, S. I., Hacker, K.A (2010) "Framework to Identify the Costs of Providing Language Interpretation Services" Journal of Health Care for the Poor and Under served 22 (2011): 523–531. Journal of Health Care for the Poor and Underserved 22 (2011): 523–531.

12. Bureau of Labor Statistics, Occupational Outlook Handbook, http://www.bls.gov/ooh/media-and-communication/interpreters-and-translators.htm

13. Kelly, N., Stewart G., R., Hegde, Vijayalaxmi, *The Interpreting Marketplace, A Study of Interpreting in North America Commissioned by InterpretAmerica,* June 2010

The International Medical Interpreters Association (IMIA), the national professional association for healthcare interpreters, is the only organization that has published salary data specific to medical interpreting, found in the *2010 IMIA Compensation Survey – Executive Summary Report*[14]. The top three categories constituting the majority (53%) of respondents (n=4,357) in this survey claimed a pay range of $15.00 to $40.00/hour, for in-person staff interpreting services, paid by the hour by hospitals. This signifies a mean, or average of $27.50, and a median (which accounts for the spread) of $20.00/hr. Add fringe benefits of 33% ($6.60) and that becomes $26.60 for staff employees. Per diem and contractors make more than staff employees, yet do not have benefits. Using the same calculations, per diem and contractor interpreters reported a median income of $12.00/hr., and $30.00/hr. respectively - without benefits, yet reliant on administration.

Rates will vary according to state, condition, language, and other factors. Administrative costs related to language services exist and cannot be avoided. According to the New England Journal of Medicine study that surveyed 6,400 hospitals, the nationwide, administration accounted for an average of 24.8 percent of each hospital's spending in fiscal 1990. If we apply this national administrative cost to staff and per diem interpreting services (so as to include Language Interpreter Services (LIS) management, a language cost to the hospital), the cost to the hospital for staff interpreting services increases to $33.10/hour.

To simplify, this white paper estimates the average staff cost of ensuring language access per 20-minute encounter. When this is divided in three parts, to account for a shorter 20 minute encounter, the cost per encounter becomes $11.03 per 20 minute encounter. Per diem interpreters do not earn significantly more than staff interpreters, and in keeping with industry standards, do not enjoy fringe benefits.

For those paid by the minute, common in outsourced remote interpreting, 60% of interpreters are earning from 30 to 70 cents per minute, with a median of 50 cents (offshore interpreters are paid less) depending mostly on language and time of service. This represents $30/hour, or $10.00/20-minute encounter. However, hospitals are charged on average $1/minute, which equates to $60.00/hour and that is the interpreting cost to the hospital for every hour of interpretation services. These interpreters, paid by minute, work remotely and are contracted by large national Interpreter Service Providers (ISPs), which are companies that usually specialize in remote interpreting and language services, and incur the costs of administration and benefits as well. This calculation was also done with contractor interpreters and video interpreters. Both remote and on-site interpreters are needed in order to provide adequate interpreting services for language minority patients.

14. 2010 IMIA Compensation Survey – Executive Summary Report, *International Medical Interpreters Association*, 2010. http://imiaweb.org/about/salarysurvey2008.asp

It is useful at this point to develop a gross 'figure-per-encounter' that can represent a nationwide baseline. This white paper defines a healthcare encounter as an in-person or remote meeting between a healthcare provider and a language minority patient for the provision of healthcare services.

Cost Matrix for Medical Interpreting Services

Modality of Service	Cost per 20 min. Encounter
Staff	$11.03
Per diem	$12.00
Contractor	$30.00
Telephonic	$20.00
Video	$40.00
Average Cost per 20 Minute Encounter	$22.61

Notes:

Median, or average is $22.61/20 minute encounter = $67.83/hour across all modalities..
Mean will vary depending on their individual spread of these five modalities.

Until further compensation data is published, the following equation of $22.61 per 20 minute encounter or $67.83 per hour can be used as a median national cost model for healthcare interpreter costs across all modalities.

The *2014 IMIA Salary Survey* results have not been published as of the date of this publication. It will be published at www.imiaweb.org in the near future.

Until further compensation data is published, this n*ational cost model for language interpreting* in healthcare may be useful: $22.61 per 20-minute healthcare encounter or $67.83 per hour. It is important to note that this figure is a comprehensive figure, and it does not necessarily showcase how much interpreters earn, but rather focuses on the actual cost of language services to healthcare organizations.

These calculations were based on data prior to national medical interpreter certification. In other words, it is the national cost of non-certified services. As more interpreters become certified, healthcare organizations will demand certification to guarantee patient safety. Likewise, healthcare organizations should require certification in order to get reimbursed. In an operating room, for example, all parties are certified, doctors, nurses, technicians, yet it is still common for the medical interpreter to be the only party in the surgery suite that is not certified. This poses an unnecessary risk to the patient and to the healthcare organization. If reimbursement is only given to certified medical interpreters, then the onset of reimbursement itself will protect patient safety. Therefore, the national cost model for language interpreting presented herein might rise in the future due to the requirement of the provision of certified medical interpreting services.

Hidden Costs

The difficulty with assessing interpreting costs is that usually only financial costs are calculated. Opportunity costs are sometimes added to financial accounting costs when estimating the total economic cost of a service. Unlike financial accounting costs that are reported in financial records, as previously explained, opportunity costs represent the intangible benefit of using the resources. These include enhanced satisfaction, improved patient safety, and lower negative health outcomes caused due to miscommunication or no communication at all. Another type of cost model requires the calculation of the benefit cost savings of using such resources or the cost drain of not using them. It is important to assess the recurrent risks and complications involved related to the lack of such services, in many cases when proven adverse outcomes ensue due to lack of professional interpretation services, as additional cost factors.

The biggest risks are lawsuits due to negative health outcomes, loss of accreditation, or loss of federal funds. As stated before, lawsuits have risen in the last five years. Loss of accreditation by the Joint Commission, a "Determination of Need" by the State Office of Minority Health, and loss of federal funds are also serious possibilities and consequences of a lack of full compliance. While complaints rarely reach the media, when there is an adverse outcome or complaint that does, it can become a very negative public relations situation for a healthcare organization or network to manage, with immeasurable costs and repercussions to the organization and certain loss of confidence and trust from a specific patient community.

Hospital risk analysts may conclude that providing some level of service of protection will protect them in case of an audit or a lawsuit, providing a mitigation factor to such risk when considering the likeliness of such situations or costs arising. The low rate of probability is key in risk analysis, and can curtail efforts for healthcare organizations to improve language services.

What Other Costs are Involved?

Medicaid, Medicare and most private insurers do acknowledge the expenses related to complications, delays in hospital stay, missed follow-up appointments, and delay of care, and are working to curb these costs. Numerous studies have documented these unnecessary expenses within the United States. However, few realize that these same cost-drainers also affect language minority patients, and that they can be mitigated or eliminated by employing the services of a professional interpreter for the 20% of the general population that has a language barrier. As most underserved populations, LEP and Deaf patients are more likely than others to defer needed medical care, leave the hospital against medical advice, miss follow-up appointments, or experience drug complications. They are also less likely to have a regular health care provider, affecting continuity of care.

30-Day Readmission Rates and LEP and Deaf and Hard of Hearing Patients

One of the highest preventable costs to US healthcare is the 30-day readmission rate. Legislators are working to curb these costs. Here are some examples:

- U.S. Senator Joe Manchin (D-WV) introduced the Hospital Readmissions Program Accuracy and Accountability Act of 2014, which would make important adjustments to the Medicare Hospital Readmissions Reduction Program (HRRP). Specifically, the bill would require the Centers for Medicare and Medicaid Services (CMS) to take into account certain socio-economic factors, using census data, when evaluating hospital performance in HRRP. The Hospital Readmissions Program Accuracy and Accountability Act of 2014 would take important steps to address these concerns by ensuring that hospitals caring for our most vulnerable patients are not unfairly penalized, while also continuing to promote high-quality care.

- Hospitals across the country are making progress in efforts to reduce avoidable readmissions for all patients. Under HRRP, hospitals can be penalized if their 30-day readmission rate from past years is higher than the national average rate. In addition to the long, 30-day, post-discharge window and overly punitive fiscal character of the policy, The Healthcare Association of New York State (HANYS) is concerned about the failure of this policy to effectively differentiate between avoidable readmissions and those that are widely considered unavoidable. HANYS has long argued that a key part to the program should be a socio-economic risk adjusted to account for certain factors that can impact the risk of a patient readmission. A language barrier is one of such socio-economic factors.

- A similar legislation, The Establishing Beneficiary Equity in the Hospital Readmissions Program Act (H.R. 4188) was recently introduced in the House by Representative Jim Renacci (R-OH). HANYS appreciates the members of the New York State Congressional Delegation who have already signed onto H.R. 4188 and continues to work with Representative Renacci's office to build support for the bill in the House of Representatives.

Studies Investigating Impact of Language Access and Healthcare Costs

The costs and potential savings due to short and long-term changes in patient utilization of the healthcare system provide crucial data in assessing interpreting costs.

A lack of discharge planning, miscommunication, and poor follow-up care can lead to many unnecessary readmissions, experts say. The result: more tests, more treatments, more time away from home for patients and higher health care costs. If the patient is LEP, a lack of ability to communicate with doctors as an inpatient could greatly impact patient safety[15].

Another study, published by the *Journal of Health Care for the Poor and Underserved* involving 149 residents, noted the practice of working with professional interpreters was only requested during procedural consents (9%) or family meetings (17%), whereas the majority of the communication was assisted by bilingual individuals who are not trained to provide professional medical interpreting services that produce accurate communication between providers and patients. This study showcased the need to improve variation of language assistance, and the need for clear, enforceable guidelines for accurate resident communication with hospitalized LEP patients.

Research has shown that, while 92.4% of residents stated they had worked with an interpreter during their hospitalization, they were most likely to work with bilingual individuals, not professional interpreters. They conceded that the use of professional services was limited to the following situations: during their initial history taking and at discharge, since they declined use during the patient's hospitalization ($P < 0.001$).

A study on the cost of hospital readmissions finds that about 1 in 12 adults discharged from a hospital is readmitted within 30 days, adding $16 billion to the cost of healthcare in the United States. According to analysts, this underscores the need for a comprehensive approach to reforms. Readmission rates are high, as much as 13-30%, with Medicaid and Medicare patients having the highest rates of 30% and 26% respectively. Nationwide, the average penalty to a hospital is roughly $125,000 (Williams, 2012).

15. Sommers, Anna, Cunningham, J. Peter, "Physician Visits After Hospital Discharge: Implications for Reducing Readmissions" No. 6 Dec (2011) *NIHCR Research Brief*

Last, a study published by the *Journal of Internal Medicine* showed results that indicate that LEP patients stayed in hospital longer for 7 of 23 conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement), with Length of Stay (LOS) differences ranging from approximately 0.7 to 4.3 days[16].

LEP patients stayed in the hospital longer, from 0.7 to 4.3 days, representing a cost of $1,231.30 to $7,566.56.

With the average inpatient day at $1,759 (Kaiser State Health Facts), a reduction of LOS for a 0.7 to a 4.3 day Length of Stay (LOS), would represent a cost of $1,231.30 to $7,566.56 per patient that could be mitigated by the presence of a professional healthcare interpreter. Another study by the University of Massachusetts Medical Center has found that professional interpreting services at both admission and discharge reduced a patient's length of stay by a more modest 0.75 to 1.45 days. This represents a cost savings of $1,319.25 to $2,550.55.These patients were also less likely to be readmitted within 30 days[17] .

Medical interpreters play an essential role in the medical team, providing qualified linguistic and cultural services to reduce length of stay and readmissions.

16. Tang, AS, Kruger, JF, Quan J, Fernandez A. "From Admission to Discharge: Patterns of interpreter use among resident physicians caring for hospitalized patients with Limited English Proficiency." *Journal of Health Care for the Poor and Underserved*, 2014, Nov; 25 (4): 1784-98.

17. John-Baptiste A, Naglie G, Tomlinson G, Alibhai SM, Etchells E, Cheung A, Kapral M, Gold WL, Abrams H, Bacchus M, Krahn M. The effect of English language proficiency on length of stay and in-hospital mortality. *Journal of Internal Medicine,* 2004 March 19(3):221-228.

The language minority patient is 20% of the general population; so one can extrapolate that of the $16 billion lost to readmissions, $3.2 billion dollars might grossly reflect the cost of readmission for language minority patients. Toward an effort to reduce readmissions, certified healthcare interpreters should be seen as a very low cost tool to assist language minority patients that are hospitalized. Most language minority patients only get language assistance when they are admitted and the day they are discharged. Most hospitals are striving for that goal, which means that some patients are not even getting that, since many providers rely on unqualified family members to relay messages. This common practice is deceiving as it seems seamless yet it is quite different from having meaningful confidential communication about serious healthcare issues with a patient with the services of a certified medical interpreter. Some patients are left several days in the hospital without any form of meaningful communicatio

Drug Complications and the LEP, Deaf and Hard of Hearing Patient

Let's look at another example of the hidden costs of ineffective health care cost management: drug complications. Among 2,248 patients reporting prescription drug use, 394 (18%) reported a drug complication. For example: On chart review, 3 (5%) of the patients with an adverse drug event required hospitalization and 8 (13%) had a documented previous reaction to the causative drug. 18% of that patient base is a large number and if this is relevant to the general population, it seems that it is another high cost that can be easily avoided with language minority patients by requiring the services of certified healthcare interpreters to avoid drug related miscommunications and complications[18]. Researchers at the University of California at San Francisco looked at the prices California hospitals charge for 10 common blood tests. Researchers studied charges for a variety of tests at 160 to 180 California hospitals in 2011 and found a huge variation in prices. The median charge for a basic metabolic panel, which measures sodium, potassium and glucose levels, among other indicators, was $214.00[19] .

Public Safety Cost

After several epidemics, with the current one being Ebola, national and international disasters can affect our healthcare system in a significant manner with little time to adjust. Is the US ready for a national epidemic or catastrophic event that will bring many language minority patients to the hospital at once? What would be the repercussions if it happened in one of the states with the highest LEP populations? How is the Health Department going to communicate with the diverse communities about safety measures, evacuation and other such communication needs?

18. Tang, AS, Kruger, JF, Quan J, Fernandez A. "From Admission to Discharge: Patterns of interpreter use among resident physicians caring for hospitalized patients with Limited English Proficiency." *Journal of Health Care for the Poor and Underserved*, 2014, Nov; 25 (4): 1784-98.

19. Gandhi, T.K, "Drug Complications in Outpatients" Journal of General Internal Medicine 15, No. 3 (2000): 149–154.

A medical interpreter intervention costs an average of $23/medical encounter. Compare this to a basic blood test intervention, which averages $214.

After the 2011 Tsunami and Fukushima nuclear disaster, Japan learned a lot regarding language access. Japanese officials had great difficulty communicating with foreign residents of Japan, who did not speak Japanese. The country now is developing a massive plan of language access in preparation for the 2020 Olympics and Paralympics[20]. They have established a 5-year goal so that every prefecture increases its language access capabilities, and is working towards language services reimbursement for their Universal Healthcare Plan.

A paradigm shift in the US is needed now. The United States needs to be cognizant that language needs will increase at a rate of 46% according to the Bureau of Labor Statistics, and therefore has to create mechanisms to support these changes.

Ambulatory Utilization Rate Penalties

The *National Hospital Ambulatory Care Survey* was used to analyze the Emergency Department (ED) utilization, disease severity (assessed by triage category), hospitalization rates, and follow-up plans for adults with five chronic ACS conditions (asthma, chronic obstructive lung disease, congestive heart failure, diabetes mellitus, and hypertension). The *National Health Interview Survey* was used to estimate the prevalence of these conditions in similarly aged US adults. The results show that Black persons and Hispanic persons were less likely than White persons to have follow-up with the physician who referred them to the Emergency Department (ED). Follow-up arrangements for these patients suggest that they are less likely to have ongoing primary care. Barriers to primary care appear to contribute to the higher ED and hospital utilization rates seen in these groups.

The Perfect Storm is Imminent

The current system for providing comprehensive language services is on a collision course. Several factors are contributing to an unsustainable financial framework for providing LEP and Deaf patients quality and cost-effective healthcare services. This white paper has indicated the size of the language minority patient population is increasing at a faster pace than the rest of the population and can no longer be ignored. It has also demonstrated that the costs involved to remedy negative outcomes and avoid unnecessary costs are much lower than the cost of not providing such services.

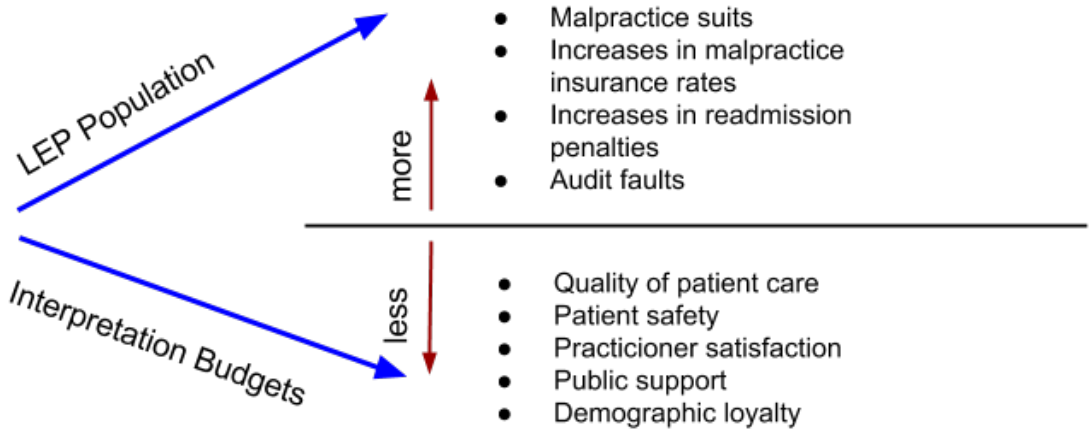
20. Suzuki, Noriyuki, "Medical interpreters discuss goal for 2020 Olympics," Nov. (2014) *The Japan Times* http://www.japantimes.co.jp/news/2014/11/14/national/science-health/medical-interpreters-discuss-goal-for-2020-olympics/#.VTBsgmY3Uq4

Health studies indicate that language minority patients are at a greater risk for longer hospital stays and drug complications. While the language minority population grows, hospital language services are shrinking. Many community hospitals have shut down in the past two decades. Community healthcare centers are also suffering, competing with large well-endowed hospitals for outpatient care. Within this financially grim environment, most hospitals are attempting the impossible task of providing language services to higher patient population with a lower budget per patient.

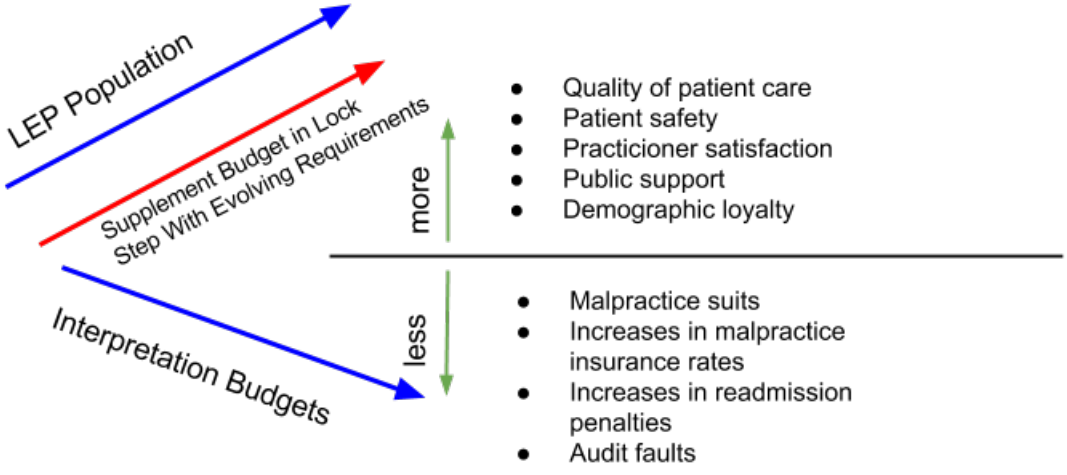
Data collection is difficult since some hospitals are still not identifying the primary language of every patient, a basic element of an effective language access plan. Hospitals across the country are seeing their medical interpretation budgets for language access cut to save costs, compliance to ensure equal access to all is increasing, lawsuits for lack of compliance are on the rise, and the new Affordable Care Act has actually penalized hospitals for not doing an adequate job in removing the language barrier for non-English patients. The lack of reimbursement in the near future will potentially endanger the health and safety of these patients, financial stability of healthcare facilities, and the overall quality of care in our ever-diversifying country. Without a paradigm shift, we will see the healthcare of language minority patients erode and the costs of this erosion will tax the healthcare system in a significant manner.

Paradox vs. Paradigm Shift

Paradox



Paradigm Shift



Negative Trends Leading to the Perfect Storm	Positive Trends with Services Reimbursement
Language minority patient population growing rapidly.	All language minority patients and providers have meaningful access to healthcare.
Malpractice suits are increasing and consequently insurance costs will continue to rise.	Quality and patient safety rises.
Compliance will continue to rise to stem the increase of sentinel events.	Patient compliance improves due to less misunderstanding in cross-cultural interactions.
Readmission penalties are rising.	Reliance on family members and other unqualified personnel is eliminated.
Audits are failing more often.	Insurance prices decline.
Some language minority patients go abroad for treatment.	Decrease in overall health costs for 20% in the population.
Patient safety risks due to miscommunication.	Medical interpreter workforce increase that supports diversity and further economic growth.
Patient and provider who cannot communicate disclose lower satisfaction.	Patient and provider satisfaction increases.
Risk of negative outcomes and sentinel events	Language minority readmissions decrease.
Quality of service and safety suffers as hospital budgets continue to be cut.	Clean audits and decrease in lawsuits due to lack of healthcare interpreter presence.

What Can Be Done to Mitigate This?

It is time for a concerted multi-stakeholder national effort to reimburse medical interpreting services. The reality is that Medicaid, Medicare and private insurers pay for diagnostic exams in order to prevent health problems, and as such by modifying the current perspective to view the certified medical interpreter as a partner in the healthcare team, will have a critical impact on the patient's level of understanding, compliance, trust which then contributes to the direct success of the desired treatment. This high level the paradigm shift relates to seeing the interpreter intervention as a low cost preventative intervention ($22.61 per encounter) diagnostic exam, rather than an unreimbursed hospital administrative cost to be avoided.

Organizations such as the Department of Human and Health Care Services, CMMI, or the American Medical Association, and The Joint Commission, may decide to consider ways to speed this paradigm shift. There are already organizations in the marketplace that are getting hospitals reimbursed for private insurance claims. Why are all hospitals not partaking of this leading edge? Historically, private insurance carriers have reimbursed for medical procedures, based on what Medicare and Medicaid do. When will CMS and HHS finally offer equality across the board and reimburse in all fifty States? When will the government finally allow for full national Medicare reimbursement, particularly after private insurance companies are already reimbursing for medically necessary language access expenses, to ensure the safety of their commercial patients. Private insurance is quickly recognizing that the most effective path to excellent medical care for language minority patients is to ensure that all language barriers are removed so that patient safety is guaranteed, readmission rates lowered, and proper diagnoses can be effectively and properly communicated. This paradigm shift is clearly a win for all parties, and all organizations in the healthcare sector, government, hospitals, clinics and insurance must now move in lock step to ensure equality and effective care for all patients, particularly those of language minorities.

What Will This Shift Look Like in 5 Years?

If the supply can keep up with the demand via reimbursement, there will be numerous benefits and it will allow for healthcare services to be provided at a higher quality, and with less risk and cost drain.

All patients will be able to fully communicate their healthcare needs and therefore get meaningful and accurate services, unencumbered by miscommunication. Providers will be able to diagnose without fear, and rely on the healthcare interpreter as a team member to provide linguistic and cultural services to ensure a culturally and linguistically appropriate care to an expanding diverse population. Patients and providers will be more satisfied and not feel the frustration of 'attempting' to communicate, on ever important matters pertaining to them[21].

The ability to pay medical interpreters at a premium commensurate with their specialized training, would allow hospitals and agencies to hire and contract with more seasoned and highly qualified professionals, creating jobs in their communities. An expanded workforce of elite and credentialed resources will ensue, willing and ready to bridge the linguistic and cultural demands that currently are not being fulfilled due to lack of funding. The Bureau of Labor Statistics has an expected growth of the profession to be at 46%. Hospitals would not have to incur the full burden of such rising costs and would be able to manage their diverse patients' needs more effectively. Several countries also have a strong demand for professional healthcare interpreters, and the U.S. can export this talent as much of the work is provided remotely and is already crossing borders. Facilitating reimbursement and raising the bar on pay for certified medical interpreters will have a direct impact on our country's level of preparedness for an international health crisis and will position us as a world leader in high level of language services availability, at our and others' disposal for a myriad of applications.

21. Wanzer, M. B., Booth-Butterfield, M. & Gruber, K. (2004). "Perceptions of health care providers' communication: Relationships between patient-centered communication and satisfaction." *Health Care Communication*, 16 (3), 363-384.

Note About Written Translations

This white paper focused on interpretation services, which are provided by interpreters orally. Another cost analysis white paper is needed to develop a pricing model for translation services in healthcare, which are provided by translators in written form. The translation of essential documents, such as consent forms, patient educational information, pre and post procedure instructions and other information for patients, is of the utmost importance for language minority patients to be able to have meaningful communication.

Conclusion

It is time for a call to action. The healthcare system must be willing to address these issues in the provision of language services in healthcare aggressively. These major factors contributing to the high costs of healthcare in United States must be mitigated. The current policy debate argues over the "who and the how" of paying for LIS provided to LEP patients. This white paper can be used to redirect reimbursement policy discussions for the purpose of rapid evolution in healthcare reform.

The new paradigm shift will view medical interpreters as in integral component of the medical team. Commensurate and fair compensation for the highest quality healthcare interpreters will be made available as a sustainable course, established for all types of insurance reimbursement. When this unfunded mandate evolves into its deserved status as a funded order of law, standards will rise and greater investment dollars will be fielded for additional qualified resources.

Until further compensation data is published, a national pricing model for language interpreting costs in healthcare of $22.61 per 20 minute encounter or $67.83 per hour can be useful to policymakers, providers, interpreters, educators, and advocates and all stakeholders, including patients. It is clear that the cost and benefit of preventative LIS measures far outweighs the expenses and potentially disastrous consequences of not provisioning it. More research is needed in the area of language services payment models. The results will play a significant role as policy makers and legislators shift the paradigm in order to avoid the perfect storm and mitigate impending disaster for all involved assisting language minority patients.

A national standard for interpreter reimbursement must be established such that medical interpretation becomes a completely self-sufficient and sustainable healthcare service, with certified medical interpreters working alongside every other member of the qualified medical team, supporting the linguistic and cultural needs of the language minority patient. With the most expensive healthcare costs in the world, rising at an unprecedented pace, and the language minority population growing to over 20% of the US population, this is a matter of critical impact with repercussions of monumental consequence to our multi-cultural nation.

Louis and Izabel have worked together to advocate for language minority patients since 2007.

All of their work, including this white paper, is dedicated to all medical and healthcare interpreters, the essential healthcare professionals who work alongside providers to ensure patient safety and save lives.

About the Authors

Izabel E. T. de V. Souza (Arocha)

Izabel E. T. de V. Souza, M.Ed., CMI-Spanish (previously Izabel S. Arocha) is a passionate global advocate for language access in health care. After working as a translator and interpreter (medical, legal, conference, religious) for many years, Souza dove into what is now a lifetime mission of volunteering and later working for the International Medical Interpreters Association (IMIA) in many different capacities (member, Regional Director, Secretary, President) and last, as Executive Director for almost three years.

She was fortunate to have the opportunity, as President of IMIA, to co-launch, along with Mr. Louis Provenzano Jr., the first national medical interpreter certification in over 600 testing centers nationwide, amidst much controversy in the field about the readiness of interpreters to get certified. This has always been a patient safety issue, and interpreters couldn't wait any longer. On October 2009, medical interpreters started upgrading their qualifications in order to become nationally certified medical interpreters by the National Board of Certification for Medical Interpreters (www.certifiedmedicalinterpreters.org). This work, along with other initiatives, has helped change the scope and status of medical interpreting not only in the US but worldwide, as other countries have adopted the IMIA Standards of Practice.

As an ISO and ASTM expert, Souza contributes to the development of several other national and international standards in the field related to language services. She travels extensively nationally and abroad to present and advocate on the need for advancement of these services, as a human right issue, and as an imperative for patient safety worldwide, specifically in the field of migrant health and medical tourism. As of 2015, she is finishing an international PhD dissertation at Osaka University, Japan, on the cultural aspect of the medical interpreters' practice, to contribute to the field with more practitioner research about the interpreter's role in providing culturally sensitive and appropriate services. Souza's blog at http://certifiedmedicalinterpreter.wordpress.com posts articles on important topics related to the advancement or medical and healthcare interpreting. She also advocates for greater maturity and unity in the field, leadership development, and an ethical, participatory and transparent approach to professional advancement, where all stakeholders contribute.

Louis F. Provenzano Jr.

Louis Provenzano is the Co-Founder of Certified Medical Interpreters, LLC and former Chief Executive Officer of Language Line Services. He frequently writes on medical interpretation and language access issues for various publications on his personal blog and has a newsletter on language news, events and happenings in the world (www.languagetime.org).

Mr. Provenzano is a frequent speaker around the world on immigration and language access issues. He holds a bachelor's degree in Romance Languages from Boston College speaks six languages and lives in New York City.

Mr. Provenzano is an active medical interpreter advocate and lobbyist in Washington, D.C. He remains passionate about securing national reimbursement for medical interpretation services and augmenting the overall quality and success of the profession. Mr. Provenzano is a proud co-founder of the National Board of Certification of Medical Interpreters, along with Izabel E.T. de V. Souza (Arocha) the first certification board for medical interpreters in the United States.

He is the recipient of the "Friends of CHIA" (California Healthcare Interpreters Association), the Hispanic Leadership Award from the San Francisco Hispanic Chamber of Commerce, the Monterey Business Council Top Leaders of 2012, and the Rachel Cashman Language Access Award, the highest honors from the IMIA (International Interpreters Medical Association).

He writes his own blog at www.louisprovenzano.wordpress.com , "Tweets" @ louisprovenzano (www.twitter.com/louisprovenzano), has a Facebook page (louisprovenzano) and is currently co-writing writing a book with Izabel E. T. de V. Souza (Arocha) on the pathway to National Medical Certification and medical interpretation reimbursement for Hospitals and Healthcare organizations around the country.