Preventable emergency department visits for patients with limited English proficiency in Minnesota

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Policy Proposal
Published July 31, 2019

The Problem

A disproportionate number of Minnesotans, who don't speak English very well, rely on the emergency department (ED) as their primary source of healthcare[1]. In 2015, Hennepin County and Ramsey County had 95,612 multilingual residents, who also identified as speaking English "less than very well" or otherwise known as being limited English proficient (LEP)[1]. A study in Minnesota from Mayo Clinic revealed that patients who use interpreter services were twice as likely to have three or more ED visits compared to patients who don't [2]. Previous research has demonstrated that LEP patients have overall poorer quality of health, lower use of preventative services, decreased understanding of medical information, and increased usage of EDs/frequent hospitalizations [2].

This policy proposal addresses the high frequency of preventable ED visits by LEP patients in Minnesota.

Why is it Important?

In Minnesota, over 120 languages are spoken [3]. Accessibility to healthcare services, such as establishing primary care, can be severely hindered by language barriers and lead to miscommunication and inadequate care [4].

The ED is a highly accessible and convenient place to receive care because it's open 24/7, offers several services to in-house specialties such MRI/CT imaging and guarantees care regardless of health insurance status [5]. Additionally, there has been slight upward trend in the number of ED visits in Minnesota [6]. From 2015 to 2017 the total number of ED visits increased by 14,000 visits (Figure 1) [6].

The Main Issue

Given the crucial role of language interpreting services for LEP populations, the main issue that needs to be addressed now is state-wide standards in Minnesota for language interpreters in order to provide higher quality of care.

Policy Question

How can the Minnesota State Legislature address the lack of statewide standards for language interpreters in order to reduce preventable ED visits and improve health outcomes among LEP populations in Minnesota?

Problem Trajectory

Title VI Civil Rights Act of 1963 mandates that language interpreter services be offered at no cost to patients [7,8]. Language interpreter agencies and local healthcare systems set their own requirements for their interpreters [7]. However, there are no minimum standards in place at the state level or a state certification process [7]. In 2011, MN Stat. 256B.0625 was passed and requires healthcare interpreters to pay a $50 annual fee to be on a roster to qualify for Medical Assistance (MA) reimbursement [7,8]. However, Minnesota Department of Health (MDH) doesn't verify the qualifications or backgrounds of the interpreters.

LEP patients often feel ashamed about their English skills, so they don't ask their providers clarifying questions [4]. If LEP patients don't feel comfortable speaking with their primary care providers, they might omit pertinent information about their symptoms which could lead to delayed treatment. Symptoms that might seem minor initially can become more severe to the point where it warrants an ED visit. Additionally, American healthcare norms such as preventative care services (e.g. vaccinations), primary care, or chronic disease management may be unfamiliar to patients with different cultural backgrounds [2].

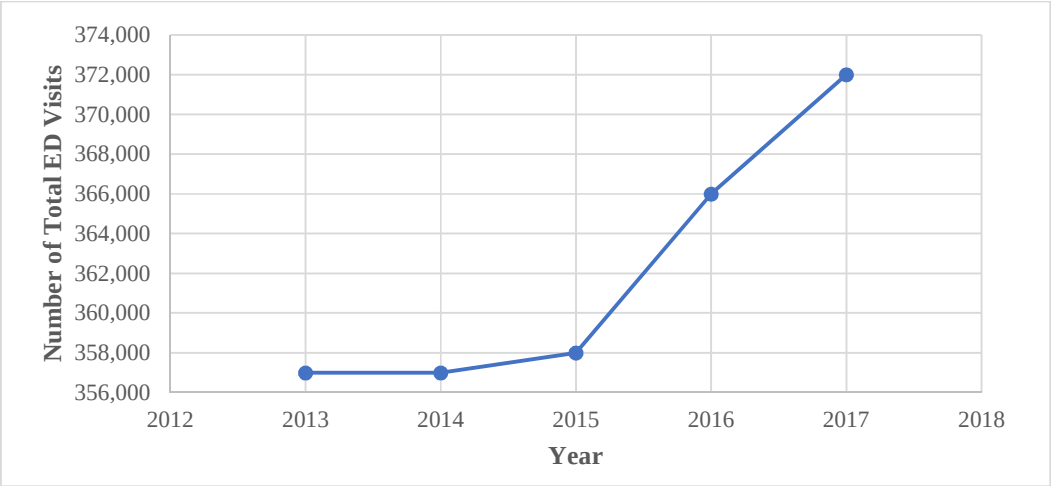

Figure 1. *Annual Number of ED Visits 2013-2017.* This was created by the author using the data from, "Hospital Emergency Room Visits per 1,000 Population by Ownership Type," from the Kaiser Family Foundation Website [6].

Pressure For Action

In the U.S., the LEP population has grown by 80% over the past 20 years and is projected to continue increasing [2]. Minnesota cannot allow for the number of preventable ED visits to follow suit with this trend. Healthcare providers and patients place a significant amount of trust in language interpreters to accurately present information and act as a bridge of communication, so we must assure LEP populations in Minnesota the availability and accessibility of high-quality language interpreters. Multiple studies have shown that use of congruent language providers and interpreters mitigate several health disparities, including reduced ED visits, experienced by LEP populations [2]. If state-wide standards are set for interpreters, we can reduce the number of preventable ED visits.

Policy Options

1. Develop and mandate statewide certification for medical interpreters

The MDH previously recommended a multi-tiered registry system where entry level interpreters were expected to fulfill minimum requirements such as passing the Medical Interpreter Ethics and Standards of Practice Test and Medical Terminology Test which didn't pass in the legislature [8].

Similar requirements would be used to establish and mandate statewide certification to be on the registry including [8,9]:

- Minimum age of: 18
- Minimum hours of training: 100
- Pay for and pass a comprehensive state certification exam once every 5 years for certification renewal
- Topics include: medical terminology, interpreter ethics and standards of practice, English proficiency and second language proficiency
- Provide proof of qualifications including national certification, prior relevant courses, etc.

Effectiveness

Although there has not been a study examining the relationship between statewide medical interpreter certification and reduced preventable ED visits from LEP patients, several other studies have demonstrated a positive association between trained professional interpreters and LEP patients who had higher patient satisfaction, increased health care access, and lower ED return visits [10-13]. Another study showed that professional interpreters with greater than or equal to 100 hours of training had significantly lower rates of producing interpreter errors with a total of 12 errors compared to those who had less hours of training with 32.5 errors [14]. By creating and implementing state-wide standards for medical interpreters, potentially harmful clinical errors such as incorrect dosing of medications can be reduced [14].

Political Feasibility

In the 2019-2020 legislative session, there are bills in both the Minnesota House (HF1400) and Senate (SF875) that both propose additional requirements before being added to the interpreter roster including relevant training/coursework, passing an exam, and certification [9,15]. Both bills also demonstrate bipartisan support as they are co-sponsored by democratic and republican members [9,15]. Furthermore, the Senate bill was passed by the Human Health and Services committee on 3/4/19 [15]. All of these current events support the likelihood of this bill making it to the both the House and Senate floors for a final vote compared to previous attempts in 2010, 2014, and 2018 [16].

Financial and Administrative Feasibility

Since the interpreter roster was first established in 2011, the collected fees have not been spent on anything [17]. As of 2014, there were nearly 3600 interpreters which amounted to $180,000 in revenue [8]. This money could be used to hire administrative staff whose responsibilities would include checking the qualifications and criminal backgrounds of the interpreters, as well as record maintenance. With regards to state certification testing, another fee could be established to take the state certification exam once every 5 years. Testing fees would cover for testing materials, test evaluators, and help fund important resources for interpreters such as continuing education courses or training. In Michigan, interpreter certification exams are $125 [18]. Minnesota could charge a similar price, ensure interpreters are keeping up with new material, and have a steady income to help train future medical interpreters. Lastly, state certification exams could be modeled off of existing national exams, such as Certification of Commission for Healthcare Interpreters and the International Medical Interpreters Association both of which are not mandated at the federal level [19].

Furthermore, on an administrative level, Minnesota already has a court interpreter certification process in place and could apply many of the same procedures to medical interpreters [20]. For specifics related to healthcare, a specially formed committee could discuss, develop, and agree upon appropriate state requirements for medical interpreters such as medical terminology and Health Insurance Portability and Accountability Act (HIPAA). The committee would consist of members from various local interpreter agencies and healthcare systems such as Hennepin Health, who have their own interpreter standards.

Ethical Feasibility

There has been concern from local interpreters that instilling state-wide standards would act as a barrier for new medical interpreters and decrease the overall number of language interpreters available for those who don't meet the state requirements [21,22]. With lower numbers from an already limited pool of interpreters, LEP patients might have less access to such a valuable communication resource [22]. However, without certification that ensures interpreters all have proper training, there is a higher risk of producing interpreting errors which can stem from lack of knowledge of medical terminology, omitting information, inaccurate substitutions, etc. [23]. Interpreter errors can be detrimental and compromise patient safety of the already vulnerable LEP population [24]. Quality of interpreters is just as important as quantity, if not more so, in reducing health inequities and disparities for LEP populations.

2. Increase reimbursement rates of community health workers (CHWs) from Medical Assistance (MA) /MinnesotaCare as an incentive to work with local LEP communities.

CHWs have acted as an important bridge between patients and healthcare by offering patient education about disease prevention and chronic disease management, encouraging healthier lifestyle choices, and even help community members keep their medical appointments [25]. Although multiple studies have shown CHWs to be an effective method of reduced preventable ED visits, they have limited/inconsistent funding which primarily comes from grants [25-29]. However, Minnesota does currently offer MA/MinnesotaCare reimbursement for CHWs [30]. If reimbursement rates were increased as an incentive to work with LEP communities, CHWs could educate LEP patients about how to navigate the American healthcare system and encourage better medication adherence which could reduce preventable ED visits.

Effectiveness

CHWs would be helpful for LEP communities because they can address language barriers by effectively communicating with providers and other healthcare personnel and serve as peer information resource for LEP patients [29]. One study demonstrated a significant reduction in ED visits by 45% after patients began working with CHWs [26].

Political Feasibility

In 2016, Minnesota spent $47.1 billion on healthcare which increased by 1.9% from 2015 [31]. Projected budgets predict Minnesota will continue to spend more on healthcare over the next decade, so it will be difficult to persuade more financially conservative legislators to increase funding for CHWs since they wish to reduce healthcare spending overall [31]. Additionally, since the state already has a tight budget with regards to Medicaid, proposing MA as a source for funding may not go over well. However, with a DFL party majority in the MN House and a DFL governor, there is still hope to pass this policy as an approach to reduce health inequities experienced by LEP populations, given their historical support for MA funding [32].

Financial and Administrative Feasibility

Investment in CHWs can lead to significant reduced healthcare costs by facilitating more efficient access to healthcare and healthier lifestyle choices. The same study that reduced ED visits by 45% with CHW intervention also saved an estimated $1,446,280 in ED visit costs [26]. A different study conducted a cost-benefit analysis of how many ED visits CHWs would have to reduce to achieve cost savings [27]. They determined CHWs would need to reduce 7-12% of ED visits for most chronic conditions which seems plausible given previous data of reduction of preventable ED utilization [26,27],

Ethical Feasibility

Since this policy proposal uses MA as a source of funding, only LEP Minnesotans who have MA or MinnesotaCare would be eligible to receive CHW services. Ideally, these beneficial services would be offered to all LEP populations regardless of their insurance status. This policy could also potentially exclude LEP patients, who speak a more obscure language for which there is no appropriate CHW counterpart to work with. However, by utilitarian principles, it is better to offer help to some LEP patients rather than none.

Policy Recommendation

Although CHWs have been proven to reduce preventable ED visits in Policy 2, the source of funding is problematic. It limits who can receive CHW services and may not be financially or politically feasible. Furthermore, since interpreters are required in clinics and hospitals by federal law, they will come into contact with more patients by volume and more frequently than CHWs [8]. Additionally, CHWs would still likely end up working with interpreters when they work with patients. Therefore, I would recommend Policy 1 to develop and mandate statewide certification for medical interpreters. Ensuring quality interpreters for LEP patients in Minnesota goes beyond just reducing preventable ED visits; it also improves utilization and assess to primary/specialty clinics [14]. Highly competent interpreters facilitate increased patient understanding about their medical condition, treatment, and diagnostic procedures. [10] By empowering LEP patients with more knowledge about their health, they can also make better lifestyle decisions which could prevent future ED visits.

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