Rural Hospitals and Spanish Speaking Patients with Limited English Proficiency

South Carolina Rural Health Research Center

At the Heart of Public Health Policy

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Executive Summary

There are more than 40 million Latinos in the United States, 14.2% of the population. Many of these individuals have limited English proficiency (LEP), which can lead to poor health outcomes in the absence of effective medical interpretation or translation services.

Our study explored how rural hospitals are meeting the needs of LEP patients, reflecting the Federal standards for culturally and linguistically appropriate services (CLAS standards). We identified hospitals in two types of rural counties: those with substantial growth in the Latino population between the 1990 and 2000 Censuses, and counties with large and stable Latino populations. We contacted 319 rural hospitals, most of which had fewer than 100 beds (67.4%) and were located in counties with large, stable Hispanic populations (68.0%). About half (54.5%) were located near metropolitan areas, with potential competition from other larger hospitals.

Findings:

- Seventy-eight percent of hospitals reported having a written policy related to language assistance and 91.7% reported having tools for patients to communicate their language needs, yet only 40% reported language assistance advertisements in Spanish.

- While almost every hospital (98.7%) reported providing oral interpretation to Spanish-speaking patients, only 19.6% used staff interpreters or those employees whose primary workforce responsibility is interpretation. A large percentage of hospitals (85.6%) reported having documents or materials available in Spanish.

- Hospitals in counties with newly growing Hispanic populations were more likely to report "high" or "very high" demand for Spanish interpretation in the emergency department (ED), outpatient (OP), and inpatient (IP) than those in counties with stable Hispanic populations. Hospitals in high-growth counties were also more likely to report having tools for patients to communicate their language needs and documents or materials in Spanish.

- Rural hospitals adjacent to a metropolitan area were more likely to report "high or very high numbers" of visits by Hispanic patients in need of interpretation services in the ED, OP, and IP and the highest demand for Spanish interpretation was in the ED.

- Lack of state agency resources (65.6%) and the lack of hospital funding for interpretation or translation (65.3%) were most often noted as potential barriers to effective language assistance. Hospitals that voluntarily reported sample or model programs stressed the importance of training interpreters in-house or collaborating with colleges and universities that offer nationally recognized programs.

PRACTICE IMPLICATIONS

The hospitals participating in our study indicate that rural hospitals with LEP Spanish-speaking patients are using a variety of methods to provide linguistically appropriate care and the findings support the following practice implications for the provision of linguistically and culturally appropriate care.

Patient Safety and CLAS Compliance

- Hospital administrators should increase employer knowledge of language assistance programs, resources, and hospital policies pertaining to language assistance so that LEP patients can be identified quickly and directed to the appropriate services to improve access and outcomes.
- Efforts should be made to increase the availability of translated documents, especially in counties with an emergent Hispanic population. Although hospitals reported having educational materials in Spanish, few hospitals reported having documents such as complaint forms or applications to participate in a program or activity translated into Spanish. The language assistance policies should include an effort to translate all documents readily available in English into Spanish as well.
- In addition to the federal CLAS standards, several organizations have provided valuable guidance on how best to implement and maintain language assistance programs. The Joint Commission on Accreditation of Healthcare Organizations and the UCHCAN Ohio Language Task Force provide standards and practical recommendations for language assistance programs.

Staffing and Development Issues

- Hospital administrators in emergent Hispanic population counties should actively recruit and train quality medical interpreters; especially departments with high/very high demand, such as the emergency department.

RECOMMENDATIONS FOR FUTURE RESEARCH

- Given that a large number of rural hospitals are using bilingual employees whose primary role is not interpretation, further research is needed to evaluate the quality of their interpretation services. The research should focus on the correlation, if any, between untrained interpreter quality and the primary workforce role (clerical, front desk staff) and quality of care.
- Some studies have suggested that the lack of language assistance programs in hospitals leads to unnecessary clinical tests and complications. Further research should perform costs analyses of language line interpretation programs and patient outcomes to determine their efficacy.

Chapter 1: Introduction

Increasing health care access for minorities whose primary language is not English requires an examination of the provision of culturally and linguistically appropriate health care. Studies indicate that for Hispanic Spanish-speaking populations, limited English proficiency (LEP) is a barrier to quality health care[1].

There were 40.4 million Latinos in the United States in 2004, an increase of 14% since 2000 (US Census Bureau, 2004, Pew Hispanic Center, 2005). The total US population increased only 13.2% between 1990 and 2000 while the Hispanic population increased by 57.9% (Pew Hispanic Center/Kaiser Family Foundation, 2002). The largest percentage increases in the Hispanic population occurred in the South, with increases as high as 394% in North Carolina, 211% in South Carolina, and 173% in Kentucky (US Census Bureau, 2001). The Hispanic population, the largest and fastest growing minority group representing an estimated 14.2% of the population, is projected to rise to 47.7 million by 2010 and 60.4 million by 2020 (US Census Bureau, 2004; Pew Hispanic Center, 2005).

The Census Bureau estimates that approximately 47 million people speak a language other than English at home (US Census Bureau, 2000). Furthermore, 40% of Hispanics in the United States reported speaking little or no English (Pew Hispanic Center/Kaiser Family Foundation, 2002). Latino patients are often the most unsatisfied with their care due to the lack of interpreter services and studies have shown that only half of LEP patients in need of an interpreter are provided one (Flores & Mendoza, 2002; Brown, Gerzoff, Karter, Gregg, Safford,

[1] The literature on Latino health has no consensus regarding the preferred term to use referring to persons of Latin American heritage who live in the United States. Both Hispanic and Latino are used extensively, although U.S. government documents, including the census, use the term Hispanic. Given this mixed usage in the literature, this report uses the terms Latino and Hispanic interchangeably.

Waitzfelder, et al., 2003). The lack of bilingual medical staff, trained medical interpreters, translated written materials, and cultural competency training contribute to the divide between the LEP patient and the health care system (Flores & Mendoza, 2002; Brown, et al., 2003).

Conversely, the benefits for clients of linguistically appropriate care are well documented. Several studies report that patients treated by language concordant physicians were less likely to omit medication, miss office appointments and visit the emergency room than patients treated by language discordant physicians (Manson, 1996; Carter-Pokras, O'Neil, Cheanvechai, Menis, Fan, Solera, 2004). A recent survey found LEP patients treated by language discordant physicians were four times more likely to report adverse reactions to medicine, but were only twice as likely to report adverse reactions when treated in a linguistically appropriate manner (Wilson, Chen, Grumbach, Wang, Fernandez, 2005). The lack of a language barrier facilitates communication as the patient can clearly understand the clinical diagnosis and suggested treatment (Baker, et al., 1998).

In addition to language, culturally competent care is needed as well to improve health outcomes. Dissatisfaction with the interpersonal aspects of the medical visits could be the result of cultural cues and language barriers, as a component of socio-cultural barriers (Lassetter & Baldwin, 2004; Betancourt, Green, Carrillo, Anneh-Firempong, 2003).

The Office of Management and Budget estimates that $268 million annually, a 0.5% increase in the national health care expenditure, is needed to provide interpreter services in all health care encounters (Ku & Flores, 2005; Flores & Mendoza, 2002). The linguistically isolated have the right to "reasonable, timely, and appropriate language care" under Title VI of the Civil Rights Act (Department of Justice, 2002).

Policy Relevance

Several steps have been taken to ensure that federally-financed services reach all populations in the United States. Congress passed Title VI of the Civil Rights Act of 1964 stating:

> "No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (US DOJ, 1964).

In *Lau v. Nichols*, the Supreme Court ruled that LEP discrimination constituted a violation of the national origin clause in Title VI of the Civil Rights Act and that reasonable measures were needed to ensure equal access for those with primary languages other than English (414 U.S. 563 1974). On August 11, 2000 President Clinton issued the executive order 13166 entitled: "Improving Access to Services for Persons with Limited English Proficiency" (65 Fed. Reg. 50121). After a process of public comment and input, the HHS Office of Minority Health issued the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) on December 22, 2000 (65 Fed. Reg. 80865).

There are 14 CLAS standards, related to three different topics: culturally competent care, language access services and organizational supports for cultural competence (Perkins, 2003). Four of the 14 standards are related specifically to language access, and organizations receiving federal funds are mandated to comply with these standards. The organizations may adopt the remaining ten standards voluntarily, as they are only recommendations or guidelines (Shaw-Taylor, 2002). Hospitals that are not in compliance with CLAS standards are subject to fines and can lose their federal funding (Schroeder, 2002). In addition, hospitals not in compliance face increased legal risks, such as class action lawsuits by LEP patients for not providing translation and interpretation services.

There are few studies that focus on the ability of rural hospitals to meet CLAS standards. The University of Minnesota Rural Health Research Center conducted a study that provided "an in-depth assessment of the response of local rural health care systems to the needs of the growing Latino population in rural Midwest communities" (Casey, et al., 2003). This case study was conducted in three rural communities in Iowa, Kansas and Nebraska. It demonstrates how access to health care for rural Latinos is hampered by lack of transportation as well as limited availability of providers and medical interpreters. However, a single study with a national sample that systematically evaluates how rural hospitals provide assistance to LEP patients was not found in the literature.

Study Purpose and Methods

The purpose of the study is to explore how rural hospitals are meeting the needs of LEP patients. A mail survey was designed to address this question. To ensure that the survey reached rural hospitals most likely to be treating Spanish speaking LEP patients, we focused on hospitals in rural counties that experienced substantial growth in their Hispanic population between 1990 and 2000 as well as those with large stable Hispanic populations. The study is national in scope. Surveyed hospitals were selected from among all rural counties experiencing a growth in Hispanic population of 200% or more between 1990 and 2000, and are representative of high-growth regions.

Research Objectives

The objectives of this study are to:

- Describe the institutional and environmental characteristics and conditions relevant to the provision of culturally and linguistically appropriate health care to LEP clients;
- Describe the areas where LEP patients receive care in rural hospitals by Hispanic growth and county location;
- Determine the extent to which rural hospitals have implemented language assistance programs;
- Compare the language assistance resources between hospitals located in counties with emergent (high Hispanic growth) or non-emergent Hispanic populations (large stable Hispanic population);
- Compare the language assistance resources between rural hospitals located in counties adjacent and those non-adjacent to metropolitan areas;
- Ascertain the factors (strengths and barriers) associated with the provision of language assistance to Hispanic clients;
- Identify sample programs in rural hospitals being used to facilitate the provision of linguistically and culturally competent health care to Hispanic clients;
- Describe the approaches that rural hospitals perceive to be most effective for the provision of linguistically and culturally competent health care to Hispanic clients.

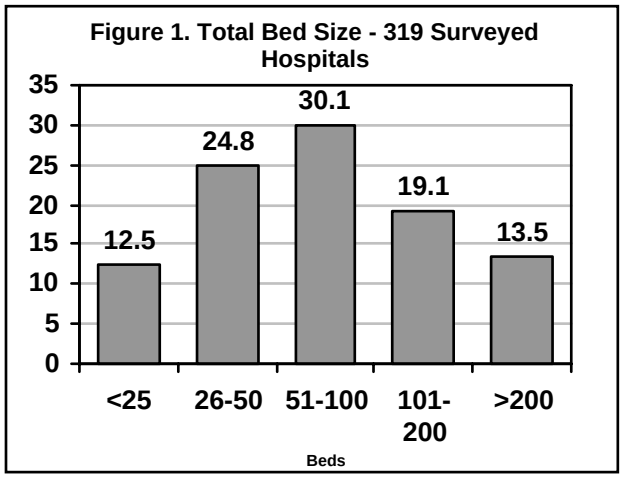
Information on rural hospitals was collected using a mailed survey. Appendices provide (A) a detailed description of the methods, (B) the designed survey instrument used in the study, (C) detailed tables, (D) sample local programs, (E) a list of CLAS standards, and (F) a list of Joint

Commission Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care crosswalked to CLAS standards.

Chapter 2: Results

Characteristics of Responding Hospitals

We surveyed 841 rural hospitals, of which 319 (37.9%) responded after three mailings. The majority of responding hospitals (67%) have 100 beds or less (Figure 1) and about a third of the surveyed hospitals have more than 100 beds. Nearly all hospitals (92%) have emergency departments (Table C-2, Appendix C) and two thirds reported having hospital-based outpatient services. Seventy-two percent of the surveyed hospitals offer obstetric services and about 60% offer "uncomplicated" obstetric level of care. About two thirds (67%) of hospitals offer hospital-based outpatient services.



County Level Demographic Information

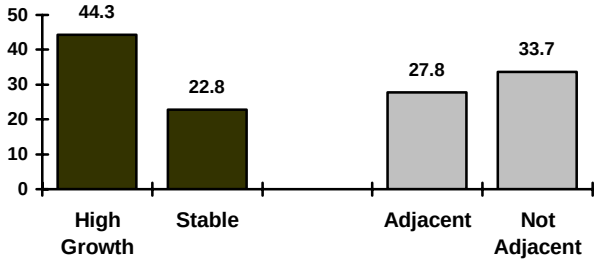
About half (52%) of responding hospitals were located in rural counties with urban populations between 2,500 and 19,999 and about half (55%) were located adjacent to a metropolitan area. Two of every five responding hospitals (40%) were the only hospital in the county, while approximately half (50%) were located in counties with two to three total hospitals and (10%) were located in counties with more than three hospitals. About a third of the hospitals (32%) were in counties with substantial Hispanic population growth between 1990 and 2000. According to the 2000 Census, the mean percent population in poverty in counties where the respondent hospitals were located, was about 13% (Table C-1, Appendix C).

Responding hospitals were located in counties with similar characteristics as those in the original sample (Table C-1, Appendix C).

Where LEP Patients Are Seen

We asked hospital administrators to estimate the number of LEP patients seen per month and to indicate via a checklist the departments within the hospital which saw large numbers of LEP patients. The majority of responding rural hospitals (69.6%) reported serving less than 100 LEP patients per month (Table C-4, Appendix C). However, about 30% reported providing services to larger numbers of Hispanic patients (100-999) per month. Proportionately, twice as many hospitals ($p<0.05$) located in rural areas with high Hispanic population growth in the last ten years reported seeing between 100 and 999 patients a month compared to hospitals in counties with large stable Hispanic populations (Figure 2, right). Adjacency to a metropolitan area was not related ($p<0.05$) to the reported number of Hispanic patients served per month.

Figure 2. Proportion of Hospitals seeing 100 or more patients per month, by Hispanic growth and adjacency to a metropolitan area



Hospitals were more likely to report "high" or "very high" numbers of visits by Hispanic patients needing interpretation services for the emergency department (ED), compared to outpatient (OP) and inpatient (IP) services (See Table 1). High perceived need for interpretation services in the ED was common across both high-growth and stable Hispanic population counties and among hospitals in counties that were or were not adjacent to metropolitan areas. Across all units, however, hospitals in counties with high-growth Hispanic populations reported

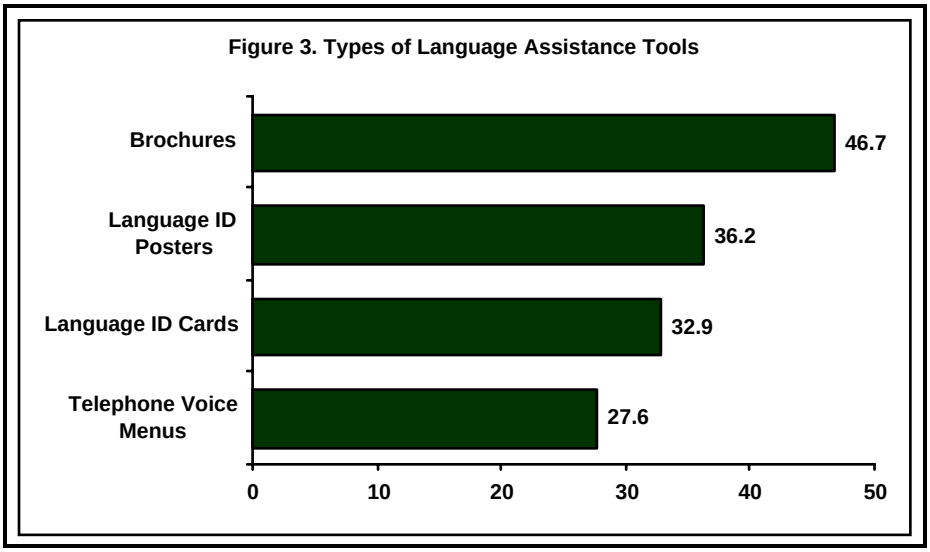
significantly ($p<0.05$) higher proportions of "high or very high" demand for Spanish interpretation than those in hospitals located in counties with stable Hispanic populations.

Table 1. Demand for Spanish Interpretation in the Emergency Department (ED), Outpatient Department (OP), and Inpatient Area (IP)

	ED		OP		IP	
	No.	%	No.	%	No.	%
High/Very High	111	50.3	73	33.2	64	28.2
Low	72	32.6	101	45.9	117	51.5
Almost never	35	15.8	42	19.1	42	18.5

Implementation of Language Assistance Programs

Virtually all hospitals have tools for their patients to communicate their language needs to the hospital's staff (91.7%;). The most commonly used tools by hospitals were brochures, posters, cards and telephone voice menus (Figure 3)

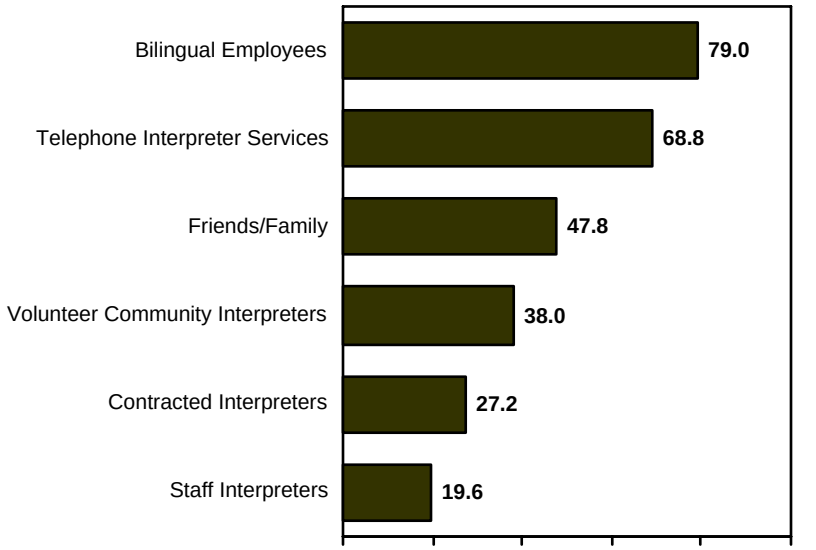


Note: Numbers add to more than 100% because the categories are not mutually exclusive

Almost every hospital reported providing oral interpretation to Spanish-speaking patients (98.7%). The most commonly used resources by hospitals to provide oral interpretation are bilingual employees whose primary role is not interpretation, telephone interpreter lines and

friends or family. It is important to note that some hospitals mentioned that the use of family and friends as interpreters was the patients' choice, not the hospital's preference. A low percentage (19.6%) of hospitals reported having interpreters on staff whose primary workforce role is to provide interpretation for LEP Spanish-speaking patients.

Figure 4. Resources for the Provision of Oral Interpretation - Spanish-Speaking Patients



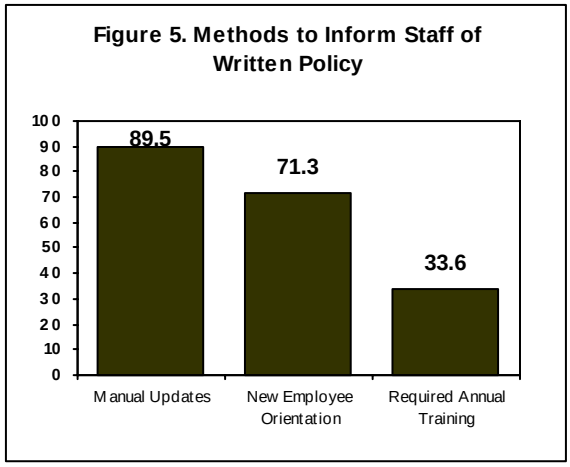
About eighty-six percent of hospitals reported having documents or materials available in Spanish. The main documents in Spanish were the patients' bill of rights (81.1%), consent forms (72.4%) and health education materials (71.9%). About forty percent reported having notices in Spanish about free language assistance, yet the nature of this question limited survey respondents to either a "yes" or "no" response. We are unable to determine the proportion of respondents with such notices in English or those that lack any notices about free language assistance.

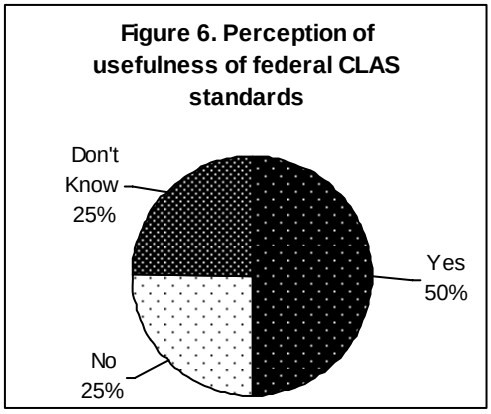
Language Assistance Services by Hispanic Growth and County Location

Compared to hospitals located in counties with stable Hispanic populations, a significantly ($p<0.05$) higher percentage of hospitals located in counties with high-growth populations reported having tools for patients to communicate their language needs and documents or materials in Spanish (Table C-6, Appendix C). Hospitals adjacent to metro areas reported a slightly higher percentage of documents and materials in Spanish compared to those not adjacent to metropolitan areas (Table C-6, Appendix C), but the difference was not statistically significant ($p<0.05$).

Hospital Policies

Seventy-eight percent of hospitals reported having a written policy related to language assistance. The majority informed the staff about the policy through policy and manual updates and during new employee orientation (Figure 5, right). The categories are not mutually exclusive because hospitals can employ more than one method of informing staff about language assistance. The vast majority of hospitals reported having the policy in place for more than 2 years (86.9%). Half (50.0%) responded that the Federal Guidelines were useful in writing that policy, while a quarter (25.2%) indicated the guidelines were not helpful and the remainder indicated either that Federal guidelines did not apply in their case or that they did not know. Those





who indicated the guidelines did not apply in their case could have written language assistance policy predating the issuance of the CLAS standards. Results were the same among hospitals in high-growth and stable Hispanic populations, and among counties adjacent and not adjacent to metropolitan areas.

Factors (Strengths and Barriers) Associated with Language Assistance

Summary of Strengths and Barriers

Hospitals located in emergent and non-emergent Hispanic growth counties as well as those adjacent and not adjacent to metropolitan areas ranked institutional support for language programs as the greatest strength for the provision of language assistance to Spanish-speaking LEP patients. The top barrier for emergent and adjacent counties was resources from state agencies. Non-emergent counties ranked funding for interpretation and translation as the most important barrier. However, the more rural non-adjacent metropolitan hospitals cited the main barrier as the lack of local language training programs. (See Appendix B for more details)

The survey asked hospitals whether a list of potential factors were strengths or barriers when trying to provide language assistance to Spanish-speaking patients in their settings (Table 2, next page).

Table 2. Top 5 Strengths and Barriers for Providing Language Assistance to Spanish Speaking Patients

Rank	Strength	No.	%
1	Institutional Support	252	94.0
2	Access to telephone interpreter lines	237	89.1
3	Staff willingness to use interpreter	243	86.5
4	Quality of telephone interpreter lines	198	85.0
5	Bilingual staff	206	72.8
	Barrier		
1	State agency resources (e.g. Health Department)	103	65.6
2	Funding for interpretation or translation	141	65.3
3	Local language training programs	110	59.1
4	Access to bilingual volunteers	106	44.5
5	Interpreter response time	70	27.6

The top five strengths reported by hospitals included: institutional support (94%) for their language programs, access to telephone interpreter lines (89.1%), staff willingness to use interpreters to serve Spanish-speaking patients (86.5%), quality of telephone interpreter lines (85%) and bilingual staff (72.8%; Table 2).

The rankings in Table C-12 (Appendix C) show that among hospitals in counties with high Hispanic growth, bilingual staff is not listed but "interpreter response time" appears among the top five strengths. Conversely, in hospitals located in counties with non-emergent Hispanic population, the interpreter response time is not among the top five strengths reported. Note that these non-emergent hospitals ranked higher quality of interpreter lines. The quality of telephone interpreter lines was not highly ranked as a strength among hospitals adjacent to metropolitan areas (Table C-13, Appendix C).

In general, the top barrier for the provision of language assistance to Spanish-speaking patients, encountered by the majority (65.6%) of surveyed hospitals is the lack of state agency resources (Table C-11, Appendix C). This was especially true for hospitals located in counties with emergent Hispanic population (Table C-12, Appendix C) and hospitals adjacent to metropolitan areas (Table C-13, Appendix C). Funding for interpretation or translation services was marked as a barrier for about two thirds of the hospitals (65.3%) and was the main barrier faced by hospitals located in areas with lower Hispanic growth (Table C-12, Appendix C) and hospitals not adjacent to metropolitan areas (Table C-13, Appendix C). Several respondents expressed that funding was the key factor to a hospital's ability to implement federal mandates.

Lack of local training programs was a barrier for hospitals providing language assistance. In addition, compared to hospitals located in areas with higher Hispanic growth, a higher proportion of hospitals in non-emergent Hispanic populations reported the lack of local training programs as a barrier (Table C-12, Appendix C).

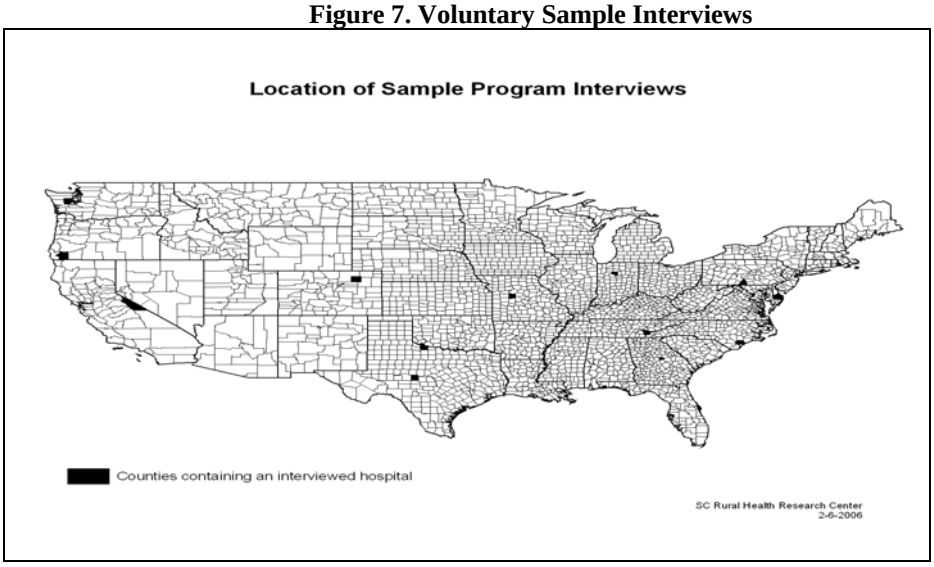
Other barriers reported were access to bilingual volunteers, interpreter response time and bilingual staff.

Chapter 3: Sample LEP Programs

Beyond the survey: looking for local approaches

There are variations among the approaches used by rural hospitals in providing linguistically and culturally competent health care for LEP patients in their communities. A follow-up interview was conducted with voluntary hospital representatives to capture the variety of programs being used. We asked if their individual hospitals had sample programs for interpreter services that could be shared with others. This follow-up interview was not intended as scientific qualitative research, rather as an investigative tool to elicit practical information for hospital administrators of rural hospitals in various states (Figure 7).

Figure 7. Voluntary Sample Interviews



We contacted thirteen hospitals that have, or were in the process of creating, a language assistance program for LEP clients. Hospitals in rural areas of Texas, Pennsylvania, Georgia,

Tennessee, Delaware, Oregon, Washington State, North Carolina, Colorado, Missouri, Indiana and California responded. Hospital characteristics are delineated below (Table 3).

Table 3. Characteristics of Sample Program Hospitals

HOSPITAL	HIGH HISPANIC GROWTH	WRITTEN POLICY	FT STAFF INTERPRETER	INTERPRETER TRAINING	STAFF DEVELOPMENT	COMMUNITY OUTREACH
A		**X**	**X**	**X**		**X**
B					**X**	
C	**X**		**X**			**X**
D					**X**	
E	**X**	**X**	**X**	**X**	**X**	**X**
F	**X**		**X**	**X**		
G	**X**		**X**		**X**	**X**
H				**X**		
I			**X**	**X**	**X**	**X**
J	**X**				**X**	
K		**X**			**X**	
L			**X**	**X**		
M			**X**		**X**	**X**

Hospital-specific case studies are described in more detail in Appendix D. Open-ended questions, such as "What would you like to share about your program with others?", conducted in English or Spanish, probed for information about the language assistance programs and resources available to support those programs. Certain themes became clear regarding the hospitals' local approaches to the provision of language assistance services. The themes are (a) organizational structure/policy development, (b) financial viability, (c) access to interpreters for LEP patients, (d) interpreter training, and (e) community involvement.

Organizational structure that supports language assistance was consistently mentioned in the interviews, as evidenced by the survey results. A Texas hospital has a written document detailing the language assistance policy as well as interpretation procedures. Another administrator provided his hospital's policy development process as a blueprint for success. A hospital representative in Pennsylvania stressed the value of her organization's commitment to

diversity in its hiring practices. It was noted that her hospital displays flags representing all the nationalities and states of those on staff. The display was a symbol of the organization's commitment to diversity and cultural sensitivity.

The theme of the financial viability and cost-effectiveness of language assistance programs in resource limited environments emerged from the interviews. The respondents detailed the business case behind employing traditional solutions such as hiring interpreters in-house or using telephone language lines and outside contractors. A Washington hospital currently budgets approximately $85,000 annually for interpretation services. The hospital representative mentioned the hospital is small and has only had 24/7 interpreter service for three years. Small rural hospitals, often with less financial resources than other institutions, could face financial difficulties in their attempts to provide language assistance. Other respondents mentioned the cost of telephone language lines and that these services can potentially become a drain on the available resources. Some hospitals spend $70 to $2000 each month on the phone line. A Missouri hospital tallies the expenses of the language line, an estimated $1000-$2000 each month, separately from the interpreter services to monitor the usage of the line by individual departments. An Oregon hospital is currently hiring for in-house interpretation services due to expensive interpreter contracts which can cost $15,000-$18,000 each month.

Unencumbered access to Spanish interpreters was another theme to emerge from the key informant interviews. All hospitals have created systems to provide interpretation services 24/7. Some have full-time interpreters during the day and call lists during the nights and holidays. Language interpretation telephone lines are widely used but the majority of hospitals use them during the night, holidays or in case of emergency when the interpreter is not readily available. Interpreters in at least three hospitals said they lived close by and they did not have a problem

providing interpretation services during nights and holidays. Some hospitals have established creative partnerships with other organizations to provide interpretation services. In exchange for health care services provided to inmates from a local detention center, interpretation services are provided by detention center staff at the hospital. Another hospital uses the language line through the sheriff's department for free. Many of the hospitals train other staff in the identification of LEP patients and the facilitation of the language assistance process.

As hospitals work to provide access to interpreter services for LEP patients, they must also work to ensure the quality of those services. Many of the hospitals mentioned the need for interpreter training during the interviews. Some hospitals have a bilingual health professional on staff in charge of interpretation but others require certification of interpreters. One hospital has developed an interpreter certification program in partnership with a local college that is accredited by the state's Board of Higher Education. The 32-hour curriculum includes information on medical terminology and HIPAA regulations. Other hospitals send staff to medical interpretation trainings. Some of the hospitals also provide beginning and intermediate Spanish classes to medical personnel. However, a hospital representative stressed that such courses can lead to overconfidence by personnel with harmful effects to patients if used as an alternative to qualified medical interpreters.

The provision of linguistically appropriate care provides an opportunity to foster better relationships between the health care system and the Hispanic communities. The efforts included care coordination services and facilitation and empowerment activities for the community. Some of the interpreters in hospitals also help patients make appointments, call other agencies and coordinate transportation services in the area. A Pennsylvania hospital representative described the actions of a task force comprised of members from the Community

Hispanic Center in partnership with the hospital. Task force members worked with ministers in the community creating a cultural diversity kit that hospital employees can use with LEP patients. Other hospitals offer cultural sensitivity training to their employees and inform the Hispanic community about their employees trained in culturally appropriate techniques.

The local approaches to the provision of linguistically and culturally competent health care for LEP Spanish-speaking patients were varied. A regional pattern regarding the provision of such care was not observed. The hospitals did have commonalities, such as full-time staff interpreters, interpreter training and efforts to develop culturally competent staff familiar with linguistically appropriate care. The lack of regional specificity highlights the generalization of such programs to most rural hospitals with a significant LEP Spanish-speaking population.

Chapter 4: Conclusions and Practical Implications

Summary of Findings

Rural hospitals in the United States are adopting a variety of measures to serve the LEP Hispanic/Latino population. Although virtually all hospitals surveyed have tools for patients to communicate their language needs to the hospital's staff through hospital brochures, language identification posters, language identification cards or telephone voice menus, less than 40% have notices in Spanish about free language assistance. The remaining respondents have such notices in English or none at all. About three fourths of the hospitals reported having a written policy related to language assistance. The staff learns about the policy through policy and manual updates and during new employee orientation. This suggests that rural hospitals across the nation have made a commitment to language assistance programs despite differences in bed size, resources and the size of the Hispanic population in various counties.

Findings on Existence of Language Assistance Programs

Almost every hospital reported providing oral interpretation to Spanish-speaking patients. A large percentage of the surveyed hospitals are using bilingual employees, whose primary role is not interpretation, or telephone interpreter lines. Friends or family also interpret for patients; however, some of the hospitals mentioned that the use of family and friends as interpreters was the patients' choice, not the hospital's preference. Hospital administrators should be aware of the potential HIPAA violations of family and friends interpreting private health information. Another potential patient safety issue is the filtered transmission of information from the patient to health care provider via an interpreter. Also at issue is the problem of potential filtering of information by informal interpreters who might selectively decide which information is pertinent

to the provider or self-filtering by the patient who might be uncomfortable conveying sensitive health information to the informal interpreter. Only about 20% of hospitals reported having interpreters on staff whose primary workforce responsibility is interpretation.

A large percent of hospitals reported having documents or materials available in Spanish, including the patients' bill of rights, consent forms and health education materials. However, only about 40% of the respondents reported having Spanish notices about the free language assistance for LEP Spanish-speaking patients, which indicates a need for more publicity to the targeted population.

Effect of High Hispanic Growth and Metro Adjacency on Language Assistance

Significantly more hospitals located in rural areas with high Hispanic population growth in the last ten years reported seeing between 100 and 999 patients a month compared to hospitals in non-emergent Hispanic population. In addition, hospitals in counties with emergent Hispanic populations reported significantly higher proportions of "high or very high" demand for Spanish interpretation in the ED, OP, and IP than those in hospitals located in counties with non-emergent Hispanic populations.

Compared to hospitals located in counties with non-emergent Hispanic populations, a significantly higher percentage of hospitals located in counties with emergent populations reported having tools for patients to communicate their language needs and documents or materials in Spanish.

Adjacency to a metropolitan area did not make a difference regarding the amount of Hispanic patients served per month when compared to rural hospitals in counties non-adjacent to metropolitan areas. However, rural hospitals adjacent to a metropolitan area were more likely to report "high or very high numbers" of visits by Hispanic patients in need of interpretation

services in the ED, OP, and IP than rural hospitals in counties not adjacent to a metropolitan area.

Strengths and Barriers to the Provision of Language Assistance Programs

The main strengths hospitals reported to be related to the provision of language assistance to Spanish speaking patients were, in decreasing order, institutional support, access to telephone interpreter lines, staff willingness to use an interpreter, quality of telephone interpreter lines and access to bilingual staff. About two thirds of the hospitals said that the most significant barriers to language interpretation for Latinos were the lack of state agency resources and the lack of hospital funding for interpretation or translation. Other barriers mentioned were the lack of local training programs and access to bilingual volunteers. Interpreter response time was a barrier for the provision of language assistance among a third of the hospitals.

Local Approaches to the Provision of Language Assistance Programs

Hospitals that voluntarily reported sample or model programs stressed the importance of training interpreters in-house or in colleges that offer nationally recognized programs. Partnerships with local colleges, agencies, and others are critical to the provision of high quality interpretation services. Several hospitals that have interpreters in-house are also developing outreach programs for Hispanics and training hospital staff on the best use of interpreters. The sample programs provide valuable information regarding the characteristics of successful language assistance programs and the adaptability to other areas.

The findings of this study validate previous recommendations for hospital interpreter services. The Language Task Force of Universal Health Care Action Network of Ohio has provided such recommendations in a blueprint for success. Their twelve recommendations are supported by the study findings and can be generally applied by hospital administrators. In an

effort to provide language assistance in compliance with Title VI of the Civil Rights Act, the UHCAN Ohio Language Task Force suggests hospitals should:

- Establish a coordinator or supervisor of interpreter services;
- Create a pool of well qualified medical interpreters;
- Establish uniform interpreter training requirements;
- Establish ethical standards for interpreters;
- Create written language assistance policy and procedures;
- Collect utilization data on LEP patients;
- Create a interpreter services task force;
- Translate all written materials (policies, signs, handouts, etc.);
- Encourage hiring of bilingual employees;
- Provide cultural competency training;
- Effectively monitor need for language assistance programs;
- Allocate sufficient resources for interpreter services and language assistance programs (UHCAN Ohio, 2003).

Strengths and Weaknesses of Study

A mail out survey typically garners a low response rate from the study participants which limits the information collected. In an attempt to proactively encourage prompt responsiveness, the survey was limited to ten questions on one page. The participants were also given the opportunity to choose their response mechanism, either by mailing the completed paper survey or completing an identical Internet version of the survey. It is interesting to note that the paper response rate far exceeded the Internet survey response rate. The Center also mailed a picture of

the researchers to the participants with an earnest plea to complete the survey with the third and final mailing. This prompted the highest response rate of all the mailings.

The design of the survey also limits the responses of the participants to the demand for language assistance services and the types of services available. In an effort to gain as much information as possible, the survey was followed up by interviews with voluntary participants. While providing valuable qualitative data, this interview was not designed as a structural qualitative research instrument.

Practice Implications

Studies have indicated that Spanish-speaking LEP patients are most unsatisfied with their care and often experience poor outcomes when not able to access health care in a linguistically appropriate way; furthermore, when federally mandated linguistically appropriate care is provided, these outcomes often improve (Brown, et al., 2003; Wilson, et al., 2005). This study shows that rural hospitals with LEP Spanish-speaking patients are aware of the need for linguistically appropriate care and these hospitals have taken appropriate measures to improve the access to care for those patients.

Patient Safety and CLAS Compliance: Accreditation

Prior research indicates that the lack of linguistically appropriate care has been linked to negative health outcomes (Wilson, et al, 2005). Adherence to the CLAS standards is more than a regulatory exercise, but also a critical patient safety concern. Hospital administrators should implement or improve policies conducive to the CLAS standards in an effort to provide the best quality care for LEP patients and as a good business practice to prevent potential Title VI and HIPAA infractions.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent accrediting body which evaluates the quality of care and patient safety for hospitals and other health care organizations (JCAHO, 2005). Hospitals with JCAHO accreditation must undergo a stringent qualification and accreditation process which evaluates the services offered by the health care organization; the accreditation is valid for three years. JCAHO has analyzed the CLAS standards and highlighted JCAHO standards that are similar in purpose to the OMH CLAS standards (JCAHO, 2004). Hospital administrators should be aware that possible CLAS violations also put institutions at risk of failing to meet certain Joint Commission standards. Certain JCAHO standards related to ethics, provision of care and services, leadership and human resources management are directly related to the CLAS standards and adherence to these can have a positive effect on the delivery of quality and appropriate health care. Appendix F lists the crosswalk with the CLAS standards, corresponding JCAHO standards, and pertinent comments from the accrediting body.

The Joint Commission also has a project specifically related to the provision of language assistance programs. The Hospitals, Language, and Culture Project, an ongoing effort to provide culturally and linguistically appropriate health care, seeks to provide real-world applications for the current federal mandates and JCAHO standards which hospital administrators can apply to their health care organizations. The staff visit hospitals and provide feedback and suggestions for improving the provision of such care. The Joint Commission has also implemented a new requirement that language preference be recorded in medical records (JCAHO, 2005). A white paper detailing the public policy of health literacy and patient safety was recently released by the Joint Commission and a study evaluating adverse events in LEP patients was recently approved (JCAHO, 2005).

A potential gap in the health care system could lie with rural hospitals who are not JCAHO accredited. One solution may be to have state hospital associations serve as a resource to unaccredited rural hospitals. In addition, the CLAS standards and JCAHO standards are available publicly and can be used to create language assistance programs. The CLAS mandates, JCAHO standards and the UHCAN Ohio blueprint provide a more than adequate basis for hospital administrators to create, implement and evaluate language assistance programs in rural hospitals.

Staffing and Development Issues

Hospital administrators in emergent Hispanic population counties should actively recruit quality medical interpreters; especially departments with high/very high demand, such as the emergency department. In hospitals with limited resources, the human resources department should actively recruit bilingual applicants for relevant job openings.

The hospitals in our study depend heavily on bilingual employees to meet the high or very high demand of Spanish interpretation in rural Hispanic emergent counties. Local institutions and administrators should consider recruiting and training bilingual and culturally competent health providers to work in rural counties with a high Hispanic population. The existence of a diverse workforce could positively impact the health of minority patients in an effort to reduce health disparities.

Hospitals administrators should also create a position for a supervisor of interpreter services. Hospitals using in-house or contracted interpreters should have an effective method for monitoring and evaluating the interpreting staff. Hospitals using bilingual employees should clearly articulate in the language assistance policy any additional compensation for those bilingual employees fulfilling dual roles. The interpreter coordinator or Human Resources

should work to schedule bilingual employees in order to provide round-the-clock access to interpreter services to best serve the LEP population. This position will most likely be filled by adding the responsibility to an existing position, such as the Director of Nursing or Director of Human Resources.

Hospital administrators should also increase the knowledge of language assistance programs, resources and hospital policies pertaining to language assistance to employees so that LEP patients can be identified quickly during the intake process and directed to the appropriate services to improve access and health outcomes. Cultural respect for authority figures might deter some Hispanics from asking for an interpreter when needed and non-verbal cues, such as nodding, could symbolize respect, not an understanding of the information (Lasseter & Baldwin, 2004). These staff development sessions and policy procedures should include effective, yet culturally appropriate ways of asking Spanish-speaking LEP patients about their need for language assistance.

Efforts should be made to increase the availability of translated documents, especially in counties with an emergent Hispanic population. Although hospitals reported having educational materials in Spanish, few hospitals reported having documents such as complaint forms or applications to participate in a program or activity translated into Spanish. The language assistance policies should include an effort to translate all documents readily available in English into Spanish as well. These translated materials should be made available and accessible to Spanish-speaking LEP patients; language assistance services should also be well-publicized in Spanish to effectively reach the target population.

Areas for Future Research

Given that a large number of rural hospitals are using bilingual employees whose primary role is not interpretation, further research is needed to evaluate the quality of their interpretation services. The research should focus on the correlation, if any, between untrained interpreter quality and the primary workforce role (clerical, front desk staff) and quality of care.

Some studies have suggested that the lack of language assistance programs in hospitals leads to unnecessary clinical tests and complications (Wilson, et al, 2005; Manson, 1996). Further research should perform costs analyses of language line interpretation programs and patient outcomes to determine the cost of unnecessary services to LEP patients. A study of geographic variation could also provide information on a correlation, if any, between health disparities witnessed in rural and urban LEP patients dependent on the type of language assistance available to them.

Appendix A: Methods

Design and Procedure

We conducted a cross sectional study using a survey mailed to rural hospital administrators in the United States. The survey was developed based on the Federal standards for culturally and linguistically appropriate services. It was reviewed by experts (researchers and staff from the Office of Rural Health) and then pre-tested among several hospital administrators resulting in the final survey instrument (Appendix B).

The survey procedure was conducted using three mail-outs: an initial mailing on May 6, 2005, followed by a second mailing four weeks later and a final mailing three weeks after the second. A reminder postcard was also mailed four days after the final mailing. Each of the three survey mailings included the single-page survey instrument accompanied by a cover letter and a self-addressed envelope with prepaid postage. Also contained within the cover letter were instructions on how participants who chose to do so could complete the survey instrument online using an internet-hosted survey form, utilizing a private URL and a unique user identification code supplied within the cover letter. The final reminder postcard also contained this information. Secondary data pertaining to county characteristics used in sample selection and analyses came from the 2003 Area Resource File. Information about hospital characteristics, beyond that obtained by the survey, was drawn from the 2000 American Hospital Association Annual Survey Database.

Returned surveys were coded and entered into a database using EpiData with appropriate check fields and entry skip patterns to ensure proper data entry. Comment fields were also recorded and coded, with content reduction performed at a later date. After the conclusion of the data entry phase, every tenth completed print survey was selected for validation by checking the

contents against the respective record in the database. The print survey data was then combined with the online survey response data and duplicate entries between them were removed, favoring the earlier survey received. The final master data set was then created by merging additional hospital and county-level variables (from the 2000 AHA Annual Survey and the 2003 Area Resource File, respectively) for all sample hospitals with the survey response data.

Interview

Survey respondents who answered "yes" to the survey question: "Are you a rural hospital with a 'model' program for translation/ interpretation services? Would you like to share your program with others?" were interviewed by phone. Administrators from 13 hospitals shared, in English or Spanish, details of programs designed to assist Spanish-speaking patients. The notes from the telephone conversation were sent to the respondents and five contacted the Rural Health Research Center giving permission to publish their reports.

Sample Selection

The sample was drawn on the basis of county characteristics, to reflect the study's goal of assessing services for LEP patients among both stable and emerging Hispanic populations. Using data from the 2003 Area Resource File, U.S. counties were selected (n=554) with the following attributes:

- designated as rural using Metropolitan Statistical Area classifications,
- having at least one hospital within the county as of 2001,
- having a base Hispanic population in 2000 as reported in the 2000 U.S. Census of at least 600 persons and
- having an increase in Hispanic population from 1990 to 2000 of greater than 25%.

Counties with greater than 200% increase in the Hispanic population from 1990 to 2000 were characterized as "high growth." (Table C-1, Appendix C)

After counties had been selected, we identified all hospitals in those counties using the 2000 AHA Annual Survey. All hospitals operated by the Federal government were excluded from the sample, including military hospital facilities. The sample of hospitals in the initial mailing contained 856 facilities.

Each survey mailing was addressed to the hospital administrator for each hospital in the sample as identified in the 2000 AHA Annual Survey file. In cases where mailings were returned by the postal service for any reason (insufficient address, no proper receptacle, person not known, etc.), a corrected name or address was sought using the 2005 AHA Hospital Guide or other online resources. If a correction was found, subsequent mailings were sent to the corrected name and address. If a hospital was positively identified as closed, it was removed from both subsequent mailings and the sample. Also, if mailed material addressed to any single hospital was returned on every mailing, the hospital was removed from the sample. Hospitals for which address information was initially incorrect, but for which correct information was obtained, were retained in the survey. Finally, one former hospital facility was removed from the sample upon confirmation that they were currently operating as an assisted-living facility. The table below shows the response rate for each mailing and the total response rate of 319 hospitals.

Response by Mailing Period

Mailout #	*Surveys Received by Completion Method*		*# Surveys Mailed*	*Mailout Response Rate*
1	*Print*	93		
	Online	23		
			841	13.8%
2	*Print*	47		
	Online	13		
			725	8.3%
3	*Print*	131		
	Online	12		
			665	21.5%

Final Response Rate = 37.9%

The final sample of valid hospitals totaled 841. All respondents were asked to voluntarily identify programs in their hospitals that exemplified the provision of linguistically and culturally appropriate services; 13 hospitals voluntarily identified sample programs.

Measurement

See Appendix B for a reproduction of the survey. An online version of the survey was created to mirror the structure of the printed survey. Particular attention was given to ensure that any possible combination of responses that could be created on the printed version of the survey (including those appearing to be contradictory or invalid) could also be selected on the online version of the survey. For example, since a respondent could fail to follow a directed skip pattern or choose to select multiple exclusive responses on the printed survey, the online version similarly did not enforce any skip patterns or restrict multiple responses per question, outside of directions in the survey text to do so. Also, access to the online version of the survey was limited to sample participants using unique user identification codes for each hospital, which also protected against duplications in survey completion.

Analysis

Chi-square tests were used to analyze the data. Chi squares with p-values less than 0.05 were considered statistically different. Due to a printing error in the third mailing, some data were missing: the number of Spanish-speaking patients served each month, the demand for interpretation in the ED, IP, and OP, the use of tools in language assistance, and the provision of interpretation and translation services. Instead of a sample size of 319 hospitals, for those questions, the sample size ranged from 216 to 229 and calculations were performed accordingly.

Results of the interviews were analyzed using qualitative analysis of the primary themes. The themes were (a) organizational structure/policy development, (b) financial viability, (c) access to interpreters for LEP patients, (d) interpreter training, and (e) community involvement.

Appendix B: Survey

Are you a rural hospital with a 'model' program for translation/ interpretation services? Would you like to share your program with others?

[ ] Yes! We believe our hospital has a model program for translation and interpretation services for our Spanish-speaking patients and we would like to share.

[ ] Yes! We believe our hospital has a model program for translation and interpretation services for our patients who speak _____ and we would like to share.
(Print language)

Please contact:

Name: _____

Title: _____

Name of Hospital: _____

Address: _____

_____

_____

Phone: _____

Email: _____

What is the best way to reach you to schedule a telephone call?

[ ] Phone [ ] Email

Please return the survey to the South Carolina Rural Health Research Center using the envelope provided.

Thank you!

Rural Hospitals and Limited English Proficiency Patients (Spanish speakers)

South Carolina Rural Health Research Center

Arnold School of Public Health

220 Stoneridge Drive, Ste. 204

Columbia, SC 29210

P: 803-251-6317

F: 803-251-6399

rhr.sph.sc.edu

UNIVERSITY OF SOUTH CAROLINA

Please circle the answer that best describes your hospital.

Demand for Services

1. On average, how many Spanish-speaking patients needing language assistance do you serve each month (all services, all departments)?

a. Less than 100 b. 100 – 999 c. 1,000 – 2,999 d. 3,000 or more

2. What is the demand for Spanish interpretation services in your hospital's:

	Very high	High	Low	Almost Never	Don't know
Emergency Department	4	3	2	1	DK
Outpatient Department	4	3	2	1	DK
Inpatient Area	4	3	2	1	DK

Services Available

3. What tools do you have that help Spanish-speaking patients communicate their language needs? *(Circle all that apply).*

a. We don't have any tools
b. Language identification cards
c. Hospital brochures
d. Language identification posters
e. Telephone voice menus
f. Other, specify:_____

4. Does your hospital provide oral interpretation for Spanish-speaking patients?
[ ] No [ ] Yes *(if Yes, please circle all the ways you provide oral interpretation):*

a. Contracted interpreters
b. Employee interpreters whose primary role is interpretation
c. Bilingual employees whose primary role is not interpretation (i.e. nurses, administrative assistants, housekeeping staff)
d. Volunteer community interpreters or community based organizations
e. Friends or family
f. Telephone interpreter services
g. Other, specify:_____
_____

5. Does your hospital have documents or materials available in Spanish?
[ ] No [ ] Yes *(if Yes, please circle all the materials available in Spanish):*

a. Intake forms
b. Complaint forms
c. Consent forms
d. Eligibility forms
e. Patients bill of rights
f. Health education materials
g. Notices about free language assistance
h. Applications to participate in a program or activity
i. Other. _____

6. Does your hospital have a written policy regarding language assistance?

a. No If no, please skip to Question 10
b. Yes Please answer Questions 7 through 11

7. How does your hospital inform staff of the hospital's written policy? (Circle all that apply)

a. New employee orientation
b. Policy and procedure manual updates
c. Required annual training
d. Other. Specify _____
_____

8. How long has your written policy regarding language assistance been in place?

a. less than 2 years b. 2 to 4 years c. More than 4 years

9. Were the Federal guidelines for Limited English Proficiency (LEP) patients helpful in writing your policy?

a. No b. Yes c. Does not apply

10. For each of the issues below, please circle if it is a strength or barrier for providing language assistance to your Spanish-speaking patients at your hospital.

a. Institutional support	Strength	Barrier	Does Not Apply
b. Funding for interpretation or translation	Strength	Barrier	Does Not Apply
c. Bilingual staff	Strength	Barrier	Does Not Apply
d. Access to bilingual volunteers	Strength	Barrier	Does Not Apply
e. Access to telephone interpreter lines	Strength	Barrier	Does Not Apply
f. Quality of telephone interpreter lines	Strength	Barrier	Does Not Apply
g. Local language training programs	Strength	Barrier	Does Not Apply
h. State agencies' resources (e.g., Health Dept.)	Strength	Barrier	Does Not Apply
i. Staff willingness to use interpreter	Strength	Barrier	Does Not Apply
j. Interpreter response time	Strength	Barrier	Does Not Apply

11. Please add any additional comments you believe will be of interest regarding translation or interpretation services for Spanish-speaking patients at rural hospitals

_____
_____
_____
_____

____

Appendix C: Detailed Tables

Study Sample Counties:
Rural Counties with >200% increase in Hispanic population (1990-2000), base Hispanic population of 300+, and at least 1 hospital

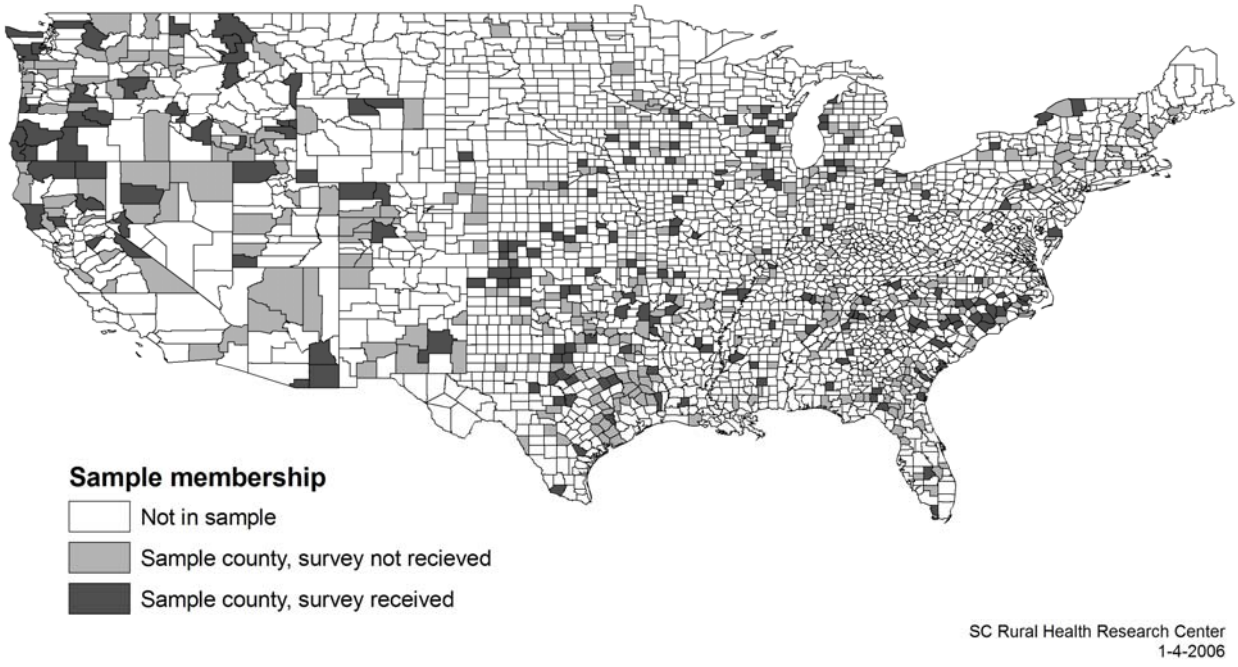


Table C-1. Demographic Characteristics of Sampled Counties and Counties with Responding and Non-responding Hospitals

	Initial County Sample (n=544)	Responding County Sample (n=211)
Mean County Population, 2000 Census	47395 (SD=)	46106 (SD=)
Population, by quartiles		
100% Maximum	186742	156638
75% Q3	62839	65514
50% (Median)	39676	39678
25% Q1	24096	22835
0% Minimum	3782	3966
Mean Hispanic Population, 2000 Census	3662 (SD=)	3388 (SD=)
Hispanic Population quartiles		
100% Maximum	102817	52278
75% Q3	3545	3258
50% (Median)	1689	1585
25% Q1	965	915
0% Minimum	600	600
Mean percent population in poverty, 2000	13.7% (SD=)	13.4% (SD=)
Poverty, by quartiles		
100% Maximum	44.9%	44.9%
75% Q3	16.3%	15.9%
50% (Median)	13.3%	13.0%
25% Q1	10.6%	10.5%
0% Minimum	3.8%	5.3%
Number of hospitals by county, 2001	841	319
1	322 (38.29%)	129 (40.44%)
2	283 (33.65%)	110 (34.48%)
3	137 (16.29%)	49 (15.36%)
4+	99 (11.77%)	31 (9.71%)
Location		
Adjacent to a metro area (codes)	469 (55.77%)	174 (54.55%)
Not adjacent	372 (44.23%)	145 (45.45%)
Growth status		
High Hispanic growth, 1990-2000	244 (29.01%)	102 (31.97%)
Stable Hispanic population	597 (70.99%)	217 (68.03%)

Table C-2. Characteristics of Sampled, Responding, and Non-responding Hospitals

	Original Sample		Responding Hospitals		P value
Characteristic	No.	%	No.	%	
Type of Services					
ED					0.7087
Yes	667	91.62	265	92.3	
No	61	8.38	22	7.7	
OB					0.9675
Yes	526	72.25	207	72.1	
No	202	27.75	80	27.9	
OB Level of Care					0.9215
Uncomplicated	296	60.41	123	61.5	
All Uncomplicated & Most Complicated	169	34.49	66	33.0	
Serious Illnesses & Abnormalities	25	5.10	11	5.5	
Free Standing OP Center					0.3046
Yes	134	18.41	45	15.7	
No	594	81.59	242	84.3	
Hospital-Based OP					0.7840
Yes	483	66.35	193	67.3	
No	245	33.65	94	32.7	
OP Surgery					0.7906
Yes	651	10.58	255	88.9	
No	77	89.42	32	11.1	

[1] 32 observations missing from the AHA Survey

Table C-3. Hospitals, by County Characteristics (Source: 2000 AHA Annual Survey; 2003 Area Resource File)

	Initial Sample		Responding Hospitals		P value
Characteristics – County Level	No.	%	No.	%	
County Level of Rurality (Based on RUC Codes)[1]					0.3315
Large (RUC 4-5)	359	42.7	136	42.6	
Medium (RUC 6-7)	453	53.9	166	52.0	
Small (RUC 8-9)	29	3.5	17	5.3	
County's Adjacency to a metropolitan area[1]					0.7086
Adjacent to a metro area (RUC 4, 6, 8)	469	55.8	174	54.5	
Not adjacent to a metro area (RUC 5, 7, 9)	372	44.2	145	45.5	
Number of Hospitals in 2001					0.5551
1 Hospital	321	38.2	129	40.4	
2-3 Hospitals	420	50.0	159	49.8	
More than 3 Hospitals	99	11.8	31	9.7	
Persistent Poverty (USDA classification)					0.2778
Yes	95	11.3	29	9.1	
No	746	88.7	290	90.9	
Hispanic population Growth (> than 200%)					0.3248
Yes	244	29.0	102	32.0	
No	597	71.0	217	68.0	

Table C-4. Number of Spanish-Speaking Patients Served per Month - All Services, All Departments by Hispanic Growth

			High Growth Counties		Stable Population Counties	
	All Hospitals					
Number of Spanish-speaking Patients Served per month	No.	%	No.	%	No.	%
Less than 100	156	69.6	112	77.2	44	55.7
100 – 999	66	29.5	32	22.1	34	43.4
1,000 or more	2	0.9	1	0.7	1	1.3
Total	319	100.0	145	100	79	100

Chi-square (High vs. Stable Population), P=0.0036.
Fisher's Exact Test (High vs. Stable Population), p = 0.0015.

Table C-5. Demand for Spanish Interpretation by Department, by Hispanic Growth and County Location

	Total	**Population Change**		**Location**	
	all responding hospitals	**Rapidly growing Hispanic Population**	**Stable Hispanic Population**	**Adjacent to a Metro Area**	**Not Adjacent to a Metro Area**
Emergency Department	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
High/Very High	111 (50.92)	55 (70.5)	56 (40.0)	65 (50.8)	46 (49.5)
Low	72 (33.03)	18 (23.1)	54 (38.6)	43 (33.6)	29 (31.2)
Almost Never	35 (16.06)	5 (6.4)	30 (21.4)	18 (14.1)	17 (18.3)
Total	218 (100.00)	78 (100)	140 (100)	128 (100)	93 (100)
Outpatient Services					
High/Very High	73 (33.80)	41 (51.9)	32 (23.4)	39 (30.7)	34 (36.6)
Low	42 (19.44)	31 (39.2)	70 (51.1)	64 (50.4)	37 (39.8)
Almost Never	101 (46.76)	7 (8.9)	35 (25.5)	22 (17.3)	20 (21.5)
Total	216 (100.00)	79 (100)	137 (100)	127 (100)	93 (100)
Inpatient Services					
High/Very High	64 (28.70)	35 (43.8)	29 (20.3)	35 (26.7)	29 (30.2)
Low	42 (18.83)	36 (45.0)	81 (56.6)	73 (55.7)	44 (45.8)
Almost Never	117 (52.47)	9 (11.3)	33 (23.1)	21 (16.0)	21 (21.9)
Total	223 (100.00)	80 (100)	143(100)	80 (100)	96 (100)

Chi-square (Emergency Department: High vs. Stable), p<.0001.
Chi-square (Outpatient Services: High vs. Stable), p<.0001.
Chi-square (Inpatient Services: High vs. Stable), p=.0006.

Table C-6. Language Assistance Services by Hispanic Growth and County Location

	Total	Population Change		Location	
	all responding hospitals	Rapidly growing Hispanic Population	Stable Hispanic Population	Adjacent to a Metro Area	Not Adjacent to a Metro Area
Yes	210 (91.70)	79 (97.5)	131 (88.5)	118 (91.5)	92 (92.0)
No	19 (8.30)	2 (2.5)	17 (11.5)	11 (8.5)	8 (8.0)
Total	229 (100.00)	81 (100)	148 (100)	129 (100)	100 (100)
Provision of oral interpretation					
Yes	224 (98.68)	79 (98.8)	145 (98.6)	126 (97.7)	98 (100.0)
No	3 (1.32)	1 (1.3)	2(1.4)	3 (2.3)	0 (0.0)
Total	227 (100.00)	80 (100)	147 (100)	129 (100)	98 (100)
Documents/materials in Spanish					
Yes	196 (85.59)	76 (93.8)	120 (81.1)	114 (87.7)	82 (82.8)
No	33 (14.41)	5 (6.2)	28 (18.9)	16 (12.3)	17 (17.2)
Total	229 (100.00)	81 (100)	148 (100)	130 (100)	99 (100)
Written language assistance policy					
Yes	247 (77.92)	80 (79.2)	167 (77.3)	139 (80.4)	108 (75.0)
No	70 (22.08)	21 (20.8)	49 (22.7)	34 (19.7)	36 (25.0)
Total	317 (100.00)	101 (100)	216 (100)	101 (100)	144 (100)

Chi-square (Provides Tools: High vs. Stable), p=.0180.
Chi-square (Documents in Spanish: High vs. Stable), p=.0086.

Table C-7. Tools Hospitals Use for Patients to Communicate Their Language Needs by Hispanic Growth and County Location

	Total	Population Change		Location	
Number of Hospitals Reporting Tool (% of those reporting any language ID tool, n=210)	All responding hospitals (n=210)	Rapidly growing Hispanic Population (n=79)	Stable Hispanic Population (n=131)	Adjacent to a Metro Area (n=118)	Not Adjacent to a Metro Area (n=92)
Language identification cards	69 (32.9)	23 (29.1)	46 (35.1)	40 (33.9)	29 (31.5)
Hospital brochures	98 (46.7)	45 (57.0)	53 (40.5)	51 (43.2)	47 (51.1)
Language identification posters	76 (36.2)	30 (38.0)	46 (35.1)	43 (36.4)	33 (35.9)
Telephone voice menus	58 (27.6)	30 (38.0)	28 (21.4)	32 (27.1)	26 (28.3)
Other	116 (55.2)	45 (57.0)	71 (54.2)	61 (51.7)	55 (59.8)

Chi-square (Provides Brochures: High vs. Stable), p=.0202.
Chi-square (Provides Telephone Voice Menus: High vs. Stable), p=.0091.

Table C-8. Ways Hospitals Provide Oral Interpretation by Hispanic Growth and County Location

	Total	Population Change		Location	
	All Responding Hospitals (n=224)	Rapidly growing Hispanic Population (n=79)	Stable Hispanic Population (n=145)	Adjacent to a Metro Area (n=126)	Not Adjacent to a Metro Area (n=98)
Contracted interpreters	61 (27.2)	23 (29.1)	38 (26.2)	36 (28.6)	25 (25.5)
Employee interpreters (primary role)	44 (19.6)	26 (32.9)	18 (12.4)	27 (21.4)	17 (17.4)
Bilingual employees (not primarily interpreters)	177 (79.0)	57 (72.2)	120 (82.8)	102 (81.0)	75 (76.5)
Volunteer community interpreters	85 (38.0)	34 (43.0)	52 (35.2)	46 (36.5)	39 (39.8)
Friends or family	107 (47.8)	40 (50.6)	67 (46.2)	60 (47.6)	47 (48.0)
Telephone interpreter services	154 (68.8)	61 (77.2)	93 (64.1)	91 (72.2)	63 (64.3)
Other	8 (3.8)	3 (3.8)	5 (3.5)	8 (6.4)	0 (0.0)

Chi-square (Has Employee Primary-Role Interpreters: High vs. Stable), p=.0002.
Chi-square (Has Telephone Interpreter Services: High vs. Stable), p=.0436.
Chi-square (Has Other Interpretation Services: Adjacent vs. Non-adjacent), p=.0111.

Table C-9. Documents/Materials Available in Spanish by Hispanic Growth and County Location

	Total	Population Change		Location	
	All responding hospitals (n=196)	Rapidly growing Hispanic Population (n=76)	Stable Hispanic Population (n=120)	Adjacent to a Metro Area (n=114)	Not Adjacent to a Metro Area (n=82)
Intake forms	90 (45.9)	39 (51.3)	51 (42.5)	50 (43.9)	40 (48.8)
Complaint forms	54 (17.6)	25 (32.9)	29 (24.2)	25 (21.9)	29 (35.4)
Consent forms	142 (72.5)	57 (75.0)	85 (70.8)	83 (72.8)	59 (72.0)
Eligibility forms	63 (32.1)	29 (38.1)	34 (28.3)	36 (31.6)	27 (32.9)
Health education materials	141 (71.9)	59 (77.6)	82 (68.3)	84 (73.7)	57 (69.5)
Notices about free language assistance	76 (38.8)	26 (34.2)	50 (41.7)	43 (37.7)	33 (40.2)
Applications for programs or activities	46 (23.5)	19 (25.0)	27 (22.5)	31 (27.2)	15 (18.3)
Patient's bill of rights	159 (81.1)	64 (84.2)	95 (79.1)	87 (76.3)	72 (87.8)
Other	26 (13.3)	14 (18.4)	12 (10.0)	18 (15.8)	8 (9.8)

Chi-square (Has Complaint Forms in Spanish: Adjacent vs. Non-adjacent), p=.0378.
Chi-square (Has Patient's Bill of Rights in Spanish: Adjacent vs. Non-adjacent), p=.0426.

Table C-10. Ways to Inform Staff of the Hospital's Written Policy by Hispanic Growth and County Location

	Total	Population Change		Location	
	All responding hospitals (n=247)	Rapidly growing Hispanic Population (n=80)	Stable Hispanic Population (n=167)	Adjacent to a Metro Area (n=139)	Not Adjacent to a Metro Area (n=108)
New employee orientation	176 (71.3)	63 (78.8)	113 (67.7)	101 (72.7)	75 (69.4)
Policy and procedure manual	221 (89.5)	75 (93.8)	146 (87.4)	128 (92.1)	93 (86.1)
Required Annual training	83 (33.6)	28 (35.0)	55 (32.9)	52 (37.4)	31 (28.7)
Other	16 (6.5)	3 (3.8)	13 (7.8)	10 (7.2)	6 (5.6)

Table C-11. Strengths and Barriers for Providing Language Assistance To Spanish Speaking Patients

	Strength	Barrier	Does Not Apply
a. Institutional support	252 (82.1)	16 (5.2)	39 (12.7)
b. Funding for interpretation or translation	75 (24.5)	141 (46.1)	89 (29.1)
c. Bilingual staff	206 (66.5)	77 (24.8)	25 (8.1)
d. Access to bilingual volunteers	132 (43.4)	106 (34.9)	66 (21.7)
e. Access to telephone interpreter lines	237 (77.0)	29 (9.4)	42 (13.6)
f. Quality of telephone interpreter lines	198 (66.0)	35 (11.7)	64 (21.3)
g. Local language training programs	76 (25.5)	110 (36.9)	112 (37.6)
h. State agencies' resources (e.g., Health Dept.)	54 (18.0)	103 (34.3)	142 (47.3)
i. Staff willingness to use interpreter	243 (79.2)	38 (12.4)	25 (8.1)
j. Interpreter response time	184 (62.0)	70 (23.6)	40 (13.5)

Table C-12. Top 5 Strengths and Barriers for Providing Language Assistance to Spanish Speaking Patients by Hispanic Growth

	Emergent Hispanic Population	Non-emergent Hispanic Population
Category	Rank (%)	Rank
Strengths		
Institutional support	1 (94.4)	1 (93.8)
Access to telephone interpreter lines	2 (90.0)	3 (88.6)
Staff willingness to use interpreters	3 (84.1)	4 (87.6)
Quality of telephone interpreter lines	4 (77.4)	2 (89.3)
Interpreter response time	5 (68.2)	-
Bilingual staff	-	5 (77.0)
Barriers		
State agencies resources (e.g. Hlth Dept)	1 (66.1)	2 (65.3)
Funding for interpretation/translation	2 (63.3)	1 (66.4)
Local language training programs	3 (53.4)	3 (62.8)
Access to bilingual volunteers	4 (44.6)	4 (44.5)
Bilingual staff	5 (35.9)	-
Interpreter response time	-	5 (25.3)

Table C-13. Top 5 Strengths and Barriers for Providing Language Assistance to Spanish Speaking Patients Hospital Adjacency to Metropolitan Areas

	Adjacent to a Metro Area	Not Adjacent to a Metro Area
Category	Rank (%)	Rank (%)
Strengths		
Institutional support	1 (95.3)	1 (92.5)
Access to telephone interpreter lines	2 (90.7)	3 (87.0)
Staff willingness to use interpreters	3 (84.0)	2 (89.6)
Interpreter response time	4 (73.7)	-
Bilingual staff	5 (72.0)	5 (72.0)
Quality of telephone interpreter lines	-	4 (82.2)
Barriers		
State agencies resources (e.g. Hlth Dept)	1 (71.6)	3 (58.0)
Funding for interpretation/translation	2 (66.9)	1 (63.2)
Local language training programs	3 (57.7)	2 (61.0)
Access to bilingual volunteers	4 (41.2)	4 (48.6)
Bilingual staff	5 (28.0)	-
Interpreter response time	-	5 (29.1)

Appendix D: Sample Programs

Colorado Plains Medical Center: Committee and Staff Volunteer

Hospital Contact and Information:
Alida C. Patiño
Staff Accountant / Interpreter
Colorado Plains Medical Center
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Hospital Responsibilities:
Alida Patiño is the chair of the LEP committee. The committee holds quarterly meetings. She also meets with interpreters to discuss the problems they have encountered in their interpretation. She mentioned that not all Spanish speakers are suitable for interpretation because they are not proficient enough in English.

Alida is a certified medical interpreter. She attended the 40 hour "Bridging the Gap" medical interpretation training at the Spring Institute in Denver, Colorado. Alida and her husband are putting together a plan for on-site Spanish classes for clinical personnel only.

Alida lives 5 minutes from the hospital and she is on call after hours. This is a volunteer activity and she does not receive compensation for this extra work. She is happy to do that because she empathizes with the feelings of immigrant people in her state. She comes from Europe and knows how it feels to be an immigrant.

Mammoth Hospital: Full-Time Interpreter Staff & Detail Policy Development

Hospital Contact and Information:
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E-mail: jose.garcia@mammothhospital.com

Hospital Background:

Mammoth hospital is a 15-bed Critical Access Hospital with 11 outpatient clinics. The clinics and hospital service 45,000 patient visits a year, which includes the ER servicing about 8,800 patients a year. One of the hospital's strategic plan goals is to meet the needs of the growing Hispanic population. To reach that goal, the hospital hired a consultant to do a "Needs Assessment." In addition, the hospital has collaborated with the Language Line University Proficiency testing program.

Two years ago, the hospital created a "Hispanic Outreach" program within its community relations department, to connect with the Hispanic community. The coordinator of this program is America Mendoza, who is also a patient advocate. Ms. Mendoza makes presentations to Latino organizations about the hospital services that includes:

- The clinics they have and the services they provide
- Interpreter services program
- Answering questions about the hospital

About a year ago, another program was created: the "Interpreter Services Program." This program hired a full-time supervisor and full-time interpreters for the hospital, family medicine, pediatrics, dental clinic and women's health. The hospital has staff that are dual-role interpreters, for example the clinical assistant in the women's health clinic also serves as the interpreter for that department. They have also an interpreter from 3:00 – 11:00 PM to cover the entire hospital. In addition, the hospital has interpreters on-call from 11:00 PM – 7:00 AM. One of the advantages of this program is that all interpreters are now under one supervisor who is also helping to shape policy regarding interpreting services.

The hospital has a very complete policy regarding interpreter services, reproduced on the next two pages. The full policy includes specific compensation levels, which are not included in this report.

Hospital Policy:

Mammoth Hospital
Mammoth Lakes, CA 93546
Policy on Interpreter Services

PURPOSE:
It is the purpose of Mammoth Hospital to ensure adequate and speedy communication between LEP (LEP) patients (and their appropriate family members) and hospital staff in order to provide quality health care services. LEP individuals are those who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

Mammoth Hospital shall maintain compliance with State and Federal legislation and accrediting agency guidelines pertaining to interpreter services, and shall have an established mechanism to provide interpreter services to patients with language or communication barriers. A language or communication barrier results from speaking different languages or visual languages.

POLICY:
- Signage relating to interpreter services shall be posted throughout Mammoth Hospital and the Sierra Park Clinics. The signage shall include:
  - Notification that interpreter services are available upon request.
  - List of languages for which interpreter services are available.
  - How to obtain an interpreter.
  - Internal and State department numbers where complaints may be filed concerning interpreter service problems including Telecommunications Device for the Deaf (TDD) or Teletypewriter (TTY) – see policy on Communicating with the Hearing-impaired Patient.
  - Local address and telephone number to the Licensing and Certification Division of the State Department.
- An interpreter will be provided if the patient indicates the need for an interpreter, or if a health care professional determines that an interpreter is necessary.
- Hospital Staff shall identify the language needed for a client who requests interpreter services by using the Language Indicator Card, the desk-top posters, or the "I Speak Card."
- Dual-role and full-time dedicated site interpreters (see criteria below) within the department should be utilized first. If the department is unable to provide language coverage, contact the Interpreter Services Supervisor, Monday – Friday 0800 – 1600, by calling extension 2640, by paging overhead or by calling 1-877-209-4708 (pager). For interpreter services coverage 24 hours/7 days a week, see Outlook's "Interpreter Services Calendar" for contact information. ***All dual-role and full-time interpreters will be identified with an ORANGE ID badge.***
- If an interpreter is unavailable, contact Language Line Services for assistance – see Language Line Services guidelines attached or access on the hospital Intranet system.
- To provide continuity of care, the patient's primary language and/ or dialect (other than English) shall be recorded in the patient's medical record and the Dairyland Healthcare Solutions System.
- The name of the interpreter providing interpretive services must be documented in the patient's medical record.
- If a LEP patient refuses Mammoth Hospital interpreter assistance, he/she must sign a waiver releasing Mammoth Hospital from interpreter responsibilities.

Mammoth Hospital Interpreter Program Criteria

A) Bilingual Ambassadors - bilingual staff are our Hispanic ambassadors for the hospital. They provide direct service; they do not provide interpretive services. Bilingual staff are our points-of-contact for the Hispanic patients until an interpreter is called. They assist with scheduling appointments, talk with family members, help comfort patients, and direct

patient callers. They are compensated through the Employee Advancement Program (EAP). To qualify for EAP compensation, the bilingual employee must pass the Language Line proficiency test at a level III. After completion, the employee will qualify for step U on the EAP application valued at two points. All hospital staff are expected to serve as ambassadors to patients. Those staff who have some knowledge of a second language are encouraged to use it in their ambassador role. But only those staff who pass a Spanish proficiency test and use their Spanish skills on a regular basis will be eligible for EAP compensation.

B) Level I – non-medical interpreters. They provide interpretive services in a non-medical setting holding a full-time job in another department (dual-role interpreter). Their primary job is not interpreting, but they are available to interpret when needed. They are compensated not only for their interpreting skills, but also for their availability to interpret. They must pass the proficiency test at a level III and complete the 40-hour interpreter training, in addition to completing two practicum hours on the clock with two different providers (after the practicum evaluations, two additional observations may be required). Compensation **is not** automatically given. To qualify for compensation, interpreter must have a full-time status and **must turn-in** "interpreter monthly log" signed by supervisor **the first day of each month.**

C) Level II – medical interpreters. They provide interpretive services in a medical setting holding a full-time job in another department (dual-role interpreter). Their primary job is not interpreting, but they are available to interpret when needed. They are compensated not only for their interpreting skills, but also for their availability to interpret. They must pass the proficiency test at a level III and complete the 40-hour interpreter training, in addition to completing two practicum hours on the clock with two different medical providers (after the practicum evaluations, two additional observations may be required), complete an English medical terminology course, and complete a bilingual medical terminology course provided by Mammoth Hospital. The level II medical interpreter is also eligible to participate for on-call coverage during the 2330 – 0700 shift and the weekend shift. Compensation **is not** automatically given. To qualify for compensation, interpreter must have a full-time status and **must turn-in** "interpreter monthly log" signed by supervisor **the first day of each month.**

D) Level III – full-time dedicated site medical interpreters. Their full-time salary reflects their compensation. They must pass the proficiency test at a level IV, complete the 40-hour interpreter training, complete two practicum hours with two different medical providers (after evaluations, may require two additional observations), complete English medical terminology course, and complete a bilingual medical terminology course provided by Mammoth Hospital. The level III dedicated site medical interpreter is also eligible to participate for on-call coverage during the 2330-0700 shift and the weekend shift.

E) Non-Spanish bilingual options. At this time, there is not a high bilingual demand other than Spanish. Language Line will continue to assist with languages that have low utilization.

Continuing education of at least one training a year is required of all levels. The California Healthcare Interpreting Association (CHIA) is now providing four trainings a year in the Eastern Sierra making it easy to complete these criteria.

Mammoth Hospital will pay for the Language Line University Proficiency Test up to three times. If the interpreter does not attend scheduled test, Mammoth Hospital will not incur any cost.

Memorial Hospital: Documenting the Business Case

Hospital Contact and Information:
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Responsibilities:

Mr. Shockney was appointed by the governor to represent the health sector on the state commission for interpreters and translators. The goal of the commission is to educate providers and legislators on the importance of adequate interpretation and create a certification program in Indiana. This will be a program similar to "Bridging the Gap" where people get certified before they start their work as medical interpreters. There was a bill before the Indiana General Assembly in 2005 to make the Commission's recommendations law. However, a budget battle in the Indiana General Assembly killed this bill and many others. The Commission's hope is to see legislative approval in Indiana in January 2006.

Hospital Background:

The hospital is located in a rural county where Tyson established a plant and created 1,200 jobs that are being filled by Hispanics mainly. The hospital started to prepare for that large influx of Spanish speaking population. Mr. Shockney met with staff in other hospitals from other states where they have had the same experience. A community task force called Diversity Dynamics was created to help assure successful assimilation of the new residents to the community. The task force created plans to include how they were going to embrace the new community and how their needs would be met. The hospital's mission is to ensure that every citizen receives access to quality care regardless of race, nationality, color, or creed, economic, or social status.

The hospital began with a language telephone line but discussed that this tool was not appropriate because it was impersonal and they could not verify the credentials of the interpreter. Therefore, they hired a full-time interpreter and then another one. They also started several activities:

- Medical Spanish classes to physicians
- Diversity trainings
- Partnered with a school to do health screenings. A Pediatric clinic in a school that has the largest growth of Hispanic population
- Worked with a pastor in local Latino congregation
- Created a scholarship program to pay for bilingual persons to study nursing (addressing the health professionals shortage areas)
- Started bilingual billing
- Childbirth classes

Hospital Policy:

The Case for Hiring of Qualified Interpreters
Memorial Hospital
Logansport, IN

- The Mission of Healthcare Providers
  "To provide quality healthcare to all who seek services regardless of their ability to pay, nationality, race, or creed"
    - This means ensuring adequate communication to all regardless of race, creed, sex, and national origin
    - Anything shy of this lends me to believe that margin is your mission
- Liability Issues
  - Without ensuring understanding between the provider and the patient, the provider assumes exponentially higher liability
  - As health care liability continues to reach crisis levels in America and force many providers to reduce services, providers can retrench and create more access issues by not providing adequate communication/interpretation or they can push forward and ensure lower liability costs compared to other providers by ensuring quality interpreter services.
  - Memorial Hospital has continued to see increases in its liability costs as have all health care providers in our nation, however, we have not experienced one complaint or claim as a result of inability to communicate with patients due to language barriers. This has occurred in a County where the minority (mostly Hispanic/Latino) population has increased from less than one-half of a percent to over 15% in a few short years.
- Memorial Hospital's Progression
  - Language Interpretation Line
    - Difficult at best due to necessary access to a speaker phone at every interpretation opportunity
    - Non assurance of the provider that what is being interpreted is physiologically correct
    - Emergent or Field experiences not covered by this service due to logistics and timing which is the most critical time for the interpretation services
  - Added on-call Spanish speaking citizens
    - In addition to the language line, Memorial kept a list of local citizens that informed the hospital of their ability to interpret
    - Memorial discovered as they utilized these individuals that their health care knowledge was basic at best for interpretation
  - Continual Provision of Medical Spanish Courses for Employees and Providers
    - This allowed Memorial's employees and providers to at least be able to understand the basic physiological issues such as chief complaint of the patient and ascertain consent from the patients.
  - Incident Occurred that 'woke us up to reality'
    - Grandmother interpreting for daughter for circumcision of the baby.
    - The nurse had participated in medical Spanish course and left the conversation uncomfortable that something was not right.
    - Called in interpreter on our 'on-call' list and discovered that the grandmother was trying to push her wishes for the circumcision of the baby when the mother and father did not want this to occur.
    - Additionally, we struggled deeply with children interpreting medical issues for their parents and family as there are very sensitive issues to which no child should have to be exposed.
  - Added Full-time Interpreter

        - No only alleviated the liability, availability, quality, and communication issues, but provided less anxiety for the providers and staff when caring for non-English speaking patients.
    - Developed Policies & Procedures to Ensure Qualifications
    - Added Second Full-time Interpreter
    - Partners In Education with Columbia Elementary
        - School activities with students, families, and faculty
        - Tours of hospital to promote health and health careers
    - Pediatric Clinic in Columbia Elementary
        - Health is the key to classroom learning
        - Connecting kids with community resources (programs and services such as Medicaid, clinic, medicine, etc.)
        - Education to students and parents regarding the U.S. health system and linking with a primary care provider
    - Link with local Latino Congregations
        - Health scholarship program for identified health care worker shortage areas
        - Linking patients with providers
        - Facilitating care delivery (surgeries, medicine, etc.)
- Statistical Progress
    - In 2004 Memorial Hospital spent $67,632 to employ two full-time interpreters including benefits, educational assistance, training and certifications.
    - Memorial reduced its language interpretation costs from two dollars ($2.00) per minute for the interpretation line to twenty-seven cents (.27) per minute for two full-time interpreters.
    - Memorial has been able to contract its interpreters to other healthcare providers on the campus on an as needed basis, thus improving the quality of care for our citizens at every health care encounter. Memorial also recoups its costs for contracting out these services through reimbursement from these providers and the provider receive quality interpretation and translation services for a minimal fee per fifteen minute increments. *Sharing the costs among the medical community makes this feasible for everyone.*
    - The costs of translation (not interpretation) of documents, forms, signage, etc. that are required by the Federal Regulations are included in this cost as our qualified interpreters do this during their normal working hours between interpretation services. This represents an additional reduction in costs to Memorial of over one thousand and five hundred dollars ($1,500) per year.
    - By ensuring quality interpretation and thus quality care for non-English speaking persons and their families, a reduction in health care costs is experienced as evidenced by a higher compliance rate with prescribed treatment plans and thus reductions in future health care costs that often times are born by the state Medicaid program or the health care provider themselves.
- Organizational Effects
    - Have experienced increase total bad debts and community care as a whole.
    - Memorial Hospital has experienced financial rewards from the implementation of a quality interpretation services.
    - Memorial sends its interpreters to the manufacturing plants and businesses that employ the non-English speaking citizens to provide education regarding health insurance and its importance. This has increased the number of non-English speaking patients that have health insurance from approximately three percent (3%) to over forty percent (40%) today.
    - Memorial has been able to collect co-payment and deductibles as well as work with non-English speaking patients regarding payment of their healthcare bills.
    - Memorial provides health education classes (childbirth, smoking cessation, etc.) in Spanish which are fee for service classes.

- Memorial has experienced an ever increasing cash collection rate as a direct result of these programs and services.
- Memorial has experienced decreases in bad debts among the Latino population to the point that the percent of bad debts for the Latino population are equal to or less than all other populations per capita.

While the interpretation and translation services can never be perfect or always available to every situation twenty-four hours a day/seven days per week, health care providers have an obligation to fulfill their mission and work together to ensure quality healthcare for those that they serve.

Oconee Regional Medical Center: Bilingual Employees

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Hospital Background:
Oconee Regional Medical Center (ORMC) has 2-3 staff members who speak Spanish and are in charge of interpretation. There are also two Spanish-speaking physicians on the Medical Staff.

ORMC is also able to use the AT&T interpretation line (Language Line) through the Sheriff's Department without charge. At this point, the Hispanic population in Milledgeville is not large, but Hispanics do come to the hospital from surrounding areas, as well. Frequently those who speak no English are accompanied by someone who does know English well.
When there is no one accompanying a patient who speaks no English, one of the Spanish-speaking staff members is called or the Language Line is used.

ORMC's greatest need is for translation of written documents. Although a number of the basic documents used by the hospital have been translated, there is still a definite need in this area. Some areas have translations for basic documentation needed (such as Registration), and the Cancer Treatment Center has flashcards of basic commands to use with an unaccompanied patient who speaks no English. Same Day Surgery and the OB Unit have translations of various documents, including discharge instructions.

The hospital staff is very interested in learning Spanish. However, it is important to remember that it takes years to learn Spanish well, and that there is danger in possible overconfidence with regard to medical interpretation.

Appendix E: Office of Minority Health CLAS Standards

Federal Standards for Culturally and Linguistically Appropriate Health Care Services

Preamble: Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers can:

Culturally Competent Care:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning

Language Access Services:

4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served. (Mandate)
5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery. (Mandate)
6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services. (Mandate)
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge. (Mandate)

Organizational Supports for Cultural Competence

8. Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities
10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization’s management information system as well as any patient records used by provider staff

11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community
12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs
13. Develop structures and procedures to address cross- cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services
14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources

Note: Standards 4-7 are federally designated mandates.

www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf

Appendix F: Office of Minority Health CLAS Standards Crosswalked to Joint Commission Standards

Office of Minority Health National CLAS Standards Crosswalked to Joint Commission 2004 Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care

Note: The entire text of the Joint Commission standard was not included. Please reference the appropriate Joint Commission Accreditation Manual for the full text of the standards.

Chapter/Manual Title Acronym	Manual/Chapter Title Expansion
RI	Rights, Responsibilities, and Ethics
PC	Provision of Care, Treatment, and Services
PS	Behavioral Health Promotion and Disease Prevention
LD	Leadership
HR	Management of Human Resources
PI	Improving Organization Performance
IM	Management of Information

OMH CLAS Standard	JCAHO Standards	Comments
Standard 1. Health care organization should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.	**RI.2.10** The organization respects the rights of (patients/residents/clients). **EP.2** **RI.2.20** Patients receive information about their rights. **EP 15 (Applicable only to BHC-OTP)** **RI.2.100** Organization respects the [patient's/resident's/client's] right to and need for effective communication. **EP.2, 3, 4** **RI.2.220 (LTC only)** Residents receive care that respects their personal values, beliefs, cultural and spiritual preferences, and life-long patterns of living. **PC.2.20 (AHC, HAP, LTC, OME only)** The organization defines in writing the data and information gathered during assessment and reassessment.	Standard 1 is the foundation on which other CLAS standards are based and incorporates a variety of the JCAHO standards. OMH provides the following suggestions for implementing this standard: • Cross-cultural education and training for staff • Assessment of staff learning skills through testing, direct observation, monitor patient/personnel encounter

	EP.4 (HAP and AHC only) **EP.6** (**OME only)** **EP.8** (**OME only**) **EP.14 (LTC only)** **EP.17 (LTC only)** **PC.6.10** The [patient/resident/client] receives education and training specific to [patient's/resident's/client's] needs and as appropriate to care and services provided. **EP.2** **LD.2.10** An individual or designee(s) [leader(s) – for BHC] is responsible for operating the organization according to the authority conferred by governance. **EP.5 (BHC OTP only)** **LD.3.60** Communication is effective throughout the organization. **HR.2.10** Orientation provides initial job training and information. **EP**. **5** **HR.2.30** Ongoing education, including in-services, training, and other activities, maintains and improves competence. **EP. 3** **LD.3.20** Patients with comparable needs receive the same standard of care, treatment, and services throughout the org. **EP.1,2,3**	• Assess in staff performance review • HCO should provide patients/consumers with information regarding existing laws and policies prohibiting disrespectful or discriminatory treatment or marketing/enrollment practices
Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.	**HR.1.10** The organization provides an adequate number and mix of staff (and licensed independent practitioners applicable only to AHC and LTC) that are consistent with the organization's staffing plan **EP. 1.** **HR.1.20** The organization has a process to ensure that a person's qualifications are consistent with his or her job responsibilities. **HR.2.30** Ongoing education, including in-services, training, and other activities, maintains and improves competence. **EP. 3, 7** **LD.3.60** Communication is effective throughout the organization. **EP. 1, 2**, **3** **LD.3.70** The leaders define the required qualifications and competence of those staff who provide care, treatment, and	The Joint Commission does not directly hold organizations accountable to recruit, retain, and promote diverse staff. The Joint Commission standards that support this are more general and expect that staffing is consistent with the organization's mission. In addition, the Joint Commission expects the organization leadership to define the qualifications and competencies of staff. OMH CLAS standard 2 emphasizes commitment and good faith effort

	services, and recommend a sufficient number of qualified and competent staff to provide care, treatment, and services. **EP.1** **LD.3.20** Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital. **EP.1,2,3**	rather than specific outcomes. Organizations should encourage retention by fostering a culture of responsiveness toward the challenges and ideas that a culturally diverse staff offers and should incorporate the goal of staff diversity into the organization's mission statement, strategic plans, and goals.
Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.	**HR.2.10** Orientation provides initial job training and information. **EP. 5** **HR.2.30** Ongoing education, including in-services, training, and other activities, maintains and improves competence. **EP. 3, 7**	JCAHO standards address orientation on cultural diversity and sensitivity, and expect ongoing in-services and other education and training offered to be appropriate to the needs of the population(s) served and in response to learning needs identified through performance improvement findings and other data analysis. If an organization incorporates data regarding the CLAS standards in their regular performance improvement activities the educational needs may be addressed. However, the Joint Commission does not require ongoing education and training specific to culturally and linguistically appropriate service delivery. OMH suggests organizations involve community representatives in the development of CLAS education and

		training.
Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	**RI.2.100** Organization respects the [patient's/resident's/client's] right to and need for effective communication. **EP.3, 4** **LD.1.30** The organization complies with applicable law and regulation.	The JCAHO standards recognize the need for effective communication. The elements of performance address the use of interpretation and translation services. However, the JCAHO standards are less specific than OMH as to the provision of these services. OMH specifies how to provide the services with the preferred method being a bilingual staff member who can communicate directly with patients/consumers. The next preferred method is face-to- face interpretation by a trained staff contract or volunteer interpreter and as a last resort a telephone interpreter. A telephone interpreter should be used as a supplement when services are needed instantly or for infrequently encountered languages.
Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language	**RI.2.20** Patients receive information about their rights. **RI.2.100** Organization respects the [patient's/resident's/client's] right to and need for effective communication. **EP 1, 2, 3,4**	JCAHO standards are not this specific. The Joint Commission expects that patients/consumers receive information on their rights and it must be in a manner that they understand. However, the Joint Commission does not dictate that the information be provided in writing.

assistance services.		OMH suggests informing patients/consumers by using the following: • Using language identification cards • Posting and maintaining signs with regularly encountered languages at all entry points • Creating uniform procedures for timely and effective telephone communication between staff and patients • Including statements about services available and right to free language assistance services
Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).	**HR.3.10** Competence to perform job responsibilities is assessed, demonstrated, and maintained. **EP.1**. **RI.2.100** Organization respects the [patient's/resident's/client's] right to and need for effective communication. **EP 1, 2, 3,4**	The Joint Commission expects that staff are able to perform job responsibilities. Although not specific to the competence of interpreters, organizations are expected to define the competencies and have a mechanism to assess competency. This OMH standard would also be supported with the Joint Commission standard that addresses the appropriateness of communication. OMH suggestions include: • Patient/consumer may choose family member after being informed of free services available • Suggest trained interpreter be present

		to ensure accurate translation • Minor children should never be used as interpreters
Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	**PC.6.10** The [patient/resident/client] receives education and training specific to [patient's/resident's/client's] needs and as appropriate to care and services provided. **EP.2** **LD.3.120** The leaders plan for and support the provision and coordination of patient education activities. **EP.2**	JCAHO standards require organizations to assess the learning needs of patients with consideration given to cultural beliefs and barriers to communication related to patient education. The leadership standards also specify providing the necessary resources for patient education. OMH standards are written in a broader context especially in the general environment where patients/consumers would be going to a specific part of the organization. Suggestions for meeting compliance should include: • A written policy and/or procedure to ensure development of quality non-English signage and patient related materials • A minimum translation process that includes translation by trained individual, back translation, and/or review by target audience group and periodic updates • Compliance with existing state or local nondiscrimination laws
Standard 8. Health care	**LD.2.20** Each organizational program, service, site, or	Although JCAHO requires

organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, and operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.	department has effective leadership. **EP.1, 2, 3, 4**, **5** **LD.3.10** The leaders engage in both short-term and long-term planning. **EP.1, 2** **LD.4.10** The leaders set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities. **EP.1,2,3,4,5**	organizational leadership to engage in long and short term planning there is no requirement for a written strategic plan to provide culturally and linguistically appropriate services. OMH suggests the following activities to meet the intent of this standard: • Designated personnel or department should have authority to implement CLAS specific activities as well as monitor responsiveness of whole organization • Strategic plan developed with participation of consumers, community and staff • Results of data gathering and self assessment processes should informed the development and refinement of goals, plans, and policies.
Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their	**PS.2.10 (BHC ONLY)**The organization's behavioral health promotion services are appropriate to the needs of the community or population served. **EP.1, 2** **PI.1.10** The organization collects data to monitor its performance.	The Joint Commission standards do not directly address this OMH standard. However, an organization may choose to conduct assessments of these activities as part of their performance improvement activities. OMH standards note that surveys are a good tool for collecting data however the surveys should be culturally and linguistically appropriate. Findings

internal audits, performance improvement programs, patient satisfaction assessments, and outcomes based evaluations.		from surveys should be integrated into the existing QI activities
Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.	**IM.6.20** Records contain [patient/resident/client]-specific information, as appropriate, to the care, treatment, and services provided. **EP 1** **IM.6.60** The organization can provide access to all relevant information from a patient's record when needed for use in patient care, treatment, and services. **EP.1, 2**	JCAHO standards require organizations to provide access to all relevant information from a patient's record however this information does not include the items specific to the OMH standard. JCAHO does require organizations to define their assessment process relevant to the care, treatment and services of the individual patient. Cultural and language barriers are listed as possible barriers to the patient reaching specific goals. *NOTE: The Joint Commission is conducting a field review on a proposed standard for the collection of information on race, ethnicity, primary language in the medical record.* OMH suggests collecting data about race, ethnicity and language at the first point of contact from the patients/consumers. The organization should also be sensitive when

		requesting this information and emphasize with patients/consumers that this information is confidential and not intended to be used for discriminatory practices.
Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.	**PS.2.10 (BHC ONLY)** The organization's behavioral health promotion services are appropriate to the needs of the community or population served. **EP.1, 2** **LD.3.10** The leaders engage in both short-term and long-term planning. **EP.1**	The Joint Commission Behavioral Health Care program is the only program that requires a needs assessment of its community or population served. Specifically, the needs assessment should include : • A definition of the community or population served • The number of people in the community or population served • The distribution of community or population by age or age group, gender, socioeconomic status, ethnic and cultural background, and/or level of functioning • An inventory of behavioral health promotion services appropriate to the age, gender, community need, and level-of functioning distributions of the population or community served The only other related Joint Commission standard is the leadership planning standard. OMH suggests an HCO involve the

		community in the design and implementation of the community profile and needs assessment.
Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.		There are no JCAHO standards that address this OMH standard, however an organization might consider incorporating CLAS standards as an agenda item in a community council if one exists. OMH suggests involving relevant community groups and patients/consumers in the implementation of the community profile and needs assessment.
Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.	**RI.2.120** The hospital addresses the resolution of complaints from patients and their families. **EP.1**	JCAHO addresses this item in the Ethics, Rights and Responsibilities chapter but does not specifically address the need for the processes to be culturally and linguistically sensitive. OMH suggests an organization can meet the intent of this standard by considering some of the following: • Provide cultural competence training to staff who handle complaints and grievances or other legal or ethical

		conflict issues • Provide notice in other languages about the right to file a complaint or grievance • Provide name and number of individual responsible for disposition of grievance • Offer ombudsperson services • Include oversight and monitoring of culturally or linguistically related complaints/grievances are part of organization quality program
Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.		The Joint Commission standards do not require an organization to publish this type of information, nor does the Joint Commission expect organizations to make public any of their performance improvement information. OMH suggests organizations can report CLAS standards implementation progress in a standalone document or existing organizational reports or documents. In order to provide information to the public about their progress organizations may use newsletters, newspaper articles, television, radio or posting on a website

http://www.jcaho.org/about%2Bus/hlc/hlc_omh_xwalk.pdf

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