Language Access Services in Critical Access Hospitals for Patients with Limited English Proficiency in Rural Minnesota

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Abstract

Objectives. This study examined how well Critical Assess Hospitals (CAHs) were meeting the needs of patients with limited English proficiency in rural Minnesota. The specific objectives were to: 1) describe the level of resources and policies devoted to the provision of language access services; 2) assess the demand for language access services; 3) assess the availability, quality and costs of providing language access services; and 4) compare the costs of providing language access services in rural areas in Minnesota by region and proximity to metropolitan areas.

Methods. Respondents were staff from CAHs in rural areas in the state of Minnesota (n=60). Data on language access services were obtained using a mail questionnaire. Results were analyzed using counts, frequencies, and cross-tabulation analysis.

Results. Key findings were: 1) less than half (41%) of CAHs had designated staff for managing language access services for patients with limited English proficiency; 2) a majority of CAHs provided oral and written translation services as well as signage posted in languages other than English; 3) nearly one quarter (23%) of CAHs assessed the skills and competencies of interpreters; 4) the average reported cost to provide language access services for each limited English proficient patient encounter was $68, but reimbursement for providing these services was limited; and 5) the costs of providing language access services varied by region and proximity to metropolitan areas.

Conclusions. CAHs used a variety of methods to provide language access services for patients with limited English proficiency. Practice and policy implications of study findings are discussed.

Introduction

Improving health care access and quality of care for patients with limited English proficiency requires the provision of language access services within health care settings. Language access services include the use of interpreters, availability of translated materials, use of signage and informing limited English proficient patients of their right to receive these services at no cost. Linguistically diverse populations are residing in Greater Minnesota in larger numbers than ever before (U.S. Census, 2006). Rural health care providers need assistance to overcome language barriers during encounters with limited English proficient patients. This is especially relevant to Critical Access Hospitals (CAHs) and other safety net providers in rural communities who may serve underserved populations, including linguistically diverse populations.

There is currently little information available about the demand, availability, and quality of language access services in rural health care settings. Information is also lacking about the costs and financial implications of providing these services. The purpose of this study is to describe how CAHs are meeting the needs of linguistically diverse populations in rural Minnesota. Results from this study will further understanding of CAH efforts to prepare for changing health care needs due to an increase of cultural and ethnic minorities, especially immigrants and refugees, in rural areas of Minnesota.

Limited English Proficient Populations in Minnesota

The U.S. Census Bureau estimates that 54 million U.S. residents (19.7%) spoke a language other than English in the home in 2006. Of these, about 24 million (44%) reported being able to speak English less than “very well.” Large increases in the

Hispanic population account for most of the growth in limited English proficient populations. The Pew Hispanic Center found the total U.S. population increased only 13.2% between 1990 and 2000 while the Hispanic population increased by 57.9% (2002). Between 1990 and 2000, 15 states experienced more than 100% growth in their limited English proficient populations – Arkansas, Colorado, Georgia, Idaho, Kansas, Kentucky, Minnesota, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Utah and Washington (U.S. Census, 2004). This demographic shift affects rural states and counties as well as urban populations.

Minnesota's cultural and ethnic minorities form a significantly smaller proportion of the state population when compared to the national average. As of 2004, 6.1% of Minnesota residents were foreign-born compared to 12% for the nation (U.S. Census, 2004). About 460,000 (10%) of Minnesota residents spoke a language other than English at home in 2006. This percentage is much lower than the national average (19.7%) (U.S. Census, 2006). Of these, 270,000 (58%) report being able to speak English "very well," slightly higher than the national average (56%). The common languages used at home in Minnesota other than English include (U.S. Census, 2005):

- Spanish (36%)
- Asian/Pacific Island languages (27%)
- Indo-European languages (German, French, Russian, Scandinavian) (24%)
- African languages (9%)
- Other (Native American, Arabic) (4%).

Minnesota has the largest Hmong and Somali immigrant populations in the U.S. while the Hispanic population is growing rapidly in both urban and rural areas (Migration Policy Institute, 2007).

The need for interpreters in rural Minnesota used to peak during summer months when migrant workers came to work at farms or food processing industries. That changed as the Hispanic population grew and its members became permanent residents of rural communities. Rural counties such as Nobles and Watonwan have experienced five- to six-fold increases in immigrant populations (Jensen, 2006). Recently, many linguistically diverse populations have settled in rural areas. In 2006, more than 120,000 residents of Greater Minnesota aged 5 years and older spoke a language other than English at home (U.S. Census). Roughly 43,000 of these individuals spoke English less than "very well." As the number of rural Minnesotans with limited English proficiency increases, so does the demand for language access services in rural health care settings.

Effective communication between providers and patients with limited English proficiency is one of the fundamentals of providing quality health care. Every health care encounter has a communication component, from scheduling an appointment to assessment and diagnosis to self-care instructions. For limited English proficient populations, effective communication in health care encounters is connected to proper medication management (Andrulis, Goodman and Pryor, 2002) (Apter, Reisine, Affleck, Barrows and ZuWallack, 1998), improved patient satisfaction (Lee, Batal, Maselli and Kutner, 2002) (Baker, Hayes and Fortier, 1998) and improved health outcomes (G. Flores, 2000). Use of a professional interpreter leads to improved quality and lower cost of follow-up care for limited English proficient patients seen in emergency departments (Bernstein, Bernstein, Dave, Hardt, James, Linden, Mitchell, Oishi and Safi, 2002). The provision of professional interpreter services has been shown to increase access to preventive and primary care (Jacobs, Lauderdale, Meltzer, Shorey, Levinson and Thisted,

2001). Interpreters improve cross-cultural understanding (Barrett, Shaddick, Schilling, Spencer, del Rosario, Moua and Vang, 1998) and address negative attitudes and statements among providers during health care interactions (Ngo-Metzger, Massagli, Clarridge, Manocchia, Davis, Iezzoni and Phillips, 2003). Professional interpreters can improve communication to a degree that approximates clinical encounters in which no language barrier exists (Hampers and McNulty, 2002).

Unfortunately, language remains a major barrier to quality health care for limited English proficient populations. The Institute of Medicine found that communication barriers contribute to reduced quality, adverse health outcomes, and health disparities (2002). Studies suggest that language may be the most important determinant of health disparities between Hispanic and white, non-Hispanic populations (Fiscella, Franks, Doescher and Saver, 2002). Patients with limited English proficiency are less likely to seek preventative and primary care (Facione, 1999) (Fox and Stein, 1991) and more likely to use emergency rooms for non-emergency care (Bernstein et al, 2002). Language barriers play a role in outpatient drug complications, which are related to lower patient satisfaction (Ghandi, Burstin, Cook, Puopolo, Hass, Brennan and Bates, 2000). Hospitals across the country report that language barriers and inadequate funding of language access services are major barriers to limited English proficient patients' access to quality health care (Hasnain-Wynia,Yonek, Pierce, Kang and Hedges Greising, 2006).

Federal and State Policies Regarding Limited English Proficient Populations

Several steps have been taken to ensure that federally financed services, including health care services, reach all populations in the U.S. In 1964, Congress passed Title VI of the Civil Rights Act, 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."

In *Lau v. Nichols*, the U.S. Supreme Court ruled that discrimination against people with limited English proficiency was a violation of the national origin clause in Title VI of the Civil Rights Act. They concluded that reasonable measures were needed to ensure equal access for those with primary languages other than English. According to the Department of Justice, the linguistically isolated have the right to "reasonable, timely, and appropriate language care (1974)."

In August of 2000, President Clinton issued executive order 13166 entitled "Improving Access to Services for Persons with Limited English Proficiency." This requires every federal agency providing financial assistance to non-federal entities to publish guidance on how recipients can provide meaningful access to limited English proficient persons in order to comply with Title VI regulations. The Department of Health and Human Services Office of Minority Health issued National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) in December 2000.

The 14 CLAS standards are categorized in three topic areas: 1) culturally competent care; 2) language access services; and 3) organizational supports for cultural

competence. Organizations receiving federal funds are mandated to comply with the four CLAS standards related to language access services and may voluntarily adopt the remaining 10 standards (see Appendix A for a description of CLAS standards). Hospitals not in compliance with CLAS mandates are subject to fines and may lose federal funding. Hospitals may face increased legal risks, such as class action lawsuits, if they do not provide translation and interpretation services.

Rural hospitals must determine the extent of their obligation to provide language access services. Smaller recipients with limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets. Federal aid recipients are required to take "reasonable steps" to ensure "meaningful access" to federally sponsored programs. The four factors used to make this determination are:

> 1) The number or proportion of limited English proficient persons served or encountered in the eligible patient population.
> 2) The frequency with which limited English proficient individuals come in contact with the hospital.
> 3) The nature and importance of the program or service provided by the hospital.
> 4) The resources available to the limited English proficient individual (Hunt, 2003).

Rural hospitals should first examine their prior experiences with limited English proficient patient encounters and determine the breadth and scope of language access services that are needed. It is important in conducting this analysis to include language minority populations that are eligible for programs, but may be underserved because of existing language barriers. Resource and cost issues can often be addressed through technological advances, so rural hospitals should carefully explore the most cost-effective

means of delivering competent and accurate language access services before limiting services due to resource concerns.

Studies show the majority of hospitals nationwide (80%) treat patients with limited English proficiency. However, only a small fraction (3%) receives any reimbursement for providing language access services (Hasnain-Wynia et al., 2006). The Center on Budget and Policy Priorities recommends several ways the federal government could help health care providers ensure quality care by paying for language access services (Ku, 2006). 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 and Flores, 2005).

Minnesota began to reimburse fee-for-service providers (with the exception of inpatient hospitals) for interpreter costs through the state Medicaid program in 2001. Providers pay for interpreting related to covered medical services for fee-for-service providers at a billing rate of $12.50 per 15 minute increment. Document translation, appointment scheduling, and language access services provided by bilingual medical providers or staff interpreters are not reimbursed. These and other factors may lead to variation in the costs associated with providing language access services. The state also provides reimbursement for language interpreter services for Prepaid Medical Assistance Program (PMAP) and MinnesotaCare enrollees.

Hospitals lack clearly defined guidelines for medical interpretation services, including the level of training that is sufficient for a medical interpreter to provide services (Kinsey, Agger-Gupta, Schinske and Riley, 2006). Interpreters in most states are

not evaluated for the specialized vocabulary and communication skills needed in health care settings.

Language Access Services for Patients with Limited English Proficiency

Few studies focus on the need for language access services in rural health care settings. As the number of rural residents with limited English proficiency increases, so does the demand for language access services in rural health care settings. A study conducted by the Health Research and Educational Trust (HRET) in conjunction with the National Health Law Program analyzed hospitals' frequencies of encounters with limited English proficient patients (Hasnain-Wynia et al., 2006). They found that 21% of rural hospitals encounter limited English proficient patients on a daily basis, 22% on a weekly basis and 23% on a monthly basis. This study found that hospitals across the country in urban and rural areas receive limited reimbursement (3%) for language access services.

The South Carolina Rural Health Research Center conducted a study of rural hospitals and Spanish speaking patients with limited English proficiency (Torres, Parra-Medina, Martin, Johnson, Bellinger and Probst, 2005). This was the first national study to evaluate how rural hospitals provide language access services to limited English proficient patients. This study found that while almost every hospital (98%) provides oral interpretation to Spanish-speaking patients, only 20% use staff interpreters or bilingual employees for interpretation purposes. About three-fourths (78%) of hospitals reported having a written policy related to language assistance. Hospitals in high-growth counties were more likely to report having translated documents and tools for patients to communicate their language needs. This study analyzed proximity to metropolitan areas

as an indicator variable regarding the demand for language access services and types of services provided.

Studies related to language access services specific to the rural Midwest are limited. The University of Minnesota Rural Health Research Center conducted a study of the response of local rural health care systems to the needs of the growing Latino population in rural Midwest communities (Casey, Blewett and Call, 2003). This study was conducted in rural areas of Iowa, Kansas and Nebraska. It describes how access to health care for rural Latinos is diminished by limited availability of medical interpreters, health care providers and inadequate transportation.

One Minnesota clinic-based study related to language access services was found. Stratis Health, Minnesota's Medicare Quality Improvement Organization (QIO), conducted a study of 27 primary care clinics in metropolitan and rural areas of Minnesota to assess and promote CLAS standards at the practice level (Dahl, 2007). They found that 41% of clinics surveyed met or exceeded CLAS standards to provide interpreters and to inform limited English proficient patients of their right to receive language services at no cost. Only 27% of clinics made translated documents available for commonly encountered limited English proficient populations and 22% ensured the competency of interpreters and bilingual staff.

The demand and costs for language access services may be affected by proximity to metropolitan areas and the region where they are located. Rural hospitals in close proximity to larger health care systems compete for patients within the regional service area. However, close proximity to metropolitan areas may provide opportunities for

resource sharing. In addition, the demand and costs of language assess services may vary by region because local and hospital resources vary by region.

The purpose of this study was to describe how CAHs in rural areas in Minnesota are meeting the language access needs of limited English proficient patients. The specific objectives of this study were to:

1) Describe the resources and policies devoted to language access services in rural areas of Minnesota.
2) Assess the demand for language access services in rural areas of Minnesota.
3) Assess the availability, quality, and costs of language access services in rural areas of Minnesota.
4) Compare the costs of providing language access services in rural areas of Minnesota by region and proximity to metropolitan areas in Minnesota.

Methods

Study Design

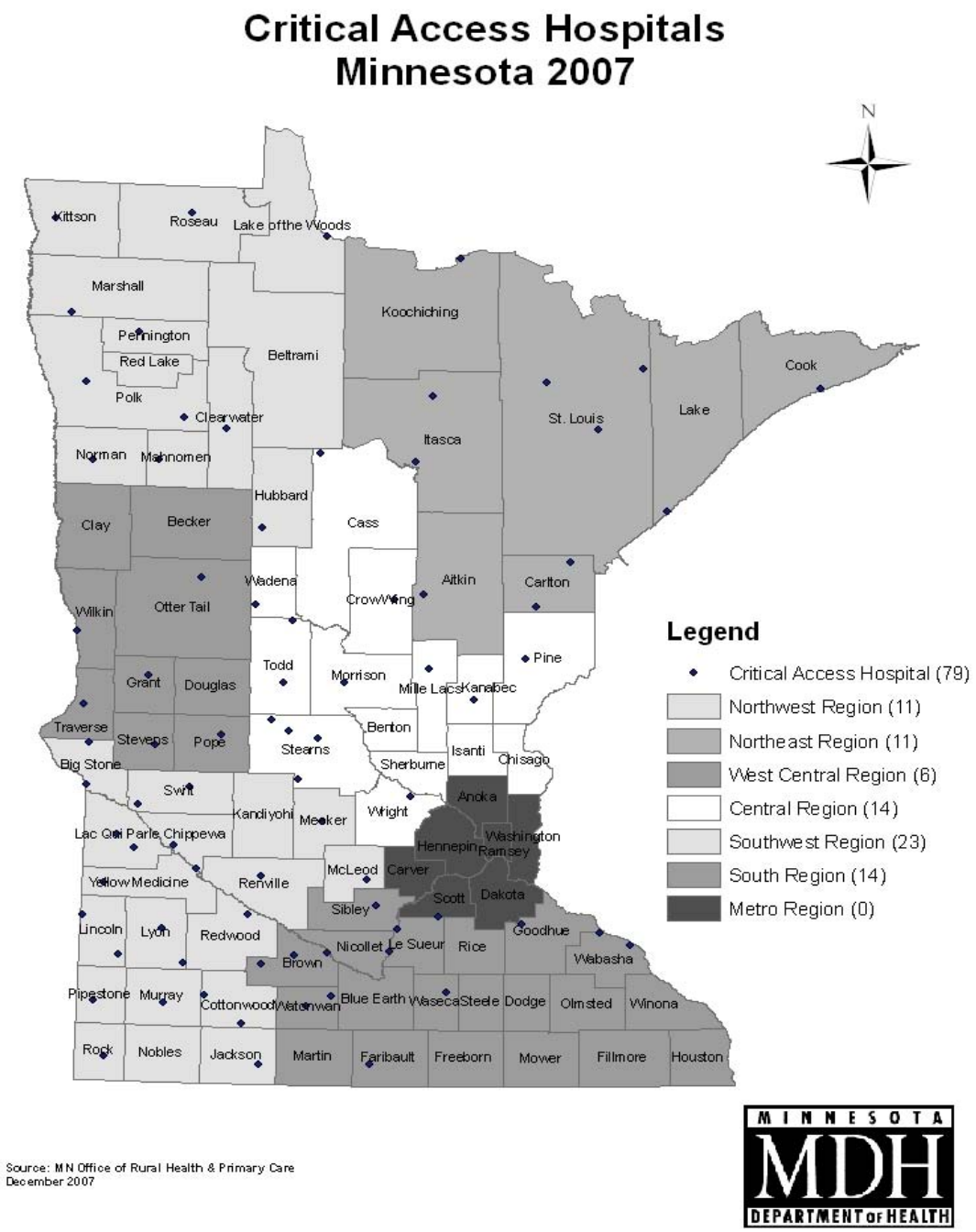
We utilized a cross-sectional study design. Descriptive studies are often cross-sectional, i.e., they collect data at a single point in time.

Sample

Our sample consisted of Critical Access Hospital (CAH) administrators and staff in rural Minnesota. Congress created the CAH Program in the Balanced Budget Act of 1997 to support limited-service hospitals in rural areas (Figure 1). Requirements for federal CAH designation include: 1) location in a rural area; 2) provision of 24-hour emergency care services; 3) average length of stay of 96 hours or less; 4) location more than 35 miles from a hospital or another CAH or certified by the State of Minnesota as a "necessary provider" of health care services to residents in the area; and 5) operation of up to 25 beds for acute inpatient care.

The names and addresses of CAH administrators and staff were obtained from Medicare Rural Hospital Flexibility Program records. The initial survey mailing was addressed to the CAH administrator. Other staff were permitted to complete the survey at the discretion of the CAH administrator. A total of 79 CAHs administrators and staff were contacted, of which 60 (76%) responded after three follow-up mailings.

Figure 1: Map of Critical Access Hospitals in Minnesota by Region



Data Collection

Data were collected via a mail questionnaire. Items for the questionnaire were based on the language access services portion of the National CLAS standards (See Appendix A). The survey tool had closed and open-ended questions regarding a wide range of issues including staff resources devoted to language access services, the level of demand for language access services, as well as the availability, quality and cost of such services (See Appendix B).

The survey tool was reviewed by experts (researchers and staff from the Minnesota Department of Health (MDH) Office of Rural Health and Primary Care, MDH Center for Health Statistics and UCare Minnesota) and then pre-tested among five hospital staff not involved in the study. This process resulted in the final survey instrument.

The survey was conducted using three mailings between September 17 and October 24, 2007. The initial paper mailing was followed by an electronic mailing three weeks later and a final electronic mailing and follow-up phone call two weeks after the second attempt. The initial mailing included a two-page double-sided survey instrument accompanied by a cover letter and a self-addressed envelope with prepaid postage. Disbursement of the electronic survey was limited to hospitals not replying to the mailed survey one week after the proposed submission deadline, which protected against duplications in survey completion. All mailings included a unique user identification code located on the survey instrument for tracking purposes.

Returned surveys were pre-coded and entered into a database using Microsoft Excel with appropriate check fields to ensure proper data entry. After the conclusion of

the data entry phase, 10% of all surveys were selected at random for validation by checking the survey responses against the respective record in the database.

Measures

Resources and policies related to language access services. Items measuring resources and policies related to language access services included the number of staff providing language access services, the number of staff providing community outreach to limited English proficient populations and the existence of a written policy or plan for language access services (yes or no).

Demand for language access services. The availability of language access services may vary by the actual demand for these services. We assessed the demand for language access services in terms of the number of languages spoken in service area and the number of limited English proficient patient encounters per day, week, and month.

Availability and scope of language access services. We measured the availability and scope of language access services in terms of whether the hospitals provided oral interpretation services, written translated materials, signage in multiple languages and targeted outreach activities to limited English proficient patients, and/or collaborated with other organizations or groups to improve outreach to limited English proficient patients.

Quality of language access services. Simply providing language access services is not enough. These services also must be of a high quality. We assessed the quality of language access services at CAHs in terms of whether CAHs considered the level of skills and competencies of interpreters hired by the hospitals.

Costs of language access services. We measured the costs of providing language access services in terms of the costs per patient encounter, costs per year to provide language access services and whether hospitals were reimbursed for language services.

Hospital characteristics. We assessed the characteristics of CAHs in terms of their size (number of beds) and type (non-profit, state, county, city owned). Information about hospital characteristics was obtained from two sources: our survey of CAH hospital administrators and the Minnesota Hospital Association.

Demographic variables. Demographic variables included population, region and proximity to a metropolitan area. Six regions were identified: Northwest, Northeast, West Central, Central, Southwest, and South. The Office of Rural Health and Primary Care currently uses regional designations for mapping the location of primary care physicians practicing in rural areas of Minnesota and for convening community forums. Regional considerations are important for program development and for funding purposes at a statewide policy level.

For purposes of this study, metropolitan areas were defined as the seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Scott, Ramsey, and Washington counties) and the cities of Duluth, Fargo-Moorhead, Rochester, and St. Cloud. Hospitals less than 100 miles from metropolitan areas were considered in close proximity while hospitals more than 100 miles were considered in distant proximity. Close proximity to metropolitan areas may create potential for competition as well as resource sharing with larger health care systems.

Analysis

Data on language access services were analyzed using cross-tabulation analysis, which is appropriate for descriptive studies. Data on costs of providing language access services were analyzed by region and proximity to metropolitan areas. All statistical analysis were conducted using SAS (version 9).

Results

Characteristics of Critical Access Hospitals

CAHs are small with the average number of beds being 23. About half of the hospitals were nonprofit organizations, while the remaining hospitals were owned by cities, counties, districts or the state, or joint-owned. Responding hospitals had characteristics similar to those of non-responding hospitals (Table 1).

Table 1. Characteristics of Responding and Non-responding Critical Access Hospitals

	Responders	Non-responders
Overall Response Rate	60 (76%)	19 (24%)
Number of Hospital Beds	Average = 23 Range = [8 – 25]	Average = 24 Range = [12 – 25]
Hospital Ownership	City – 10 City/County – 2 County – 3 District – 12 Non-profit – 31 State – 1	City – 1 City/County – 1 County – 3 District – 0 Non-profit – 13 State – 0

The average population size of cities with CAHs was approximately 3,400. More than half of these hospitals (55%) were located in cities within 100 miles of a metropolitan area. Non-responding CAHs were located in slightly larger cities and in cities that were closer to larger metropolitan areas (Table 2).

Table 2. Demographic Characteristics of Responding and Non-responding Critical Access Hospitals

	Responders	Non-responders
Overall Response Rate	60 (76%)	19 (24%)
Average City Population (2006 Census)	Average = 3397 Range = [451 – 13,406]	Average = 4226 Range = [666 – 11,479]
City Proximity to Metropolitan Areas (within 100 miles)	Average = 91 miles Less than 100 mi. = 33 More than 100 mi = 27	Average = 83 miles Less than 100 mi. = 12 More than 100 mi = 7

CAHs were located in rural regions where the limited English proficient percentage of the population was lower than the statewide average (Table 3).

Table 3. Limited English Proficiency Populations in Minnesota (2000 Census)

	Total population	**LOTESAH Pop.* Aged 5+**	**Speak English less than "very well"**
Region 1: Northwest	164,633	8729 (5.3%)	2552 (1.6%)
Region 2: Northeast	322,073	14,177 (4.2%)	3638 (1.1%)
Region 3: W. Central	210,059	10,264 (4.5%)	3591 (1.4%)
Region 4: Central	610,139	25,318 (4.3%)	8142 (1.4%)
Region 5: Southwest	287,627	17,855 (5.7%)	7182 (2.2%)
Region 6: South	582,892	43,759 (6.5%)	18,332 (2.7%)
Rural Regions	2,177,423	120,102 (5.5%)	43,437 (2.0%)
7-County Metro Region	2,642,056	269,886 (10.2%)	124,074 (4.7%)
Statewide Total (2000)	4,919,479	389,988 (8.5%)	167,511 (3.6%)
Statewide Total (2006)**	5,167,101	463,132 (9.6%)	193,188 (3.7%)

*Language Other Than English Spoken at Home (LOTESAH)
**Data provided by the American Community Survey, 2006.

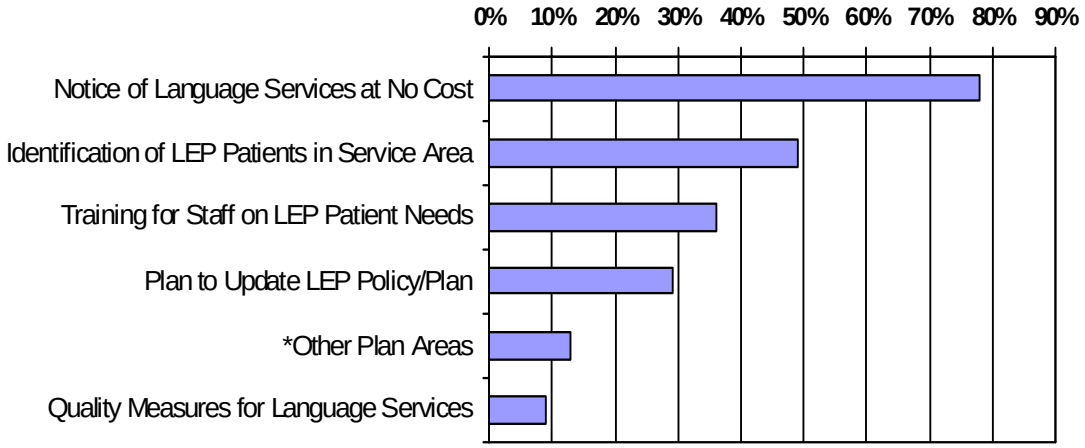
Language Access Services Provided by Critical Access Hospitals

CAHs showed variation in the level of resources devoted to language access services, demand for language access services, and the availability, quality and costs of language access services.

Resources and Policies Related to Language Access Services. Less than half (41%) of CAHs had designated staff for managing language access services for patients with limited English proficiency. A small number of CAHs (8%) designated staff for community outreach efforts to limited English proficient populations. However, over three-fourths (78%) of hospitals reported having a written policy or plan regarding the provision of language access services for patients with limited English proficiency. The areas most likely to be addressed in the plan were a notice of language access services

available to patients at no cost and the identification of limited English proficient patients within the service area (Figure 2).

Figure 2. Areas Included in Language Access Services Plans of Critical Access Hospitals



*Other plan areas include: Lists of community volunteers (2), onsite and offsite options for interpretation, contacts for interpretation, policy on use of multi-lingual software, guidelines for interpreters, and annual plan review policy.

Demand for Language Access Services. Two thirds (67%) of the hospitals collect information on various languages spoken by patients at their hospitals. The

The most common languages spoken by patients other than English were Spanish and Hmong (Table 4). Information on the language backgrounds of patients was typically obtained from hospital records on the preferred oral language of patients (25%), census data (15%), or by tracking patient admissions (13%) (Table 5).

Table 4. Languages Other Than English Spoken by Patients in Critical Access Hospitals (n=60)

Language	Number of Hospitals (%)
1. Spanish	40 (67%)
2. Hmong	6 (10%)
3. Somali	2 (3%)
4. Ojibwe	2 (3%)
5. Finnish	2 (3%)
6. Russian	2 (3%)

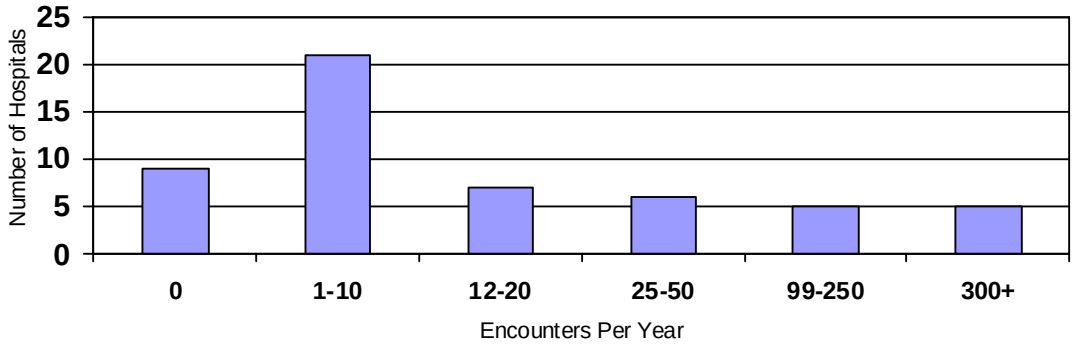
Table 5. Critical Access Hospital Determination of Prevalent Languages (n=60)	
Methods Used to Determine Prevalent Languages	**Number of Hospitals (%)**
1. Hospital data collection of preferred oral language of patients	15 (25%)
2. Census data	9 (15%)
3. Upon admission	8 (13%)
4. Hospital data collection of preferred written language of patients	5 (8%)
5. Local community known population	5 (8%)
6. Medical records	4 (7%)
7. Primary Home Language Counts (MN Dept. of Education)	1 (2%)

CAHs had the greatest contact with Spanish-speaking limited English proficient patients. While a third (33%) reported encounters with Spanish speaking patients on a monthly basis, 13% reported encounters on a weekly basis and 10% on a daily basis. A total of 10% of respondent hospitals encountered Hmong speaking patients on a monthly basis (Table 6).

Table 6. Number of Encounters with Limited English Proficient Patients					
	Number of Hospitals Experiencing Frequency (n=60)				
LANGUAGE	DAILY	WEEKLY	MONTHLY	RARELY	NEVER
Spanish	6	8	20	14	12
Hmong	1	0	6	6	47
Somali	0	1	3	3	53
Russian	1	0	4	0	55
Laotian	0	2	2	1	55
Ojibwe	0	1	0	2	57
German	0	1	1	0	58
Finnish	0	0	1	1	58
Vietnamese	0	0	0	2	58
ASL	0	0	1	0	59
Oromo	0	0	1	0	59
Arabic	0	0	0	1	59

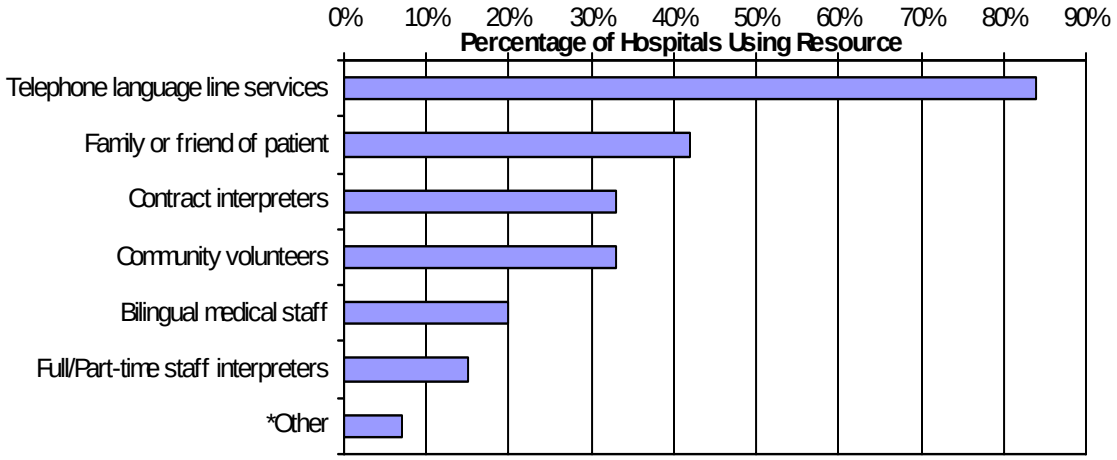
Hospitals reported an average of 59 patient encounters per year that required language access services. Nine CAHs reported having no patient encounters requiring language access services, while six reported having 300 or more patient encounters (Figure 3).

Figure 3. Critical Access Hospital Patient Encounters Per Year Requiring Language Access Services (n=53)



*Availability of Language Access Services***.** Oral interpretation services were provided by the majority of CAHs (92%) through a variety of sources including telephone language line services (84%), family or friend of patient (42%), contract interpreters (33%) and community volunteers (33%). A lower percentage of hospitals reported having bilingual medical staff (20%) or interpreters on staff whose primary role is to provide interpretation services (15%) (Figure 4).

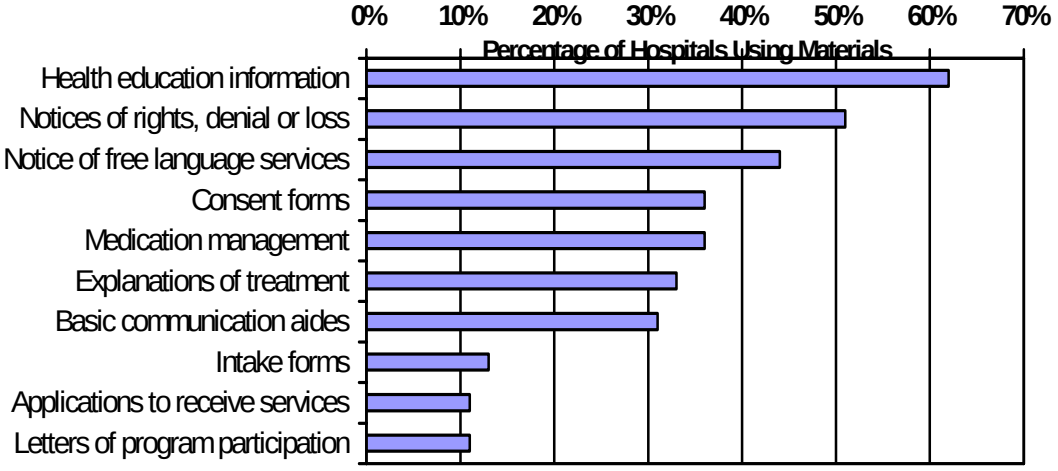
Figure 4. Resources for the Provision of Oral Interpretation in Critical Access Hospitals (n=55)



*Other resources for oral interpretation include: bilingual employees (3) and if an interpreter can be found.

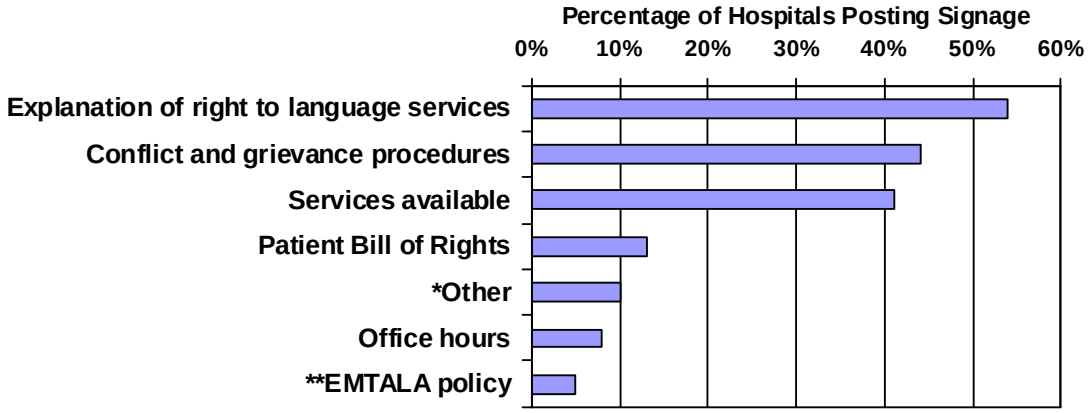
Translation services were routinely provided by most hospitals (75%). The most commonly translated documents were health education materials (62%), notices of rights, denial, loss or decrease in services (51%) and notices advising of free language access services (44%). Intake forms (13%), applications to receive services (11%) and letters regarding participation in a program (11%) were translated less frequently (Figure 5).

Figure 5. Translated Materials Available in Critical Access Hospitals (n=45)



Almost two thirds of hospitals (65%) posted signage in languages other than English. Of these hospitals, the majority posted signs in Spanish (90%) or Hmong (10%). Common signage topics were explanation of the right to language access services at no costs (54%), conflict and grievance procedures (44%) and services available (41%) (Figure 6).

Figure 6. Signage Topics in Critical Access Hospitals



*Other materials include: computer instructions, OB/GYN materials in Spanish, recognition of parentage form for unwed parents, and Micromedex care notes.

**The Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency rooms to screen and stabilize all patients regardless of ability to pay.

We also examined whether the availability of language access services varied by level of demand. In areas of low demand, (Northeast and Northwest) CAHs provided a basic set of language access services. In areas of high demand (Southwest and West), CAHs provided a more comprehensive set of services. For example, CAHs located in areas of high need provided both oral and written language services, had a wide range of translated materials available and posted signage on several topics and in more than one language.

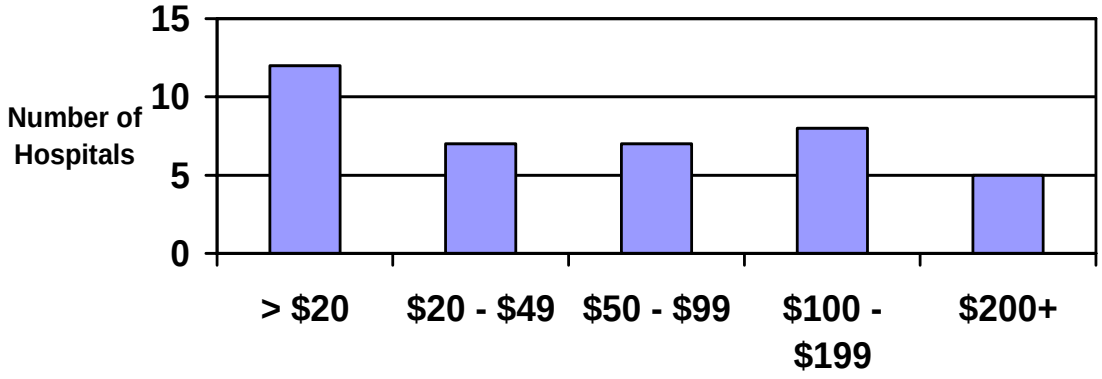
Only one quarter of CAHs (25%) reported hospital collaboration with community-based organizations to improve outreach to patients with limited English proficiency. These partnership organizations were most likely to be local public health agencies or county human services agencies. Few CAHs (8%) maintain targeted outreach efforts to limited English proficient populations independent of these organizations (Table 7).

Table 7. Critical Access Hospital Collaboration to Improve Outreach to Limited English Proficient Patients (n=60)	
	Number of Hospitals (%)
Any Organization	15 (25%)
Local Public Health Agencies	8 (13%)
County Human Services Agencies	8 (13%)
Ethnic and Minority Organizations	5 (8%)
Faith-based Organizations	2 (3%)
ECHO (Health Related Cable TV Show)	1 (2%)

*Quality of Language Access Services***.** Nearly one quarter (23%) of CAHs assessed the skills and competencies of interpreters. The most common areas covered in a quality assessment of interpreters included the ability to interpret effectively (19%), proficiency in English and non-English languages (15%) and knowledge of confidentiality requirements (15%). Factors CAHs considered regarding the quality of translated materials included the source of the materials (66%) and literacy levels of limited English proficient patients (40%).

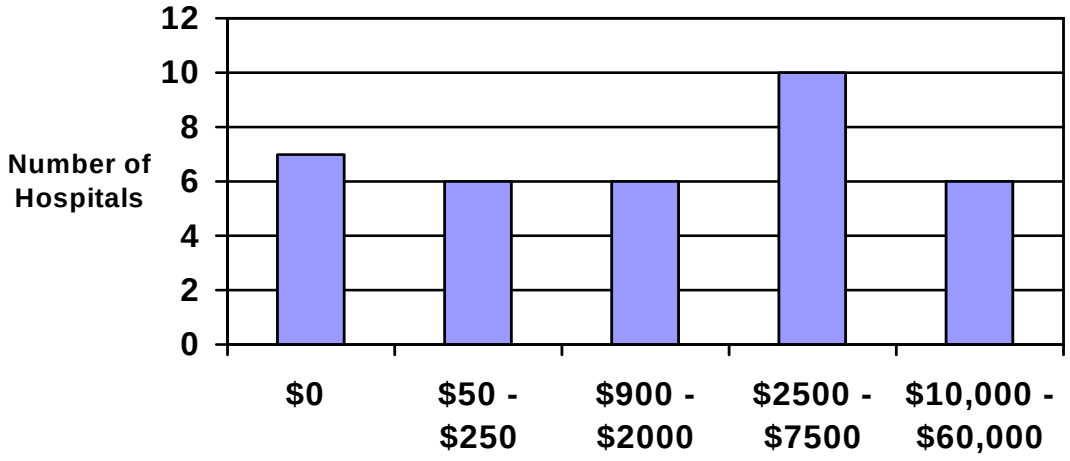
*Cost of Language Access Services***.** The average reported cost to provide language access services for each limited English proficient patient encounter was $68. This figure ranged from zero dollars (when services are provided by staff) to $250 (Figure 7). It should be considered that respondents self-defined the term “patient encounter” so no standard definition was used. Therefore, these cost estimates are not specific to any length of time for the encounter (i.e. cost per hour or cost per 15 minute increment).

Figure 7. Cost per Limited English Proficiency Patient Encounter in Critical Access Hospitals (n=39)



The average reported cost to provide language access services in each CAH per year was $4,684. This figure ranged from zero dollars (when no language access services were used) to $60,000 (Figure 8).

Figure 8. Cost to Provide Language Access Services Per Year in Critical Access Hospitals (n=36)



A small number of CAHs (3%) were reimbursed for costs associated with providing language access services. One quarter (25%) faced significant financial obstacles in providing language access services. Common types of financial obstacles

included a lack of state funding for language access services (22%), lack of hospital funding for language access services (17%) and low reimbursement for language access services (15%).

Average Costs to Provide Language Access Services by Region

The average number of encounters with limited English proficient patients, costs per encounter and costs per year were analyzed to examine regional variation. The average number of limited English proficient patient encounters per year was greatest in the South region (119 encounters) and smallest in the Northeast region (2 encounters) and ranged from zero to 750 encounters per hospital. The average cost per limited English proficient patient encounter was highest in the Central region ($114) and lowest in the West Central region ($24) and ranged from zero to $250. The average hospital cost per year was highest in the Southwest region ($9776) and lowest in the Northeast region ($224) and ranged from zero to $60,000 (Table 8).

Table 8. Frequency and Cost of Providing Language Access Services in Critical Access Hospitals by Region

	Region 1: Northwest (n=11)	**Region 2: Northeast (n=11)**	**Region 3: W.Central (n=6)**	**Region 4: Central (n=14)**	**Region 5: Southwest (n=23)**	**Region 6: South (n=14)**
Average Number LEP Patient Encounters	**11** [0-50]	**2** [0-12]	**33** [3-99]	**57** [0-400]	**95** [0-750]	**119** [3-300]
Average Cost per LEP Patient Encounter	**$53** [$0-$200]	**$42** [$0-$200]	**$24** [$0-$50]	**$114** [$0-$250]	**$51** [$20-$100]	**$88** [$10-$200]
Average Hospital Cost per Year	**$1411** [$0-$4000]	**$224** [$0-$1000]	**$1488** [$0-$4700]	**$4600** [$0-$16,025]	**$9776** [$100-$60,000]	**$6300** [$1000-$15,600]

Note: Numbers in brackets represent the range of responses in each region. Some CAHs were not able to provide cost estimates.

Average Costs to Provide Language Access Services by Proximity to Metropolitan Areas

The average costs to provide language access services per patient encounter and per year were analyzed by proximity to metropolitan areas. The average number of limited English proficient patient encounters was roughly equal regardless of proximity to metropolitan areas and ranged from zero to 750 patient encounters per year. The average cost per limited English proficient patient encounter was $36 for hospitals in close proximity to metropolitan areas and $98 for hospitals more than 100 miles from metropolitan areas. This figure ranged from zero to $250 per limited English proficient patient encounter. The average hospital cost per year was roughly equivalent regardless of proximity to metropolitan areas and ranged from zero to $60,000 (Table 9).

Table 9. Frequency and Cost of Providing Language Access Services in Critical Access Hospitals by Proximity to Metropolitan Areas

	Less than 100 miles Proximity to Metro Areas (n=33)	**More than 100 miles Proximity to Metro Areas (n=27)**
Average Number of LEP Patient Encounters	**58** [0 - 750]	**61** [0 - 400]
Average Cost per LEP Patient Encounter	**$36** [$0 - $100]	**$98** [$0 - $250]
Average Hospital Cost per Year	**$4977** [$0 - $60,000]	**$4392** [$0 - $16,025]

Note: Numbers in brackets represent the range of responses by proximity to metro areas. Some CAHs were not able to provide cost estimates.

Discussion

Summary

There were several noteworthy findings from this survey of language access services in Minnesota CAHs. First, most CAHs had few staff resources devoted exclusively to the management of language access services. However, a majority of CAHs had written policies regarding the provision of language access services.

Second, CAHs had the greatest contact with Spanish-speaking limited English proficient patients. This was not surprising given the most common language spoken in the service areas other than English was Spanish.

Third, CAHs provided a range of language access services including oral translation services, written translated materials, and posted signage in languages other than English. The level of language services provided by CAHs varied by region with high demand areas providing more extensive services. Thus, “one size does not fit all” and CAHs remain flexible to the needs of limited English proficient populations in their service areas.

Fourth, CAH collaboration with community organizations and direct outreach to limited English proficient patient populations occurred infrequently. One quarter of CAHs collaborated with community organizations, most commonly local public health and county human service organizations. Although these are key partners for linking limited English proficient patients to other health-related and community services, ethnic and cultural-based community groups, interpreters and community health workers are important links to the communities they serve. These groups may be better positioned to disseminate health information and push for prevention with the limited English

proficient population because they are more likely than CAHs to understand cultural learning styles (for example, the use of music or group discussion) and avoid cultural taboos.

Fifth, CAHs received limited reimbursement for providing language access services. Although one quarter of CAHs reported facing significant financial obstacles to providing language access services, only a small percentage (3%) obtained reimbursement for costs associated with providing language access services. However, this low percentage was equal to the national percentage of hospitals receiving direct reimbursement (also 3%).

Sixth, the average number of limited English proficient patient encounters was slightly lower in CAHs less than 100 miles from metropolitan areas, suggesting that competition with larger hospitals or health care systems may draw limited English proficient patients away from small rural facilities. An additional finding was the cost of limited English proficient patient encounters in CAHs more than 100 miles from metropolitan areas was nearly three times higher than CAHs in close proximity to metropolitan areas.

These findings were consistent with those of Torres et al. who reported that most rural hospitals (98%) provided language access services and had written plans regarding language access services. However, our findings differ somewhat from the Health Research and Educational Trust (HRET) national hospital study. We found that 13% of CAHs served limited English proficient patients on a daily basis, 17% on a weekly basis, and 33% on a monthly basis. The national HRET hospital study reported that 21% of rural hospitals experienced limited English proficient patient encounters on a daily basis,

22% on a weekly basis and 23% on a monthly basis. The percent of residents speaking a language other than English at home in Minnesota is roughly half that of the national average, which may account for comparatively lower numbers of limited English proficient patient encounters in Minnesota's rural hospitals.

Practice and Policy Implications

CAHs participating in this study indicate that rural hospitals serving limited English proficient patients use a variety of methods to provide linguistically appropriate care. In light of our findings, CAH administrators may wish to consider the following issues and recommendations:

CLAS Compliance Issues

- Increase staff awareness of the needs of limited English proficient patients, resources for serving these patients, and hospital policies related to providing language access services. Early and ongoing identification of limited English proficient patients and referrals to appropriate services will improve overall safety and quality of care. A majority of CAHs in our sample had a written policy or plan related to the provision of language access services for limited English proficient patients, but staff may not be aware of these policies or plans.
- Incorporate "best practice" areas in policies or plans related to language access services. Research on best practices suggests that 1) identification of limited English proficient individuals who need language assistance 2) provision of appropriate language assistance 3) training of staff on limited English proficient

patient policies and procedures 4) provision of notices to limited English proficient persons of availability of language assistance services at no charge and 5) planning to monitor and update the language access services policy are all important elements of an effective language access services plan. In our study, although most CAHs had a plan related to language access services, few followed "best practices." For example, only 44% of CAHs provided translated information regarding free language access services at their hospitals.

- Prohibit the use of minors as interpreters due to cultural and privacy (HIPAA) considerations. In our study, 42% of CAHs relied on family or friends to provide oral interpretation services and some of these family members were likely children.

Rural Hospital Staff Development Issues

- Use trained medical interpreters in all encounters with limited English proficient patients and work effectively with interpreters as part of a coordinated care team. Very few CAHs in our study had bilingual medical staff.
- Increase collaboration with interpreters, community health workers and outside organizations for improved outreach to limited English proficient populations. Few CAHs in our sample had staff devoted to community outreach activities related to limited English proficient populations.

Policymakers, in collaboration with state departments and key stakeholders, may wish to support the following policy and program development recommendations for the provision of linguistically appropriate care in rural Minnesota hospitals based on our findings:

Statewide Policy Development

- Clarify the definition(s) of "qualified medical interpreter." In our study, CAHs used both formal and informal types of interpreters.

Statewide Coordination of Resources

- Increase the availability of translated documents, especially in rural counties with emerging limited English proficient populations, through coordination at the state level. Although CAHs in our study reported having health education materials available in various languages, few reported having translated intake forms or applications for services.
- Provide technical assistance for language access plan development, with a focus on regions with high limited English proficient population growth or large established limited English proficient communities.

Study Limitations

Our study has limitations that can inform future studies of language access services provided by CAHs. First, our study was limited to CAHs and did not include information about language access services provided by large hospitals or community clinics in rural Minnesota. Close proximity to large hospitals and health care systems in metropolitan areas may be one factor that draws limited English proficient patients away from small rural health care facilities. Uninsured limited English proficient patients may be more likely to receive health care services at community clinics. Future studies may wish to include CAHs, large hospitals and community clinics in rural Minnesota.

Second, our study was based on cross sectional data, i.e., data collected in one point in time. Thus, we do not know if our findings would have differed had we surveyed CAHs at additional points in time.

Third, our results are descriptive. For example, we did not examine the association between costs by region and proximity to metropolitan areas. Our study was intended to be descriptive and identify future hypotheses that could be tested regarding such associations.

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Appendices

A. Office of Minority Health CLAS Standards

B. Survey Instrument

Appendix A: Office of Minority Health CLAS Standards

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

- CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).
- CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

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.

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.

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.

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 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).

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.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

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 internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

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.

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.

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.

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.

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.

Appendix B: Survey Instrument

Survey of Language Access Services in Critical Access Hospitals for Patients with Limited English Proficiency

The Rural Hospital Flexibility Program Advisory Committee is conducting a statewide survey of Minnesota's Critical Access Hospitals focused on language access services for patients with limited English proficiency. Please complete and return the survey by mail in the self-addressed stamped envelope by October 1, 2007. For questions, please contact Kristen Tharaldson at (651) 201-3863 or kristen.tharaldson@health.state.mn.us

(1) The person completing this survey is (check one):

- ☐ Director of Nursing
- ☐ Director of Quality
- ☐ Hospital Administrator
- ☐ Other (specify position title) _____

(2) Does your hospital provide any language access services for patients with limited English proficiency? YES NO

< If "YES," go to (2a). If "NO," skip to (3). >

(2a) Does your hospital have designated staff for managing language access services for patients with limited English proficiency? YES NO

(3) Does your hospital have a written policy or plan regarding the provision of language access services for patients with limited English proficiency? YES NO

< If "YES," go to (3a). If "NO," skip to (4). >

(3a) What areas does the plan cover? (check all that apply)

- ☐ Identification of limited English proficient patients in service area
- ☐ Quality measures for language access services
- ☐ Training for staff on limited English proficient patient needs
- ☐ Notice of language access services available to patients at no cost
- ☐ Plan for monitoring and updating the written policy/plan
- ☐ Other (please specify) _____

(4) Does your hospital determine the prevalent languages (frequently encountered non-English languages) of residents in its service area? YES NO

< If "YES," go to (4a). If "NO," skip to (5). >

(4a) What are the prevalent languages? (check all that apply)

- ☐ Spanish
- ☐ Somali
- ☐ Hmong
- ☐ Other (please specify) _____

(4b) How are they determined? (check all that apply)

- ☐ Hospital data collection of preferred oral language of patients
- ☐ Hospital data collection of preferred written language of patients
- ☐ Primary Home Language Counts (MN Dept. of Education)
- ☐ Census data
- ☐ Other (please specify) _____

(5) For each language listed, check the box that describes how often encounters with limited English proficient patients occur in your hospital:

LANGUAGE	DAILY	WEEKLY	MONTHLY	NEVER
Spanish				
Somali				
Hmong				
Laotian				
Vietnamese				
Russian				
Cambodian				
Other-				
Other-				

(6) Does your hospital provide *oral* interpretation services for patients with limited English proficiency? YES NO

< If "YES," go to (6a). If "NO," skip to (7). >

(6a) How? (Check all that apply)

- ☐ Bilingual medical staff
- ☐ Bilingual community health workers
- ☐ Full or part-time staff interpreters
- ☐ Contract interpreters
- ☐ Telephone language line services
- ☐ Family or friend of patient
- ☐ Community volunteers
- ☐ Other (please specify) _____

(7) Does your hospital assess the skills and competencies of interpreters that the hospital uses? YES NO

< If "YES," go to (7a). If "NO," skip to (8). >

(7a) Which areas are covered in the assessment? (Check all that apply)

- ☐ Proficiency in English and non-English languages
- ☐ Knowledge of confidentiality requirements
- ☐ Knowledge of medical terminology
- ☐ Ability to interpret effectively
- ☐ Ability to avoid other roles
- ☐ Other (please specify) _____

(8) Does your hospital provide *written* translated materials for patients with limited English proficiency? YES NO

< If "YES," go to (8a). If "NO," skip to (9). >

(8a) What translated materials are available? (Check all that apply)

- ☐ AI Speak cards or other basic communication aides
- ☐ Notices advising of free language access services
- ☐ Applications to receive services
- ☐ Intake forms
- ☐ Consent forms
- ☐ Health education information
- ☐ Explanations of screening, diagnosis or treatment options
- ☐ Medication management/prescription directions
- ☐ Notices of rights, denial, loss or decrease in services
- ☐ Letters regarding participation in a program
- ☐ Other (please specify) _____

(8b) What factors are considered regarding the quality of translated materials?

- ☐ Literacy level of limited English proficient patients
- ☐ Field testing of translated materials
- ☐ Source of translated materials
- ☐ Other (please specify) _____

(9) Are there signs posted in your hospital in languages other than English? YES NO

< If "YES," go to (9a). If "NO," skip to (10). >

(9a) In which languages is your signage? (check all that apply)

- ☐ Spanish
- ☐ Somali
- ☐ Hmong
- ☐ Other (please specify) _____

(9b) Which topics does the signage address? (check all that apply)

- ☐ Services available
- ☐ Explanation of right to language access services
- ☐ Conflict and grievance procedures
- ☐ Office hours
- ☐ Other (please specify) _____

(10) Does your hospital do targeted outreach to patients with limited English proficiency? YES NO

(11) Does your hospital collaborate with community-based organizations to improve outreach to patients with limited English proficiency? < If "YES," go to (11a). If "NO," skip to (12). > YES NO

(11a) With which organizations do you collaborate? (Check all that apply)

- ☐ Local public health departments
- ☐ County human services departments
- ☐ Refugee settlement agencies
- ☐ Ethnic and minority organizations
- ☐ Faith-based organizations
- ☐ Other (please specify) _____

(12) Does your hospital designate staff for community outreach efforts with limited English proficient patients? YES NO

(13) Approximately how many patient encounters per year require language access services at your hospital? _____

(14) How much does it cost *per patient encounter* to provide language access services? (Note if estimated or actual costs.) $_____ ESTIMATE ACTUAL

(15) How much does it cost *per year* to provide language access services? (Note if estimated or actual costs.) $_____ ESTIMATE ACTUAL

(16) Does your hospital obtain reimbursement for costs associated with the provision of language assistance services? YES NO
< If "YES," go to (16a). If "NO," skip to (17). >

(16a) For which patients do you obtain reimbursement? (Check all that apply)

- ☐ Medicaid/PMAP patients
- ☐ Minnesota Care/PMAP patients
- ☐ Privately insured patients
- ☐ Other (please specify) _____

(17) Does your hospital face significant financial obstacles to providing language access services? < If "YES," go to (17a).> YES NO

(17a) What types of financial obstacles do you face? (Check all that apply)

- ☐ Lack of state funding for language access services
- ☐ Lack of hospital funding for language access services
- ☐ Low reimbursement for language access services
- ☐ Other (please specify) _____

Thank you for completing this survey.