



HOSPITAL LANGUAGE SERVICES
FOR PATIENTS WITH LIMITED ENGLISH PROFICIENCY:
RESULTS FROM A NATIONAL SURVEY

Romana Hasnain-Wynia | Julie Yonek | Debra Pierce | Ray Kang | Cynthia Hedges Greising



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Health Research and Educational Trust/AHA
One North Franklin, 30th Floor
Chicago, IL 60606
www.hret.org



National Health Law Program
1101 14th St NW, Suite 405
Washington, DC 20005
www.healthlaw.org

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E X E C U T I V E S U M M A R Y

Health care providers from across the country have reported language difficulties and inadequate funding of language services to be major barriers to limited English proficiency (LEP) individuals' access to quality health care. Almost 52 million people—over 19% of the U.S. population—speak a language other than English at home. The Census Bureau's 2005 American Community Survey documented that over 29% of all Spanish speakers, 22% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English “not well” or “not at all.” Estimates of the number of people with LEP range from a low of about 12 million, or 4.5% of the U.S. population—who speak English “not well” or “not at all”—to over 23 million people, or 8.6% of the U.S. population—if one includes those who speak English less than “very well.”

The Health Research and Educational Trust (HRET), the research and educational affiliate of the American Hospital Association, in collaboration with the National Health Law Program, conducted a national survey of hospitals in the United States to seek information about patient language services in hospitals. The purpose of the survey was to better understand the processes and resources available to hospitals in providing language services to patients with LEP.

This report describes current practices, common barriers, and the specific resources and tools needed to provide language services to patients with LEP. The results of the survey will inform federal policymakers, practitioners, providers, and

others of the issues and potential solutions facing hospitals as they work to improve language services for all patients with LEP.

KEY FINDINGS

- 63% of hospitals encountered patients with LEP either daily or weekly; an additional 17% encountered LEP patients at least monthly.
- Hospitals used a wide variety of sources to assess the language needs of communities including using census data and collecting language information directly from patients.
- The most common approach for creating policies and procedures to provide language services was through hospital management.
- 82% of hospitals indicated that staff interpreters were the most frequently used resource for providing language services.
- 92% of hospitals indicated that telephonic services were the most available resource for providing language services.
- 88% of hospitals reported providing language services during off-hours.
- 3% of hospitals indicated receiving direct reimbursement for providing language services.
- Of the 3% of hospitals that received direct reimbursement, 78% indicated receiving reimbursement from Medicaid.
- The most frequent barrier hospitals faced in providing language services was that staff had no means of identifying patients who needed language services before they arrived at the hospital.
- Tools that hospital staff would find useful for providing language services included packaged

in-service training programs and model approaches and promising practices demonstrated by other health care institutions serving LEP patients.

- Training that hospital staff would find most useful for providing language services included how to respond to patients and family members who did not speak English and cultural competency training.
- 33% of hospitals were engaged in initiatives to improve language services, and 72% of those engaged indicated that they would be willing to share information about their initiatives.

Evidence shows that effective communication between patients and clinicians is a critical component of providing high-quality health care. When communication is compromised by language barriers, the quality of care is also compromised. Consequently, providing individuals with LEP the means to communicate effectively with their health care providers is critical to

improving their experience in the health care setting, the quality of care they receive, and their health outcomes.

As racial and ethnic diversity in the United States continues to increase, so does the demand for appropriate and effective language services. With 80% of hospitals encountering individuals with LEP frequently, and only 3% receiving direct reimbursement for providing language services, the question and challenge are: Who will pay for these services?

Hospitals that commit to providing high-quality language services to their patients likely will be rewarded with greater patient and staff satisfaction, which can provide them with a competitive advantage as the demographics of the United States continue to change. Resources should be targeted toward monitoring and improving language services for all patients with LEP.

HOSPITAL LANGUAGE SERVICES

I. INTRODUCTION

The Health Research and Educational Trust (HRET), the research and educational affiliate of the American Hospital Association, conducted a national survey of hospitals to seek information about patient language services in hospitals. The purpose of the survey was to better understand the processes and resources available to hospitals in providing language services to patients with limited English proficiency (LEP). Looking forward, the results of the survey will inform federal policymakers, practitioners, and providers of the issues and potential solutions facing hospitals as they work to improve language services for their patients and communities.

Nearly 52 million people—over 19% of the U.S. population—speak a language other than English at home.ⁱ The Census Bureau’s 2005 American Community Survey documented that over 29% of all Spanish speakers, 22% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English “not well” or “not at all.”ⁱⁱ Estimates of the number of people with LEP range from a low of about 12 million, or 4.5% of the U.S. population—who speak English “not well” or “not at all”—to over 23 million people, or 8.6% of the U.S. population—if one includes those who speak English less than “very well.”ⁱⁱⁱ

Health care providers from across the country have reported language difficulties and inadequate funding of language services to be major barriers to LEP individuals’ access to health care and a

serious threat to the quality of the care they receive.^{iv} Demographic trends continue to document the diversity of the country, underscoring the challenge for health care providers,^v who must determine which language services are most appropriate based on their setting, type, and size; the frequency of contact with LEP patients; and the variety of languages encountered. But without adequate attention and resources being applied to address the problem, the health care system cannot hope to meet the challenge of providing LEP individuals appropriate access to quality health care.

A report by the Access Project found that 161 uninsured patients who received health care at 23 primarily safety net hospitals had differing experiences based on access to an interpreter.^{vi} Patients who needed and got an interpreter rated their hospital experience and the care they received more positively than those patients who needed an interpreter but did not get one. Other studies have found that racial and ethnic minorities tended to report worse care than Whites but linguistic minorities of any race reported worse care than did English-speaking racial and ethnic minorities.^{vii} Beyond patient satisfaction, solid evidence shows that language barriers can adversely affect quality of care. Poor patient outcomes that have been attributed to language barriers include increased use of expensive diagnostic tests, increased use of emergency services and decreased use of primary care services, and poor or no patient follow-up when follow-up is indicated.^{viii}

| T A B L E 1 | | | | |
|---|--------------------|------|------------|------|
| Comparison of Survey Respondents to Overall Hospital Population | | | | |
| | Sample Respondents | | Population | |
| Region | N | % | N | % |
| New England | 34 | 3.9 | 182 | 4.0 |
| Mid Atlantic | 80 | 9.3 | 436 | 9.5 |
| South Atlantic | 155 | 18.0 | 694 | 15.1 |
| East North Central | 122 | 14.2 | 695 | 15.1 |
| East South Central | 85 | 9.9 | 409 | 8.9 |
| West North Central | 156 | 18.1 | 656 | 14.2 |
| West South Central | 87 | 10.1 | 668 | 14.5 |
| Mountain | 61 | 7.1 | 340 | 7.4 |
| Pacific | 81 | 9.4 | 526 | 11.4 |
| Bed Size | | | | |
| | N | % | N | % |
| 6-24 Beds | 50 | 5.8 | 338 | 7.3 |
| 25-49 Beds | 142 | 16.5 | 918 | 19.9 |
| 50-99 Beds | 137 | 15.9 | 911 | 19.8 |
| 100-199 Beds | 284 | 33.0 | 1,079 | 23.4 |
| 200-299 Beds | 112 | 13.0 | 590 | 12.8 |
| 300-399 Beds | 45 | 5.2 | 339 | 7.4 |
| 400-499 Beds | 37 | 4.3 | 179 | 3.9 |
| 500 or More Beds | 54 | 6.3 | 252 | 5.5 |
| LEP Growth* | | | | |
| | N | % | N | % |
| Growth | 367 | 42.6 | 3,349 | 27.3 |
| Non-Growth | 494 | 57.4 | 1,257 | 72.7 |
| Urban/Rural Status | | | | |
| | N | % | N | % |
| Rural | 412 | 47.9 | 2,003 | 43.5 |
| Urban | 449 | 52.1 | 2,603 | 56.5 |
| Teaching Status | | | | |
| | N | % | N | % |
| Non-Teaching | 725 | 84.2 | 3,999 | 84.4 |
| Teaching | 136 | 15.8 | 738 | 15.6 |
| Hospital Ownership | | | | |
| | N | % | N | % |
| Government (Nonfederal) | 207 | 24.0 | 1,111 | 24.1 |
| Not-for-Profit | 562 | 65.3 | 2,786 | 60.5 |
| Private-for-Profit (Investor Owned) | 92 | 10.7 | 709 | 15.4 |
| System Member | | | | |
| | N | % | N | % |
| Yes | 425 | 49.4 | 2,436 | 52.9 |
| No | 436 | 50.6 | 2,170 | 47.1 |
| Total | 861 | | 4,606 | |

* Fifteen states were considered LEP growth states: Arkansas, Colorado, Georgia, Idaho, Kentucky, Kansas, Minnesota, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Utah, and Washington.
Source: HRET, 2006.

In addition, several laws require hospitals to provide language assistance to individuals with LEP. These include Title VI of the Civil Rights Act of 1964, the Emergency Medical Treatment and Active Labor Act, the Hill-Burton Act, and Medicaid and Medicare regulations.^{ix}

This report describes the findings from a national survey of hospitals with the goal of understanding current practices, common barriers, and the specific resources and tools needed to provide language services to patients with LEP. The report aims to provide information that can be acted upon by policymakers, health care providers, practitioners, and others to improve language services for all patients with LEP.

II. CHARACTERISTICS OF RESPONDENTS

We compared respondents to the hospital population based on select characteristics including region, bed size, LEP growth (those hospitals in states that experienced more than a 100% growth in their LEP populations between 1990 and 2000), urban/rural status, teaching status, control status (not-for-profit, private for-profit, or government), and whether the hospital was part of a health system or a stand-alone (Table 1). Hospitals that responded to the survey did not differ significantly from the population of hospitals based on the select characteristics. (We define hospital characteristics in Section VI of this report.) Since we oversampled hospitals in LEP growth states, 43% of the hospitals that responded to the survey were in LEP growth states, compared to 27% in the population.

III. RESULTS FROM THE SURVEY

1. Language Needs of Populations Served

We asked respondents how often they encountered patients with limited English proficiency (LEP). Eighty percent (80%) of the hospitals responded that they encountered patients with limited English proficiency frequently (defined as at least monthly, if not weekly or daily): 43% reported daily

encounters, 20% reported weekly encounters, and 17% reported monthly encounters. Table 2 shows the frequency of LEP encounters by hospital type and region. The size, urban/rural status, region, teaching status, and whether the hospital was a system member or a stand-alone were significantly related to the frequency of LEP encounters. Large and teaching hospitals and those in urban settings were more likely to see a higher number of patients with LEP.

Table 3 shows languages that at least 20% of hospitals encountered frequently. In addition to 32 listed languages, we provided a write-in response option. Eleven percent (11%) of hospitals wrote in a language (labeled as “other” in Table 3), and 17 hospitals specified American Sign Language as a write-in response.

We asked hospitals to identify the sources of information they used to assess the language needs of the communities they serve. Hospitals were more likely to use census data or collect language information directly from patients to assess language needs of the community (Figure 1). Forty-six percent (46%) of hospitals collect language information from patients and over 50% collect language information from the community (31% of data comes from local community organizations and 21% comes from a hospital conducting a community needs assessment).

In January 2006, the Joint Commission on Accreditation of Healthcare Organizations instituted a new standard requiring hospitals to collect and document language information about their patients as part of its accreditation process. In addition, according to a newly released consensus report *Improving Communication—Improving Care* by the Ethical Force Program,¹ which focuses on improving communication with diverse populations, hospitals should collect information

| T A B L E 2 | | |
|--|------------|---|
| Encounters with LEP Patients by Hospital Characteristics | | |
| | N | % Hospitals that encounter LEP patients monthly, weekly, or daily |
| Total | 858 | 80 |
| Hospital Ownership | | |
| Government (Nonfederal) | 207 | 77 |
| Not-for-Profit | 559 | 81 |
| Private-for-Profit (Investor Owned) | 92 | 74 |
| Size* | | |
| Small | 328 | 64 |
| Medium | 395 | 90 |
| Large | 135 | 97 |
| Urban/Rural Status* | | |
| Rural | 410 | 66 |
| Urban | 448 | 89 |
| Census Region* | | |
| Northeast | 113 | 82 |
| South | 326 | 83 |
| Midwest | 277 | 69 |
| West | 142 | 88 |
| Teaching Status* | | |
| Non-Teaching | 722 | 75 |
| Teaching | 136 | 98 |
| System Member* | | |
| Yes | 424 | 80 |
| No | 434 | 78 |
| Critical Access Hospital* | 187 | 53 |
| Sole Community Hospital* | 122 | 70 |
| Rural Referral Center* | 106 | 93 |

*Significance level, $p < .05$.
 Percents are weighted using hospital weights.
 Source: HRET, 2006.

from patients about their primary language as well as information from local groups about the languages spoken in the community.^x Both data

¹ The report represents a consensus of the members of the Ethical Force Program™ Oversight Body. The Ethical Force Program™ is a collaborative project led by the Institute for Ethics of the American Medical Association. For a complete list of Ethical Force Program™ Oversight Body members, go to <http://www.ama-assn.org/ama/pub/category/3652.html>.

T A B L E 3

| Languages That 20 Percent or More of the Hospitals Indicated They Encountered Frequently | |
|--|-----|
| Spanish | 93% |
| Chinese | 47% |
| Vietnamese | 39% |
| Japanese | 37% |
| Korean | 37% |
| Russian | 37% |
| German | 36% |
| French | 31% |
| Arabic | 26% |
| Italian | 26% |
| Laotian | 23% |
| Hindi | 22% |
| Polish | 22% |
| Tagalog | 21% |
| Thai | 20% |
| Other | 11% |

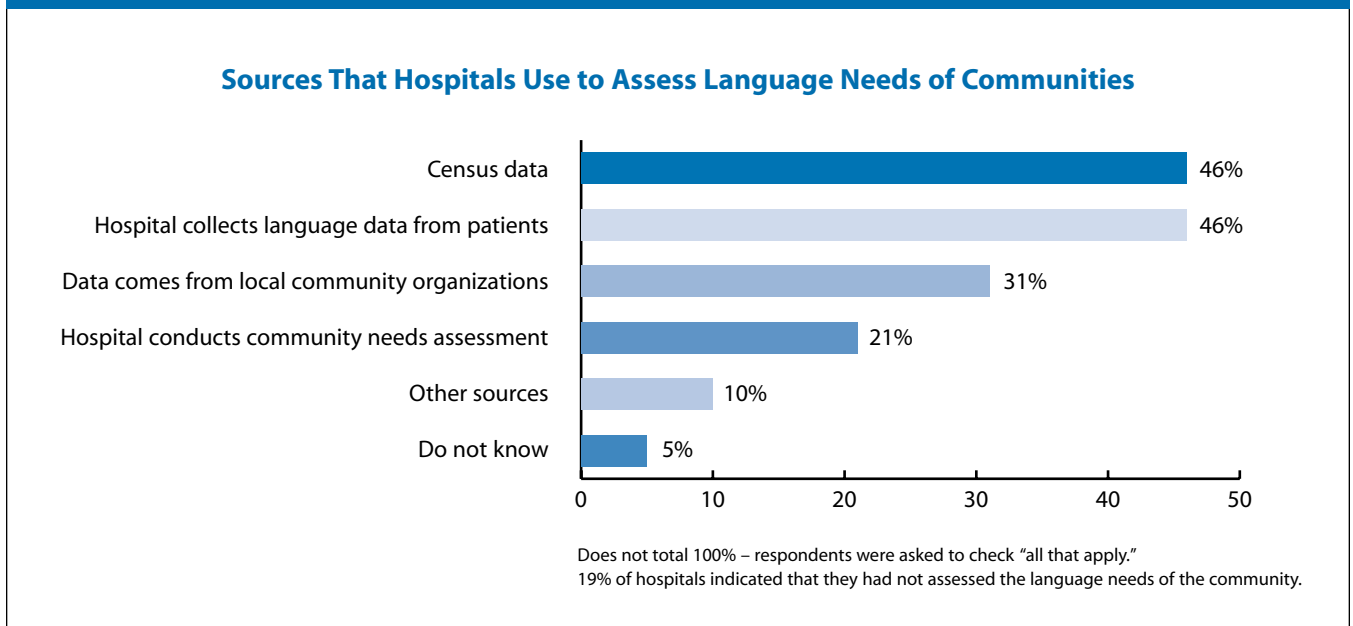
Source: HRET, 2006.

collection activities facilitate effective communication with diverse populations as well as enable hospitals to make the case for improving resources for providing language services. In addition, community-level information can help hospitals in guiding strategic planning. For example, if a hospital is inadvertently failing to meet the language needs of a specific group, and as a result the majority of the population avoids receiving care at that hospital, it may be missing an opportunity.^{xi}

The results of the survey indicate that hospitals are gathering information both at the individual level (from patients) and at the community level (from census data, local community organizations, and community needs assessment). However, since the two most common sources of collecting these data are from the census and directly from patients, we show these results by hospital characteristics in Table 4.

We saw significant differences by hospital characteristics. For example, not-for-profit hospitals were significantly more likely to use census data

F I G U R E 1



Source: HRET, 2006.

while for-profit hospitals were more likely to collect the information from patients. Large and urban hospitals were significantly more likely to use census data and information from patients. There was not a significant difference by region. Teaching hospitals were significantly more likely than non-teaching hospitals to use both sources for getting information. Critical access hospitals, which tend to be small (no more than 15 inpatient beds), were the least likely of all hospitals to use both as sources for getting information.

2. Resources Used to Provide Language Services

We asked hospitals about the approaches (e.g., by management, internal committees, etc.) they used to create policies and procedures related to providing language services to patients (Figure 2). Respondents were asked to select all that apply.

Hospitals used a variety of approaches for creating policies and procedures to provide language services. The most common approach was to use hospital management followed by a designated staff person. The use of external/internal committees was much lower compared to other approaches. A total of 95 hospitals (11% of the sample) indicated that they used combined external/internal committees. As a hospital develops or expands its language service programs, increasing community participation may be a highly effective strategy.

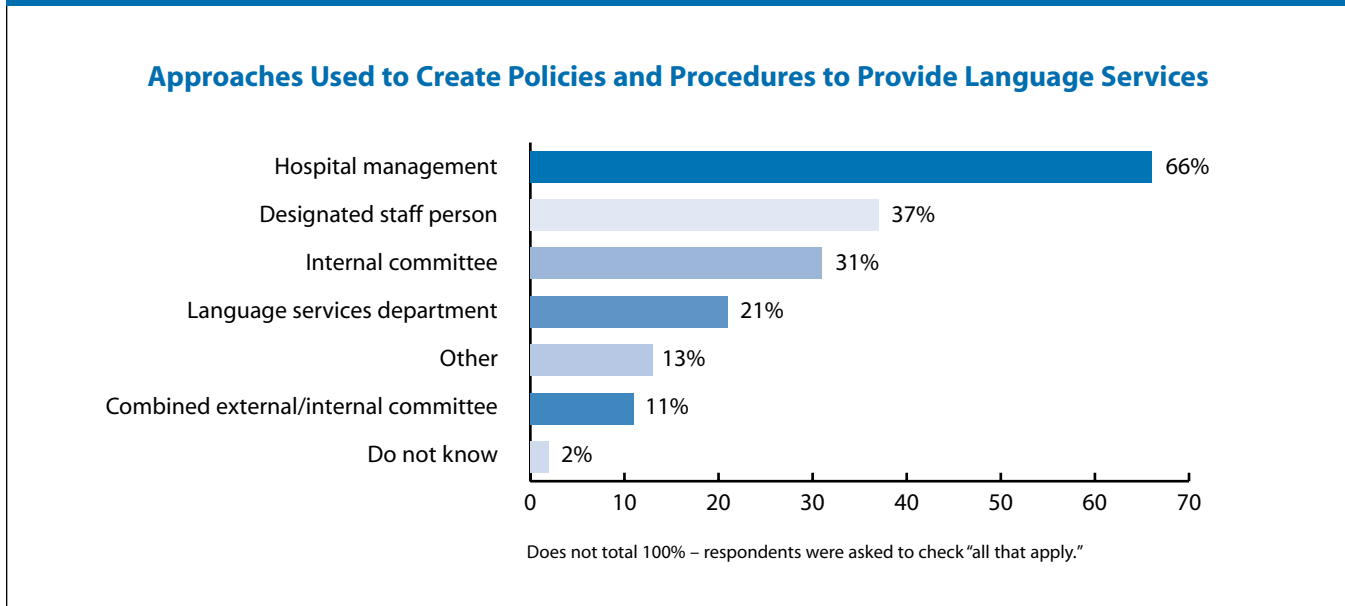
Approaches used to create policies and procedures varied by hospital characteristics. For-profit hospitals were more likely than government or not-for-profit hospitals to use hospital management or internal committees to create policies and procedures for language services. Large and urban hospitals were more likely than midsize and small hospitals in rural settings to use internal committees. Teaching hospitals were more likely to use combined external/internal

| T A B L E 4 | | |
|--|---------------------|---------------------------------------|
| Using Census Data and Collecting Information From Patients Varies by Hospital Type | | |
| | Use Census Data (%) | Collect Information from Patients (%) |
| Hospital Ownership | | |
| Government (Nonfederal) | 41* | 38* |
| Not-for-Profit | 52 | 48 |
| Private-for-Profit (Investor Owned) | 33 | 52 |
| Size | | |
| Small | 38* | 36* |
| Medium | 52 | 50 |
| Large | 64 | 64 |
| Urban/Rural Status | | |
| Rural | 38* | 32* |
| Urban | 55 | 56 |
| Census Region | | |
| Northeast | 60* | 51 |
| South | 39 | 45 |
| Midwest | 42 | 42 |
| West | 62 | 52 |
| Teaching Status | | |
| Non-Teaching | 45* | 41* |
| Teaching | 58 | 66 |
| System Member | | |
| Yes | 45 | 48 |
| No | 51 | 43 |
| Critical Access Hospitals | 38* | 25* |
| Sole Community Hospitals | 42 | 34* |
| Rural Referral Center | 44 | 40 |

*Significance level, $p < .05$.
Source: HRET, 2006.

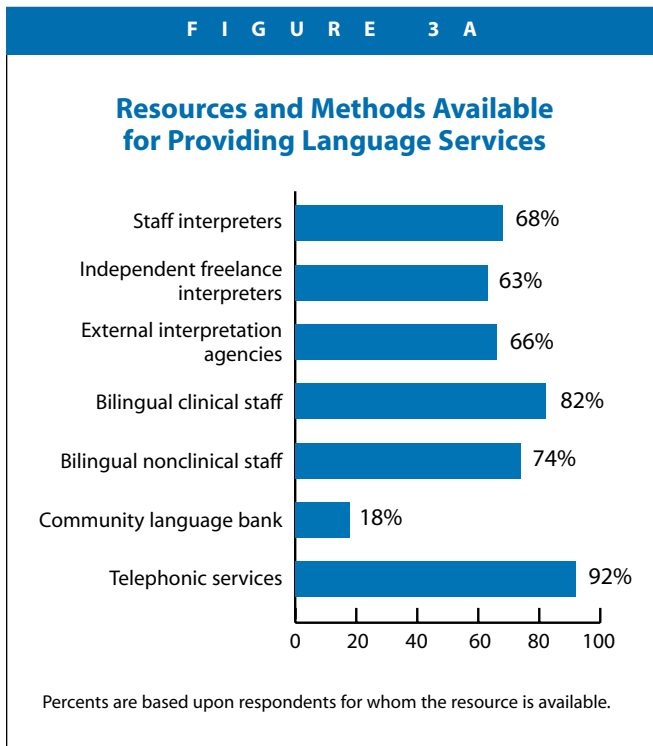
committees. Government, not-for-profit, and urban hospitals were more likely than for-profit hospitals to use a designated staff person. Teaching hospitals were more likely than non-teaching hospitals to use a designated staff person to create

F I G U R E 2



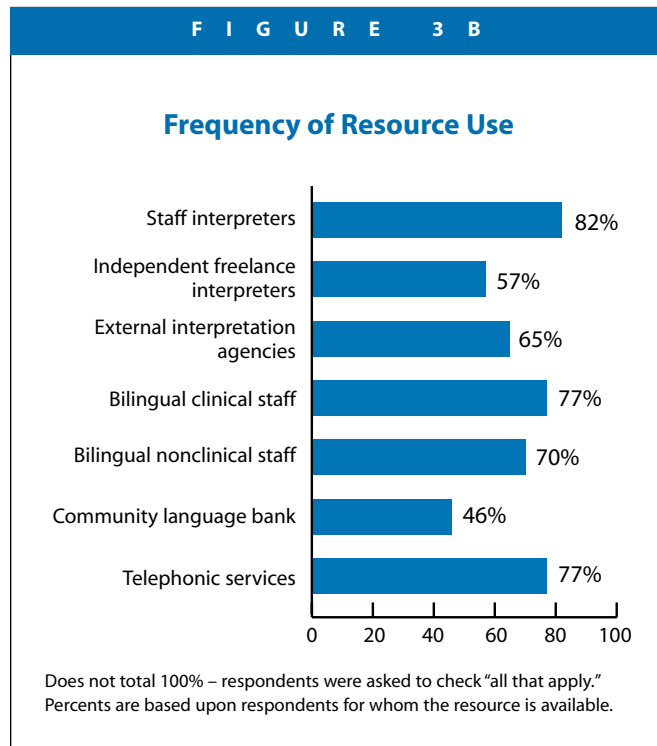
Source: HRET, 2006.

F I G U R E 3 A



Source: HRET, 2006.

F I G U R E 3 B



Source: HRET, 2006.

policies and procedures for language services. Large, not-for-profit, and urban hospitals and those with teaching/residency training programs were more likely than other hospitals to use language services departments to create policies and procedures. We asked hospitals to identify the types of

resources available to them for providing language services and the frequency of resource use. Figures 3A and 3B show the results. Telephonic services were the most cited resource available for providing language services. The frequency of resource use was based only on those respondents

T A B L E 5

**Resources Available to Hospitals for Providing Language Services
by Hospital Characteristics and Region (%)**

| | Staff Interpreters | Freelance Interpreters | Interpretation Agencies | Bilingual Clinical Staff | Bilingual Nonclinical Staff | Community Language bank | Telephonic |
|-------------------------------------|--------------------|------------------------|-------------------------|--------------------------|-----------------------------|-------------------------|------------|
| Hospital Ownership | | | | | | | |
| Government (Nonfederal) | 69* | 57 | 51* | 77* | 69 | 14* | 84* |
| Not-for-Profit | 65 | 66 | 70 | 82 | 74 | 17 | 93 |
| Private-for-Profit (Investor Owned) | 82 | 61 | 76 | 91 | 80 | 35 | 90 |
| Size | | | | | | | |
| Small | 65 | 60 | 52* | 68* | 59* | 19 | 83* |
| Medium | 68 | 64 | 73 | 90 | 82 | 17 | 96 |
| Large | 76 | 70 | 85 | 97 | 93 | 16 | 99 |
| Urban/Rural Status | | | | | | | |
| Rural | 63* | 60 | 46* | 70* | 57* | 18 | 85* |
| Urban | 71 | 66 | 79 | 90 | 85 | 18 | 95 |
| Census Region | | | | | | | |
| Northeast | 69* | 62 | 73 | 93* | 85* | 14 | 95* |
| South | 73 | 64 | 61 | 86 | 80 | 19 | 85 |
| Midwest | 55 | 66 | 68 | 66 | 53 | 18 | 93 |
| West | 82 | 58 | 63 | 93 | 89 | 20 | 93 |
| Teaching Status | | | | | | | |
| Non-Teaching | 66* | 61* | 61* | 79* | 70* | 18 | 89* |
| Teaching | 76 | 73 | 87 | 96 | 90 | 18 | 99 |
| System Member | | | | | | | |
| Yes | 71 | 66 | 73* | 83 | 74 | 21* | 94* |
| No | 65 | 61 | 59 | 79 | 74 | 15 | 87 |
| CAH | 54* | 57* | 44* | 57* | 45* | 18 | 80* |
| SCH | 75 | 53* | 42* | 77 | 70 | 16 | 91 |
| RRC | 65 | 71 | 52* | 82 | 82 | 15 | 91 |

*Significance level, $p < .05$.

Percents are weighted using hospital weights.

CAH – Critical Access Hospital; SCH – Sole Community Hospital; RRC – Regional Referral Center.

Freelance interpreters are hired by hospitals as independent contractors to provide language services. They are not employees of an interpretation agency. **Interpretation agencies** are external organizations that provide interpreter services to hospitals. **Community language bank** consists of a group of bilingual individuals who provide interpreter services to a variety of organizations within a community, typically on a volunteer basis.

Source: HRET, 2006.

who indicated that the resource was available. The most cited method used was staff interpreters. Table 5 shows the types of resources available to hospitals for providing language services by hospital characteristics.

Staff interpreters

For-profit, urban, and teaching hospitals and those in the western region of the country and system members indicated greater availability of staff interpreters compared to other hospitals. Of the three types of rural hospitals, sole community

T A B L E 6

| Percentage of Hospitals Receiving Direct Reimbursement for Language Services by Hospital Characteristics | |
|--|-------------------------------------|
| | % Hospitals Receiving Reimbursement |
| TOTAL | 3 |
| Hospital Ownership | |
| Government (Nonfederal) | 2 |
| Not-for-Profit | 5 |
| Private-for-Profit (Investor Owned) | 0 |
| Size | |
| Small | 2 |
| Medium | 5 |
| Large | 5 |
| Urban/Rural Status* | |
| Rural | 1 |
| Urban | 5 |
| Census Region* | |
| Northeast | 11 |
| South | .9 |
| Midwest | 2 |
| West | 4 |
| Teaching Status* | |
| Non-Teaching | 2 |
| Teaching | 10 |
| System Member | |
| Yes | 3 |
| No | 4 |
| CAH* | 2 |
| SCH | 1 |
| RRC | 0 |

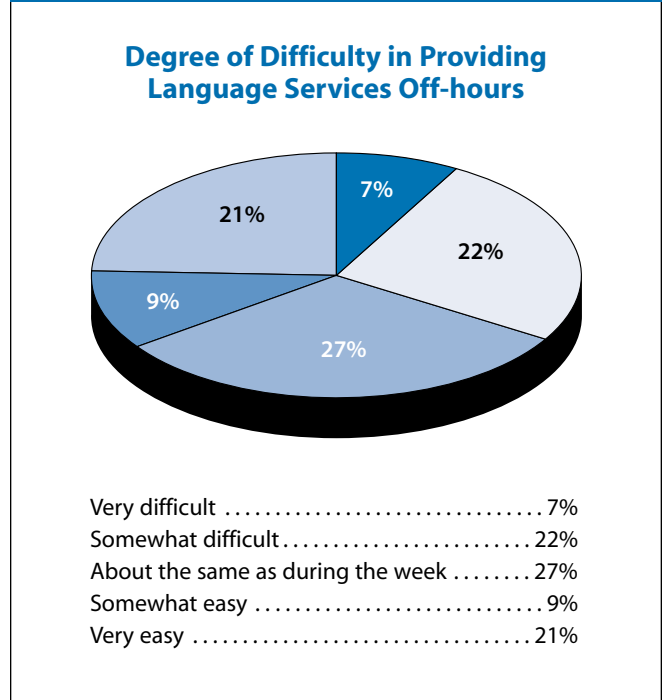
*Significance level, $p < .05$.
 Percents are weighted using hospital weights.
 CAH – Critical Access Hospital; SCH – Sole Community Hospital;
 RRC – Regional Referral Center.
 Source: HRET, 2006.

hospitals were the most likely to have staff interpreters.

Freelance Interpreters

Teaching hospitals and regional referral centers were more likely to indicate the availability of freelance interpreters. Critical access hospitals were

F I G U R E 4



Source: HRET, 2006.

the least likely to indicate availability of freelance interpreters.

Interpretation Agencies

Large, teaching, and urban hospitals and system members were more likely to indicate availability of interpretation agencies. Critical access hospitals, sole community hospitals, and regional referral centers were less likely to indicate availability of interpretation agencies.

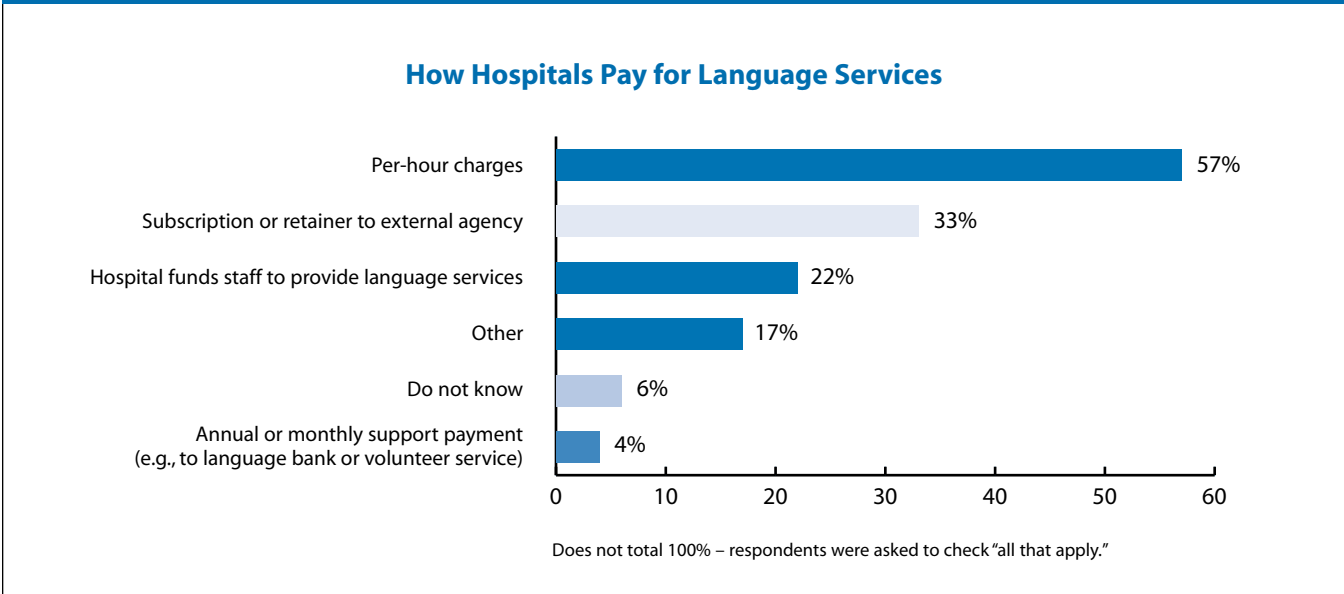
Bilingual Clinical Staff

For-profit, large, urban, and teaching hospitals and hospitals in the northeast and the western regions of the country were more likely to indicate availability of bilingual clinical staff. Critical access hospitals were the least likely to indicate availability of bilingual clinical staff.

Bilingual Nonclinical Staff

Large, urban, and teaching hospitals and those in the western region of the country were more likely to indicate availability of bilingual

F I G U R E 5



Source: HRET, 2006.

nonclinical staff. Critical access hospitals were the least likely to indicate availability of bilingual nonclinical staff.

Community Language Bank

For-profit hospitals and system members were more likely to indicate availability of a community language bank.

Telephonic Services

Large, not-for-profit, urban, and teaching hospitals, and system members in the northeast region of the country were more likely to indicate availability of telephonic services. Critical access hospitals were least likely to indicate availability of telephonic services but still indicated availability at high levels (83%). Overall, telephonic services were the most commonly available resource, and community language banks were the least available resource.

3. Providing Language Services Off-hours

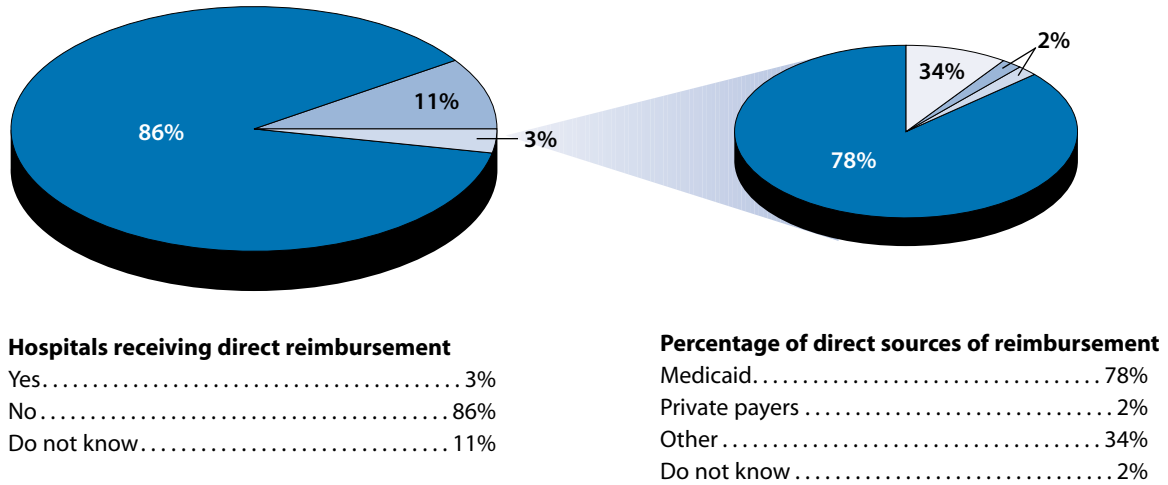
We asked hospitals if they provide language services during off-hours (i.e., 24 hours a day, 7 days per week) and 88% of hospitals responded “yes.” However, critical access hospitals and sole community hospitals were less likely than other

hospitals to provide language services during off-hours (CAH 76%, SCH 85%). But 96% of rural referral centers indicated that they provided language services during off-hours. Figure 4 shows the degree of difficulty hospital respondents perceived in providing language services off-hours. Twenty-nine percent (29%) indicated it was difficult to provide language services 24 hours a day, 7 days per week.

4. Covering the Cost of Language Services

Virtually all hospitals are required by law to provide language services to patients with LEP, and they are prohibited from asking patients to pay for these services. But a very small percentage received direct reimbursement for providing language services, as indicated in Figure 6. The first pie chart shows that only 3% of hospitals received direct reimbursement for language services. The second pie chart, based upon the 3% that indicated receiving reimbursement, shows the sources of direct reimbursement. Medicaid was the largest source of direct reimbursement (78%) while private payers were the smallest source (2%). Table 6 shows the percentage of hospitals receiving direct reimbursement by hospital characteristics.

Percent of Hospitals Receiving Direct Reimbursement for Language Services



Does not total 100% – respondents were asked to check “all that apply.”
 Percentages are based upon 3% of participants who indicated receiving direct reimbursement.

Source: HRET, 2006.

Large and medium-sized hospitals were significantly more likely to get reimbursement than small hospitals. Urban, teaching, and hospitals in the northeast were more likely to receive reimbursement for language services compared to other hospitals.

Figure 5 shows how hospitals pay for language services. The most frequent response (57%) was through “per-hour charges,” which means that hospitals contract with or pay external interpretation agencies for freelance interpreters on a per-hour basis for language services. This is different from paying external agencies through a retainer or subscription mechanism, which 33% of the respondents indicated using.

We wanted to know the aggregate annual cost to hospitals for providing language services and found that a large percentage (41%) could not provide this information. Because hospitals are not directly

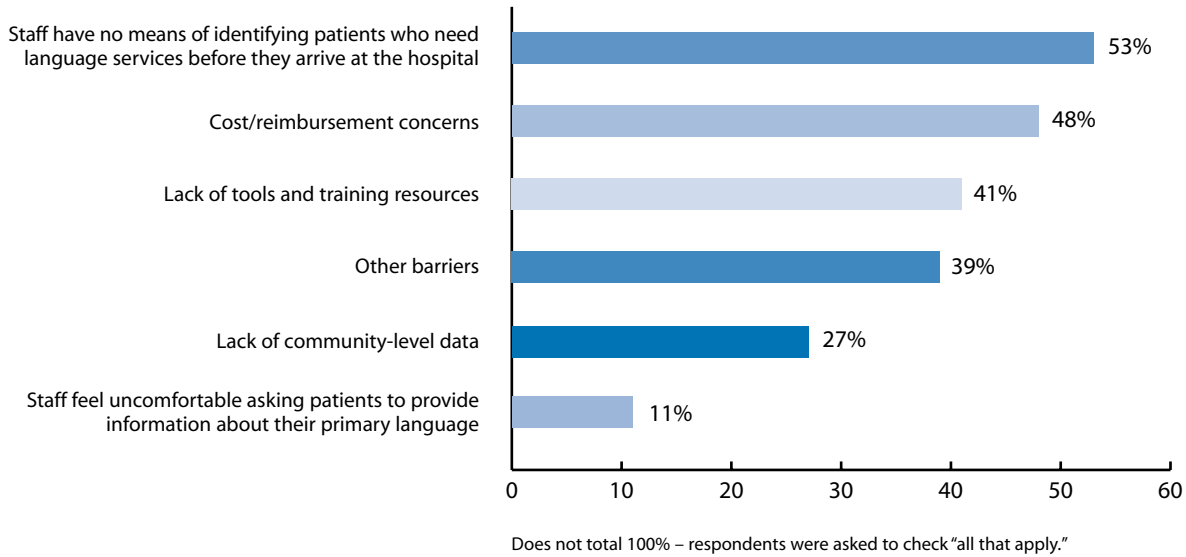
reimbursed for providing language services, most do not have a specific line item in their budget to track these costs. It is likely that they spread the costs over a variety of departments, making it difficult to identify what is actually spent on language services on an annual basis.

5. Need for Tools and Resources

We asked hospitals about the types of barriers they face in providing language services. As illustrated in Figure 7, the most commonly cited barrier was the inability of staff to identify patients who need language services, before they arrive at the hospital (53%), followed by concerns over cost and reimbursement for providing language services (48%). Hospitals found it more difficult to obtain community-level data than obtaining information from patients about the primary language they speak. As illustrated in Figure 8, 18% of hospitals found it difficult to obtain information directly

F I G U R E 7

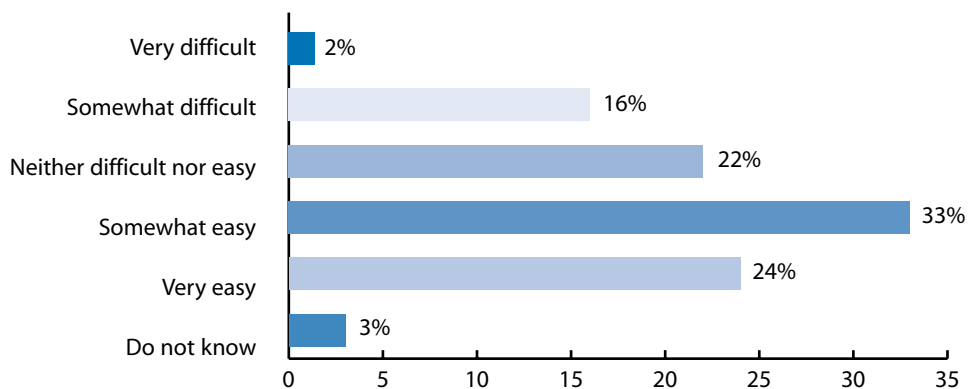
Barriers That Hospitals Face in Providing Language Services



Source: HRET, 2006.

F I G U R E 8

Degree of Difficulty Hospitals Experience in Obtaining Information From Patients About the Primary Language They Speak



Source: HRET, 2006.

from patients. In contrast, almost double of that percentage (33%) found it difficult to obtain community-level data (Figure 9).

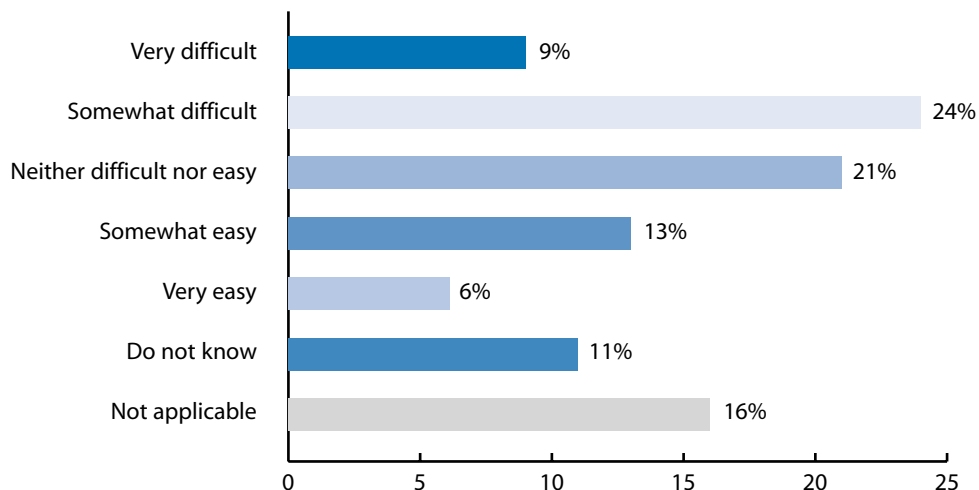
6. Tools and Training That Hospitals Would Find Useful in Providing Language Services

Many hospitals identified the need for tools and

training for hospital staff that would be useful in providing language services. Fifty-eight (58%) indicated that packaged in-service training programs would be a helpful tool. In addition, 50% believed model approaches/promising practices demonstrated by other health care institutions serving LEP patients would also be useful (Figure 10).

F I G U R E 9

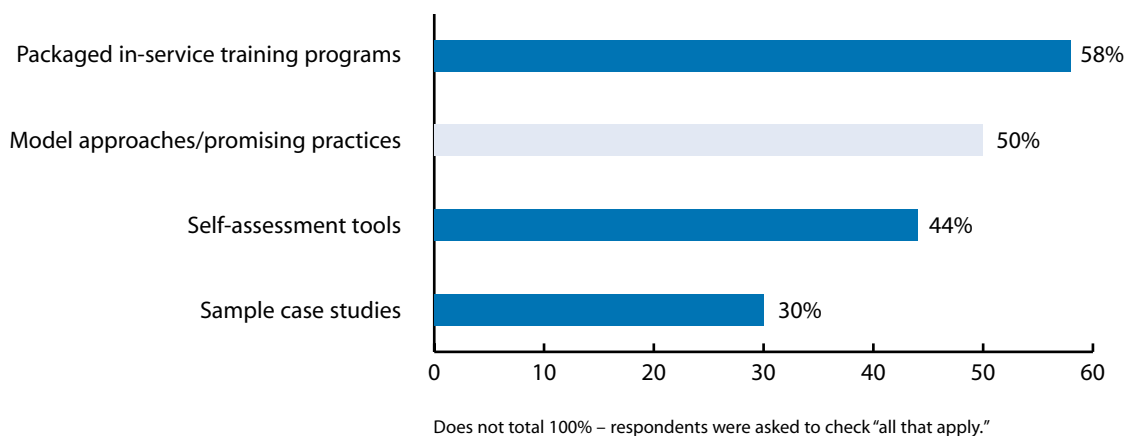
Degree of Difficulty Hospitals Experience in Obtaining Community-level Data to Design Language Services Programs



Source: HRET, 2006.

F I G U R E 10

Tools That Hospital Staff Would Find Useful for Providing Language Services



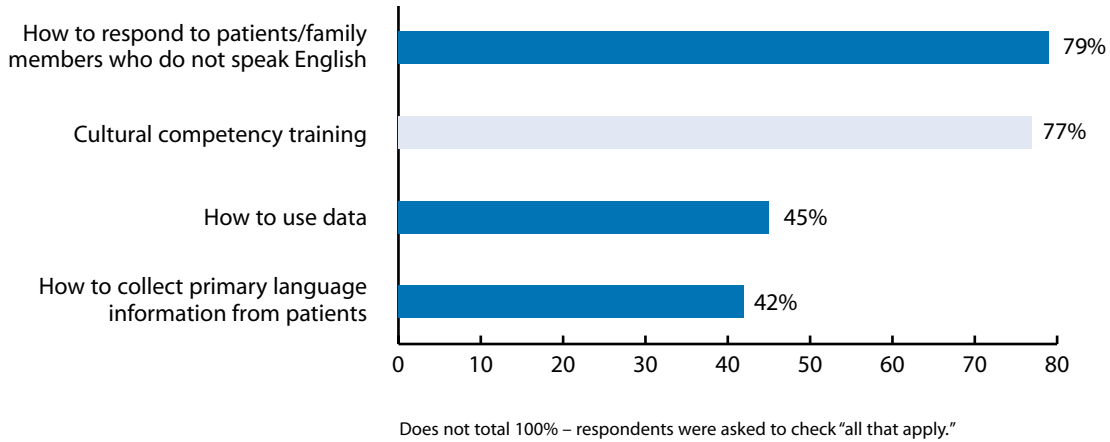
Source: HRET, 2006.

Hospitals identified that specific training on the collection and use of data would be helpful. In addition, 79% of respondents indicated that training on how to respond to patients/family members who do not speak English would facilitate providing language services, as would cultural competency training (77%) (Figure 11).

Though a larger number of hospitals maintain information about patients’ primary language in medical records, far fewer maintain a database of patients’ primary languages that can be tracked over time. It may be that hospitals with Electronic Medical Records (EMR) are the ones that are able to track patients’ primary language over time but, in this survey, we did not ask about whether hospitals had EMR (Figure 12).

F I G U R E 1 1

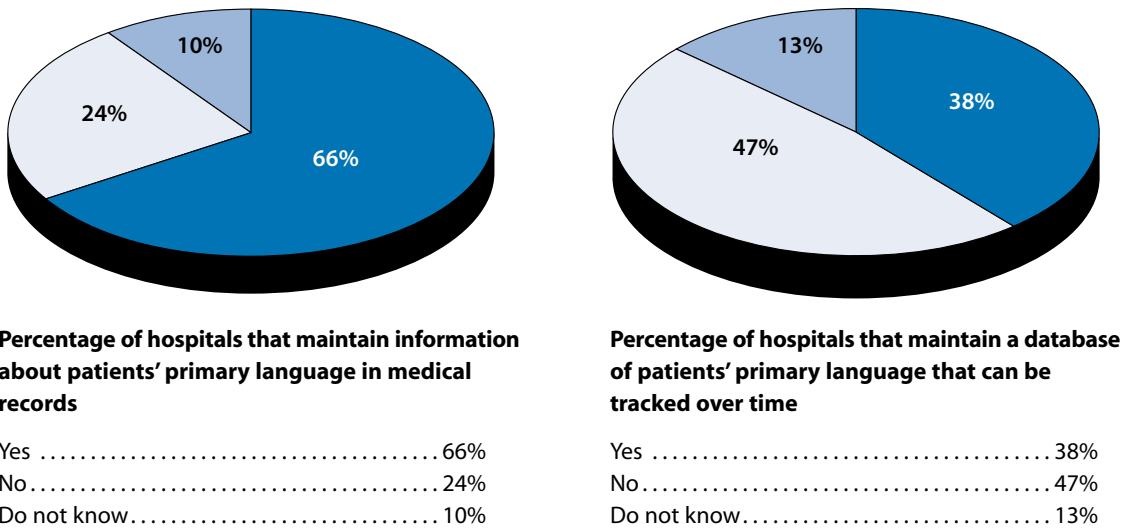
Training That Hospital Staff Would Find Useful for Providing Language Services



Source: HRET, 2006.

F I G U R E 1 2

Tracking Patients’ Primary Language



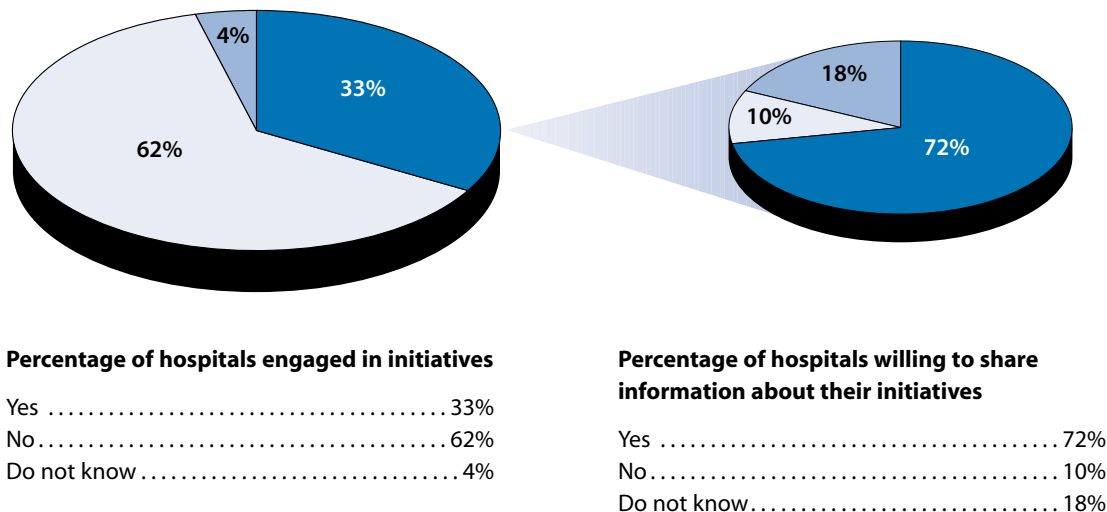
Source: HRET, 2006.

7. Engagement in Initiatives to Improve Language Services

We asked hospitals whether they were currently engaged in any specific initiative focused on improving access to language services and whether such engaged hospitals would be willing to share

information regarding these initiatives (Figure 13). Thirty-three percent (33%) responded that they were engaged in some type of initiative, and 72% of these hospitals indicated that they would be willing to share information.

Hospitals Engaged in Initiatives to Improve Language Services



Source: HRET, 2006.

8. Comparing LEP Needs and Language Services Provision Among Hospitals in LEP Growth States and Non-LEP Growth States

To determine whether hospitals in LEP growth states differ from those in non-LEP growth states with respect to LEP needs and their ability to provide language services, we compared answers to a subset of survey questions. Table 7 shows that the frequency with which hospitals encounter LEP patients is identical between hospitals in LEP growth and non-LEP growth states (79%). Similarly, there is no difference between the two groups with regard to the difficulty in providing language services off-hours. However, fewer hospitals in LEP growth states (86%) offer language services around the clock compared to hospitals in non-LEP growth states (92%).

The sources of information hospitals use to assess the language needs in a community vary between LEP growth and LEP non-growth states (Table 8). More hospitals in non-LEP growth states rely on census data and information from a community

needs assessment compared to hospitals in LEP growth states. The use of data from local community organizations, patients themselves, and other sources does not differ with respect to LEP growth status.

Although the availability of resources used to provide language services does not vary significantly between hospitals in LEP growth and LEP non-growth states, telephonic services were most readily available for both groups as shown in Table 9 (89% and 92%, respectively) followed by bilingual clinical staff (71% and 86%).

IV. METHODS

The Health Research and Educational Trust (HRET) conducted a survey in 2005–2006 to collect information about patient language services in hospitals. We identified hospitals from the 2004 American Hospital Association Annual Survey Database. All general medical and surgical hospitals within the United States were eligible. The sample was drawn to ensure a variety of hospitals including:

T A B L E 7

Hospitals in States With Over 100% Growth in Their LEP Populations Between 1990 and 2000 Compared to Hospitals in Non-LEP Growth States

| Hospitals in | Encounter LEP patients monthly, weekly, or daily | Offer language services 24 hours/day, 7 days/week | Find it difficult to provide language services off-hours |
|-----------------------|--|---|--|
| LEP Growth States | 79% | 86%* | 35% |
| Non-LEP Growth States | 79% | 92% | 36% |

*Significance level, p<.05.

Percents are weighted using hospital weights.

Hospitals in LEP growth states encounter LEP patients with about the same frequency as all hospitals that participated in the survey (79% of hospitals in LEP growth states and 80% of all hospitals).

Source: HRET, 2006.

T A B L E 8

Sources of Information Used by Hospitals to Assess the Language Needs of the Communities They Serve

| Hospitals in | Census data | Local community organizations | Community needs assessment | Collect from patients | Other | Do not know |
|-----------------------|-------------|-------------------------------|----------------------------|-----------------------|-------|-------------|
| LEP Growth States | 42%* | 28% | 18%* | 42% | 6% | 4% |
| Non-LEP Growth States | 50% | 33% | 25% | 47% | 5% | 4% |

*Significance level, p<.05.

Percents are weighted using hospital weights.

Source: HRET, 2006.

T A B L E 9

Resources Available to Hospitals for Providing Language Services

| Hospitals in | Staff interpreters | Independent freelance interpreters | External agencies | Bilingual clinical staff | Bilingual nonclinical staff | Community language bank | Telephonic services |
|-----------------------|--------------------|------------------------------------|-------------------|--------------------------|-----------------------------|-------------------------|---------------------|
| LEP Growth States | 63% | 69% | 61% | 71% | 63% | 21% | 89% |
| Non-LEP Growth States | 70% | 61% | 67% | 86% | 77% | 16% | 92% |

Percents are weighted using hospital weights.

Source: HRET, 2006.

- Hospitals in states that had experienced more than a 100% growth in their LEP populations between 1990 and 2000
- Hospitals in large urban areas with diverse populations
- Rural hospitals with a focus on examining critical access hospitals, sole community hospitals, and rural referral centers

HRET surveyed 1,983 hospitals. In total, 861 hospitals responded to the survey resulting in a 43% response rate. Hospital-based respondents completed the survey either by paper questionnaire or electronically via the Internet. The survey consisted of 21 questions covering the language needs of the populations served, resources used, and the types of tools, resources, and other support hospitals could use to support language services. The survey cover letter requested that individuals who were most knowledgeable about the provision of language services in the hospital complete the survey. Individuals with diverse titles in various departments responded to the survey. Respondents included individuals from interpreter services, quality and risk management, human resources, social services, and hospital administration departments. Respondents held titles such as chief executive officer, chief nursing officer, director of customer relations, patient advocate, director of planning and business development, and compliance officer.

V. STATISTICAL ANALYSIS

We used sampling weights in the analysis to take into account the sampling design. For this study, we used a stratified sample design to create strata based upon specific demographic characteristics from which hospitals were then selected. The weights represent the ratio between the stratum-specific selection probabilities in the total population and in the final sample of respondents. For example, we oversampled a number of states with high LEP growth (defined as 100% growth in the LEP population between 1990-2000), therefore we weighted the results to correct for this oversampling.

We conducted descriptive and bivariate analyses of the data. In order to identify characteristics associated with provision of language services in

hospitals, we examined the following hospital characteristics: region of the country, hospital size, teaching status, system membership, hospital ownership, and urban/rural status. For rural hospitals we examined critical access hospitals, sole community hospitals, and rural referral centers. The characteristics are described below.

Hospital characteristics in this survey were derived from the 2004 American Hospital Association's Annual Survey Database of health care providers, which was the most recent version available at the time of this survey. Below we describe AHA's definitions and categories for each of these characteristics. In some instances, we modified the AHA categories for reporting purposes. We clearly identify the types of modifications we made.

VI. HOSPITAL CHARACTERISTICS

1. Region

Hospital region is defined in the AHA database as New England (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut), Mid Atlantic (New York, New Jersey, and Pennsylvania), South Atlantic (Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida), East North Central (Ohio, Indiana, Illinois, Michigan, and Wisconsin), East South Central (Kentucky, Tennessee, Alabama, and Mississippi), West North Central (Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas), West South Central (Arkansas, Louisiana, Oklahoma, and Texas), Mountain (Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, and Nevada), and Pacific (Washington, Oregon, California, Alaska, and Hawaii).

We modified these categories to the following: Northeast, Midwest, South, and West.

2. Hospital Size Based Upon Number of Beds

The number of beds is used to determine hospital size:

- 6–24 beds
- 25–49 beds
- 50–99 beds
- 100–199 beds
- 200–299 beds
- 300–399 beds
- 400–499 beds
- 500 or more beds

We modified the above categories and defined hospitals by size using the following criteria:

- Small hospitals: 0–99 beds
- Medium hospitals: 100–299 beds
- Large hospitals: 300 or more beds

3. Teaching Status

The hospital is considered a teaching hospital if it is a member of the Council of Teaching Hospitals of the American Medical Association or if it has residency training approval by the Accreditation Council for Graduate Medical Education.

4. System Membership

System hospitals are part of a corporate body that owns, leases, religiously sponsors, or manages health provider facilities. Freestanding hospitals are individually owned and operated.

5. Hospital Ownership (Control)

Hospital ownership is captured in one of three categories: government (public), not-for-profit, and for-profit.

1. Government (public) hospitals are nonfederal hospitals that are controlled by an agency of state, county, city, city-county, or hospital district or authority.
2. Not-for-profit hospitals are church-operated or other not-for-profit.
3. For-profit hospitals are owned by individual, partnership, or corporation investors.

6. Urban/Rural Status

If a hospital is located in a Metropolitan Statistical Area (MSA), then it is an urban hospital. If is not located in a MSA, then it is designated as a rural facility.

7. Medicare's Special Rural Designations

1. *Critical access hospitals*: These facilities have no more than 15 inpatient beds, offer 24-hour emergency care, and are located more than a 35-mile drive from any other hospital. They are reimbursed based on what they spend for each patient, rather than on the average expected cost for specific diagnoses that most hospitals are paid.
2. *Sole community hospitals*: These facilities serve as the sole source of inpatient care in a community, either because they are geographically isolated, or because severe weather conditions or local topography prevents travel to another hospital. They can be paid higher rates based on their own previous costs.
3. *Rural referral centers*: These facilities are located in rural areas, have 275 or more beds, and provide services primarily to Medicare beneficiaries, 60% of whom live more than 25 miles from the hospital. At least 50% of these beneficiaries are referred from other hospitals or physicians who are not on the staff of the hospital. Rural referral centers receive higher pay to assist in caring for low-income patients and can more easily qualify for higher payments based on nearby urban wage rates.

VII. Conclusion

Evidence shows that effective communication between patients and clinicians is a critical component of providing high-quality health care. When communication is compromised by language barriers, the quality of care is also compromised. Consequently, providing individuals with LEP the means to communicate effectively

with their health care providers is critical to improving their experience in the health care setting, the quality of care they receive, and their health outcomes. As racial and ethnic diversity in the United States continues to increase, so does the demand for appropriate and effective language services. With 80% of hospitals encountering individuals with LEP frequently, and only 3% receiving direct reimbursement for providing language services, the question and challenge

are: Who will pay for these services? Hospitals that commit to providing high-quality language services to their patients likely will be rewarded with greater patient and staff satisfaction, which can provide them with a competitive advantage as the demographics of the United States continue to change. Resources should be targeted toward monitoring and improving language services for all patients with LEP.

R E S O U R C E S A N D T O O L S

American Hospital Association (AHA)

AHA key issue page on racial and ethnic disparities provides a wide variety of resources for hospitals from AHA and other sources including self-assessments, case examples, and tools to address cultural competency and the elimination of racial and ethnic disparities.

http://www.aha.org/aha_app/issues/Disparities/index.jsp

Health Research and Educational Trust (HRET)

HRET is the research and educational affiliate of the AHA. The HRET Web site provides information about HRET's research on racial and ethnic disparities in health care; collecting race, ethnicity, and primary language data; and linking data to quality of care measures.

<http://www.hret.org>

HRET Disparities Toolkit

The toolkit is designed to help hospitals and health systems, community health centers, health plans, and other potential users in understanding the importance of accurate data collection, assessing organizational capacity to do so, and implementing a framework designed specifically for obtaining information from patients/enrollees about their race, ethnicity, and primary language efficiently, effectively, and respectfully.

<http://www.hretdisparities.org>

Institute for Diversity in Health Management (IFD)

The Institute works to promote greater racial and ethnic diversity in the management and executive ranks of health care organizations, cosponsors studies in this area, supports a minority internship

program, and presents employment opportunities through its Internet site.

<http://www.diversityconnection.org/>

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

JCAHO works to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. Visit the Web site below for information about its "Hospital, Language, and Culture" project.

http://www.jointcommission.org/HLC/Resources_Standards.htm

National Health Law Program (NHLP)

The National Health Law Program is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly, and people with disabilities. Its language access Web page includes a variety of information, reports, and resources.

<http://www.healthlaw.org/>

White Coats and Many Colors: Population Diversity and Its Implications for Health Care

Issue briefing report by Emily Friedman

The report focuses on how the United States population is becoming more diverse racially and ethnically and how these changes are occurring in areas of society other than those traditionally associated with diversity. Two sectors are always affected first: health care and education.

<http://www.aha.org/aha/content/2005/pdf/WhiteCoatsManyColors.pdf>

R E F E R E N C E S

- i U.S. Bureau of the Census, American Community Survey (2005) *Language Spoken at Home* (Table S1601), available at <http://factfinder.census.gov>. See also Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* at 70-71 (2002) (reporting that more than one in four Hispanic individuals in the U.S. live in language-isolated households where no person over age 14 speaks English “very well,” over half of Laotian, Cambodian, and Hmong families are in language-isolated households, as well as 26%-42% of Thai, Chinese, Korean, and Vietnamese).
- ii See U.S. Bureau of Census, American Community Survey (2005), *Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over* (Table 16004) available at <http://factfinder.census.gov>.
- iii Ibid.
- iv Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (Feb. 2001) (prepared by Leighton Ku and Alyse Freilich, The Urban Institute, Washington, DC). See also Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 71-72 (2002) (describing recent survey finding that 51% of providers that believed patients did not adhere to treatment because of culture or language, but 56% reported no cultural competency training).
- v For the purposes of this document, “providers” includes health care institutions such as hospitals and nursing homes; managed care organizations; insurers; and individual clinicians and practitioners.
- vi The Access Project. “What a Difference an Interpreter Can Make.” April 2002.
- vii Weech-Maldonado, R, Morales, LS, Elliot, M, Spritzer, K, Marshall, G, and Hays, RD. “Race, Ethnicity, Language, and Patients’ Assessments of Care in Medicaid Managed Care.” *Health Services Research* 38(3). June 2003.
- viii Timmins, CL. “The Impact of Language Barriers on Health Care of Latinos in the United States: A Review of the Literature and Guidelines for Practice.” *Journal Of Midwifery and Women’s Health*. Vol. 47(2). 80-96. March/April 2002.
- ix National Health Law Program and The Access Project, Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency. 2004. www.healthlaw.org.
- x Ethical Force Program Oversight Body. *Improving Communication-Improving Care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations*. Chicago, IL: The Institute for Ethics at the American Medical Association. June 2006.
- xi Ibid.



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