



Language Accommodations for Limited English Proficient Patients in Rural Health Care

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Abstract

Over 25 million individuals living in America are limited English proficient, many of whom live in rural communities. Adequate language accommodations are critical to providing effective healthcare for these populations. An online questionnaire was delivered to 42 rural facilities in Washington State. It included questions about their demand for language services, modalities of interpretation, translated documentation and barriers to providing accommodations. Fifteen of 42 (35.7%) responded. Spanish, Russian, Vietnamese, Japanese, Ukrainian and Mam were encountered daily. Telephonic and virtual remote interpreter services were the most widely available. Not all facilities had vital documents translated to frequently encountered languages. Challenges to providing language access were reported by nearly all participants. The rural facilities surveyed all encountered LEP patient populations and offered oral interpretation. Overall, these facilities were meeting requirements for providing language accommodation services. Even so, many facilities reported experiencing barriers to providing these services.

Keywords Language barrier · Limited English proficiency · Interpreter · Rural health

Background

According to the 2018 American Community Survey (ACS), over 67 million individuals currently living in the United States speak a language other than English in their household. Of these households, over 25 million were identified as either non-English speaking or limited English proficient (LEP) [1]. These individuals were self-reported as speaking English less than “very well” and would likely face a language barrier within the healthcare delivery setting. Title VI of the Civil Rights Act of 1964 states that all federally funded institutions and programs are restricted from discriminating against individuals based on their color, race, or national origin. In August of 2000, an executive order by President Clinton extended this protection to persons not proficient in the English language [2]. Hospitals and clinics

are subject to these laws, preventing them from excluding patients based on their ethnicity or language of origin. Since that time, all hospitals and clinics receiving federal subsidies have been required by law to provide language services to ensure equitable access for all patients regardless of literacy in English [2].

It has been well documented that language barriers can lead to poor understanding between medical staff and LEP patients, contributing to increased medical errors [3] and to decreased compliance [4] and medication adherence [5, 6]. These negative outcomes in aggregate further contribute to healthcare disparities within LEP patient populations, as summarized extensively in the California Endowment annotated bibliography [7].

Patients in rural communities are often underserved and rural hospitals and clinics are often under-resourced. Thus, these healthcare facilities frequently face challenges in providing ample language services [8, 9]. Consequently, there is a need to examine the demand for and barriers to, accommodating all LEP communities in these rural regions. Washington State was previously ranked ninth in the country for both the largest population and growth rate of LEP residents, with the LEP population increasing 209.7% between 1990 and 2010 [10]. These numbers have only grown since 2010,

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constituting a need to better understand how hospitals and clinics comply with these requirements [10]. Understanding the challenges faced by facilities in accommodating the interpretation needs of these patients will be critical to improving healthcare outcomes for LEP populations. This study aims to examine how rural providers accommodate LEP patients.

Methods

Participants

Forty two rural hospitals and clinics were identified from a database maintained by the Elson S. Floyd College of Medicine of which 15 participated in this study.

Data Collection

A recruitment letter and consent form were sent to each hospital and clinic. An 11-item survey was then delivered electronically using the Qualtrics Survey Software™.

Measures

The self-administered online questionnaire assessed participants on four main criteria: the demand for interpretation services, the demographic of LEP patients served, the strategies used to accommodate these populations and the barriers faced in providing language access.

Participants were asked to identify their facility type as a critical access hospital, community hospital, rural health clinic, or federally qualified health center. After providing information about the frequency of LEP patient visits, participants were asked to specify which language groups they served. Respondents were then asked to indicate their strategies to assess language needs, including but not limited to patient data collection and census data. The survey also included questions regarding the modalities of interpretation available at each site. The options that respondents could select from included staff interpreters, independent contractors, volunteer interpreters, clinical and non-clinical bilingual staff, telephone interpreters, virtual remote video interpreters, bilingual family members and iPhone applications. Participants were also asked to indicate what translated medical documents their facilities had available: information about interpretation services, educational materials, results forms, consent forms, procedure and preparation instructions and discharge instructions. The survey also included questions regarding the accessibility of services, ranging from limited days per week to 24 h a day, 7 days a week. Lastly, participants were asked to provide insight into what barriers they face as a rural institution in providing

accessible language services, including but not limited to financial limitations, lack of training, small LEP populations, lack of bilingual staff, technological constraints and staff discomfort in collecting patient preferences. Using a 10-point scale, participants were asked to rate their success in accommodating LEP patients, with one being the least effective and ten being the most.

Results

Fifteen out of 42 Qualtrics surveys (35.7%) that were delivered to the rural hospitals and clinics were returned. Participant demographics were broken down as follows: twelve critical access hospitals (80%) two community hospitals (13.3%) and one rural health clinic (6.7%). The majority of respondents reported serving LEP patients on a daily basis (53%). The facilities serving LEP patients daily were clustered in the northwest regions around the Olympic Peninsula and the south-central regions of Washington State (Fig. 1). Three hospitals reported encountering LEP patients on a weekly basis (20%), ranging from central to western Washington (Fig. 1). The remaining facilities reported a less-than-monthly demand (26.6%). These hospitals and clinics were clustered in the eastern and south-eastern regions of Washington (Fig. 1).

To assess language need, 53% of respondents reported using data collection of patients who present to the clinic, while 40% reported using census data. Two facilities noted the use of patient panels and community health needs assessments as additional strategies to assess language needs. Participants from all across Washington State reported encountering a multitude of languages, other than English, within their healthcare facilities.

The most frequently and widely spoken language was found to be Spanish, with participants reporting daily (53.3%), weekly (13.3%) and monthly encounters (6.7%). Every participating facility denoted Spanish as a language they encountered to a certain degree (Fig. 1). One hospital in central Washington reported Russian, Vietnamese, Japanese and Ukrainian, as languages that they saw daily. One hospital on the Olympic Peninsula reported Mam as a language they encountered daily. Chinese and Korean were reported by facilities all across central and eastern Washington as languages they encountered on a monthly or less than monthly basis. Tagalog was also encountered monthly by multiple hospitals across western and central Washington. One hospital in central Washington reported monthly encounters with patients who spoke Ilocano, Somali, Laotian, Romanian and American Sign Language (Fig. 1).

Telephone interpreter services were both the most widely available and frequently utilized modality of interpretation, with 60% of participants reporting this service was used

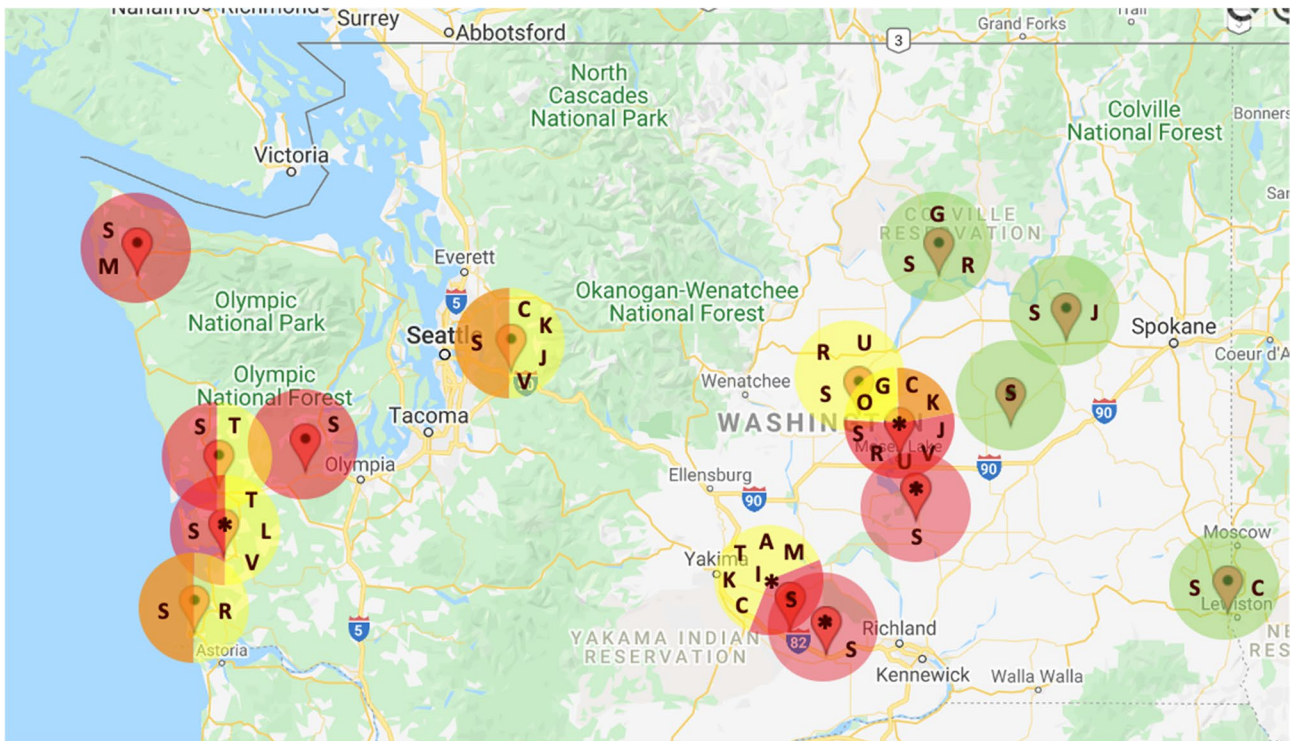


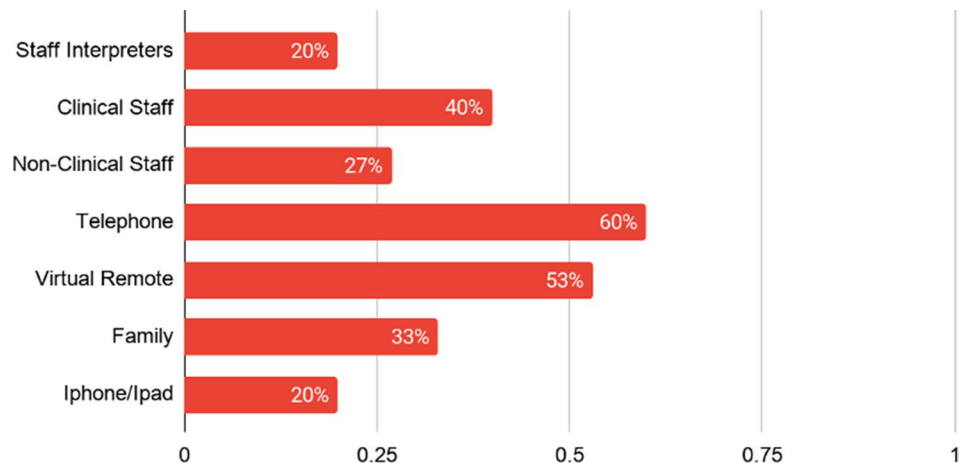
Fig. 1 Frequency of encounters with LEP patients. The tear-drop marker at the center of each colored circle denotes the location of the facility surveyed. Fifteen out of 42 (35.7%) facilities completed and returned the survey (13 Critical Access Hospitals, 2 Community Hospitals and 1 Rural Health Clinic). The color within the circle represents the frequency at which LEP patients are served at each site: red=daily, orange=weekly, yellow=monthly, green=less than monthly. The letters represent languages encountered at each site, at

the frequency specified by the color of that portion of the circle on which the letter rests. Most of the languages are denoted by the first letter of their name: American Sign Language, Chinese, German, Ilocano, Japanese, Korean, Laotian, Mam, Russian, Spanish, Tagalog, Ukrainian and Vietnamese. Romanian and Somali are denoted by the letter O and N, respectively. *Denotes locations where the Hispanic population exceeds 20% of the total population (<https://datausa.io>) (Color figure online)

“often” or “always” (Fig. 2). The second most frequently used interpretation service was virtual remote (53%) followed by bilingual clinical staff (40%). A third of the participants reported frequently relying on patient family members as ad-hoc interpreters during clinical care. Four hospitals

reported using non-clinical staff to interpret medical visits (27%), while three participants hired professional on-staff interpreters (20%). All participants reported offering interpretation services of some kind 24 h a day, 7 days a week (data not shown).

Fig. 2 Various modalities of interpretation services available to patients. Each bar represents the percentage of total facility participants that indicated each resource type was used either “often” or “always.”



Nearly all participants (93%) reported posting information about available interpretation services in a multitude of languages (Fig. 3). However not all facilities, even those with a daily demand of LEP patients, provided consent forms, result forms, procedure and preparation instructions and discharge instructions in Spanish or other frequently encountered languages (Fig. 3). Only one hospital reported offering a variety of forms in Spanish, Japanese and Ukrainian (data not shown).

When asked to self-rate their efficacy of delivery of interpretation services on a scale of one to ten, the average self-reported rating was 7.9 out of 10. Three fourths of respondents indicated their facility experienced a barrier of some kind (data not shown). The most commonly cited barriers were inability to assess specific patient need prior to appointments (40%) and small LEP patient numbers (40%). Other barriers included lack of staff training, limited bilingual staff, technological constraints and lack of a document translation service or interpreting certifications

for infrequent languages. However, financial limitations and staff discomfort in obtaining patient's primary language preferences were not cited as barriers by any of the participants (Fig. 4).

Discussion

Taken as a whole, the rural hospitals and clinics surveyed collectively demonstrated their ability to accommodate underserved LEP patients by offering around the clock services, either in the form of telephonic or virtual remote video interpreters. There were no differences in the how facilities accommodated LEP patients that correlated to the type of facility (critical access hospital versus rural clinic or community hospital). However, using the Hispanic population of the community, the largest LEP population at all sites, as a metric for the size of the LEP population, all the sites with large LEP populations (> 20% Hispanic residents; Fig. 1)

Fig. 3 Translated documents available across facilities. Each bar represents the percentage of total participants that reported offering translated medical documents of each type. Of these facilities, 13 offer medical documents in Spanish, while 1 hospital offered documents in Spanish, Japanese and Ukrainian. Information regarding the availability of services were offered in 20+ languages, while other translated documents were offered in Spanish, Japanese and Ukrainian

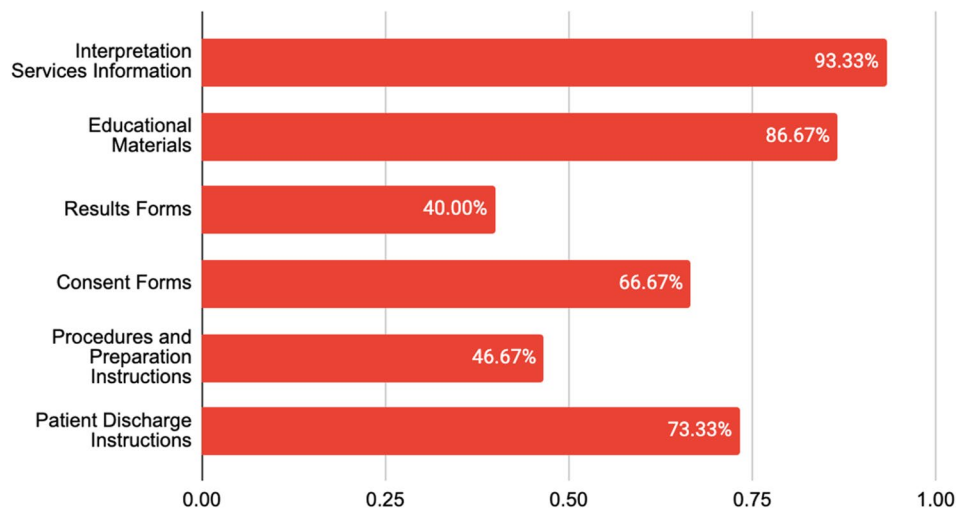
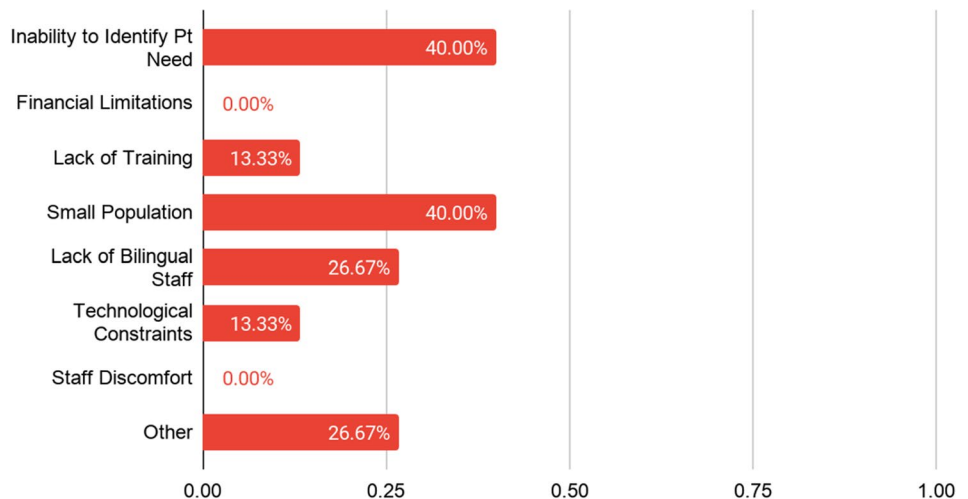


Fig. 4 Barriers to accessing language services. Each bar represents the percentage of total facility participants that reported facing that challenge in providing interpretation services. "Other" includes limited interpreter availability for rarer languages and lack of document translation services



had either staff interpreters or bilingual clinical staff or both, whereas those with small LEP populations relied primarily on telephone or virtual interpreters (data not shown). These results suggest that there is likely an insufficient number of in-person medical interpreters in regions with fewer LEP patients and less of a demand for interpretation.

Though facilities appear to have adequate oral interpretation services made available, this study highlights the various challenges they faced in applying and delivering this care accommodation. The most commonly cited barriers to providing language access in this study were inability to identify patient need and small LEP patient populations. The facilities that cited these two barriers had small Hispanic populations ($\leq 20\%$; data not shown).

Small patient populations may present challenges to accommodation due to infrequent language access. With a potentially less consistent need for interpretation services, rural hospitals and clinics may be limited for resources or have a less robust framework for scheduling and providing services at the time of appointment. Additionally, certain populations may speak rarer languages, such as the Mam communities of western Washington. Mam is an indigenous language that is primarily spoken by Guatemalan individuals of Mayan descent. The Mam population in northwest Washington is a result of the transcontinental migration of Guatemalan workers from Todos Santos to the Olympic Peninsula of Washington State. Mam communities began migrating to the United States after the end of the Guatemalan Civil War in the early 1990s. Since that time, migrant workers from Todos Santos continue to find work in Washington State agriculture, harvesting salal and local forest brush that is sold and distributed to florists all across the country [11]. Mam communities, however, often face barriers to accessing quality medical care as there are limited numbers of indigenous language interpreters and a lack of interpreter certifications for less frequently encountered languages [11]. This finding is consistent with previous literature on small LEP populations and rare, indigenous languages [9, 11–13].

An additional barrier identified was present in the form of limited translated written material. Apart from posting signage regarding free, available services, the majority of participants offered other medical documents only in Spanish. Furthermore, not all facilities, even those with high rates of LEP patient visits, offered all necessary documents in any given language. The most limited types of documents were found to be result forms, procedure preparation instructions and consent forms, despite the latter's status as a vital document.

Vital documents, as defined by the United States Department of Health and Human Services, are those that “affect access to, retention in, or termination or exclusion from a recipient's program services or benefits” [14]. Consent forms are only one example of vital documents that should

be translated to the primary language of LEP patients to comply with federal regulations. Furthermore, a systematic review of quality in medical translations suggests that providing quality, level-appropriate documents in a patient's primary language may help to mitigate healthcare inequalities [15]. Given that rural providers encountered Spanish, Russian, Vietnamese, Japanese, Ukrainian and Mam daily, an area for improvement could be additional translation of written material to these languages in highest demand. Translation of vital documents into patient's primary language, in combination with oral interpretation services, may improve LEP patient experiences and healthcare outcomes.

Although this study included facilities from geographically diverse regions of Washington State, these results may not be generalizable to all rural communities across different states and regions. Furthermore, with a sample size of 15 and most participants being critical access hospitals, additional data collected from federally qualified health centers and rural health clinics will be critical to better understanding how language services are delivered across a multitude of healthcare settings.

Conclusion

This study is significant in that it provides new data on the breadth of languages spoken in rural Washington, how healthcare providers in these communities meet the translation needs of their LEP patients and reveals some of the barriers to providing these services. To our knowledge, this is the first such study of rural hospitals and clinics in Washington State. Many rural hospitals and clinics surveyed reported serving LEP patients either on a daily or weekly basis, consistent with the rise in linguistic diversity in Washington State. All surveyed providers had oral interpretation services available, either via telephonic or virtual remote video interpreters. Nearly all participants reported experiencing a challenge of some kind in delivering language accommodations, such as offering all vital documents in the languages most frequently encountered. Although the demographics of LEP patient populations and demand for language services vary within the state of Washington and may vary from state to state, language accommodations must be prioritized to ensure that all non-English speaking patients receive equitable and quality care irregardless of the setting in which they live. Amidst a rising demand for interpretation services nationwide, increased resources are clearly needed if all rural hospitals and clinics are to better understand and accommodate their LEP patient population.

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Declarations

Conflict of interest No potential conflicts of interests were reported by the authors.

Ethical Approval The Washington State University Human Research Protection Program determined that the study (No.18422-001) met criteria for Exempt Research under Exempt 45-CFR 46.104 (d) 2 (i).

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