

**2009 NH Health Care Provider
Communication Access Capacity Survey
Summary of Results**

August 2010

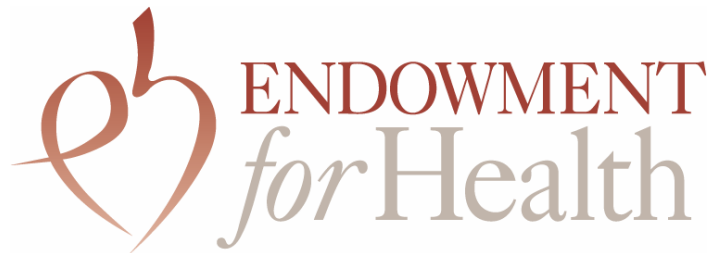
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FOUNDATION FOR
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INTRODUCTION

New Hampshire is a state of growing ethnic diversity. Between 2000 and 2008, there has been a 23% growth in the state's foreign-born population.¹ In 2008, an estimated 29,787 residents with limited English proficiency (LEP) lived in the state, about 2.4% of the state's 1.3 million residents.² This represents an increase of 6.1% since 2000.³ Of the LEP residents living in New Hampshire, approximately 46% speak Indo-European languages other than English, 30% speak Spanish, 20% speak Asian or Pacific Island languages, and 4% speak other languages. While the number of New Hampshire residents who are deaf or hard of hearing is unknown, national data suggests that approximately 15% of the general adult population in the United States has hearing trouble.⁴ This figure would project about 196,845 NH residents may have hearing trouble.

LEP residents largely live in the southern portion area of the state. Hillsborough County, which includes the cities of Manchester and Nashua and accounts for 30% of the state's population, is home to 56% of the LEP population. The only other county for which data are available, Rockingham County, accounts for 23% of the state's population and comprises 17% of the state's total LEP population.⁵

As the population of New Hampshire continues to diversify, ensuring that medical, dental and mental health care providers and patients are able to effectively communicate is critical. Patient-provider communication affects every aspect of quality, patient-centered care from diagnosis to patient treatment compliance. In addition, effective communication has risk management implications as well as legal/regulatory ramifications. Over the past few years, individual providers as well as statewide organizations such as the Medical Interpretation Advisory Board and the Cultural Awareness Healthcare Workgroup as well as others, have worked to enhance the capacity of provider organizations to communicate with LEP and deaf or hard of hearing (D/HH) patients.

This report summarizes the results of a web-based survey conducted between July 2009 and January 2010 of hospitals, community health centers (CHCs), dental clinics and community mental health centers (CMHCs) in New Hampshire about their language interpretation capacity. The survey was conducted to answer several questions:

- How many LEP and D/HH individuals are currently being served by providers and how has this changed over time?

¹For individuals 5 years and over. 2000 figure, 54,154 comes from the 2000 US census. 2008 figure, 66,550, is an estimate and the source is the U.S. Census Bureau, 2006-2008 American Community Survey, 3 Year Estimates.

http://factfinder.census.gov/servlet/DTable?_lang=en&-mt_name=ACS_2008_3YR_G2000_C16005&-CONTEXT=dt&-tree_id=3307&-redoLog=true&-all_geo_types=N&-geo_id=04000US33&-geo_id=05000US33011&-geo_id=05000US33015&-search_results=01000US&-format=&-

² LEP is defined as speaking English less than "very well." U.S. Census Bureau, 2006-2008 American Community Survey, 3 Year Estimates.

³ In 2000, the LEP population was 28,073.

⁴ U.S. Department of Health and Human Services, Health Interview Survey for 2008, <http://www.cdc.gov/nchs/fastats/disable.htm>

⁵ U.S. Census Bureau, 2006-2008 American Community Survey, 3 Year Estimates.

- To what extent are demographic data collected and used by provider organizations?
- How are medical interpretation needs currently being met by providers?
- To what extent do providers have an infrastructure to support culturally competent care?

This survey is similar to one conducted in the state in 2004 by the Access Project.⁶ An invitation to complete the survey was provided to all hospitals, CHCs, CMHCs, and dental clinics in the state. Private practices and specialty providers were not included in this survey. The survey did not assess the quality of language services provided by organizations. The overall survey response rate was 57%. A complete discussion of the methodology is provided in Appendix A.

Report Limitations

There are several limitations to the survey results that are worth noting:

- Because not all organizations receiving the survey completed it, results in this report are limited to the respondent pool and cannot be generalized to all CHCs, hospitals, CMHCs, and dental clinics in New Hampshire.
- The survey collected self-reported data which was not verified by other sources. While the survey was piloted tested for question understanding, a number of questions included a “don’t know” option in order to increase accuracy of responses, and confidentiality of respondents was assured, survey responses are subject to concerns about self-reported data including incomplete or inaccurate question understanding by respondents and a social desirability bias.⁷
- While there was a desire to compare the 2009 survey results to the 2004 survey results, the ability to actually do so was severely limited. Due to the inability to obtain detailed information about the specific organizations that responded to the survey in 2004, the comparison of results between the two years is limited to broad themes and patterns.⁸

⁶ Kohn, N., Stubblefield-Tave, B., Seifert, R. (Nov 2004). *Assessing Language Interpretation Capacity Among New Hampshire Health Care Providers*.

⁷ Social desirability bias occurs when respondents answer questions with a view to what they believe is the answer that is viewed as most favorable by others.

⁸ Due to confidentiality processes during the 2004 survey, survey administrators could not release a list of respondent organizations by name.

FINDINGS

Patient Characteristics of Responding Organizations

Table 1 summarizes information about the patients served by responding organizations.

Table 1: Patient Visits and Proportion of LEP and D/HH Visits

Type of Organization	Total Patient Visits Last Fiscal Year (range)	Proportion LEP Visits (range)	Proportion D/HH Visits (range)
Hospitals (N=13)	5,600 – 258,800	<1% - 15%	<1% - 10%
CHCs (N=10)	7,500 - 61,000	0 – 45%	0 – 2%
CMHCs (N=5)	1,700 – 263,100	<1% - 2%	<1% - 1%
Dental Clinics (N=6)	200 ⁹ – 10,000	0 – 10%	1 – 1%

There is substantial variation in both patient visits and proportion of LEP patients served across the organizations responding to the survey. Data about the proportion of D/HH patients should be interpreted with caution and are likely underrepresented as these data typically reflect those patients who are deaf and may not include those who are hard of hearing.¹⁰

Respondents were asked to identify the 5 most common languages other than English spoken by patients. Across all respondent groups, Spanish was identified among the top 3 most common languages. American Sign Language (ASL) was cited as common language by organizations that did not serve a large proportion of LEP patients. Beyond this, there are no other languages that were consistently cited as common across all organizations. Responses mirror the diversity that increasingly characterizes New Hampshire including languages from throughout Africa, Asian, Latin American and Eastern Europe. Not surprisingly, organizations in Manchester and Nashua identified the most diversity of languages. Compared to results in 2004, the 2009 results indicate a greater diversity of languages.

Respondents were asked in an open-ended question to describe trends in their patient population over the past five years. Organizations that, in general, indicated that they served few LEP or D/HH individuals in 2009 did not describe any changes, noting, for example, “volume remains very low” (CHC), “no changes observed in the past 5 years” (hospital), “no change, very rare occurrence” (dental clinic). By contrast, those organizations in communities that have grown more diverse over the past few years or which served a number of LEP patients, noted changing trends, primarily in the volume of LEP patients and in the diversity of languages. Comments included: “increase in refugee patients and concurrent increase in need for interpretation” (CHC), “we have seen little increase in need, however more diversity in dialects/languages” (hospital), “we have seen a dramatic increase in the number of foreign patients who cannot speak English” (dental clinic).

⁹ Dental clinic had recently opened.

¹⁰ As discussed in the introduction, while no data about New Hampshire’s deaf and hard of hearing population exist, national estimates indicate that about 15% of the adult population in the United States has trouble hearing.

The proportion of LEP visits of total visits was used to inform analysis. The data discussed in the rest of this report are presented by type of organization as well as whether organizations reported a high, medium or low volume of LEP and D/HH patient visits. Organizations that reported that 15% or more of their patient visits in the prior fiscal year were LEP patient visits were identified as those with a “high” proportion of LEP patient visits. There were 3 organizations, all CHCs, in this category. These organizations reported that between 35% - 45% of their total patient visits in the prior fiscal year were LEP patient visits. Organizations identified as “medium LEP,” of which there were 8, were those that reported between 5% and 15% of their visits were LEP patients.¹¹ Finally, organizations that reported less than 5% of their visits in the prior fiscal year were LEP patient visits were identified as “low LEP” organizations. There were 22 of these.

It is important to emphasize that this categorization was established solely for the purpose of the analysis presented in this report as a way to better understand differences and similarities across organizations based on their reported LEP patient visits. It does not reflect any standard or established categorization.

Meeting Language Demands

A substantial portion of survey questions related to how provider organizations met the need to effectively communicate with LEP and D/HH patients. Respondents were asked to identify their usage of each type of service on a 5-point scale (where 1=most used and 5=least used) for both 2004 and 2009. Table 2 presents information about the proportion of responding organizations reporting that they “most used” (5) each interpretation method.

Table 2: Proportion of Organizations Reporting Interpretation Method is “Most Used”¹²

Type of Organization	In-person trained interpreters		Bilingual staff ¹³		Telephonic interpretation		Video interpretation		Patient’s family member/friend	
	2009	2004	2009	2004	2009	2004	2009	2004	2009	2004
Hospitals (N=15)	27%	0	7%	33%	43%	39%	0	0	13%	40%
CHCs (N=10)	50%	44%	30%	50%	20%	11%	0	0	10%	22%
CMHCs (N=5)	40%	20%	40%	40%	20%	25%	0	0	0	0
Dental Clinics (N=4)	0	0	0	0	75%	33%	0	0	25%	67%
High LEP (N=3)	100%	100%	67%	67%	0	0	0	0	0	0
Medium LEP (N=8)	38%	14%	0	13%	38%	43%	0	0	25%	57%
Low LEP (N=19)	16%	6%	22%	44%	39%	27%	0	0	11%	33%

¹¹ No organizations reported that their LEP patient population was between 15% and 35%.

¹² High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

¹³ No distinction was made in the survey question as to the training of bi-lingual staff who provide interpretation services, i.e., whether they are bilingual clinical staff or other staff.

Patterns of interpretation methods use varied by organization type and need. A higher proportion of CHCs, CMHCs, and high LEP organizations reported that “most used” in-person trained medical interpreters than hospitals, dental clinics, or medium or low LEP organizations. Bi-lingual staff were also a frequently used source for medical interpretation in high LEP organizations, CMHCs, and CHCs. Telephonic interpretation was a “most used” method for a good number of reporting hospitals and dental clinics as well as by medium and low LEP organizations. Video interpretation was not reported as “most used” by any organization.

Reported use of family and friends for interpretation decreased markedly in hospitals, dental clinics, and medium and low LEP organizations. For example, the proportion of hospitals reporting that they “most used” patients family and friends decreased from 40% in 2004 to 13% in 2009; the proportion of dental clinics reporting this decreased from 67% to 25% and the percentage of medium LEP organizations reporting this decreased from 57% to 25%. Among these three types of organizations, decreased used of family and friends appears to have been offset by increased use of telephonic interpretation and in-person trained interpreters. Use of bilingual staff has also decreased while use of in-person trained medical interpreters has increased. For CHCs, CMHCs, and high LEP organizations there was little change in usage patterns over the five years: usage of in-person trained interpreters and bi-lingual staff was high in both 2004 and 2009.

Communication in the health care setting is not limited to the clinician-patient interaction. The ability to communicate is needed at many stages of the medical care process and in many places in health care organizations. Tables 3 through 7 present survey information about the use of different communication methods in various other places in reporting organizations.

Table 3: Communication Methods at the Switchboard^{14,15}

Organization	In-Person Interpreter	Bi-lingual Staff	Tele/Video Interpretation	None
Hospitals (N=16)	19%	19%	69%	25%
CHCs (N=9)	22%	33%	33%	22%
CMHCs (N=5)	0	20%	80%	20%
Dental Clinics (N=2)	0	50%	100%	0
High LEP (N=3)	67%	67%	0	0
Medium LEP (N=7)	0	29%	57%	29%
Low LEP (N=18)	17%	22%	78%	17%

¹⁴ Because respondents could choose more than one response, the total is greater than 100%.

¹⁵ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

Table 4: Communication Methods in the Reception Area¹⁶

Location	In-Person Interpreter	Bi-lingual Staff	Tele/Video Interpretation	None
Hospitals (N=16)	44%	25%	88%	6%
CHCs (N=10)	30%	60%	50%	10%
CMHCs (N=4)	25%	25%	50%	25%
Dental Clinics (N=4)	25%	50%	75%	0
High LEP (N=3)	33%	67%		
Medium LEP (N=7)	63%	50%	88%	0
Low LEP (N=19)	26%	32%	74%	16%

Table 5: Communication Methods in the Social Work Department¹⁷

Location	In-Person Interpreter	Bi-lingual Staff	Tele/Video Interpretation	None
Hospitals (N=16)	75%	38%	81%	0
CHCs (N=9)	44%	56%	56%	0
Dental Clinics (N=3)	67%	33%	100%	0
High LEP (N=3)	67%	33%	0	0
Medium LEP (N=7)	86%	43%	86%	0
Low LEP (N=17)	59%	47%	76%	0

Table 6: Communication Methods in the Billing Department^{18,19}

Location	In-Person Interpreter	Bi-lingual Staff	Tele/Video Interpretation	None
Hospitals (N=16)	44%	13%	81%	13%
CHCs (N=8)	38%	38%	38%	38%
CMHCs (N=5)	40%	60%	40%	20%
Dental Clinics (N=4)	25%	50%	75%	0
High LEP (N=2)	50%	0	0	50%
Medium LEP (N=7)	57%	43%	71%	0
Low LEP (N=20)	35%	35%	65%	20%

¹⁶ Because respondents could choose more than one response, the total is greater than 100%.

¹⁷ Because respondents could choose more than one response, the total is greater than 100%. CMHCs not included.

¹⁸ Because respondents could choose more than one response, the total is greater than 100%.

¹⁹ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

Table 7: Communication Methods in the Hospital Emergency Room Reception Desk²⁰

Location	In-Person Interpreter	Bi-lingual Staff	Tele/Video Interpretation	None
Hospitals (N=14)	50%	29%	93%	0

Telephone interpretation was the most often used interpretation method in other organizational locations among reporting organizations with the exception of high LEP organizations where bilingual and in-person interpreters were reported to be most used. Use of in-person interpreters are reported to be more frequent in the social work departments of responding organizations. Among low LEP organizations, the telephone is the most frequently cited interpretation method used. Multiple methods are used by hospitals. Some organizations report not having any interpretation method in these locations.

Table 8: Satisfaction with Language Services²¹

Type of Organization	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
Hospitals (N=16)	0	12%	69%	19%
CHCs (N=9)	0	11%	44%	44%
CMHCs (N=5)	0	0	60%	40%
Dental Clinics (N=4)	0	25%	50%	25%
High LEP (N=2)	0	0	50%	50%
Medium LEP (N=8)	0	13%	63%	25%
Low LEP (N=20)	0	15%	60%	25%

Most respondent organizations felt “somewhat” satisfied with the language services at their facilities. Only a few reported being “somewhat dissatisfied.” A small proportion reported being “very satisfied.”

²⁰ Because respondents could choose more than one response, the total is greater than 100%.

²¹ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

Table 9: Primary Obstacles to Providing Interpretation Services^{22,23}

Type of Organization	CHCs (N=10)	Hospitals (N=16)	Dental Clinics (N=5)	CMHCs (N=5)	High LEP (N=3)	Medium LEP (N=9)	Low LEP (N=21)
Insufficient Policies	0	6%	0	0	0	0	5%
Lack of staff training to use interpreters	0	44%	20%	20%	0	25%	24%
Staff/Physician resistance	0	31%	0	0	0	0	10%
Funding	40%	19%	20%	80%	67%	38%	29%
Operational issues	30%	25%	0	20%	33%	25%	24%
Lack of executive support	0	0	0	0	0	0	0
No awareness of legal requirements	0	0	0	0	0	0	0
Too few interpreter services staff	30%	56%	20%	20%	33%	50%	33%
None	20%	6%	40%	0	0	0	14%
Other	20%	36%	20%	0	33%	0	29%

Responses varied across organizations about the primary obstacles to providing interpretation services. Funding was cited by many responding CHCs, CMHCs and high and medium LEP organizations. Funding was cited as a barrier by fewer dental clinics and hospitals. Some organizations in each category cited too few interpreter services staff as a barrier, with over 50% of hospitals and half of medium LEP organizations reporting this. For hospitals responding to the survey, lack of staff training to use interpreters was also cited as a barrier as was staff/physician resistance. Awareness of legal requirements and insufficient policies were cited as barrier by very few respondents and none in many cases. 40% of dental clinics cited no barriers. Open-ended comments by several organizations note particular challenges in locating American Sign Language/English interpreters.

²² Because respondents could choose more than one response, the total is greater than 100%.

²³ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

Tables 10 and 11 identify how interpreters are scheduled and budgeted for in responding organizations that work with in-person medical interpreters.

Table 10: Scheduling of In-Person Medical Interpreters²⁴

Type of Organization	Centrally Scheduled	Scheduled by Department/Office	Other
Hospitals (N=13)	54%	31%	15%
CHCs (N=7)	43%	57%	14%
CMHCs (N=5)		80%	20% ²⁵
Dental Clinics (N=2)	100%		
High LEP (N=3)	67%	33%	
Medium LEP (N=7)	71%	29%	
Low LEP (N=14)	21%	71%	7%

Table 11: Budgeting of Medical Interpretation Services²⁶

Type of Organization	Central Budget with Own Line Item	Part of Department Budgets	Office Expense	Other
Hospitals (N=14)	50%	36%	7%	7% ²⁷
CHCs (N=8)	63%	13%	13%	13% ²⁸
CMHCs (N=5)	40%	60%		
Dental Clinics (N=5)	40%	20%		40% ²⁹
High LEP (N=3)	100%			
Medium LEP (N=6)	50%	50%		
Low LEP (N=17)	47%	35%	12%	6%

Centrally scheduled in-person medical interpreters was more common among reporting organizations than department or office-specific scheduling, with the exception of CMHCs and low LEP organizations where department scheduling was more prevalent. Central scheduling was very common among those organizations that serve a larger proportion of LEP patients. More organizations reported centrally budgeting for medical interpretation services than using other ways of billing with the exception of CMHCs which report billing by department.

²⁴ For respondents reporting that they schedule in-person medical interpreters.

²⁵ Lutheran Social services

²⁶ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

²⁷ Historically done centrally but in FY2010 by department.

²⁸ Comes from general clinical budget.

²⁹ Specific grants.

Language Support Services

Table 12 presents results from questions about other communication-supportive practices within provider organizations.

Table 12: Language Support Services³⁰

Type of Organization	“I Speak” Signs Posted ³¹	Translated Wayfinding Signs	Translated Written Materials	Medical Interpreter Policies ³²	Organizational Entity ³³
Hospitals (N=16)	38%	6%	88%	100% ³⁴	63%
CHCs (N=11)	55%	55%	100%	90% ³⁵	36%
CMHCs (N=5)	40%	40%	80%	80%	60%
Dental Clinics (N=6)	17%	17%	67%	50% ³⁶	33%
High LEP (N=3)	0	100%	100%	100%	0
Medium LEP (N=8)	63%	25%	100%	100% ³⁷	75%
Low LEP (N=22)	36%	23%	77%	85% ³⁸	50%

The highest proportion of respondents reported that their organizations have translated written materials for their non-English speaking patients as well as medical interpreter policies in place. Fewer report having “I Speak” signs, which are signs or posters in multiple languages that inform patients of their right to free interpretation services. Hospitals, dental clinics and medium and low LEP organizations reported having translated wayfinding signs. Low LEP organizations reported the fewest of these support services. Overall, CHCs and high LEP organizations (all of which are CHCs) reported that they have more of these support services than other types of organizations. Over half of responding hospitals and three-quarters of medium LEP organizations reported that they have an organizational entity responsible for improving culturally and linguistically appropriate care in their organizations. Fewer CHCs and dental clinics and no high LEP organizations reported having such an entity.

³⁰ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

³¹ Response for this question should be interpreted with caution as follow up data collection indicates that the question may have been misunderstood by respondents.

³² Whether policies are in place relative to when and how to use medical interpreters.

³³ Group/task force/committee responsible for improving culturally and linguistically appropriate care in the organization.

³⁴ N=15

³⁵ N=10

³⁶ N=6

³⁷ N=5

³⁸ N=20

Staff Training

Several survey questions related to the training of organizational staff. Table 13 presents survey results relative to the types of training topics offered to staff by responding provider organizations while Table 14 presents information about whether training is incorporated into new hire training.

Table 13: Training Topics Offered³⁹

Type of Organization	Communication Access Policies and Procedures	Working with a Medical Interpreter	Culture specific orientations ⁴⁰	PTSD ⁴¹	Serving D/HH Patients	Other
Hospitals (N=16)	88%	50%	50%	19%	50%	25% ⁴²
CHCs (N=9)	67%	67%	56%	33%	44%	33% ⁴³
CMHCs (N=5)	100%	40%	60%	80%	80%	40%
Dental Clinics (N=6)	33%	33%	50%	17%	17%	29%
High LEP (N=2)	50%	50%	50%	0	50%	50%
Medium LEP (N=8)	75%	63%	89%	25%	63%	0
Low LEP (N=22)	77%	41%	46%	32%	46%	23%

Table 14: Whether Any Above Training Topics are Included in New Hire Training⁴⁴

Type of Organization	Included in new hire training
Hospitals (N=15)	80%
CHCs (N=8)	75%
CMHCs (N=5)	60%
Dental Clinics (N=4)	100%
High LEP (N=2)	100%
Medium LEP (N=8)	100%
Low LEP(N=19)	63%

Training in the area of communication access policies and procedures was reported by the largest number of organizations with the exception of dental clinics. Fewer organizations reported providing training in other areas, including working with a medical interpreter, with training in

³⁹ A question about health literacy was also included in the survey. However, responses indicate that the question may have been misinterpreted.

⁴⁰ Culture-specific orientations to ethnic groups represented in patient population

⁴¹ Post-Traumatic Stress Disorder.

⁴² Cultural diversity awareness at orientation; Discharge planning, dietary variations, cultural competency; The policy is reviewed with department managers who in turn reviews with their departments.

⁴³ Cultural sensitivity; all staff meetings specifically for cultural competency trainings.

⁴⁴High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

PTSD least provided.⁴⁵ This question was asked about because growing research suggests that PTSD and physical health are closely related and that refugee populations disproportionately suffer from PTSD.⁴⁶ Screening for PTSD in medical settings is increasingly recommended.⁴⁷

Resources and Support

Table 15 presents information about where respondent organizations have obtained resources and support in helping them to address communication access and culturally responsive care.

Table 15: Source of Resources, Tools, and Supports⁴⁸

Type of Organization	MIAB ⁴⁹	CAHW ⁵⁰	MIAB/CAHW listservs	SNHAHEC or NHMHC ⁵¹	Local interpreter agencies	NCIHC Listserv ⁵²	CLAS-Talk Listserv	Other
Hospitals (N=13)	46%	69%	54%	62%	70%	0	15%	15% ⁵³
CHCs (N=9)	33%	0	11%	89%	67%	0	0	0
CMHCs (N=5)	40%	0	40%	20%	100%	0	0	60% ⁵⁴
Dental Clinics (N=3)	0	0	0	33%	33%	0	0	33%
High LEP (N=3)	67%	0	33%	67%	67%	0	0	0
Medium LEP (N=7)	57%	43%	29%	71%	71%	0	14%	29%
Low LEP (N=16)	25%	19%	25%	63%	69%	0	0	25%

SNH AHEC and NHMHC and local interpreter agencies are reported as the sources of support and tools by the largest proportion of responding organizations. A large proportion of responding hospitals reported participating in the CAHW, a peer network convened by the Foundation for

⁴⁵ A question about health literacy was also included in the survey. However, responses indicate that the question may have been misinterpreted. CMHCs reported high levels of staff training in post-traumatic stress disorders.

⁴⁶ See <http://www.ptsd.va.gov/professional/pages/ptsd-refugees.asp> for connection of PTSD to refugee populations and see <http://www.ptsd.va.gov/professional/pages/ptsd-physical-health.asp> for connection between PTSD and physical health.

⁴⁷ <http://www.ptsd.va.gov/professional/pages/ptsd-physical-health.asp>

⁴⁸ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

⁴⁹ Participation in Medical Interpretation Advisory Board

⁵⁰ Participation in the Cultural Awareness Healthcare Workgroup

⁵¹ Southern New Hampshire Area Health Education Center or New Hampshire Minority Health Coalition

⁵² The National Council of Interpreters in Healthcare

⁵³ OIG website, other conferences, HRET tools

⁵⁴ Member of local refugee group and cultural diversity group; Greater Nashua Healthy Community Collaborative; Other agencies have shared policy resources, Lutheran Family services, State Government

Healthy Communities and formed in Fall 2005.⁵⁵ No other organizations reported relying on this resource although it is open to all healthcare entities. The MIAB is also reported as a resource for a good number of responding organizations.

Respondents who reported using the translated health forms and documents section of the Foundation for Healthy Communities website were also asked about how helpful they found that section. Sixteen respondents reported using the website; 75% reported it to be “very helpful” and 19% reported it to be “somewhat helpful.”

Respondents were asked in an open-ended question to identify additional support needs and results are presented below for each type of organization. Among CHCs responding to this question (N=6), funding for interpreters was cited as a need by the largest number of respondents. Education was cited as a need by two of respondent CHCs. Hospitals (N=13) reported a need for interpreters, particularly ASL interpreters, as well as more education and staff training. A couple of respondents reported needing more information about other ways to provide services. One respondent identified a need for “information/support on transitioning the organization to a more multicultural/multilingual organization,” another wanted a “gap analysis” while a third respondent wanted a “road map in terms of providing the services. Seems we are left to develop the work plan and how to implement and maximize use of the resource elements.” CMHCs (N=4) reported a need for funding (N=3) and staff training (N=2). One dental clinic reported a need for legal information regarding interpreters for a medical setting while another felt education, tools, staff awareness and accountability were needed.

⁵⁵ The purpose of the CAHW is to bring together staff from healthcare organizations interested in improving the cultural and linguistic appropriateness of services offered by their own organizations. Membership is open to staff from health care provider organizations in New Hampshire.

Collection and Use of Demographic Information

Table 16 presents information about the types of data collected by respondent organizations while Table 17 identifies how organizations use these data.⁵⁶

Table 16: Organizations by Types of Data Collected⁵⁷

Type of Organization	Race	Ethnicity	Country of Origin	Primary/ Preferred Language	Type of Interpreter Needed
Hospitals (N=16)	93% ⁵⁸	54% ⁵⁹	9% ⁶⁰	80%	73%
CHCs (N=10)	90%	80%	89% ⁶¹	100%	90%
CMHCs (N=5)	100%	80%	0	75%	75%
Dental Clinics (N=6)	50%	50%	17%	67%	50%
High LEP (N=3)	67%	67%	100%	100%	100%
Medium LEP (N=8)	100%	100%	33%	100%	100%
Low LEP (N=20)	80%	52% ⁶²	22% ⁶³	70%	63% ⁶⁴

Data about race, primary/preferred language and type of interpreter needed were those most commonly collected by respondent organizations. Data about ethnicity and country of origin were collected by the fewest organizations. Across organizations, the highest proportion of CHCs, CMHCs, and high LEP organizations (which are all CHCs) reported collecting these data. Dental clinics were less likely to report collecting these data with the exception of primary language. As this survey did not question how the data was collected, no assessment can be made regarding the quality of data. (Were interpreters used? Were patients asked to self-report? What racial and ethnic categories were used? etc.)

⁵⁶ Respondents were given the option of responding “Don’t Know” and these have been eliminated from analysis.

⁵⁷ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

⁵⁸ N=13

⁵⁹ N=13

⁶⁰ N=11

⁶¹ N=9

⁶² N=21

⁶³ N=18

⁶⁴ N=19

Table 17: Use of Demographic Data Collected⁶⁵

Type of Organization	Schedule Interpreters	Assess quality of care ⁶⁶	Assess utilization services ⁶⁷	Assess health outcomes ⁶⁸	Assess satisfaction with services ⁶⁹	Other ⁷⁰
Hospitals (N=12)	100%	0	0	0	8%	0
CHCs (N=9)	89%	22%	22%	33%	22%	33% ⁷¹
CMHCs (N=5)	100%	20%	20%	0	20%	0
Dental Clinics (N=4)	100%	25%	25%	0	25%	25% ⁷²
High LEP (N=3)	100%	67%	67%	67%	67%	0
Medium LEP (N=11)	100%	13%	13%	0	13%	25%
Low LEP (N=16)	94%	6%	6%	6%	6%	13%

Given the high proportion of organizations reporting collection of interpreter need, it is not surprising that demographic data collected was used most often to schedule interpreters. With the exception of the three high LEP organizations, other organizations reported low use of the data for other purposes. It is important to note that collection of these data is likely to increase, especially among hospitals, in response to a revision of data requirements by New Hampshire Department of Health and Human Services for Hospital Discharge Data Sets (effective January 2010). This revision standardizes race and ethnicity data collection to be consistent with the most current US Office of Management and Budget Standards as well as adds a required field for patient language. NH State All Payer Claims Data, another public health data set will also mandate race and ethnicity be collected in the same manner as is identified in the hospital discharge data sets. Patient language is not included in this data set.

⁶⁵ High, Medium and Low LEP organizations is a categorization of hospitals, CHCs, CMHCs, and dental clinics based on reported volume of LEP patient visits developed for this analysis.

⁶⁶ Assess and compare quality of care among different patients/clients

⁶⁷ Assess and compare utilization of health services among different patients/clients

⁶⁸ Assess and compare health outcomes across different patients/clients

⁶⁹ Assess and compare satisfaction with services among different patients/clients

⁷⁰ Open-ended response category.

⁷¹ Too few patients of different languages to use data for comparison purposes (2); grants.

⁷² For grants.

CONCLUSIONS and DISCUSSION

While methodological concerns limit the conclusions and generalizations that can be drawn from the data, the survey results do point to the status of and changes in New Hampshire providers' efforts to meet the needs of limited-English speaking and deaf and hard of hearing patients. These are:

- New Hampshire continues to be characterized by provider organizations facing very different communication access needs.

Substantial regional differences with respect to ethnic diversity continue to characterize New Hampshire as they did in the 2004 language access survey with the southern, urban areas experiencing greater ethnic diversity than northern or western parts of the state. In fact, a substantial number of responding organizations in the north and western parts of the state reported few to no LEP patients served. Of all responding organizations, the three reporting the highest proportion of LEP patients served (by a substantial margin) were community health centers in Manchester and Nashua.

Of those organizations serving LEP patients, many reported that they are facing increasing language diversity. While all respondent organizations identified Spanish as one of the top three most common languages spoken in their facilities, no other language was consistently cited as common across organizations and new languages emerged as common in 2009.

All organizations reported that they served some D/HH patients; however, this proportion was often reported to be low. This underreporting may reflect that organizations are not adept at discerning which patients may be hard of hearing. Regardless, it is notable that organizations across the board report challenges in obtaining interpretation resources to communicate with these patients.

- Overall, capacity of reporting provider organizations to provide appropriate medical interpretation services appears to have increased between 2004 and 2009. Reported use of family and friends as the “most used” interpretation resource decreased and use of in-person interpreters as the “most used” interpretation resource increased among most types of reporting organizations between 2004 and 2009.⁷³

Reported decreased use of family and friends for interpretation was particularly marked among hospitals, dental clinics, and medium LEP organizations. The proportion of hospitals reporting that they “most used” patients family and friends decreased from 40% in 2004 to 13% in 2009; the proportion of dental clinics reporting this decreased from 67% to 25% and the percentage of medium LEP organizations reporting this decreased from 57% to 25%. Among these three types of organizations, decreased use of family and friends appears to have been offset by increased use of telephonic interpretation and in-person trained interpreters.

⁷³ CMHCs and high LEP organizations reported no use of patient family or friends in either 2004 or 2009.

For CHCs, CMHCs, and high LEP organizations there was little change in usage patterns over the five years: usage of in-person trained interpreters and bi-lingual staff was high in both 2004 and 2009. All 3 high LEP organizations reported “most using” in-person trained medical interpreters in both 2004 and 2009. By contrast, among organizations serving few LEP patients, the highest proportion reported “most using” telephonic interpretation.

Fewer responding organizations reported using bilingual staff in 2009 compared with 2004. Although the survey did not ask about reasons for trends in use of different interpretation methods, decrease in use of bi-lingual staff might be explained by the growing diversity of languages among patients (thus limiting the number of patients with whom a bi-lingual or tri-lingual staff member can interact) as well as cost.

Not surprising, organizations serving the highest proportion of LEP patients made greater use of in-person trained interpreters and bi-lingual staff. All 3 high LEP organizations reported “most using” in-person trained medical interpreters (in both 2004 and 2009). By contrast, among organizations serving few LEP patients, the highest proportion reported “most using” telephonic interpretation.

- While reporting organizations appear to be addressing the need for communication access in their social work departments, in some organizations, communication access in areas such as the switchboard, reception and billing appears more limited.

A high proportion of responding organizations reported using telephonic/videographic (Video Remote Interpreting) interpretation methods at the switchboard, with the exception of the 3 organizations serving the highest proportion of LEP patients who reported using in-person interpreters or bi-lingual staff. However, 25% of responding hospitals, 22% of responding CHCs, and 20% of responding CMHCs reported that they did not provide interpretation services at the switchboard. A higher proportion of responding organizations report using in-person or bi-lingual staff in the reception area and the billing department although use of telephonic/videographic services is also high. A few responding organizations reported that they did not provide interpretation services in these departments. All reporting organizations reported using some method of interpretation in the social work department to communicate with LEP and D/HH patients with a high proportion of hospitals, dental clinics and medium and high organizations reporting using in-person interpreters in these departments.

- Scheduling and budgeting practices for medical interpretation services varies across organizations. Organizations serving higher proportions of LEP/Deaf/Hard of Hearing patients are more likely to centralize scheduling and budgeting for medical interpretation.

About half of reporting hospitals and CHCs were using central scheduling and half were using department/office level scheduling. All dental clinics reported that they use centralized scheduling, likely because these organizations do not typically have “departments.” By contrast, 80% of CMHCs reported scheduling by department/office. A high proportion of organizations serving many LEP patients reported centrally scheduling interpreters. Billing practices also varied across organizations with all high LEP organizations reporting that medical interpretation was a line item in their central budgets. Half of reporting hospitals and 63% of reporting CHCs

indicated this was the case in their organizations. 60% of CMHCs reported that medical interpretation was part of departmental budgets.

Effective planning in the area of scheduling and budgeting can lead to efficiencies being found and possible cost savings. While the appropriate model will depend on organization size, patient flow, and volume of communication access services needed, for some organizations—i.e., those that serve many LEP and/or D/HH patients—a more centralized scheduling and billing approach may be more appropriate and cost effective.⁷⁴

- Funding for interpretation services is a substantial constraint for some organizations. Additional barriers include lack of staff training in how to work with medical interpreters and too few interpreter services staff, in particular ASL/English interpreters.

Similar to findings in the 2004 survey, funding for interpretation services is a substantial constraint for some organizations, especially CHCs and CMHCs and organizations serving a high proportion of LEP patients. 40% of CHCs, 80% of CMHCs and 67% of high LEP organizations cited funding as a primary obstacle to providing interpretation services. About half of responding hospitals identified lack of staff training in how to work with medical interpreters and too few interpreter services staff as constraints. Half of medium LEP organizations cited too few interpreters as a barrier. Open-ended comments by several organizations noted particular challenges in locating ASL interpreters. One third of hospitals reported that staff/physician resistance was a barrier.

- Gaps exist in the collection of important patient demographic data and use of data to improve services and quality of care is limited.

Disparities in health care can be addressed through a quality of care framework if data on race, ethnicity, and primary language are available. Data collection has long been central to the quality assurance process and may also help evaluate population trends and help ensure nondiscrimination on the basis of race and national origin, such as providing meaningful access for persons with limited English proficiency.⁷⁵ While data about race, primary/preferred language and type of interpreter needed are collected by most reporting organizations, ethnicity and country of origin data are less commonly collected except by CHCs and high LEP organizations. Few reporting organizations, with the exception of high LEP organizations, noted that they use demographic data to better understand patient care, service satisfaction, and outcomes. This is likely to improve, especially among hospitals, in response to a revision of data requirements for the Uniform Hospital Discharge Data Sets (effective January 2010). This revision standardizes race and ethnicity data collection to be consistent with the most current US Office of Management and Budget Standards as well as added the required field for patient language.

- While medical interpretation policies and translated materials are prevalent in responding organizations, fewer organizations report having translated wayfinding signs or translated signs informing patients of their right to interpreters (“I Speak” posters).

⁷⁴ <http://www.rwjf.org/files/research/080328speakingtogetherissuebrief.pdf>

⁷⁵ <http://www.hret disparities.org/WhyCMaki-4155.php>

Language support services, such as signage, translated materials, and policies related to use of medical interpreters, relate to ease of access to health care and therefore, health outcomes. The highest proportion of respondents reported that their organizations have translated written materials for their non-English speaking patients as well as medical interpreter policies in place. Fewer report having “I Speak” signs posted.⁷⁶ With the exception of CHCs, CMHCs and high LEP organizations, few other organizations reported having translated wayfinding signs. Low LEP organizations reported the fewest of these support services. Overall, CHCs and high LEP organizations (all of which are CHCs) reported that they have more of these support services than other types of organizations.

- Staff training in communication access policies and procedures is offered by a large proportion of responding organization. Far fewer organizations reported training in areas such as working with a medical interpreter, orientation to specific cultures and serving D/HH patients.

Ensuring that staff understands the importance of effective communication and cultural competency is a key component to enhanced patient care. Staff training in these areas is a key aspect of organizational infrastructure that helps to ensure that staff is aware and competent in these areas. While a large proportion of responding organizations reported providing staff training in communication access policies and procedures, far fewer organizations reported training in areas such as working with a medical interpreter, orientation to specific cultures and serving D/HH patients. With the exception of CMHCs, few reporting organizations provide training to staff in the area of post-traumatic stress disorder. Overall, dental clinics reported the least amount of trainings offered of all organization types. A large proportion of respondents reported that at least some of the training was offered as new hire training.

- Responding organizations value Southern NH Area Health Education Center, the Minority Health Coalition and local interpreter agencies as helpful organizations offering support and tools to provide communication access services. A large proportion of responding hospitals reported participating in the Cultural Awareness Workgroup. The Medical Interpretation Advisory Board is also reported as a resource for a good number of responding organizations.

SNH AHEC and NHMHC and local interpreter agencies are reported as the sources of support and tools by the largest proportion of responding organizations. A large proportion of responding hospitals reported participating in the CAHW, a peer network convened by the Foundation for Healthy Communities and formed in Fall 2005.⁷⁷ No other organizations report relying on this

⁷⁶ U.S. DHHS guidance on Title VI compliance states the public should be informed of the availability of interpreter services at all points of contact. Important points of contact for signs and notices include registration and waiting areas. <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html> An “I Speak” sign is a sign or poster that informs patients of their right to free interpretation services written in multiple languages. Staff utilize signs to identify a patient's preferred language to discuss their healthcare. Sample signs are available from: [Horizontal Layout \(PDF 1MB\)](#) and [Vertical Layout \(PDF 1MB\)](#)

⁷⁷ The purpose of the CAHW is to bring together staff from healthcare organizations interested in improving the cultural and linguistic appropriateness of services offered by their own organizations. Membership is open to staff from health care provider organizations in New Hampshire.

resource although it is open to all healthcare entities. The MIAB is also reported as a resource for a good number of responding organizations. Respondents who reported using the translated health forms and documents section of the Foundation for Healthy Communities website were also asked about how helpful they found that section. Sixteen respondents reported using the website; 75% reported it to be “very helpful” and 19% reported it to be “somewhat helpful.”

While a causal connection cannot be made, these survey results reflect positive progress in the work by the MIAB, CAHW in partnership with provider organizations to help providers understand and address communication barriers and culture issues to improve effective communication, and therefore, quality of care.

RECOMMENDATIONS

Currently, there are many expert opinions, recommendations, suggested guidelines relative to implementing communication access in medical settings. But clear best practice standards are still formulating. Section 504 of the Rehabilitation Act of 1973, Title III of the Americans with Disabilities Act of 1990 (ADA), and Title VI of the Civil Rights Act of 1964 establish the foundational rights of individuals to nondiscrimination and accommodation. In addition, for provider organizations, the Joint Commission on Accreditation of Healthcare Organizations has established standards relative to communication access.⁷⁸ Joint Commission surveyors will evaluate compliance with the Patient-Centered Communication standards beginning January 1, 2011; however, findings will not affect the accreditation decision. It is not clear when Patient-Centered Communication standards will be included in the accreditation decision. The Centers for Medicare and Medicaid Services (CMS) has conditions for hospital participation in their program stipulating that hospitals must be in compliance with applicable Federal Laws related to the health and safety of patients.⁷⁹ The National Standards on Culturally and Linguistically Appropriate Services (CLAS) created by the US Department of Health and Human Service Office of Minority Health set guidelines to improve culturally competent care, language access, and organizational supports for cultural responsiveness. Standard 3 states that “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.”⁸⁰ But the Standards do not suggest clear measures to indicate achievement. Performance measures for language services were posted at the Agency for Healthcare Research and Quality (AHRQ) National Quality Measures Clearinghouse (NQMC) during August 2010.⁸¹ The six process measures suggest a standardized approach to gauge inpatient and outpatient interpreter services programs, yet lack success indicators.

⁷⁸ http://www.jointcommission.org/NR/rdonlyres/26D4ABD6-3489-4101-B397-56C9EF7CC7FB/0/Post_PatientCenteredCareStandardsEPs_20100609.pdf
<http://www.jointcommission.org/PatientSafety/HLC/>
<http://www.jcrinc.com/common/PDFs/fpdfs/pubs/pdfs/JCReqs/JCP-01-10-S8.pdf>

⁷⁹ <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=73477aa6d4a760f68535010b42b630b0&rgn=div8&view=text&node=42:5.0.1.1.1.2.4.1&idno=42>

⁸⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

⁸¹ <http://www.qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?objid=15480>

The 2009 survey results point to progress in several important areas relative to communication access for the people of New Hampshire. They also point to several areas for further attention. Healthcare providers in New Hampshire should consider taking a systematic, comprehensive approach in assessing and addressing communication access needs. Components of this might include:

- Examining and addressing accessibility and communication barriers across the organization. This includes communication in clinical settings as well as communication in ancillary areas like reception, switchboard, and billing departments. Wayfinding signs in multiple languages should be posted throughout the organization.
- Ensuring that patients understand their rights to an interpreter by using “I Speak” signs, posters or cards.⁸²
- Enhancing staff training in communication access and cultural effectiveness topics and ensuring that they are incorporated into new hire training. Assess adherence to related organizational policies in annual staff performance reviews.
- Collecting and using race, ethnicity and language demographic data to identify differences in utilization of services, health outcomes, and patient satisfaction to improve quality of care and services.
- Assessing the relative benefits and costs of a centralized versus decentralized approaches for scheduling and billing structures for interpretation services.
- Integrating communication access services into quality improvement efforts by collecting data, applying measures, and assigning responsibility.⁸³

Developing cost effective yet workable models for communication access services is not simple. Each provider organization has unique characteristics and needs. Several tools exist to help organizations assess and address communication access needs. These include: the *Improving Communication – Improving Care Toolkit* from the Ethical Force Program® at the American Medical Association⁸⁴, from the Joint Commission *Advancing Effective Communication, Cultural Competence and Patient-and Family-Centered Care*⁸⁵, and ideal for outpatient

⁸² U.S. DHHS guidance on Title VI compliance states the public should be informed of the availability of interpreter services at all points of contact. Important points of contact for signs and notices include registration and waiting areas. <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>. Staff can utilize signs to identify a patient's preferred language to discuss their healthcare. Sample signs are available from: [Horizontal Layout \(PDF 1MB\)](#) and [Vertical Layout \(PDF 1MB\)](#) or <http://www.lssne.org/getdoc/960a52e5-df93-4c3d-b197-e1e25a360abf/LSS-I-Speak-poster2.aspx>

⁸³ Performance measures for language services are posted at the Agency for Healthcare Research and Quality (AHRQ) National Quality Measures Clearinghouse (NQMC). <http://www.qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?objid=15480>

⁸⁴ <http://www.mihealthandsafety.org/pdfs/06-improving-communication1.pdf>

⁸⁵ <http://www.jointcommission.org/NR/rdonlyres/87C00B33-FCD0-4D37-A4EB-21791FB3969C/0/ARoadmapforHospitalsfinalversion727.pdf> pages 47-48.

organizations, the *Addressing Language Access Toolkit* produced by the California Academy of Family Physicians⁸⁶.

On a macro-level, statewide efforts should continue to:

- Provide support to provider organizations, through general guidance and connection to resources as well as individual technical assistance.

The tools discussed above can help organizations assess and address communication access needs. The staff of the Foundation for Healthy Communities with their Cultural Effectiveness and Quality Healthcare Project have emerged as resources to support organizations in developing communication access plans and enhancing their capacity in this area.

- Work with relevant organizations to increase numbers of ASL interpreters capable of working in medical settings.

Consideration should be given to increasing the number of American Sign Language/English interpreters through training (currently, a Bachelor in Science in Sign Language Interpretation is offered by UNH) and professional development. Health care provider organizations could partner with organizations such as Northeast Deaf & Hard of Hearing and New Hampshire Registry of Interpreters for the Deaf (NHRID) to make progress on this issue. A structural constraint in this area also exists in that there is no reciprocity between New Hampshire and bordering states relative to ASL licensing. This, coupled with a national shortage as well as a statewide shortage of ASL interpreters, makes accessing ASL interpreters especially for provider organizations on the border difficult.

- Secure resources to support communication access services. Provider organizations and consumer advocates should continue advocacy efforts to enhance reimbursement for communication access services. Metrics around culturally and linguistically appropriate care tied to reimbursement should be taken into consideration as new ways to provide and pay for healthcare are explored.

Currently, reimbursement for medical interpretation services is limited to fee-for-service organizations serving Medicaid patients. No private insurance currently pays for medical interpretation services. Continued efforts to enhance reimbursement for medical interpretation is needed and advocacy work in this arena, by provider organizations as well as consumer advocates, should continue. Possibilities should be investigated as Accountable Care Organizations are explored in New Hampshire, to include metrics around culturally and linguistically appropriate care.

⁸⁶ <http://www.familydocs.org/system/files/AddressingLanguageandCulture.pdf>

APPENDIX A: Methodology

A web-based survey (SurveyMonkey) was used to collect the data presented in this report. Respondents were sent an email explaining the purpose of the study and its importance and were provided an electronic link to the survey that they could access through the web. A hardcopy survey option was provided to those who did not wish to or could not complete the survey on-line.

The 2004 survey questions were used as the starting point for the development of questions for the 2009 survey. However, substantial modifications were made that included the addition of questions, revised wording of some questions, and inclusion of questions used in similar surveys. Survey questions were modified/developed by the Evaluation Consultant in collaboration with staff from the Foundation for Healthy Communities. Questions were piloted tested with 3 organizations, two CHCs and one CMHC.

An overriding concern in survey development was to create a survey that was not overwhelmingly time consuming to complete and that did not ask for information that required respondents to conduct extensive review of program records. At the same time, it was important that information provided was accurate. Therefore, respondents were asked to provide “solid estimates” where possible and were encouraged to skip questions for which they were not confident of the answer. In a number of questions, a “don’t know” option was available.

The survey was sent to contacts in all hospitals, community health centers (CHCs), community mental health centers (CMHCs) and dental clinics in New Hampshire. Private practices and specialty providers were not included in this survey. Respondent lists were developed from existing lists of contacts held by the Foundation for Healthy Communities. Executive Directors of CHCs, CMHCs, and dental clinics were often the key point of contact for those organizations. For hospitals, the key contact was often the person known to be responsible for medical interpretation, patient, or community services in the organization. Where such a person did not exist or was not known, the survey link was sent to the President/CEO. The email to the initial respondent in all organizations included a request that the survey be forwarded to the most appropriate respondent if the initial respondent did not feel he/she was the appropriate contact.

The survey was administered from July 2009 through January 2010. The deadline was extended several times due to the extensive follow up with nonrespondents that was required. Code numbers were used to track respondents and conduct follow up with nonrespondents. In six cases, respondents completed only the first two or three questions and therefore, these responses have been eliminated from analysis. In addition, not all respondents completed all questions and nonrespondents from any question were eliminated from analysis for those questions. Response rates are summarized in the table below.

Summary of Survey Respondents

Type of Organization	Number of Potential Respondents	Number of Actual Respondents	Proportion Responding
Hospitals	30	16 ⁸⁷	53%
Community Health Centers	14	11	79%
Community Mental Health Centers	10	5 ⁸⁸	50%
Dental Clinics	13	6	46%

Response rates for the 2009 survey are slightly lower overall than response rates for the 2004 survey with the exception of CHCs where the 2004 response rate are similar to those in 2009.⁸⁹ Because all potential respondents did not respond to the survey, the results and conclusions drawn from the survey are limited to the respondent organizations and cannot be generalized to all hospitals, CHCs, CMHCs, or dental clinics in New Hampshire.

Hospital respondents were asked to identify which hospital components were included in the data provided. 38% of respondents reported that they included emergency departments in their response; 48% reported including in-patient services; 33% reported including out-patient services; and 43% reported including hospital-owned physician practices.

Quantitative (descriptive statistics) and qualitative techniques were used to analyze the results. Results are presented by each different type of organization. In addition, results are presented relative to whether organizations reported a high, medium or low volume of LEP and D/HH patient visits. Organizations that reported that 15% or more of their patient visits in the prior fiscal year were LEP patient visits were identified as those with a “high” proportion of LEP patient visits. There were 3 organizations, all CHCs, in this category. These organizations reported that between 35% - 45% of their total patient visits in the prior fiscal year were LEP patient visits. Organizations identified as “medium LEP,” of which there are 8, were those that reported between 5% and 15% of their total patient visits were LEP patients.⁹⁰ Finally, organizations that reported less than 5% of their patient visits in the prior fiscal year were LEP patient visits were identified as “low LEP” organizations. There were 22 of these in the analysis.

It is important to emphasize that this categorization was established solely for the purpose of the analysis presented in this report as a way to better understand differences and similarities across organizations based on their reported LEP patient visits. It does not reflect any standard or established categorization. It is likewise important to point out that not all organizations in communities with proportionately higher LEP populations reported a high proportion of LEP patient visits. While all 3 organizations identified as high LEP were located in Manchester or Nashua and all organizations from the north and western parts of the state were identified as low

⁸⁷ There were 20 respondents to the survey; however, four completed only the first two questions.

⁸⁸ There were 6 respondents to the survey; however, one respondent completed only the first two questions.

⁸⁹ Response rates to 2004 survey are as follows: 19 hospitals (of 29 or 66%), 12 CHCs (of 16 or 75%), 7 CMHCs (of 10 or 70%), and 4 dental clinics (of 7 or 57%).

⁹⁰ No organizations reported that their LEP patient population was between 15% and 35%.

LEP organizations, a few organizations categorized as medium and low LEP organizations were located in Manchester and Nashua.

The table below summarizes the types of organizations in each of the LEP categories:

Number of Provider Organizations in Each LEP Patient Categorization⁹¹

Category	Hospitals ⁹²	Community Health Centers	Community Mental Health Centers	Dental Clinics
High LEP (N=3)		3		
Medium LEP (N=8)	3	2		3
Low LEP (N=22)	9	5	5	3

On a final note, the methodology captured the provider perspective on their ability to provide effective communication access. Patient perspective was not ascertained. Culturally and linguistically responsive organizations with the best intent and proper systems in place may always be challenged to provide the right care for the right patient at exactly the right time, every time.⁹³

⁹¹ Represents a total of 33 organizations. Organizations that did not provide LEP patient information were not categorized.

⁹² 4 hospital respondents did not provide information about the proportion of LEP patients served and therefore, these were not included in LEP analysis.

⁹³ <http://www.rwjf.org/files/research/speakingtogetherreport.pdf>