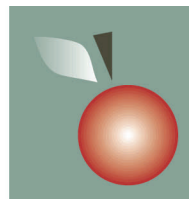


Executive Summary

NH Health Provider Communication Access Survey

September 2010



**FOUNDATION FOR
HEALTHY COMMUNITIES**



2009 NH Health Care Provider Communication Access Capacity Survey Report
prepared for Foundation for Healthy Communities to facilitate evaluation of the
Cultural Effectiveness and Quality Healthcare Project

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To see full report, go to: www.healthynh.com

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Acknowledgements

The Foundation for Healthy Communities expresses its appreciation to all the healthcare provider organizations who responded to our survey, providing information for this assessment. The Foundation for Healthy Communities also appreciates our partner organizations on the Medical Interpretation Advisory Board (MIAB) who provided comments and feedback on the report.

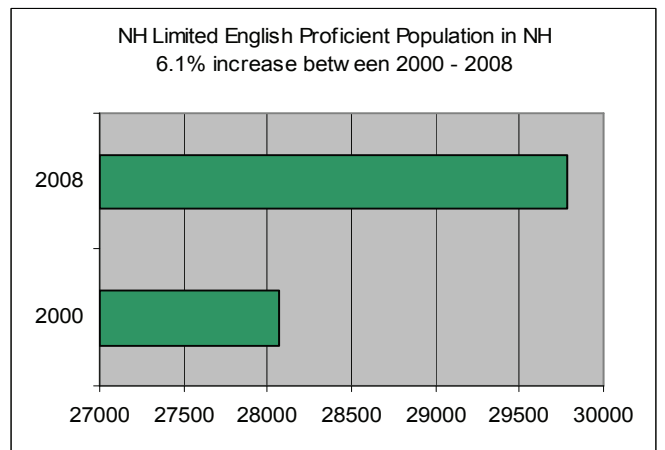
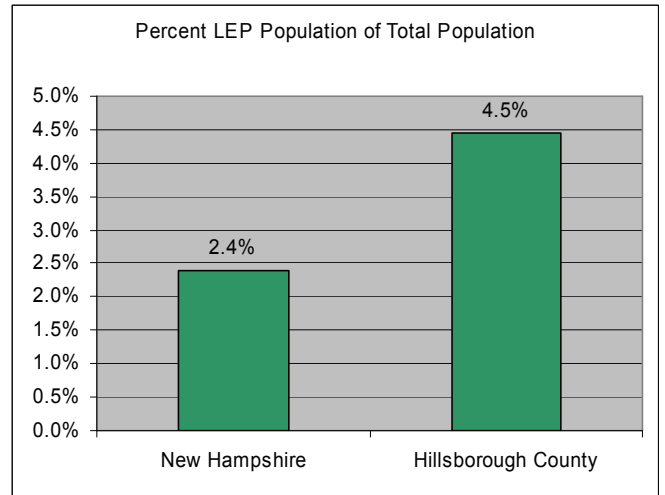
Introduction

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 to patient concordance with medical advice. In addition, effective communication has risk management implications as well as legal/regulatory ramifications. Over the past few years, individual providers as well as organizations such as the Foundation for Healthy Communities and others, have worked to enhance the capacity of provider organizations to communicate with limited English proficient (LEP) and deaf or hard of hearing (D/HH) patients. The 2009 Health Care Provider Communication Access Survey was conducted to assess how healthcare provider organizations in New Hampshire are managing to serve an increasingly diverse population in New Hampshire.

Diversity in New Hampshire

New Hampshire is a State of growing ethnic diversity. Between 2000 and 2008, there has been a 23% increase 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 1.2 million residents.² This represents an increase of 6.1% since 2000.³ 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 185,560 New Hampshire 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.⁵ Anecdotal information points to deaf residents also preferring the southern areas of New Hampshire, in particular Manchester.



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?_bm=y&-context=dt&-ds_name=ACS_2008_3YR_G00_&-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=&-lang=en

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

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

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

⁵U.S. Census Bureau; American Community Survey, 2006-2008 3 Year Estimates ; generated by Rebecca Sky; using American FactFinder; <<http://factfinder.census.gov>>; (2 August 2010).



Methodology

All New Hampshire hospitals, community health centers (CHCs), community mental health centers (CMHCs) and dental clinics were administered a web-based survey to collect the data presented in this summary. A hardcopy survey option was provided to those who did not wish to or could not complete the survey online. The survey was administered from July 2009 through January 2010. The deadline was extended several times due to the extensive follow up with non-respondents that was required. Response rate was 53% for hospitals, 79% for CHCs, 50% for CMHCs, and 46% for dental clinics. Methodology captured the health provider perspective on their ability to provide effective communication access. Patient perspective was not ascertained. The diversity of respondent organizations along with the variety of methods of response may have lead to different understandings of the questions affecting the quality of the data.

Findings

Patient Characteristics of Responding Organizations

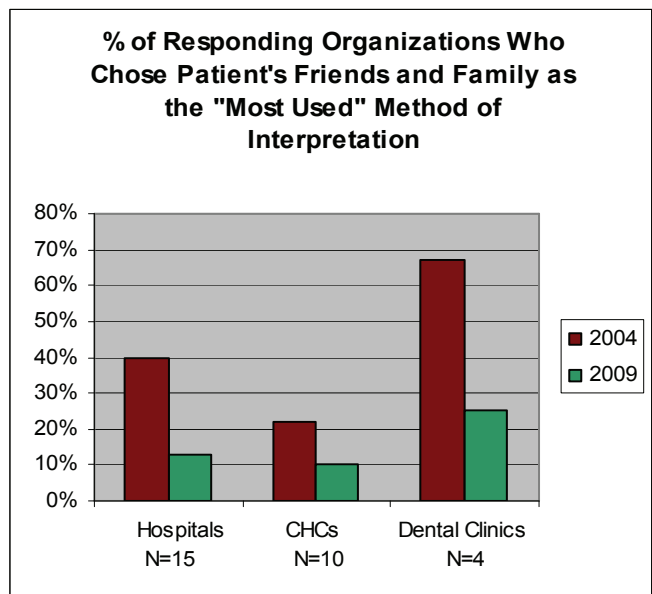
There is substantial variation in both patient visits and the proportion of identified LEP/D/HH patients served across the organizations responding to the survey. Respondents were asked in an open-ended question to describe trends in their patient population over the past five years. Organizations that, 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” (community health center), “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” (community health center), “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).

Meeting 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 in-person trained interpreters, bilingual staff, telephonic interpretation, video interpretation, and patient’s family members or friends.

Patterns of interpretation methods use varies by organization type and need. A higher proportion of CHCs, CMHCs, and organizations serving a higher percentage of LEP/D/HH patients report that they “most used” in-person trained medical interpreters compared to hospitals, dental clinics, or organizations that served a smaller percentage of LEP/D/HH patients. Telephonic interpretation is the “most used” method on aggregate for reporting hospitals and dental clinics.

Reported use of family and friends for interpretation decreased markedly in hospitals, dental clinics, and organizations serving a smaller proportion of LEP/D/HH patients. 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. Also, reported use of bilingual staff decreased while use of in-person trained medical interpreters increased.



Obstacles

Responses vary across organizations about the primary obstacles to providing interpretation services. Funding was cited by many responding CHCs, CMHCs and organizations that experience a higher volume (over 15%) of visits by LEP/D/HH patients. More than 50% of hospitals and half of the responding organizations with LEP/D/HH patients visits representing between 5% and 15% of their total patient visits cite too few interpreters as a barrier. **Open-ended comments by several organizations note particular challenges in accessing American Sign Language/English interpreters. Hospitals responding to the survey also cite as a barrier lack of staff training on how to use interpreters and staff/physician resistance.** Very few respondents named awareness of legal requirements and insufficient policies as a barrier.

Service Model

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

Staff Training

The survey questioned types of training topics offered to staff at healthcare organizations - from training on communication access policies and procedure, to how to work with an interpreter, to culture specific orientations, to how to serve deaf or hard of hearing patients, to training on Post Traumatic Stress Disorder. **Training on at least one of these topics is part of new hire training in organizations that experience over 5% of visits by LEP/D/HH patients.**

Patient Data

Use of Demographic Data Collected

Type of Organization	Schedule Interpreters	Assess Quality of Care ⁶	Assess Utilization of Services ⁷	Assess Health Outcomes ⁸	Assess Satisfaction with Services ⁹	Other ¹⁰
Hospitals (N=12)	100%	0	0	0	8%	0
CHCs (N=9)	89%	22%	22%	33%	22%	33% ¹¹
CMHCs (N=5)	100%	20%	20%	0	20%	0
Dental Clinics (N=4)	100%	25%	25%	0	25%	25% ¹²

Data about race, primary/preferred language and type of interpreter needed are commonly collected by respondent organizations. Patient ethnicity and country of origin are less commonly collected. **Use of these data to improve service provision is limited by responding organizations. The data is most often used to schedule interpreters.** With the exception of organizations that experience the highest proportion of LEP patients, other organizations reported low use of the data for other purposes.

⁶Assess and compare quality of care among different patients/clients.

⁷Assess and compare utilization of health services among different patients/clients.

⁸Assess and compare health outcomes across different patients/clients.

⁹Assess and compare satisfaction with services among different patients/clients.

¹⁰Open-ended response category.

¹¹Too few patients of different languages to use data for comparison purposes (2); grants.

¹²For grants.



Other Practices

A high proportion of respondents report their organizations have medical interpretation policies in place as well as translated written materials for their non-English speaking patients. **Fewer organizations, with the exception of CHCs, report having translated wayfinding signs or “I Speak” signs.**¹³ Over half of responding hospitals and three-quarters of the organizations with over 5% LEP/D/HH patient visits report they have an organizational entity responsible for improving culturally and linguistically appropriate care in their organizations such as a cross-department committee.

Conclusions

The survey results do point to the status of and changes in New Hampshire healthcare providers’ efforts to meet the needs of limited-English speaking, deaf, and hard of hearing patients. These are:

- ◆ There is substantial variation in the proportion of identified LEP/D/HH patients served across the organizations responding to the survey. Provider organizations face very different communication access needs.
- ◆ Overall, capacity of reporting provider organizations to provide appropriate communication access 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 2009.¹⁴
- ◆ In some organizations, communication access in non-clinical areas such as the switchboard, reception and billing appears limited.
- ◆ Scheduling and budgeting practices for medical interpretation services varies across organizations. Organizations serving higher proportions of LEP/D/HH patients are more likely to centralize scheduling and budgeting for medical interpretation.
- ◆ 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 interpreters, in particular ASL/English interpreters.
- ◆ Gaps exist in the collection of patient race, ethnicity, and language demographic data. Use of these data to improve services and quality of care is limited.
- ◆ 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).
- ◆ Staff training in communication access policies and procedures is offered by a large proportion of responding organization. Far fewer organizations report training in areas such as working with a medical interpreter, orientation to specific cultures, or serving D/HH patients.
- ◆ Responding organizations value Southern NH Area Health Education Center, the NH 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 valuing participation in the Cultural Awareness Healthcare Workgroup convened by Foundation for Healthy Communities. This group is a peer network, open to any staff from healthcare organizations interested in improving the cultural and linguistic appropriateness of services offered by their organizations.

¹³“I Speak” signs are signs or posters in multiple languages that inform patients of their right to free interpretation services.

¹⁴CMHCs and high LEP/D/HH organizations reported no use of patient family or friends in either 2004 or 2009.

Recommendations

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. Recommended components:

- ◆ Examining and addressing communication barriers across the organization. Barriers should be addressed in all patient diagnostic and treatment settings as well as in ancillary areas like reception, switchboard, billing departments. Consideration should also be given to facilitating navigation through the building for non-English speaking patients.
- ◆ Ensuring that patients understand their rights to an interpreter by using “I Speak” signs, posters or cards.¹⁵
- ◆ Including communication access and cultural effectiveness topics into new hire training and assessing adherence to related organizational policies in annual staff performance reviews.
- ◆ Including communication access services in quality improvement strategies by collecting data, applying measures, and assigning responsibility.¹⁶
- ◆ Assessing the relative benefits and costs of centralized versus decentralized approaches for scheduling and billing for communication access services.



Developing cost effective and 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: the *Improving Communication – Improving Care Toolkit* from the Ethical Force Program® at the American Medical Association¹⁷, from the Joint Commission *Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Care*¹⁸, and ideal for outpatient organizations, the *Addressing Language Access Toolkit* produced by the California Academy of Family Physicians¹⁹.

On a macro-level, statewide collaborative efforts among healthcare provider organizations and others should:

- ◆ Provide support to health care provider organizations, through general guidance and connection to resources as well as to individual technical assistance.
- ◆ Increase availability of ASL/English interpreters. Timely access to this needed service not only requires an increased supply of professional interpreters, but creative solutions to managing access to services.
- ◆ Secure resources to support communication access services. Advocacy for enhanced reimbursement for communication access services needs to continue. 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.

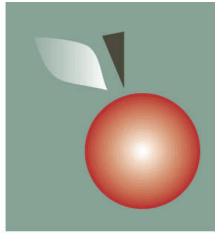
¹⁵U.S. DHHS guidance on Title VI compliance states the public should be informed of the availability of interpreter services at all points of contact. Important points of contact for signs and notices include registration and waiting areas. <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>. Staff can utilize signs to identify a patient's preferred language to discuss their healthcare. Sample signs are available from: <http://www.lssne.org/getdoc/960a52e5-df93-4c3d-b197-e1e25a360abf/LSS-I-Speak-poster2.aspx>

¹⁶Performance 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>

¹⁷<http://www.mihealthandsafety.org/pdfs/06-improving-communication1.pdf>

¹⁸<http://www.jointcommission.org/NR/rdonlyres/87C00B33-FCD0-4D37-A4EB-21791FB3969C/0/ARoadmapforHospitalsfinalversion727.pdf>

¹⁹<http://www.familydocs.org/system/files/AddressingLanguageandCulture.pdf>



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**To Participate in the
Cultural Awareness Healthcare Workgroup,
Or to join statewide collaborative efforts related to
communication access, contact the
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