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Interpretation Services for Patients with Limited English Proficiency in Critical Access Hospitals

MADELEINE PICK, MPH

MEGAN LAHR, MPH

SHEHROSE CHARANIA, BA

KEY FINDINGS

- Interviews with six Critical Access Hospitals (CAHs) revealed strengths and challenges when providing language interpretation services, many which are unique or exacerbated by their small and remote nature.
- Challenges to providing interpretation services in CAHs include a lack of qualified interpreters and logistic issues such as scheduling conflicts, long wait times, and technology problems.
- CAHs shared many strengths of their interpreter services, including offering specific training for interpreters and technology changes that have improved provision of video or audio interpreters.
- Additional support for strengthening interpreter services in CAHs may include funding, information on best practices, and specific training or education.

PURPOSE

Language interpretation in rural health care settings is an important service to consider when assessing access to equitable, safe, quality care, particularly as many rural communities become increasingly ethnically and linguistically diverse. Critical Access Hospitals (CAHs) may face additional challenges to providing language services given their small, rural nature. This brief describes common themes that emerged through interviews about language interpretation services with six CAHs located in areas with a high proportion of patients with limited English proficiency (LEP).

BACKGROUND

Language access is an important yet often overlooked component of medical care. In the U.S., health care is usually provided in English by default, but as of 2019 more than 25 million people in the U.S. have limited English proficiency (LEP).¹ This includes participants who report speaking English less than “very well,”¹ which may be an underestimate of the true LEP rate.²

Previous studies have found significant impacts of language barriers on health outcomes, health care access, patient experience, and patient safety. These studies have found that patients with LEP have higher rates of poorly controlled hypertension,³ are more likely to have no usual place for care or regular checkups,² and give lower ratings on average of inpatient care experience.⁴ In terms of patient safety, adverse events among LEP patients are more likely to result in physical harm, and of those involving physical harm, are more likely to have a higher level of harm compared to English speak-



ing patients.⁵ Conversely, interpreter services in health care facilities have been associated with better health outcomes for patients,³ increased preventive care use,² reduced emergency department return rates,⁶ and improved communication with providers.²

Health care organizations receiving federal funds (such as Medicaid and Medicare) cannot discriminate against someone based on national origin, including their primary language, according to Title VI of the Civil Rights Act.⁷ The U.S. Department of Health and Human Services (HHS) also created the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as a framework for advancing health equity through linguistically appropriate services, including four standards focused on communication and language assistance:⁸

1. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

However, one study of U.S. hospitals found that only 13% of hospitals surveyed met the four standards focused on communication and language assistance, and 19% did not meet any of the four.⁹

Despite these guidelines, there are few specific requirements for hospitals or interpreters providing interpretation services, and interpretation can fall to hospital staff in other roles or to a family member or friend of the patient (ad-hoc interpreters). While there are several nationally recognized certifications and training programs, medical interpreters are not required to hold a certification or license. Reimbursement for interpreter services is also complex, with the Centers for Medicare and Medicaid Services (CMS) allowing for some reimbursement for services, but states are not required to reimburse for language services through Medicaid.¹⁰

CAHs are important providers of health services in rural communities, many of which are also becoming increasingly racially and linguistically diverse, especially among children.¹¹ The percentage of the population that speaks English less than “very well” in non-metropolitan areas is equivalent to that of metropolitan areas.¹ Thus, there is an ongoing need to evaluate the language services available for all patients in communities served by CAHs.

Rural residents already face barriers to accessing needed health care compared to their urban counterparts, including transportation challenges, limited access to health care specialists, and higher rates of uninsured residents.^{12,13} A lack of health care services available in their language serves as an additional barrier for rural residents with LEP.

Given the small, rural nature of CAHs, providing interpreter services for patients can be even more challenging. This study aims to identify how CAHs located in areas with a large proportion of LEP patients provide language interpretation services, and to describe best practices that CAHs can emulate, and State Flex Programs can support as a key part of improving the quality of CAH services and population health in rural communities.



APPROACH

To identify CAHs to interview, the Flex Monitoring Team (FMT) used 5-year estimates from the American Community Survey (ACS) for counties with at least one CAH. More details on the FMT use of ACS language data for this project can be found [here](#). From the two counties in each state with the highest LEP, those with at least 10% LEP were selected (41 CAHs). The FMT conducted a scan of selected CAH websites for information about their interpretation services. Those with any mention of interpreter services on their website (19) were contacted for interviews.

Representatives from six CAHs were responsive to outreach, and interviews were completed between October 2021 and January 2022. Interview questions included topics about foreign language interpretation services such as program implementation, program operation, community engagement, and successes and challenges. Interviewees were not explicitly asked about American Sign Language interpretation due to the difference in requirements for these services. The job titles of interviewees varied but fell into three main categories: risk management, patient access, and human resources. Once interviews were completed, qualitative data from the interviews were coded by two members of the research team using inductive content analysis to identify key themes.

RESULTS

The interviewed CAHs are all located in the Midwest (4) or West (2) U.S. Census regions. Five of the six CAHs have 25 acute care beds, and the remaining CAH has 22. Using American Hospital Association Annual Survey data from 2020, two CAHs are system-affiliated while the remaining four are independent. Four CAHs were located in rural CBSAs, with one in micro and one in metro.

Though every CAH interviewed identified Spanish as

their main language need for interpretation services, CAH staff mentioned many additional languages spoken in their communities. Other languages spoken for which CAHs needed interpreters were Laotian, Amharic, Hmong, and Tigrinya. There was also a broad range in the volume of patients who need an interpreter, ranging from an estimated 12-80 visits per month in each CAH.

The interview data indicated that individual CAHs deliver interpreter services differently based on their specific language needs and volume. While all CAHs interviewed contract with interpreter service providers that offer an audio phone line for interpretation services, each CAH also used other interpretation methods rather than relying on just one mode. These additional methods included use of bilingual staff and providers, in-house interpreters, and video interpreters.

When asked about challenges with interpreter services in CAHs, responses fit into five main themes (see Table 1 for examples of quotes from interviewees). The most common theme with 10 mentions was related to administrative or logistic challenges, such as being unable to schedule interpreter services for emergency room visits, long wait times to connect to interpreters for less common languages, and for multilingual staff, providing interpretation in addition to their usual duties can create staffing gaps or delays. The second most common theme with eight mentions was related to a lack of interpreters. This included difficulty finding interpreters for less common languages or being unable to hire bilingual providers or in-person interpreters. Other themes included patient preferences (e.g., wanting to use family or friends as interpreters or preference for an interpreter of the patient's gender), staff attitudes (e.g., overcoming assumptions about which patients need an interpreter), and cultural barriers (e.g., building trust with the community and working to remove barriers that discourage patients with LEP from seeking medical care).



Table 1: Challenges of providing interpreter services in CAHs

Theme	Description	Quotes
Logistics	Logistic and administrative challenges including scheduling, wait times, and technology issues	<p>“We see 35-45 patients a day in our ER and that’s the most difficult providing that language because it’s not scheduled. Now, if we have a scheduled procedure say a surgery or any other scheduled procedure, we schedule that stuff in advance and so then we have that, the language that they need.”</p> <p>“The most challenging thing is to get our schedulers to not schedule, two, three and four people at a time that need an interpreter.”</p> <p>“The ongoing technology issues, you know what’s working, what’s not. Has anybody updated the iPad? Did we remember to plug it in?”</p>
Lack of interpreters	Difficulty finding qualified interpreters or bilingual providers	<p>“If we could find a Spanish speaking physician, we probably pay [them] a \$50,000 bonus... the only other hospital that’s close to our size... they have a Spanish speaking doctor over there, and a lot of our community goes there because you have a Spanish speaking doctor.”</p> <p>“The best scenario [is] in person that always works better, but this is not always possible.”</p>
Patient preferences	Patients wanting to use family or friends as interpreters or preference for interpreters of a specific gender	<p>“I think the biggest challenge is ensuring that everybody understands that you know how to interpret...communicating with a patient and family is their right to be in their preferred language. So, it’s really hard, because sometimes people don’t realize the importance of this, and they may tend to use a family member or friend as an interpreter instead of getting a qualified one.”</p> <p>“If I was a female and I really wanted a female interpreter and a male popped up, I didn’t have the ability to say, ‘I would like to have a female,’ it would have to basically hang up and try it again, in hopes that you got [a female interpreter]”</p>
Staff attitudes	Managing staff assumptions and attitudes about prioritizing language interpretation	<p>“We haven’t always had the administrative team that we have today. We have a relatively new CEO two years in the chair. I’m new. Prior to us being here, I think it was that the board members thought, ‘well why don’t... it’s just a matter of them learning our language,’ but there were a lot of ‘them’ and ‘us’ in the conversation, and so you can still hear it today, if you listen for it. Sometimes it’s a little bit more glaring than others, but we’re still fighting that sense of homogeneity in the community. And the fact that people are people, and they need medical services. Right, so if we can’t get everyone in the community to trust us to provide for their basic needs, then we’re not going to earn their business.”</p> <p>“Just last week, I was called in, you know to interpret for this person, and I walked in and I’m like, I mean I know this guy personally, and I’m like ‘Did you want an interpreter?’ [he] goes, ‘nope, they told me they were going to get one’... so I went out, and I said, ‘just because this is his last name does not mean he needs an interpreter, you need to take that one extra step and say... “would you like an interpreter?””</p>



The most common strength to providing interpretation services in CAHs raised by interviewees was related to staff. This included bilingual providers and other staff, providing training for staff on cultural sensitivity and logistics of using interpreter services, and providing education for employees who are interested in becoming interpreters. One CAH provides such training for bilingual staff through a four-hour class in which participants learn interpretation procedures, patient rights, risks and benefits, and roles and ethics of interpretation. Participants must pass an exam and then they receive a badge to indicate that they are qualified to be an interpreter. Another CAH offers a \$2500 stipend to all bilingual employees after passing a credentialing test. This applies for proficiency in any language and for staff in any role. The CAH's HR Director said, "Our goal is to offer that stipend regardless of whether you're a janitor or a doctor or a nurse or it doesn't matter...everyone interacts with patients in this hospital at some point, even me." Other strengths mentioned included use of technology such as the flexibility and fast connections of using video interpreters, and external partnerships such as relationships with local schools, employers, and nearby teaching hospitals.

When asked about how the community was involved in the design or improvement of interpreter services, most hospital representatives mentioned soliciting and incorporating patient feedback and trying to recruit community members as interpreters. The training and employee incentives discussed above also serve as recruiting tools for local residents with language skills. Other examples of community outreach and engagement included partnerships and outreach to groups in need of interpreter services that reside in their community.

When asked about resources related to interpreter services that would be helpful, interviewees identified the need for best practices, education, and financial support. Examples of these resources included insight

on what other CAHs are doing to provide effective interpreter services, cultural sensitivity resources, leadership development opportunities, and financial support for hiring interpreters and offering training. Participants were also asked if they had received any support from their State Flex Program for interpreter services, but none of the CAHs interviewed were aware of any resources they had received from Flex specifically for this purpose.

DISCUSSION

While national standards and certifications related to interpretation services in health care exist,^{8,14} they are not very specific and lack detail on how to implement language services. Information on best practices also may not be readily accessible or applicable for CAHs due to differences in CAH patient volume compared to patient volume at other hospitals, for which resources might be better tailored. Through these interviews with CAHs, some common challenges and strategies were identified that may be useful for other CAHs looking to further develop and/or improve their interpreter services. See appendix for additional resources.

The individuals responsible for overseeing interpreter services in each CAH varied but fell into three main categories: risk management (2), patient access (2), and human resources (2). Whereas larger hospitals may have a staff member dedicated to language services full-time, CAHs often operate differently in that staff may take on many roles.¹⁵ Staff roles focused on different priorities may also influence the lens through which CAH staff view interpreter services, and thus how services are provided as well as how interviewees answered the questions posed in this study. For example, interviewees in risk management positions emphasized the importance of not using family and friends as interpreters from a liability standpoint, whereas interviewees in human resources positions focused on hiring practices and incentives for bilingual staff.



The barriers that came up most often in these interviews included administrative and logistic challenges, a lack of interpreters, and patient preferences. While these are complex challenges, some of the CAHs interviewed offered strategies to combat them. Several CAHs discussed the importance of leveraging the strengths and diversity of their community to hire bilingual staff or train people who are interested in providing interpreter services. The most salient examples of this were providing financial incentives to staff in any role after they pass a credentialing test and, at another CAH, offering in-house training for staff to become qualified interpreters. In addition to creating a more robust network of qualified interpreters available, these strategies may also help circumvent some of the technological challenges posed by video or audio services. Virtual interpretation services generally do not allow for as much attention to body language, facial expressions, or broader cultural differences,¹⁶ and some interviewees noted additional technical issues such as forgetting to charge devices and needing to wait for an interpreter.

While interpreter services during clinical visits are a key component of providing quality care to residents, three interviewed CAHs acknowledged the importance of broader community engagement as well. Two interviewees mentioned that their multilingual staff act as a bridge to the broader community, which helps reduce barriers they face. Interpretation staff are key members of clinical care teams and can help build trust and connection with patients given their unique combination of training, familiarity with medical terminology and procedures, and cultural knowledge.¹⁷ One CAH mentioned organizing events such as “meet and greets” that are focused on engaging specific immigrant communities. These events provide avenues for CAHs to better understand the health needs of the residents in their service area, while also connecting community members to their local hospital and educating them on what services are available there. In another example of engaging with community, one CAH noted that their hospital’s Patient and Family Advocacy Council (PFAC) includes broad representation

from community members of different backgrounds, including those with LEP. Prior literature also suggests creating family advisory boards to engage LEP populations, which in turn promote patient-centered care and can help reduce health care disparities.¹⁸

Another theme that emerged was education for staff, patients, and the broader community. One CAH representative discussed how staff at their hospital needed continuing education on assumptions and biases to be able to better understand who does or doesn’t need an interpreter based on their appearance or name. Some CAHs also mentioned the importance of training their staff on how to use interpreter services or work with interpreters.

While the CAHs interviewed did not know of any specific resources they received from their State Flex Program (SFP) related to interpreter services, there are several opportunities for the Flex Program to participate in supporting CAHs wishing to improve their language services. SFPs may consider providing resources to their CAHs such as information about vendors and/or cultural sensitivity resources or trainings. Many CAHs also mentioned the need for financial support for hiring interpreters or offering trainings, and SFPs may also consider funding opportunities to support these services.

This study has several limitations to consider. First, the six hospitals interviewed are just a small sample of CAHs. They were also similar to each other on several characteristics including geographic region and size based on number of acute care beds. The purpose of this brief was not to obtain a representative sample of CAHs but to gain insights from CAHs that may have more established or robust interpreter services due to their location and patient population with this need.

CONCLUSION

Critical Access Hospitals across the country face many challenges to provide quality care to all their patients, especially considering additional burdens placed on



them through the COVID-19 pandemic and ongoing workforce challenges. Providing accessible care in a patient's preferred language is critically important to ensure proper care is given and to encourage comfort with seeking care in one's community. Many of the barriers to providing quality interpreter services are closely tied to other issues faced by CAHs, such as staff shortages and limited financial resources, but with additional support and continued focus on the importance of these services, rural patients with LEP can have better quality health care and health.

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APPENDIX: INTERPRETATION SERVICES RESOURCES FOR CAHS

Resource Name	Description
Agency for Healthcare Research & Quality (AHRQ) Health Literacy Improvement Tools	AHRQ’s Health Literacy Improvement webpage provides a wealth of tools and information focused on the improvement of health literacy in health-care. Resources include the Universal Precautions Toolkit, the Re-Engineered Discharge Toolkit, and the Pharmacy Health Literacy Center.
TeamSTEPS® Enhancing Safety for Patients With Limited English Proficiency Module	This module from AHRQ offers comprehensive curricula and instructional guides to develop teams who can communicate effectively with patients who have limited English proficiency
Best Practice Recommendations for Hospital-Based Interpreter Services	From the Massachusetts Department of Public Health, this extensive guide provides detailed suggestions for an optimal translation services program. Topic areas cover policies and procedures, needs assessment, delivery, training, monitoring, and evaluation.
International Medical Interpreters Association (IMIA) Guide on Medical Translation	This document provides a set of medical translation management and quality control guidelines for healthcare professionals. Formatted by question and answer, this resource is easy to navigate and understand.
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care	This “roadmap” by the Joint Commission offers guidance to better understand and address individual patients’ needs, including communication. This resource also provides several additional resources, many specific to translation.
Think Cultural Health (U.S. Department of Health and Human Services Office of Minority Health)	This website provides detailed information about the National CLAS Standards, continuing education opportunities, and other resources.
Health Literate Care Model (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion)	The Health Literate Care model is a tool for health care organizations and providers to help engage patients in prevention, decision-making, and self-management.

For more information on this report, please contact Madeleine Pick, pickx016@umn.edu.

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