

Hospitals, Language, and Culture: A Snapshot of the Nation



Exploring Cultural and Linguistic Services
in the Nation's Hospitals

A Report of Findings

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EXECUTIVE SUMMARY



As our nation becomes more diverse, so do the patient populations served by our nation's hospitals. Few studies have explored the provision of culturally and linguistically appropriate

health care in a systematic fashion across a large number of hospitals. With funding from The California Endowment, the *Hospitals, Language, and Culture: A Snapshot of the Nation* project is working to strengthen this understanding. *Hospitals, Language, and Culture* is a qualitative cross-sectional study designed to provide a snapshot of how sixty hospitals across the country are providing health care to culturally and linguistically diverse patient populations. This project sought to answer the following questions:

- What challenges do hospitals face when providing care and services to culturally and linguistically diverse populations?
- How are hospitals addressing these challenges?
- Are there promising practices that may be helpful to and can be replicated in other hospitals?

The project findings will be presented in multiple reports. This report highlights findings regarding the first two research questions.

A purposive sampling approach was used to select sixty hospitals for this study. Two methods used were judgment sampling (hand-selection) and stratified sampling (demographically-driven). Study data were collected through two mechanisms—a 26-question Pre-Visit Questionnaire completed by each hospital, and one-day site visits conducted at each hospital by a trained project researcher and a note-taker. Site visits were completed between September 2005 and March 2006. Each site visit consisted of a combination of

administrative and clinical interviews that focused on six research domains:

- Leadership
- Quality Improvement and Data Use
- Workforce
- Patient Safety and Provision of Care
- Language Services
- Community Engagement

The findings provide unique insight into the challenges, activities, and perspectives of sixty hospitals across the nation and a snapshot of their current situation. These findings cannot be generalized to all hospitals, but they provide detailed information about many ways that culture and language issues are being addressed in hospitals. Hospitals in this study had generally progressed further in their efforts to address language issues than they had in their efforts to address cultural issues.

Providing Culturally and Linguistically Appropriate Care is Challenging

Hospitals identified many challenges related to providing care to culturally and linguistically diverse patient populations. The most frequently cited challenges related to language and staffing. Hospitals often reported finding it difficult to find staff with the desired cultural or linguistic competency, and some indicated that there are challenges created by having a diverse staff. Cultural issues were also commonly cited as a challenge. All but six hospitals reported financial stresses in relation to serving diverse populations. No common characteristics were found among the hospitals that did not identify financial stresses.

Analysis of the data revealed three principal areas worthy of highlight because of their importance to patient safety. These included the provision of language services, the process for obtaining informed consent, and the collection and use of patient-level demographic data.



Language Services

The project findings suggest that systems for the provision of language services in hospitals across the country are still a work-in-progress. The majority of hospitals had mechanisms for identifying the linguistic needs of patients and written policies respecting the provision of language services. However, many did not provide ongoing training for staff on accessing language services nor did they assess the competency of interpreters and bilingual staff used to provide interpretation services. Few had policies in place regarding the use of family members as interpreters, and family members were frequently used to provide interpretation. Defined policies and procedures for the provision of language services in hospitals that serve linguistically diverse patient populations are needed to provide access to safe, high quality care for all patients served.

Many hospitals provided patient education materials in languages other than English, including those relating to patient rights and informed consent. The translation most commonly available was Spanish, but documents were identified that had been translated into Russian, Arabic, and Mandarin. When asked about the process for translating these documents, a variety of responses were received. Some hospitals had their documents translated in-house by members of the interpreter staff or other bilingual staff. Other hospitals indicated that they used computer translation programs; however, the programs they identified do not actually translate documents. As with language service provision, there is a need for greater attention to the quality of translated patient materials.

Informed Consent

Most hospitals indicated that they take patients' linguistic needs into account in the informed consent process. While many clinical staff interviewees indicated that they "always use an interpreter for informed consent," other interviewees indicated that

"our informed consent form is translated into Spanish," but that there is no use of an interpreter to facilitate dialogue with the patient about the condition and proposed treatment. Some clinical interviewees indicated that they would use practices such as "teach back," but these responses were far less common than those which indicated a reliance on a translated informed consent form. A comprehensive approach to meeting the cultural and linguistic, literacy, and other confounding needs of patients is essential to the creation of a health care system that supports informed care throughout the care process.

Collection and Use of Patient Demographic Data

Accurate, consistent, and systematic collection of data on patient race, ethnicity, and primary language is a key component of efforts to reduce health disparities. However, current hospital infrastructures for collection of these data were underdeveloped in the project hospitals. The majority of hospitals in this study had inconsistent methods for collecting these data. In some, systems were in place but not utilized; in others, staff appeared not to have been trained on methods to accurately collect data from patients. These data are needed by hospitals to analyze health care quality and patient safety findings by researchers to measure effectiveness of interventions aimed at reducing disparities. It is worth noting that only a few of the study hospitals reported that they use data on race, ethnicity, and primary language to improve the quality of care they provide.

Recommendations

The provision of culturally and linguistically appropriate care is a shared responsibility. The recommendations below are supported by the study data and current literature. These recommendations reflect an integrated effort to improve care to diverse populations by addressing recommendations to hospitals, policymakers, and researchers. Recommendations are grouped by the research domain to which they principally relate.



1. Recommendations and Observations related to Domain One: Leadership

1-1. Hospitals serving linguistically and culturally diverse patient populations should consider establishing a centralized program with executive-level reporting to coordinate services relating to language and culture as a part of the organization's commitment to quality. A centralized program would provide the necessary structure for supporting the provision of cultural and linguistic services in a consistent manner and allow for quality control. The program could be integrated with other hospital activities (such as quality improvement, social services, and community outreach), but should have a distinct place in the organization and be allocated separate, identifiable financial and other resources.

1-2. Hospital CEOs and other hospital leaders should make their commitment to culturally and linguistically appropriate care highly visible to hospital staff and patients. Hospital leaders should provide the resources and the organization motivation to improve care provided to culturally and linguistically diverse patient populations by recognizing the uniqueness and individuality of both patients and staff. Chief Executive Officers who actively work to learn more about these issues, who are aware of the diverse needs of their patient population, and who demonstrate their commitment through involvement in cultural and linguistic programs are more likely to have staff follow their lead.

1-3. Hospitals should provide for internal multidisciplinary dialogues about language and culture issues. These dialogues may be formal or informal and could be facilitated by the Hospitals, Language, and Culture site visit protocol (see Appendix 2) or organizational self-assessment tools.¹ During site visit interviews, hospital staff learned a great deal about the programs and issues that are important to the hospital as a whole. Internal multidisciplinary dialogue also made them aware of issues that they had not previously

considered. These dialogues should be used as a source for strategic planning to improve the provision of culturally and linguistically appropriate care.

1-4. Financial incentives should be created to promote, develop, and maintain accessibility to qualified health care interpreters. Hospitals are challenged by increasingly resource-intensive demands for interpretation services. While linguistic services are generally understood as a necessary component of care for patients with limited English proficiency, many hospitals find these services to be cost prohibitive. Financial incentives could serve as a “carrot” to encourage wider use of qualified interpreters. Wider use of qualified interpreters would benefit both the patients and the practitioners and thus, the hospital.

1-5. More research is needed to better understand what motivates hospital CEOs who embrace culturally and linguistically appropriate care. This research should encompass measurement of return on investment of resources, including CEO time and involvement. Given that many hospitals in the study sample indicated that financing these services is a challenge, why is it that some hospitals have been able to identify needed resources while others cannot? Research in this area could be used to inform policy development, direct funding opportunities, and encourage hospital leadership action.

2. Recommendations and Observations Related to Domain Two: Quality Improvement and Data Use

2-1. Hospitals should implement a uniform framework for the collection of data on race, ethnicity, and language. Systematic data collection using an established framework is urgently needed. A good example is the one proposed by Hasnain-Wynia and Baker², which includes a rationale for the collection of these data; a script for staff to use to collect data; a method to allow patients to self-identify using their



own words or self-selection from a list of categories; a standardized approach for “rolling up” granular responses to broader categories such as those developed by Office of Management and Budget; and assurances to patients that data will be held confidential.

2-2. Hospitals should stratify service and technical quality measures such as those reported through the Hospital Quality Alliance,³ by language, race, and ethnicity. Such stratification would allow hospitals to monitor quality of care for diverse populations and monitor the effectiveness of interventions such as the provision of language services.

2-3. A national dialogue needs to begin and decisions need to be made regarding the categorization of race, ethnicity, and language data for reporting purposes. Quality data are currently being reported on a variety of measures that would benefit from stratification by race, ethnicity, and language. Hospitals should begin collecting these data in a uniform manner (recommendation 2-1), and effective criteria should be applied for rolling up these data into broader categories. Consistent collection and reporting methods need to be employed across hospitals so that national data are accurate.⁴

2-4. Regulatory and accrediting bodies should require the collection of data on race, ethnicity, and primary language and should require organizations to use these data as part of their ongoing quality improvement efforts. The majority of hospitals currently collect some combination of patient demographic data, primarily on race.⁵ However, few are actually using the data to monitor for disparities in care or to evaluate the effectiveness of interventions aimed at improving care to vulnerable populations.

2-5. Health information technology work groups need to determine practical ways of integrating patient demographic data such as race, ethnicity, and primary language into information systems.

As advances are made in health information systems, consideration must be made for the integration of data necessary for monitoring disparities. Currently, efforts to monitor disparities are challenged not only by lack of data collection, but also by the inability of various data systems to “talk” to one another. As health information technology workgroups address issues of data usability, they also need to consider the integration of data on race, ethnicity, and primary language.

2-6. Researchers should partner with hospitals to use stratified quality measurement data to discern potential disparities and develop follow-up measures of cultural and linguistic competence to monitor actions toward improvement. In addition to the need to collect data in a consistent manner that allows for stratification, hospitals—already acknowledged to be overwhelmed with “must do” performance monitoring—nevertheless, need to take on additional monitoring activities. The health care field is hungry for data that will show the impact of interventions designed to reduce disparities and improve cultural and linguistic competence. Researchers should make efforts to partner with hospitals to stratify and use these data to measure the impact of interventions.

Recommendations and Observations Related to Domain Three: Workforce

3-1. Hospitals should engage staff in dialogues about meeting the needs of diverse populations. These dialogues can help to identify common needs and inform the development of practices and systems to meet these needs.

3-2. Hospital staff should be provided ongoing in-service training on ways to meet the unique needs of their patient population, including regular in-services on how and when to access language services for patients with limited English proficiency. Informed by hospital dialogues, practices that have been found to be useful for meeting patients’ unique needs



should be shared with staff throughout the organization. For example, one department may have developed an innovative way to address a unique cultural belief that can facilitate care provision in other departments. There are also several reports of promising practices⁶ that highlight ways to address both cultural and linguistic needs. Hospitals may also want to share their learned practices with each other and then develop a local network of evolving knowledge.

3-3. Accrediting bodies should require continuing education and training that supports the provision of culturally and linguistically appropriate care.

For example, hospital staff should be trained regularly on the hospital's mechanism for providing language services. Hospital staff should also be trained on the best ways to meet the needs of the hospital's population in the context of the resources that are available to them.

3-4. More research is needed to measure and understand the benefits of increased racial, ethnic, and linguistic concordance of hospital workforces and their patient populations. The National Standards for Culturally and Linguistically Appropriate Services in Health Care recommend that hospitals make efforts to increase the diversity of their workforce as a means to better mirror the patient population.⁷ We need to know that workforce and patient concordance truly makes health care services more culturally and linguistically appropriate. Better measures of the impact of this concordance (and conversely the impact of discordance) are needed to support these efforts.

3-5. Research is needed to develop measures of the impact of cultural competency training programs for hospital staff on patient care. While there is no national standard or certification for guiding the provision of cultural competence training, several training programs exist. Unfortunately, there is limited information about their effectiveness. Measures could

focus on staff attitudinal and behavioral change using responses from staff focus groups or satisfaction surveys. Measures could also focus on the availability of language services and the frequency of use of such services.

Recommendations and Observations Related to Domain Four: Patient Safety and Provision of Care

4-1. Hospitals should formalize their processes for translating patient education materials, including patient rights and informed consent documents, into languages other than English and evaluating the quality of these translations.

- As part of a formalized process, hospitals should establish a central “authority” within the hospital for coordinating the translation of documents, facilitating quality control, and minimizing duplication of similar documents across hospital departments.
- Hospitals may choose to collaborate with other health care providers to translate basic health education materials into other languages and share the costs thereof.
- Documents need to be translated in a manner that conveys accurate and culturally appropriate information.
- Quality controls should be in place to assure the accuracy and meaningfulness of the translation. Quality controls may include user focus groups or engagement of community representatives to assess the accuracy, meaning, and context of translated documents. Some hospitals may choose to use translation companies perform this service.⁸

4-2. Health care interpreters should be used to facilitate communication during all informed consent processes involving patients with limited English proficiency, and cultural brokers should be used as a resource when a patient's cultural beliefs impact care. Practitioners need to be mindful that informed consent is a process, not a one-time event. A person's cultural beliefs about health can have an impact on



his or her understanding of proposed treatments and can impact the trust necessary for truly informed consent. Increased effort toward trying to understand how the patient understands his or her illness allows the practitioner to tailor the information provided in a manner that the patient will best understand.

- Hospitals may have a number of resources available to them to assist in cultural brokering. Some of these resources include hospital chaplains, hospital language service departments and interpreters, and nursing staff who have been trained in transcultural nursing.
- Qualified interpreters should be used to bridge the communication gap during health care encounters involving patients with limited English proficiency. Qualified interpreters often are also able to assist in cultural brokering.
- Adequate accessibility to interpreters requires leadership support; training for staff and medical staff on how to work effectively with an interpreter; a user-friendly system to access interpreter services; and a cadre of qualified interpreters.
- Qualified interpreters can function in-person or remotely (via telephone or video). They can be bilingual staff already employed by the hospital in other roles, or they can be hospital-employed or contract interpreters. Qualified interpreters are distinguished by assessment of their competency and language proficiency, and they have been trained in the practice of interpreting in a health care setting (see definition of “qualified interpreter” in Chapter One).

4-3. Hospitals should take advantage of the internal and external resources available to educate them on cultural beliefs they may encounter. Hospitals can learn about internal and external resources by conducting focus groups with patients, consulting with professional chaplains, engaging community organizations and places of worship, and conducting focus groups with staff, particularly those who may be from the communities and populations served by the hospital.

4-4. Once a patient’s race, culture, ethnicity, language, and religion have been determined, hospital staff and medical staff should be made aware of the tendency toward stereotyping in order to avoid making assumptions about patients. Cultural competence is not meant to represent a complete understanding of each ethnic, religious, and linguistic culture. Rather, the *practice* of cultural competence is more akin to the practice of patient-centered care, whereby the practitioner works to understand the patient’s needs from the patient’s perspective.⁹ Asking open-ended questions of the patient to better understand how the patient is experiencing his or her illness or condition is important to understanding the whole patient and being able to meet individual needs.

4-5. Patient safety and quality improvement leaders need to have dialogues with language services coordinators, diversity officers, and pastoral care workers about issues relating to culture and language that can impact patient safety. While language and culture are known to impact the safety and quality of care, conversations about patient safety initiatives seldom address these issues. The worlds of patient safety and culturally and linguistically appropriate care need to meet in order to begin the integration of language services and the impact of culture into patient safety activities.

4-6. Expand the Joint Commission National Patient Safety Goal #13¹⁰ to specifically address diverse populations, particularly those with language and communication barriers. This National Patient Safety Goal addresses the need to “encourage patients’ active involvement in their own care as a patient safety strategy” and “define and communicate the means for patients and their families to report concerns about patient safety and encourage them to do so.” As part of this goal, accredited organizations should be required to consider the cultural, linguistic, educational, and literacy implications of patient engagement.



4-7. Collection and analysis of adverse event data by language, race, and ethnicity should be undertaken and be standardized as a means to support patient safety initiatives.

National adverse event databases should seek the reporting of these demographic data. There exists a preliminary understanding of the impact language can have on patient safety,¹¹ but more data are needed to understand the scope of the problem and associated factors.

4-8. More research is needed to evaluate the quality and safety impact of diversity and cultural competence training provided to health care workers.

While many hospitals provide cultural competence/diversity/sensitivity training to their staff, there is little evidence of its impact on the provision of care. No common understanding exists regarding the components of effective training on these issues (see Recommendation 3-5). A metric is needed to measure the effectiveness and impact of the various cultural competence/diversity/sensitivity training programs. The resulting data could help to refine training to meet the needs of health care workers and increase the willingness of hospitals to provide the resources necessary to support this training.

Recommendations and Observations Related to Domain Five: Language Services

5-1. Hospitals should consider establishing written policies regarding the provision of language services.

Such a policy should address what language services are available; how to access the services; what to do if a patient refuses a service; and provide guidance regarding situations in which the policy may not apply (for example, in social conversations). This policy should be shared with all staff at orientation and regularly thereafter. The hospital should review its policy regularly to determine whether it continues to meet the needs of the hospital's limited English proficient population. This review should involve

consideration of community data, aggregate patient demographic data, and other data that demonstrate the need for interpreter services.

5-2. Hospitals should implement policies that do not permit the use of family members, particularly minors, for interpreting during medical encounters, except in the case of an emergency when no other option is available.

While some patients may initially be more comfortable with a family member as an interpreter, the hospital has no way of knowing the competency of these individuals, nor can the hospital be sure that the family member has the patient's best interests in mind. Family members are not objective and in some situations, such as dealing with a dying loved one, the family member may be under stress and not have the necessary faculties to communicate effectively in two languages. Minors pose an additional challenge to the encounter because they may not have the cognitive or emotional maturity to function in the role of interpreter.

5-3. Hospitals should assess both English and target language proficiency and require or provide training on the practice of health care interpreting for all individuals used to interpret.

The practice of interpreting is a specialized skill that requires extensive knowledge of at least two languages, including medical terminology in both languages, and an understanding and adherence to ethical and professional practice standards. Not all bilingual individuals are equipped to be health care interpreters. Health care interpreters need to be familiar with hospital policies, particularly those related to confidentiality of information and patient rights. Having a trained health care interpreter on staff can facilitate communication between patient and provider with a lesser chance of error than with an unqualified interpreter. Organizations such as the National Council on Interpreting in Health Care¹² can provide guidance to hospitals that are trying to improve the quality of their interpreter programs.



5-4. Hospitals should consider incorporating language service programs into their safety and quality efforts by using process improvement structures and tools.

In order to begin to meet the goal of effective communication for all patients, hospitals need to begin to integrate the provision of language services into their efforts to improve overall quality and safety. This can be done by setting achievable objectives and using practical tools to improve care.

5-5. Policymakers need to initiate a national dialogue respecting a national certification program for interpreters in health care.

A recently-released report funded by The California Endowment outlines the current state of national certification and steps needed to establish a national certification program in the future.¹³ A national certification could provide a common understanding of the skills, experience, and training needed to be a health care interpreter. While national certification would not solve issues regarding the provision of language services in languages of limited diffusion, it could support health care interpretation as a profession that requires training and experience and thus minimize the use of unqualified interpreters.

5-6. The impact of different forms of health care interpretation on health care quality and patient safety need to be quantified.

While there is agreement that communication is essential to safe and high quality health care, generally, hospital staff have little awareness that some mechanisms used for interpreting are less safe than others. While it may be logical to some that not all bilingual individuals have the skills to interpret, others fail to recognize the complexities of language interpretation. Persuasive evidence needs to be developed to convince the health care field that more stringent requirements are needed for language services.

Recommendations and Observations Related to Domain Six: Community Engagement

6-1. Hospitals should make use of the community resources available through community networks, collaborations, and partnerships, including the involvement of community members from diverse cultures and language groups on formal boards and in hospital planning processes.

Many hospitals may be using community level data to inform cultural and linguistic service development; however, the active involvement of community members can provide insight into understanding the data that are collected. Drawing upon these insights in a collaborative manner can build trust within the community and provide a sense of investment in hospital services by community members.

6-2. Hospitals should consider partnering with local ethnic media to promote better understanding of available hospital services and appropriate routes for accessing care among all community members.

Diverse communities often receive information from sources other than the “mainstream” media. Tapping into ethnic newspapers, television news programs, and radio stations with public service announcements about available services, particularly preventive care services, can spread important information to groups of people who otherwise may not be reached. Some interview participants indicated that their emergency rooms were sometimes crowded with individuals who could have been treated through alternate means, but who were not aware of available services.



CHAPTER 1: INTRODUCTION



Safe, quality healthcare is every patient's right. Appropriate communication and understanding between patient and provider is essential to safe, quality healthcare. As the

nation's hospitals increasingly provide care to diverse populations, including individuals who do not speak English or who do not speak English well,¹⁴ hospitals need to seek ways of enhancing communication and understanding with diverse populations. Failing to do so may contribute to recognized racial and ethnic disparities in healthcare. The Joint Commission is committed to assisting hospitals in these efforts.

As several studies and reports have suggested,¹⁵ the provision of culturally and linguistically appropriate healthcare is an essential component of the elimination of healthcare disparities. However, evidence of the definition and benefit of "culturally and linguistically appropriate" care is lacking. In 2001 the Department of Health and Human Services Office of Minority Health released the Culturally and Linguistically Appropriate Services (CLAS) Standards, a set of fourteen standards that outline ways in which organizations can provide care in a manner that is sensitive to the cultural and linguistic needs of all patients. While a milestone for cultural competence and language services, few of the standards are enforceable, and there is minimal evidence of their effectiveness.

Why did we do *this* study?

The purpose of the Hospitals, Language, and Culture (HLC) study is to gather information about the activities hospitals are undertaking to address cultural and linguistic needs among an increasingly diverse patient population. We wanted to better understand the issues that the CLAS Standards meant to address. Building on the Joint Commission's knowledge of hospital infrastructure and existing survey process design,

HLC sought to collect data that accurately represents hospital activities. Since we had limited knowledge of the hospital perspective on these issues, we employed an exploratory, qualitative approach.

Very few studies have provided the opportunity for researchers to explore the issue of culturally and linguistically appropriate health care in a broad and organized a fashion. While our sampling methods do not allow generalization of our findings to all hospitals, they do provide a unique insight into the challenges, activities, and perspectives of sixty hospitals across the nation, a snapshot of the current situation. This report provides the highlights of these findings.

How to Use This Report

This report of findings is designed to provide a better understanding of the types of programs and activities in which hospitals are engaging to provide culturally and linguistically appropriate care. Hospitals can use this information to compare their current practices, learn from other hospitals' experiences, and gain ideas for selected practices that may be replicated in their institution. Policymakers can use this report to expand their understanding of current practice and inform future policy development. Researchers can use this report to better understand practices that warrant evaluation and provide context for developing evaluation protocols. This report also provides rich material for additional inquiry.

Our findings are provided in the context of our research framework. The framework identifies the structural supports for providing culturally and linguistically appropriate care and is explained in more detail in Chapter 3. Chapters 4 through 9 each provide findings in the context of one of the six HLC research domains that comprise the research framework. This framework allows hospitals to target efforts in specific areas and make the process of delivering culturally and linguistically appropriate care less daunting, while still supporting a systematic approach.



We believe that the provision of culturally and linguistically appropriate care is a shared responsibility. As such, we have highlighted recommendations that are supported by our data and are also logical and reflective of an integrated effort to improve care to diverse populations. At the end of Chapters 4 through 9, the report offers recommendations targeted to hospitals, policymakers, and researchers. Many of these recommendations are not new, but have yet to be fully implemented despite growing evidence of need.

Definitions

Throughout the report several terms are used repeatedly that warrant definition. Although some terms have variations in meaning, for the purposes of our findings and this report, we will use the definitions stated below.

Linguistic competence: providing readily available, culturally appropriate oral and written language services to patients with limited English proficiency (LEP) through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.^{16, 17}

Cultural competence: a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.

Cultural brokering: the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflicts, producing change, or advocating on behalf of a cultural group or person.¹⁸ Cultural brokering can also be conducted by a medical professional who draws upon cultural and health science knowledge and skills to negotiate with the patient and health system toward an effective outcome.¹⁹

Cultural and linguistic competence: the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter. Cultural competence requires organizations and their personnel to: 1. value diversity; 2. assess themselves; 3. manage the dynamics of difference; 4. acquire and institutionalize cultural knowledge; and 5. adapt to diversity and the cultural contexts of individuals and communities served.²⁰

Culture: integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.²¹

Competence: having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by people and their communities.²²

Culturally and linguistically appropriate care/ service: health care services that are respectful of and responsive to cultural and linguistic needs.²³

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards): the collective set of Culturally and Linguistically Appropriate Services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.²⁴

Disparities: racial and ethnic differences in healthcare not attributable to other known factors.²⁵



Limited English proficiency (LEP): a legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter. The inability to speak, read, write, or understand English at a level that permits an individual to interact effectively with health care providers or social service agencies.²⁶

Interpreter/ interpretation/ interpreting: an interpreter is a person who renders a message spoken in one language into one or more languages. The practice of interpreting is distinguished in this report from translating (see below) to include only spoken language. Interpreting refers to the process of interpretation; interpreter refers to the person who is providing the interpretation.²⁷

Hospital employed interpreter: an individual who is employed by the hospital for the sole purpose of language interpreting. For purposes of this study, we excluded contract interpreters from this definition. In other studies or literature, hospital employed interpreters may be referred to as “staff interpreters.”

Contract interpreter: an individual, either freelance or employed by an interpretation agency, who is contracted by the hospital to provide interpreter services. These individuals may be full or part-time.

Bilingual staff: for the purposes of this report, we have used this term to refer to individuals who have some degree of proficiency in more than one language. In our reporting of language services, bilingual staff are presented as those who serve in a dual role, providing interpreter services for the hospital in addition to their primary position.

Volunteer interpreter: an individual, often a member of the community, who serves in a volunteer capacity to provide interpreter services for the hospital. For purposes of this study, we define the volunteer

interpreter as someone whose relationship is primarily with the hospital; we exclude any interpreter brought by the patient to interpret.

Qualified interpreter: an individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care.²⁸

Ad hoc interpreter: an individual used for interpreting, who may or may not have a relationship with the patient, but who has no pre-existing relationship with the hospital. An ad hoc interpreter could include a family member, a minor, a friend of the patient, or someone asked to interpret because he or she has knowledge of the target language. Generally speaking, the hospital has no knowledge or evidence of language assessment or training in health care interpretation for an ad hoc interpreter.

Translator/ translation/ translating: a translator is a person who converts written text in one language into another language. Translation is distinguished from interpretation to include written language instead of spoken language.²⁹

Sight translation: translation of a written document into spoken/signed language. An interpreter reads a document written in one language and simultaneously interprets it into a second language.³⁰

Telephone interpreting: interpreting carried out remotely via telephone line. This process is considered remote interpretation since the interpreter is not in the room with the patient. Telephone interpretation can be provided by a company that is contracted by the hospital or in some cases may be provided by on-site interpreters in a central location within the hospital.



Telephone interpretation can be provided using a regular telephone, a speaker phone, or a special telephone or headset. Some special telephones may have dual handsets or dual headsets to ease use, with the interpreter connected by telephone to the principal parties. In health care settings, the principal parties (e.g., doctor and patient) are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone.³¹

Video interpreting: the process of interpreting remotely using a video camera that enables an interpreter in a remote location to both see and hear the parties for whom he or she is interpreting. Interpretation can be relayed to the parties either via telephone or two-way interactive television.³²

Language services: For purposes of this report, the term “language services” refers to mechanisms used to facilitate communication with individuals who do not speak English. These services can include in-person interpretation using a qualified interpreter, bilingual staff, or the use of remote interpreting systems such as telephone or video interpreting. Language services also refer to processes in place to provide translation of written materials or signage.



CHAPTER 2: DESIGN OF STUDY AND SAMPLE DESCRIPTION



We conducted a qualitative cross-sectional study to determine how 60 hospitals across the nation are providing healthcare to culturally and linguistically diverse patients. Specifically, we set out to answer the following research questions:

- What challenges do hospitals face when providing care and services to culturally and linguistically diverse populations?
- How are hospitals addressing these challenges?
- Are there any promising practices that may be helpful and can be replicated in other hospitals?

We designed our process for answering these research questions to paint a “snapshot” of these hospitals’ efforts to provide culturally and linguistically appropriate healthcare. Here, we report this snapshot.

The Hospitals, Language and Culture project enlisted the assistance of three project advisors³³ whose function was critical to the development of the research plan and methodology. We also worked with a statistical advisor, the National Opinion Research Center (NORC) at the University of Chicago to help determine an appropriate sample, both in size and characteristics. The qualitative nature of the study directed us to seek additional guidance from Shoshanna Sofaer, Dr. PH., who provided assistance with aspects of data collection, data coding, and analysis.

At the inception of the study HLC research staff conducted a literature review to ensure we accounted for all relevant issues. Searches were conducted using PubMed and the Internet, and materials were drawn from other sources as well. The following terms and their resulting combinations and derivatives were used during searches: culture, competence, disparity, immigrant, diversity, race, limited English proficiency, treatment, service,

evaluation, site, visit, and quality improvement. Because the databases searched were biomedical and the term was too limiting, the word “hospital” was not included in the search terminology. Initial PubMed searches yielded a combined 4,118 documents, which were reviewed by title and abstract. From these, 155 documents were selected for reading, combined with 75 documents gathered from the Internet and other sources.

Beginning in February 2005, members of the HLC research team recruited a sample of 60 hospitals using two methods for hospital selection. Sixty was determined to be a large enough sample to represent salient hospital characteristics, while small enough to allow a visit to each hospital for interviews. When selecting hospitals for the HLC study, we had to balance our desire for a randomly-selected, nationally representative sample with the need to ensure our sample would provide answers to all three of our research questions. Using a 100% random-selection process could have compromised our ability to acquire robust answers to the first two research questions, but, more importantly, could not guarantee observation of promising practices. We decided to take a purposive approach to sampling by combining two sampling methods: a “hand-selected” judgment sample and a demographically-driven stratified sample.

The Judgment Sample³⁴

In order to try to guarantee inclusion of hospitals employing promising practices in the area of cultural and linguistic services, we decided to include hospitals in our sample that were hand-selected by the HLC research team. These hospitals were self-nominated for study participation or were nominated by a member of the research team or Technical Advisory Panel who are experts on culturally and linguistically appropriate care and had first-hand knowledge of specific hospital efforts. This sampling approach ensured that hospitals making a concerted effort to address the cultural and linguistic needs of their patients were included in the study. This sample is referred to as the “judgment sample.”



The Stratified Sample

Recognizing that our judgment sample would likely bias our results in favor of hospitals that are on the advanced end of the culturally and linguistically appropriate services continuum, we also selected hospitals in a more random manner using 1990 and 2000 US Census and American Hospital Association (AHA) data. Counties that satisfied specific selection criteria were randomly selected (see Appendix A for table of counties meeting specific population criteria). These criteria included: the specified percentage of limited English proficient (LEP) residents; varied racial and ethnic composition; 20% or greater foreign born; and population size. A minimum of one county was selected for each population criterion; however, a maximum number of counties was not established for any criterion. The state of California was “over-sampled” due to specific interest in the state’s hospitals on the part of the funder.

Selected county census data were linked to AHA hospital data using Federal Information Processing Standards (FIPS) codes to establish a pool of hospitals likely to be serving diverse patients. Hospitals within selected counties were then randomly identified and recruited by phone for study participation. Specialty hospitals and hospitals with less than 25 beds were not eligible for participation. No more than one hospital was recruited from a selected county at a given time. Once a hospital from a selected county agreed to participate, no additional hospitals were recruited from that county. This approach allowed for incorporation of random, less-biased elements where all hospitals had a known probability of selection, and increased the likelihood that sampled hospitals would be faced with issues of culture and language. This sample is referred to as the “stratified sample.”

Challenges with the Sample

We initially set out to establish a stratified sample of 50 hospitals. However, recruiting hospitals selected by this method was more difficult than we anticipated. Often, our phone calls were not returned or the hospitals indicated that they were not interested in participating. Since we desired a sample of no less than 60 hospitals, and we were concerned that recruitment of 50 stratified sample hospitals would inhibit our ability to conduct site visits within a six-month time period, we reduced the number of hospitals in the stratified sample to 30 and increased the number of hospitals in the judgment sample by 20. Hospitals from the judgment sample were not difficult to recruit, and only two that were invited to participate did not participate.

Table 2-A. Sample Characteristics

| | Judgment N=30 (%) | Stratified N=30 (%) | Total N=60 (%) |
|-----------------------|------------------------------|--------------------------------|---------------------------|
| Region | | | |
| West | 8 (27) | 13 (44) | 21 (36) |
| South | 8 (27) | 9 (30) | 17 (30) |
| Midwest | 8 (27) | 4 (13) | 12 (18) |
| Northeast | 6 (19) | 4 (13) | 10 (16) |
| Locale | | | |
| Rural | 3 (10) | 12 (40) | 15 (25) |
| Semi-rural/urban | 5 (17) | 5 (17) | 10 (17) |
| Urban | 22 (73) | 13 (43) | 35 (58) |
| Size | | | |
| Small (0-99 beds) | 1 (3) | 9 (30) | 10 (17) |
| Medium (100-299 beds) | 6 (20) | 12 (40) | 18 (30) |
| Large (300+ beds) | 23 (77) | 9 (30) | 32 (53) |
| Teaching status | | | |
| Teaching | 18 (60) | 4 (13) | 22 (37) |
| Non-teaching | 12 (40) | 26 (87) | 38 (63) |
| Ownership | | | |
| Private | 22 (73) | 23 (77) | 45 (75) |
| Public | 8 (27) | 7 (23) | 15 (25) |

Table provided by the National Opinion Research Center

* See US Census Bureau for state breakdown of regions.

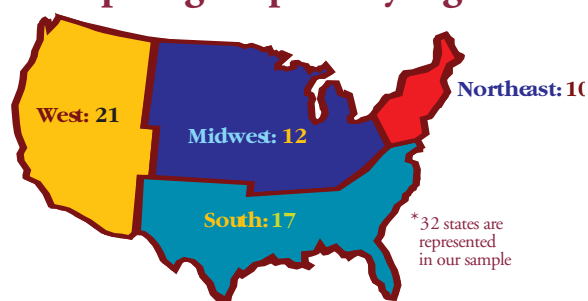


The change in our sample selection altered what and how we are able to report in our findings. We are presenting our findings both in the aggregate (n=60) and as a comparison of the judgment (n=30) and stratified (n=30) samples. We urge readers to consider the limitations of the data, while appreciating what these data can help us learn about promoting the provision of health care in a more culturally and linguistically appropriate manner.

The Entire Sample

Thirty-two states are represented in the entire sample, favoring the south and west regions* of the country, as well as large, urban, private, and non-teaching hospitals. See Table 2-A for sample breakdown.

Participating hospitals by region*:



Patient Demographics Represented in the Sample Hospitals

In addition to understanding the demographic characteristics of participating hospitals, it is important to understand the general characteristics of the populations they are serving. Most participating hospitals reported serving patients from at least two racial or ethnic backgrounds. More specifically, the majority of sample hospitals indicated they serve White, Black or African American, Hispanic or Latino, and Asian or Native Hawaiian patients (Figure 2-A). Fewer hospitals reported serving patients who are American Indian or Alaska Native, and less than one quarter indicated they serve Pacific Islanders who are not Asian or Native Hawaiian. Hospitals reported identifying patients by “other” when they are bi- or multiracial, belong to ethnic groups such as Dutch or Indo-European, or have unknown racial or ethnic backgrounds.

Figure 2-A. Hospital Reported Racial/Ethnic Backgrounds of Patients Served (Aggregate)

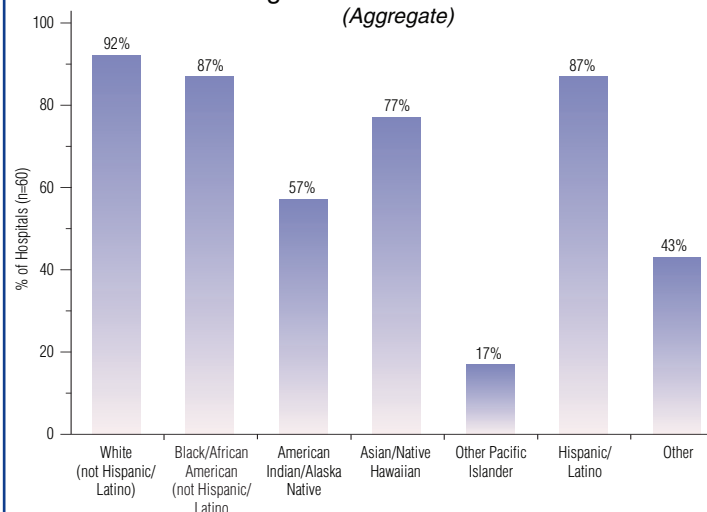
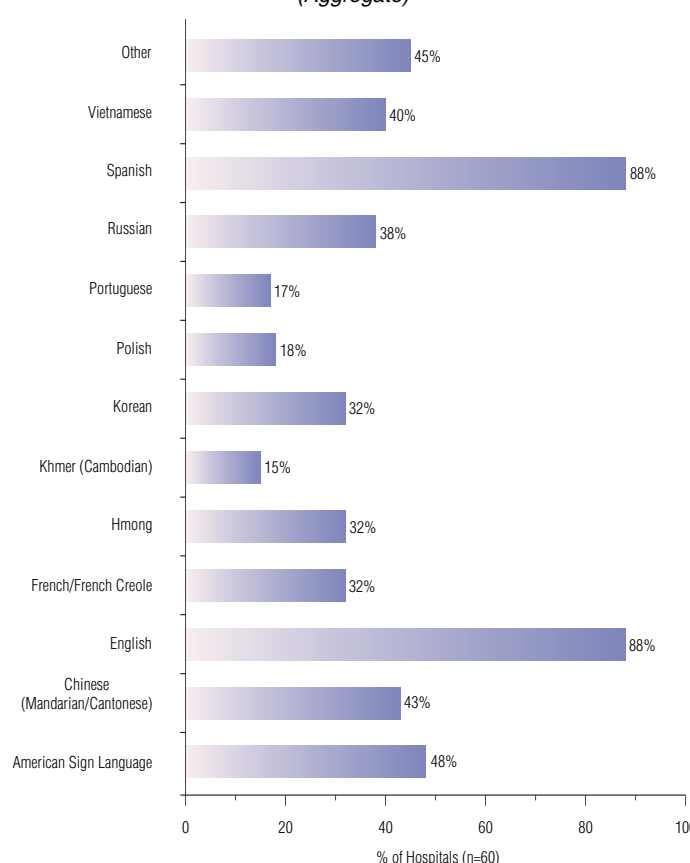


Figure 2-B. Hospital Reported Languages Spoken by Patients Served (Aggregate)





The linguistic characteristics of patients served by sample hospitals also vary. The majority of sample hospitals reported serving patients who speak English or Spanish (Figure 2-B). Patients speaking other languages such as Khmer, Polish, and Portuguese were reported by far fewer hospitals.

HLC participating hospitals also defined the cultures of their patient populations in a variety of manners. Some hospitals told us they define cultural groups by religion, such as Muslim or Jewish Orthodox. Other hospitals identified ethnicities as cultures, for example Hmong or Latino. However, some hospitals also defined the cultures of their patients according to the patient's morbidity or condition. Some examples are IV drug users, patients who suffer from obesity, and the deaf and hard of hearing community.

Institutional Review Board Approval

This study was approved by the institutional review board, Independent Review Consulting, Inc., and several participating hospital institutional review boards.

Pilot Testing

Prior to commencement of site visits, we conducted two pilot tests of our site visit protocol. Pilot tests allowed us to identify challenges with our process. For example, we recognized that we would need to be explicit about confidentiality during interviews. Typically, the hospital liaison, who was often the head of interpreter services or the Diversity Officer, expected to be able to participate in each interview session as a means of "self assessing" his or her organization. We recognized that this would compromise the integrity of our data and established a mechanism to preempt this dilemma during the scheduling process.

Data Collection

All participating hospitals were asked to complete a 26 question Pre-Visit Questionnaire and host a one-day site visit conducted by a trained project researcher and

a note-taker. The Pre-Visit Questionnaire was designed to provide the site visit researcher with information about the hospitals each team was visiting and to provide general information on each hospital's activities related to culture and language. Pre-Visit Questionnaires were administered online through the SurveyMonkey.com website. Participating hospitals were at liberty to select who among their staff completed the Pre-Visit Questionnaire, although, in most cases it was completed by the individual designated to coordinate the hospital's participation in the HLC study. These individuals were frequently leaders of the hospital's cultural and linguistic services, quality improvement, and/or patient safety efforts. For completion of the questionnaire, hospitals were allowed to seek the input of an unlimited number of hospital staff; however, only one final questionnaire could be submitted on the Survey Monkey website. All 60 participating hospitals submitted complete Pre-Visit Questionnaires. The HLC Pre-Visit Questionnaire is included in Appendix B.

Site visits were conducted between September 2005 and March 2006. Each site visit consisted of a combination of administrative and clinical interviews. Four administrative interviews took place during each site visit. Single person interviews were conducted with each hospital CEO, and three group interviews (with no more than three participants) were conducted with staff from the areas of leadership, human resources, and cultural and linguistic services. Interviews were semi-structured and focused on the organization's approach to cultural and linguistic issues, including any challenges it faced; the structure of the hospitals' provision of cultural and linguistic services; and solutions regarding care of its culturally and linguistically diverse patient population.

As part of the site visit, the research team interviewed clinical and non-clinical staff individually. These interviews focused on the scenario of a hypothetical patient



who had cultural and linguistic needs. Staff members were asked how they would care for this patient and how they would accommodate his cultural and linguistic needs. Staff were interviewed from the Emergency Department, Radiology Unit, and Medical-Surgical Unit. Appendix C contains the protocol for the administrative interviews that was used for each site visit. We are not including the protocol for clinical interviews with this report since we will be publishing those findings in a separate report.

The data presented in this report stem mainly from the Pre-Visit Questionnaire data and data from administrative interviews conducted during site visits. During data analysis, we recognized that the nature of the data collected from clinical interviews served a different purpose than the data we wished to include in this report. This report shall serve as the “snapshot” of the systems and perspectives at the organization level. A subsequent report will provide insight to the perspectives of clinical staff and the experience of our hypothetical patient.

Site visits were conducted by trained site visit researchers and a trained note taker. Site visit researchers and note-takers attended a one-day training conducted by Shoshanna Sofaer, DrPH. The training included an overview of qualitative research, interview techniques, the site visit protocol, and processes for conducting site visits, including obtaining informed consent and confidentiality of information. In addition to in-person training, each site visit researcher completed human subjects training prior to conducting a site visit. While researchers generally had little trouble complying with the interview protocols, we did observe several situations that concerned us about the potential impact on the quality of the data collected. In order to control for this, we decided to have a project staff member participate in each site visit in either the role of note taker or researcher.

Confidentiality

Strict rules of confidentiality were followed during the data collection, analysis, and reporting of this study. Each study hospital was guaranteed total anonymity. In addition, each interview subject was provided anonymity. Study hospitals are not identified in this report so that the data can be interpreted without bias for any particular hospital and so that each participating hospital can feel confident that the study results have no bearing on accreditation decisions.

Although this was not an interventional study, we recognized that risks could be perceived based on the fact that this is a Joint Commission study. As a major accrediting body (the majority of our sample hospitals were accredited), hospitals had understandable concerns how data would be used and whether it would have an impact on the institute’s accreditation status. As part of our data protection plan, we created a secured file for the storage of study data and information. To protect the integrity of this study, we were able to assure that the identity of participating hospitals would not be shared with anyone at The Joint Commission except for HLC project staff.

Data Analysis

Data for the study included both quantitative and qualitative components. Once all Pre-Visit Questionnaires were submitted, data were exported to Microsoft Excel where a simple frequency analysis was completed.

Once all site visits were complete, data were checked for completeness. In some cases, transcripts required us to return to the tapes to decipher the content of the interview. Since we had conducted the majority of the site visits, we wanted to remove any potential for personal bias that could be introduced during the coding process. Transcripts were de-identified to researchers. Each site was designated a two-digit code, and all references to the name of the hospital were removed.



In order to have a selection of transcripts that reflected site visits over the course of the data collection period, five site visit transcripts were selected from the 60 using number sequence as a proxy for the time in which the site visit was completed. We did this because we wanted to have five transcripts that reflected site visits over the course of the data collection period. Two HLC researchers (AWS and EG) independently reviewed each of the five selected transcripts and developed a set of data codes. Then, the two researchers convened and streamlined the two coding schemes into our initial coding structure. The coding scheme was refined as coding progressed. Feedback and assistance with the coding scheme was obtained from project advisors, Romana Hasnain-Wynia, PhD and Elizabeth Jacobs, MD, MPP. In addition, researchers met with Shoshanna Sofaer, Dr PH, to discuss the coding strategy.

Transcripts for the administrative interviews were coded independently by each researcher, after which discrepancies for select codes were reviewed and resolved jointly. A separate coding scheme was developed for the patient-centered assessment interview transcripts. (With few exceptions, these codes stemmed directly from interview questions.) Once complete, coding was reviewed by project researchers to ensure consistent and accurate use of the coding scheme. Qualitative research software, NVIVO 2.0 (QSR International, Victoria, Australia) was used to facilitate data management and coding of all transcripts.



CHAPTER 3: THE HOSPITALS, LANGUAGE, AND CULTURE RESEARCH FRAMEWORK



This report presents findings for easy review in the context of the six domains of the HLC Research Framework.

What follows is a

description of how this framework was developed and a brief explanation of each domain. More detailed explanations of each domain are found in Chapters 4 through 9.

Development of the HLC Research Framework

There are several tools available for organizations to conduct self assessments related to the provision culturally and linguistically appropriate care or a derivative of such.^{35, 36, 37, 38} The frameworks from these studies were reviewed by project staff and project advisors to identify common elements. These common elements were then reviewed by our Technical Advisory Panel (TAP) in the initial form of eight domains. The TAP recommended questions to be explored through the study and data elements to be collected. HLC staff then reviewed the data elements identified by the TAP, compared them to data elements identified in the four previous studies, removed overlap among the domains, and grouped data elements into focus areas within each domain.

The resulting HLC Research Framework consists of six domains: Leadership, Quality Improvement and Data Use, Workforce, Provision of Care and Patient Safety, Language Services, and Community Engagement. Each of the six domains can be mapped to domains of previous research. This is important for the validity of the study design as well as the ability to compare findings to previous work at the end of the study. Appendix D provides an overview of the frameworks used for four previous investigations of cultural competence in health care that were used to aid the development of the HLC framework.

The HLC Research Domains

Leadership encompasses leadership commitments to culture, language, diversity, organizational structure, policies and procedures, governance, and strategic planning and finance.

Quality Improvement and Data Collection includes quality improvement activities focused on issues of culture, language, diversity, or disparities; patient-level data collection activities such as the collection of race and ethnicity data; monitoring of data, performance, and outcomes; evaluation of programs to address issues related to culture and language; and information systems supporting data collection, use, and quality improvement.

Workforce covers workforce demographics, recruitment and retention strategies, staff development and training, staff competence and skills, and human resource policies.

Patient Safety and Provision of Care focuses on the actual care process for diverse patients such as assessment, informed consent, continuum of care, patient education and discharge planning, and understanding health-related needs, values, and beliefs.

Language Services encompasses all hospital activities related to the provision of language services, including interpretation and translation services such as the structure of the language service program, the type and frequency of language service used, policies and procedures for language services, and the evaluation of language service programs.

Community Engagement speaks to the assessment of community needs, understanding community demographics, outreach activities, community education activities, and access issues.



The HLC researchers felt that the six domains provided a comprehensive framework for the exploration of issues and activities in hospitals that pertain to culture, language, diversity, disparities, and communication in general. This framework was used as a guide for the development of the study's Pre-Visit Questionnaire, Site Visit protocol, and overall study approach described in Chapter 2. Appendix E contains the HLC Research Framework.



CHAPTER 4: DOMAIN ONE: LEADERSHIP



As we set out to explore how hospitals are addressing issues related to language and culture, we quickly saw that, based on our review of the literature and the advice of our technical advisory

panel, a focus on hospital leadership would be key to understanding the organization's approach. As with any successful organization initiative, the structural supports for the provision of culturally and linguistically appropriate health care need to begin with hospital leadership. According to The Joint Commission, "A hospital's leaders provide the framework for planning, directing, coordinating, providing, and improving care, treatment, and services to respond to community and patient needs and improve health care outcomes."³⁹ In light of leadership's essential role in the provision of culturally and linguistically appropriate care, we took an in depth look at how our sample hospitals' leadership were providing frameworks for addressing the cultural and linguistic needs of the patients being served.

The key elements of leadership that we investigated in this study include: leadership awareness, leadership commitment and motivation, governance, and strategic planning and finance. Reported data focus on activities that may demonstrate leadership's commitment to the provision of culturally and linguistically appropriate services through strategic planning and financial support.

Executive Level Staff Involvement

Executive leaders play an important role in guiding and integrating the hospital's programs for the provision of culturally and linguistically appropriate care, including providing the necessary resources.⁴⁰ Leaders create an organizational culture and can serve as models of culturally competent behavior. One way that some hospitals have demonstrated a commitment to meet the needs of diverse patients is to designate

an individual responsible for managing cultural and linguistic programs. Fifty-five percent of our sample hospitals reported they have a designated executive level staff member with direct responsibility for managing plans and initiatives related to cultural or linguistic competency in the hospital. There were no hospitals who indicated that they had executives responsible for cultural initiatives only (Figure 4-A). Not surprisingly, more judgment sample hospitals reported having an executive level staff with direct responsibility for both cultural and linguistic services than the stratified sample (Table 4-A).

Figure 4-A. Hospitals Designating Executives with Direct Responsibility for Cultural and Linguistic Competency (Aggregate n=60)

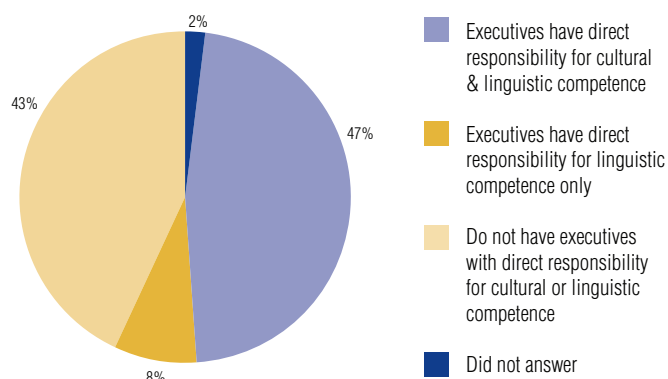


Table 4-A. Hospitals Designating Executives with Direct Responsibility for Cultural and Linguistic Competency

| Stratified n=30 | Judgment n=30 |
|-----------------|---------------|
| 37% | 73% |



The most commonly mentioned areas of executive responsibility for this work were concentrated primarily in nursing (Chief Nursing Officers, Vice Presidents of Nursing, etc.) followed by community outreach or mission, human resources, and quality improvement or regulatory affairs. Other areas mentioned include, but are not limited to, practice management, clinical social work, surgical services, guest services, and the hospital foundation. Ten of the hospitals that responded affirmatively to our question regarding executives with direct responsibility for cultural or linguistic competency listed titles of individuals at the director or manager level, which may not actually reflect *executive* level responsibility and oversight.

We observed varying levels of CEO involvement in the cultural and linguistic activities during site visits. Some hospital CEOs appeared to be less comfortable discussing their hospital's commitment to culture and language than CEOs who had a clear understanding of the issues and took an active part in the integration of cultural and linguistic activities into hospital services. In one southern hospital, for example, the CEO visually demonstrated his commitment to culturally and linguistically appropriate services by substituting his title of CEO with the motto, "Nurturing Culture." This CEO felt it was his responsibility to act as a role model of cultural and linguistic competence, even though the hospital had a designated Director of Diversity and Language Services. Site visit interviews at this hospital indicated this CEO is seen as a champion for CLAS.

Other hospitals' CEOs demonstrated similar commitment. One western hospital's CEO worked on a three-minute video message for new employee orientation about the importance of cultural and linguistic services. The hospital is also trying to incorporate the video into quarterly meetings that managers have with their employees, which would allow the message to reach existing staff in addition to newcomers. Leadership at a different western hospital has undergone intensive

cultural competence training in an effort to start cultural competence initiatives at the top, and one midwest hospital developed a leadership task force to direct its diversity initiatives.

Strategic Planning

In addition to the involvement and support of executive leadership, a majority of hospitals we sampled had a formal plan to meet one or more needs of their LEP patients. Sixty percent of our sample hospitals reported in the Pre-Visit Questionnaire that they have formal plans to meet the cultural needs of patients; 77% reported that they have formal plans to meet the linguistic needs of patients (Figure 4-B). As with the designation of executive leadership, more judgment hospitals reported strategic planning for cultural and linguistic services than did stratified hospitals (Table 4-B).

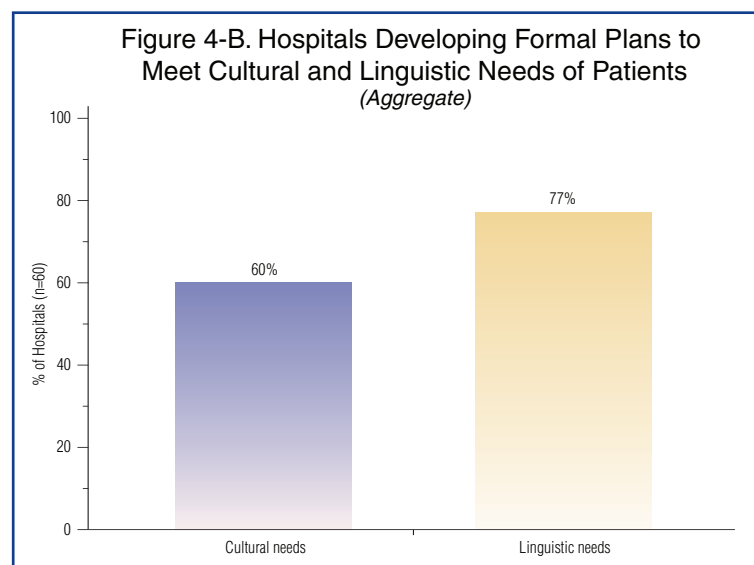


Table 4-B. Hospitals Developing Formal Plans to Meet Cultural and Linguistic Needs of Patients

| | Stratified n=30 | Judgment n=30 |
|------------------|-----------------|---------------|
| Cultural needs | 43% | 77% |
| Linguistic needs | 53% | 100% |



Budgets were the most frequently identified type of formal plan that hospitals had developed to meet the cultural and linguistic needs of patients. While a designated budget for cultural and linguistic services is a necessary support, based on our findings, few hospitals have actually developed a strategic plan or vision statement. No hospitals responded that they lacked formal plans to meet cultural or linguistic needs; however, several hospitals did not respond to this question.

During site visits, some hospitals shared their formal plans with us. One midwest hospital shared with us the diversity vision they have implemented, which has five key components: leadership commitment, engaged employees, culturally competent care, a welcoming environment, and workforce diversity. This particular hospital has a very comprehensive diversity plan that includes a business case for diversity and measures of impact for the diversity initiatives.

Figure 4-C shows that just over 60% of hospitals indicated that they have a multicultural or linguistic service department, project, or office. Interestingly, all of the hospitals in our judgment sample have a designated multicultural department/program/office (Table 4-C). While the name and exact scope of activities of these departments varied, many were responsible for developing and coordinating interpreter services (including the training and recruitment of interpreters); organizing diversity fairs and events within and external to the hospital; developing and implementing staff education programs on cultural competence; use of language services; and related issues. “Multicultural” or “Diversity” departments often were designated to coordinate and manage all diversity initiatives within the organization, which could mean overlap with other departments such as human resources, nursing, administration, social work, and other services.

Figure 4-C. Multicultural or Linguistic Service Department/Project/Office (Aggregate)

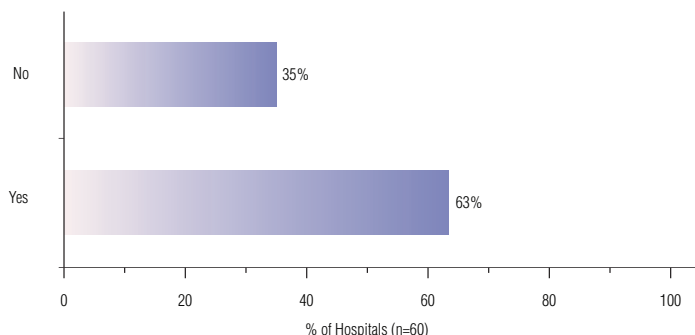


Table 4-C. Multicultural or Linguistic Service Department/Project/Office

| Stratified n=30 | Judgment n=30 |
|-----------------|---------------|
| 27% | 100% |

Our site visit protocol intentionally brought together staff from a variety of disciplines so that we were able to get a broad picture of how issues of culture and language are addressed at the hospital. Several hospitals commented to us that they benefited from convening multidisciplinary groups of staff for the purposes of this study to talk about issues related to culture, language, and diversity. During these interviews, we heard many comments such as, “Oh, I had never thought of that—that is a good idea for us to consider,” as well as comments such as, “Oh really? I didn’t know I was responsible for that!” Clearly, dialogues like these can help inform strategic planning.



Financing of Cultural and Linguistic Services

Ninety percent of sample hospitals cited the funding of services as a challenge. As an “unfunded mandate,” language services can be considered by hospitals as a drain on an already leaky financial system. However, funding for the provision of language services should be a shared responsibility of the health care community.⁴¹ As shown in Figure 4-D, the majority of participating hospitals reported that they either have a specific line item or dedicated budget for linguistic services, or they incorporated these costs into another line item or budget. Fewer hospitals have dedicated funds to specifically address cultural services; most hospitals incorporated funds for cultural services into another budget or line item. More judgment sample hospitals allocate funds to cultural and linguistic services than stratified (Tables 4-D and 4-E). Judgment hospitals that allocate funds for linguistic services more often have a specific line item while stratified hospitals more often have the funds incorporated into another line item (Table 4-E).

Interview participants shed even more light on some of the financial efforts participating hospitals have made to provide culturally and linguistically appropriate services. Some hospitals have developed discounted health care programs to meet the needs of their patient populations that don't believe in, do not have access to, or cannot afford health insurance. One hospital pays for all interpretation services out of the hospital's general guest services budget instead of asking each department to pay for interpreter services out of their own budgets. This shift decreased staff resistance to the use of interpreter services since there was no longer an impact on the individual department budgets. Yet another hospital has marketed to and developed an international private pay clientele to offset the added costs of providing culturally and linguistically appropriate services.

Figure 4-D. Operating Funds Allocated to Cultural and Linguistic Services (Aggregate)

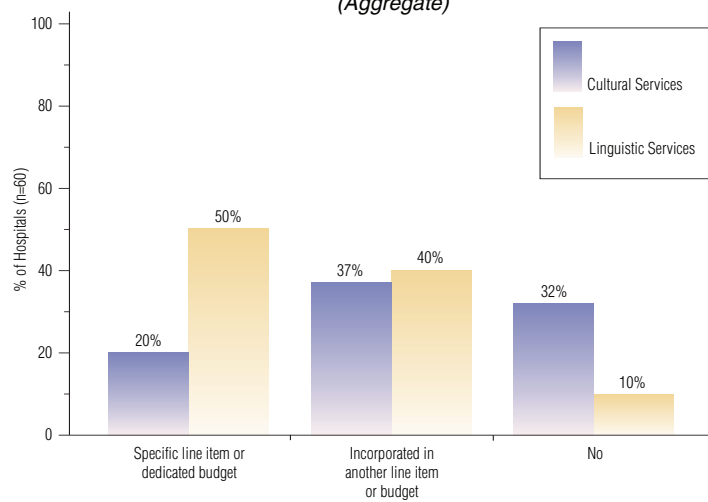


Table 4-D. Operating Funds Allocated to Cultural Services

| | Stratified n=30 | Judgment n=30 |
|-------------------------------------|-----------------|---------------|
| Specific Line Item | 10% | 30% |
| Incorporated into another line item | 30% | 43% |
| None | 47% | 17% |

Table 4-E. Operating Funds Allocated to Linguistic Services

| | Stratified n=30 | Judgment n=30 |
|-------------------------------------|-----------------|---------------|
| Specific Line Item | 30% | 70% |
| Incorporated into another line item | 50% | 30% |
| None | 20% | 0% |



Recommendations and Observations related to Domain One: Leadership

1-1. Hospitals serving linguistically and culturally diverse patient populations should consider establishing a centralized program with executive-level reporting to coordinate services relating to language and culture as a part of the organization's commitment to quality. A centralized program would provide the necessary structure for supporting the provision of cultural and linguistic services in a consistent manner and allow for quality control. The program could be integrated with other hospital activities (such as quality improvement, social services, and community outreach), but should have a distinct place in the organization and be allocated separate, identifiable financial and other resources.

1-2. Hospital CEOs and other hospital leaders should make their commitment to culturally and linguistically appropriate care highly visible to hospital staff and patients. Hospital leaders should provide the resources and the organization motivation to improve care provided to culturally and linguistically diverse patient populations by recognizing the uniqueness and individuality of both patients and staff. Chief Executive Officers who actively work to learn more about these issues, who are aware of the diverse needs of their patient population, and who demonstrate their commitment through involvement in cultural and linguistic programs are more likely to have staff follow their lead.

1-3. Hospitals should provide for internal multidisciplinary dialogues about language and culture issues. These dialogues may be formal or informal and could be facilitated by the Hospitals, Language, and Culture site visit protocol (see Appendix 2) or organizational self-assessment tools.⁴² During site visit interviews, hospital staff learned a great deal about the programs and issues that are important to the hospital as a whole. Internal multidisciplinary dialogue also

made them aware of issues that they had not previously considered. These dialogues should be used as a source for strategic planning to improve the provision of culturally and linguistically appropriate care.

1-4. Financial incentives should be created to promote, develop, and maintain accessibility to qualified health care interpreters. Hospitals are challenged by increasingly resource-intensive demands for interpretation services. While linguistic services are generally understood as a necessary component of care for patients with limited English proficiency, many hospitals find these services to be cost prohibitive. Financial incentives could serve as a “carrot” to encourage wider use of qualified interpreters. Wider use of qualified interpreters would benefit both the patients and the practitioners and thus, the hospital.

1-5. More research is needed to better understand what motivates hospital CEOs who embrace culturally and linguistically appropriate care. This research should encompass measurement of return on investment of resources, including CEO time and involvement. Given that many hospitals in the study sample indicated that financing these services is a challenge, why is it that some hospitals have been able to identify needed resources while others cannot? Research in this area could be used to inform policy development, direct funding opportunities, and encourage hospital leadership action.



CHAPTER 5: DOMAIN TWO: QUALITY IMPROVEMENT AND DATA USE



Elements explored within this domain include hospitals' patient-level data collection, quality improvement priorities that address cultural and linguistic services, data

analysis to improve care to diverse populations, and information system support for quality improvement and data collection.

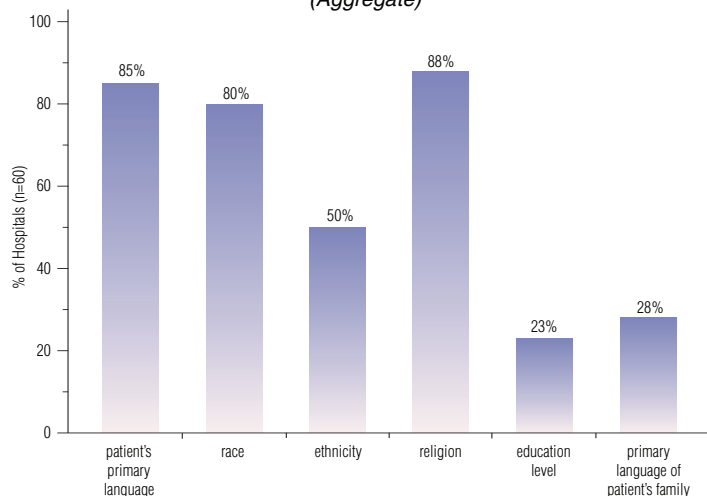
Patient-Level Data

The importance of documenting specific data about a patient's race, ethnicity, language, culture, and learning needs has been established by numerous studies as a starting point for hospitals to provide culturally and linguistically appropriate care.⁴³

Accurate patient-specific data are essential to understanding the proportion of patients with a specific need in a given hospital. This knowledge can guide the selection and provision of specific services needed by the hospital's patient population. In fact, many needs assessment tools use these data as a foundation for determining appropriate service provision,⁴⁴ including the four factor analysis contained in the language service guidance issued by the US Department of Health and Human Services' Office for Civil Rights.⁴⁵ The critical nature of these data has also been recognized by The Joint Commission as observed in their 2006 requirement for the collection of patients' language and communication needs in the patient record.⁴⁶

As shown in Figure 5-A, the two most commonly reported patient-specific characteristics documented by HLC hospitals are religion (88%) and primary language (85%). Eighty percent of participating hospitals also reported documenting patient race; however, far fewer reported documenting ethnicity (50%), education level (23%), or the primary language of patients' families (28%). In addition, over one third of sample hospitals told us during site visit

Figure 5-A. Patient-Specific Information Documented by Hospital (Aggregate)



“You have to break these [data] down by ethnicity and other areas so you better begin by collecting the data on language and ethnicity. Then you should analyze it that way if that is important to you, giving the same quality to everyone. Then you can define the problem and solve it.”

—CEO, western region hospital



interviews that they document patient cultural needs. More judgment sample hospitals reported documenting patient-specific demographic data than stratified hospitals with the exception of one characteristic: more than twice as many stratified hospitals reported documenting patient education level (Table 5-A).

Findings for sample hospitals' documentation of patient race are fairly consistent with those of previous studies.⁴⁷ Documentation of ethnicity may be underrepresented in these findings because the Hispanic category may not have been understood as "ethnicity" as it is defined by the Office of Management and Budget.⁴⁸ However, these findings overestimate hospitals' documentation of patient language when compared to national estimates of hospital collection of patient language needs and maintenance of information regarding patient primary language.⁴⁹ This overestimation may be due to our sampling methodologies: hospitals serving more diverse populations may be more compelled to track the variety of languages they encounter.

Because of the way questions were worded in the Pre-Visit Questionnaire, we cannot specify where patient demographic data are recorded by hospitals. Several site visit interview participants commented on documenting patient-specific demographics. Most comments identified the patient chart as home to these data; however, specific locations ranged from "it is included on the patient's face sheet," to "it is noted in the main chart progress notes," to "we note that in the social history."

We were also interested in how hospitals documented general patient cultural and linguistic needs. Over three quarters of sample hospitals (77%) indicated information regarding a patient's cultural or linguistic needs is included on admission forms. Much of the additional patient needs documented by site visit participants in the patient medical record relate to

Table 5-A. What Patient-Specific Information does the Hospital Document Related to Culture and Language?

| | Stratified n=30 | Judgment n=30 |
|--------------------------------------|------------------------|----------------------|
| Race | 73% | 87% |
| Ethnicity | 33% | 63% |
| Patient primary language | 77% | 90% |
| Primary language of patient's family | 20% | 33% |
| Religion | 87% | 90% |
| Education level | 33% | 13% |

“Each chart has a face sheet. On that face sheet, it says ‘religion.’ A lot of it stems from the intake. Intake does its job; it does it well. We get a lot of information.”

—Cultural and Language Session participant, northeast region hospital



language services and interpretation encounters. Several hospitals have developed special forms that are inserted in patients' medical records to record when and which interpreters are used to communicate with LEP patients. One cultural and linguistic service session participant from a northeast region hospital described their interpreter encounter tracking form to us: "The form I told you about, it's actually on carbon copy; and it has 1, 2, 3, 4 areas [where] an interpreter can document. We identify the patient, country of origin, the primary language, and the date of services. And [then there is] a legal disclaimer, a release [for them to sign] if they want to use anyone else to interpret for them... We put the person's name [who is interpreting], [for example] 'Maria Gonzalez De Pena,' 'sister,' and the patient signs it."

Quality Improvement and Data Use

Before hospitals can identify, monitor, and improve disparities in their care for diverse populations, they must go beyond simply documenting patient-specific data to stratifying their quality measures by characteristics such as primary language, race/ethnicity, education level, etc.

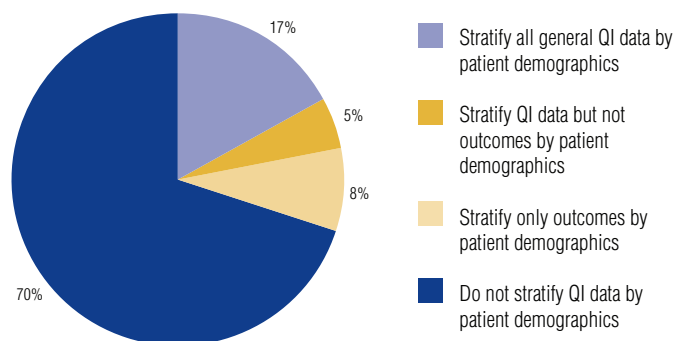
Few hospitals in our sample are stratifying their quality measures by race, ethnicity, and primary language (Table 5-B). This is not surprising in light of previous studies.⁵⁰ Other studies have found that collection of data on race and ethnicity is hindered by the sensitivity of the data, perceived legal barriers, and discomfort on the part of staff who must obtain the information.

While more judgment sample hospitals are collecting these data, there is only a modest difference between the samples for stratification of these measures (Figure 5-B). When we looked at aggregate data, less than one third of sample hospitals (30%) reported stratifying quality measures by patient demographic data. It is interesting to note that there was no difference between the samples for stratification of quality measures by primary language.

Table 5-B. Hospitals that Stratify Quality Measures by Patient Demographic Information

| | Stratified n=30 | Judgment n=30 |
|-------------------------|-----------------|---------------|
| Race | 10% | 23% |
| Ethnicity | 7% | 23% |
| Primary language spoken | 10% | 10% |
| Education level | 10% | 10% |
| Insurance status | 7% | 23% |

Figure 5-B. Stratification of Quality Measures
(Aggregate n=60)



A handful of site visit participants from hospitals that are linking patient-specific demographic data to quality improvement measures discussed their efforts with us during site visit interviews. One hospital cemented their commitment to monitoring linkages between patient-specific demographic data and quality improvement measures by making equitable health care one of their quality improvement goals. A few other hospitals addressed the issue through their adverse event systems. At least two hospitals told us they stratify adverse events by language, religion, or gender, and a participant at a



southern hospital told us their adverse event system specifically accounts for details of the interpretation encounter. This participant indicated the system helped them understand a particular situation where a Portuguese-speaking physician was attempting to communicate with a Spanish-speaking patient and family. They described the system to us as having “multiple choice answers to use and space for narrative. It can identify whether the problem relates to non-use of an interpreter. It also addresses whether interpretation was done by non-qualified staff.”

Information System Support

One possible explanation for the lack of stratification of quality measures by patient demographic data is that participating hospitals do not have information systems that allow patient demographic data and quality measures to be easily linked. The majority of participating hospitals reported having a medical record system that is a hybrid of electronic and paper records (72%); only one hospital reported having an entirely electronic medical record.

In the absence of information systems that facilitate linkages between important components of patient-level data (e.g., demographics and outcomes), hospitals will be challenged to identify, monitor, and address inequities of care that may exist between their patient populations. Failing to do so may have negative long-term consequences for both diverse patient populations and the hospitals trying to care for them.

Despite what we learned regarding the lack of consistency in the collection of data on race, ethnicity, and primary language, hospitals made little mention of the challenge collecting of these data might create. This may be evidence of the lack of awareness of the usefulness of these data, including how these data can be used to better understand patient populations and individual patients. Limited requirements for collecting these data may also be a reason.

Recommendations and Observations Related to Domain Two: Quality Improvement and Data Use

2-1. Hospitals should implement a uniform framework for the collection of data on race, ethnicity, and language. Systematic data collection using an established framework is urgently needed. A good example is the one proposed by Hasnain-Wynia and Baker⁵¹, which includes a rationale for the collection of these data; a script for staff to use to collect data; a method to allow patients to self-identify using their own words or self-selection from a list of categories; a standardized approach for “rolling up” granular responses to broader categories such as those developed by Office of Management and Budget; and assurances to patients that data will be held confidential.

“There is more than one computer program used within the hospital and they do not talk to each other. We use both paper and computer records, but we also have 2 different systems—one for medical records and one [for other information], and they don’t speak to each other. So, if you put info in one system, it is not in the other and has to be manually transferred.”

—Cultural and Linguistic Service session participant, midwest region hospital



2-2. Hospitals should stratify service and technical quality measures such as those reported through the Hospital Quality Alliance,⁵² by language, race, and ethnicity. Such stratification would allow hospitals to monitor quality of care for diverse populations and monitor the effectiveness of interventions such as the provision of language services.

2-3. A national dialogue needs to begin and decisions need to be made regarding the categorization of race, ethnicity, and language data for reporting purposes. Quality data are currently being reported on a variety of measures that would benefit from stratification by race, ethnicity, and language.

Hospitals should begin collecting these data in a uniform manner (recommendation 2-1), and effective criteria should be applied for rolling up these data into broader categories. Consistent collection and reporting methods need to be employed across hospitals so that national data are accurate.⁵³

2-4. Regulatory and accrediting bodies should require the collection of data on race, ethnicity, and primary language and should require organizations to use these data as part of their ongoing quality improvement efforts. The majority of hospitals currently collect some combination of patient demographic data, primarily on race.⁵⁴ However, few are actually using the data to monitor for disparities in care or to evaluate the effectiveness of interventions aimed at improving care to vulnerable populations.

2-5. Health information technology work groups need to determine practical ways of integrating patient demographic data such as race, ethnicity, and primary language into information systems.

As advances are made in health information systems, consideration must be made for the integration of data necessary for monitoring disparities. Currently, efforts to monitor disparities are challenged not only by lack of data collection, but also by the inability of various data systems to “talk” to one another. As health information technology workgroups address issues of data usability, they also need to consider the integration of data on race, ethnicity, and primary language.

2-6. Researchers should partner with hospitals to use stratified quality measurement data to discern potential disparities and develop follow-up measures of cultural and linguistic competence to monitor actions toward improvement. In addition to the need to collect data in a consistent manner that allows for stratification, hospitals—already acknowledged to be overwhelmed with “must do” performance monitoring—nevertheless, need to take on additional monitoring activities. The health care field is hungry for data that will show the impact of interventions designed to reduce disparities and improve cultural and linguistic competence. Researchers should make efforts to partner with hospitals to stratify and use these data to measure the impact of interventions.



CHAPTER 6: DOMAIN THREE: WORKFORCE



Our third domain concentrates on hospitals' efforts to provide culturally and linguistically appropriate care by diversifying the demographics and skills of their workforce.

Key components of this domain include staff recruitment and retention, demographics, development and training, competence and skills, and employee perceptions. Data we report here focus on hospital plans for recruitment and retention, including staff demographic data collected and used, and human resource policies and programs, including training, to improve the cultural and linguistic competency of staff.

Recruitment and Retention

Developing a diverse workforce that reflects the community and patient population is one strategy recommended to foster the provision of culturally and linguistically appropriate care as well as the complimentary benefits of increased patient trust, increased market share, and decreased staff turnover.⁵⁵ In an effort to determine how many of our sample hospitals have adopted this strategy, we asked whether or not they have plans to recruit and retain a diverse administrative and clinical workforce that is able to meet the cultural and linguistic needs of the patient population. Just over half of sample hospitals indicated they do (Figure 6-A). Not surprisingly, more judgment hospitals had plans to recruit and retain a diverse workforce than stratified hospitals (Table 6-A).

Collecting demographic information about staff is a requisite step for workforce diversification and redirection of recruitment or retention efforts when necessary.

At least half of all hospitals sampled reported collecting the race and ethnicity of staff (Figure 6-B). The margin between judgment and stratified sample hospitals was greatest for the collection of race data, where 23% more judgment sample hospitals reported collecting the characteristic than stratified hospitals (Table 6-B).

Figure 6-A. Hospital Plans to Recruit and Retain a Diverse Workforce
(Aggregate n=60)

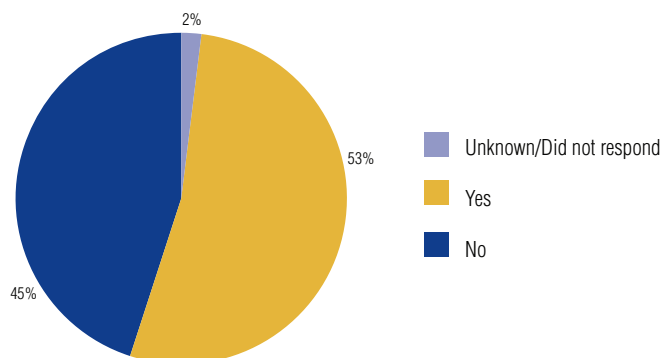
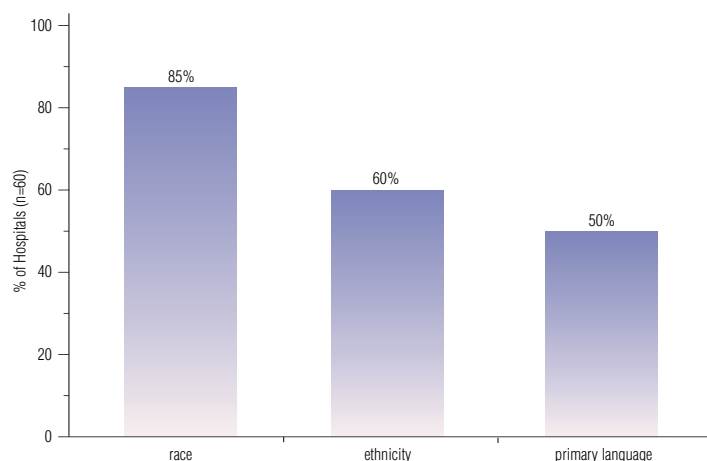


Table 6-A. Hospital Plans to Recruit and Retain a Diverse Workforce

| Stratified n=30 | Judgment n=30 |
|-----------------|---------------|
| 47% | 60% |

Figure 6-B. Staff Demographic Data Collected by Hospitals
(Aggregate)





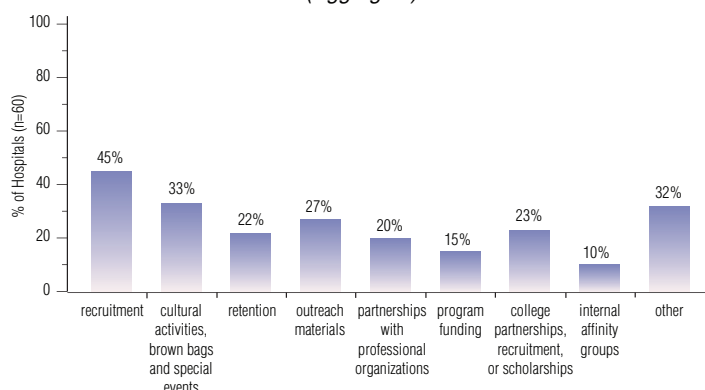
It was most commonly reported that these data were used for recruitment purposes, followed by cultural activities and “other” uses. Other uses indicated by respondents include affirmative action plans, Equal Employment Opportunity Commission (EEOC) reporting, provision of patient care, and performance improvement activities tied to outcomes and patient satisfaction. Less commonly reported uses were staff retention, development of outreach materials, and establishment of partnerships with colleges and other professional organizations (Figure 6-C).

Hospitals engage in many activities to diversify their workforce but face multiple challenges to do so. Several hospitals discussed joining or conducting community job fairs, particularly in diverse areas or ethnic pockets of their community, to encourage individuals who represent the community to work at their hospital. Yet others told us they use partnerships with local secondary schools, particularly with those that have large percentages of minority students, to increase student interest in health care professions like nursing and medical interpretation. Participants at one western region hospital told us they go as far as providing financial support for high school students who decide to pursue college education in medical interpretation. Interview participants at a different hospital also spoke about their efforts aimed at foreign nurses who have come to the US and need to enhance their credentials in order to practice here. A Human Resource Session participant from a western region hospital shared information about a program to address this, “We are currently participating in a program with our local community college called Foreign Nurse Program...we take individuals who are already here in this state who are licensed in another country and they go through a retraining to become nurses here in the United States.” Additional workforce diversification efforts mentioned during site visits include advertising and posting job opportunities in minority or non-English newspapers and magazines.

Table 6-B. Staff Demographic Data Collected by Hospitals

| | Stratified N=30 | Judgment N=30 |
|------------------|-----------------|---------------|
| Race | 73% | 97% |
| Ethnicity | 53% | 67% |
| Primary language | 43% | 57% |

Figure 6-C. How Staff Demographic Data are Used (Aggregate)



With regard to retention, some participants cited pay differentials for bilingual staff and incorporation of cultural competence elements in performance evaluations as tools they use. An interview participant at one midwestern hospital also spoke about disciplining a nurse for culturally insensitive behavior: “It was brought to our attention that a nurse was speaking out in overtones about ‘those people.’ Someone from cultural services brought it to leadership’s attention... [As a result,] the nurse was required to take a cultural sensitivity class and then come back and give a class to peers, which was a great teaching tool for the nurse and others.” Yet other interview participants indicated they thought it was the diversity of the workforce itself that retained staff.



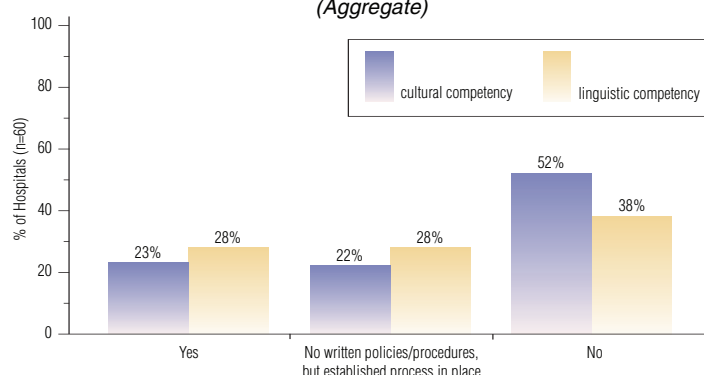
Hospitals' attempts to diversify their workforces do not come without challenges. At least one interview participant at 98% of participating hospitals told us they experienced a challenge related to their staff. Many participants indicated that developing a diverse workforce is a challenge, particularly attracting Latino, African American, and bilingual health care professionals. Fewer participants mentioned challenges with matching characteristics like age, gender, and socioeconomic status of staff to the community or patient population. One hospital that did mention challenges with matching staff gender to that of the patient population spoke about the Muslim community they served and difficulties with serving female Muslim patients by a mostly male Emergency Department physician staff. Another hospital addressed a similar challenge with a female Muslim patient by moving her to the OB Department, "even though she wasn't an OB patient because we knew there were more likely to be female caretakers there."

Tension between staff as the result of workforce diversification also presents as a challenge. A CEO from a southern region hospital commented, "If you have a diverse group of people working for you, it does not mean that they have respect for different cultural ways. In fact, often times it creates friction for our organization...so diversity doesn't necessarily mean no racial problems." Interview participants who discussed staff-to-staff tension attributed it to racial, cultural, and linguistic differences.

Human Resource Policies and Programs

One approach to ensuring that hospital staff possess a minimum level of cultural and/or linguistic competence is developing written human resource policies that establish requirements for staff members' cultural and/or linguistic competency. Few of our sample hospitals had formal policies in place regarding requirements for staff cultural or linguistic competency (Figure 6-D). This is not surprising since there are

Figure 6-D. Written HR Policies for Staff Cultural/Linguistic Competency (Aggregate)



“Our Director of Community Affairs arranged a job fair with the Chinese Business Association [CBA]. The [CBA] arranged this by putting out ads in the community; [the Chinese community] trusted them; they had a comfort level to go to this fair. There were over 300 people, and we had to extend the fair for two days. The people were lined up on Main Street. We did counseling, we had a list of the positions and how they could transfer their skills, we brought some representatives that spoke their language to help interpret and explain to them where they could get education in English as a second language. We did a little integration counseling, how they get their visas, how the nurses get their certificates. Well, after that day, I got it.”

—Human Resource Session participant,
northeast region hospital



currently no agreed upon measures of cultural competence. However, this question was not posed in a manner that could discern if there were specific policies for certain staff positions. The difference between samples was minimal (Table 6-C).

We also asked hospitals to identify which human resource programs (new employee orientation, ongoing training, and competency assessments) addressed culturally and linguistically appropriate care and for which staff type. Sample hospitals reported that new employee orientation addresses culturally and linguistically appropriate care more often than ongoing training or competency assessments for all staff categories (Figure 6-E) and judgment hospitals more so than stratified (Table 6-D). At this time, The Joint Commission Accreditation Standards do not specifically require ongoing training in cultural and linguistic competence but do require orientation on “cultural diversity and sensitivity” (Joint Commission, 2006 Hospital Accreditation Standards), which may account for the higher percentage of hospitals including this training in their orientation programs but not in ongoing training programs.

The literature calls for increased training on cultural competence and the use of language services for medical students and students in the health professions.⁵⁶ Some states, such as New Jersey, have passed laws requiring continuing medical education in culturally and linguistically appropriate care, and the Association of American Medical Colleges is developing requirements for the integration of cultural and linguistic competence programs in medical school curriculums. However, training programs for culturally and linguistically appropriate care were rarely identified for physicians, residents, and students. Substantially more judgment sample hospitals than stratified hospitals reported that their ongoing training for clinical staff, residents and students, and senior management addresses culturally and linguistically appropriate care (Table 6-E). This is not unexpected,

Table 6-C. Hospital has Written Human Resource Policies Regarding the Cultural and Linguistic Competence of Staff

| | Stratified N=30 | Judgment N=30 |
|---|----------------------------|--------------------------|
| Cultural competence policy | 23% | 23% |
| No cultural competence policy, but an established process is in place | 20% | 23% |
| Linguistic competence policy | 27% | 30% |
| No linguistic competence policy, but an established process is in place | 23% | 33% |

“We start with diversity education at new employee orientation, and we talk about the importance of it and the fact that we are a very, very diverse hospital...In that same conversation we extend it to patient rights, etc. and how all of that impacts [care]. So I think people do get a good handle on the topic.”

—Human Resource Session participant,
western region hospital



since judgment sample hospitals were selected based on their level of advancement in the area of culturally and/or linguistically appropriate care provision.

Many sample hospitals indicated they need to improve aspects of their cultural and linguistic training programs; however, staff are stretched too thin with their existing responsibilities making training and education difficult. Even so, some participating hospitals are offering education and training programs that target staff members' ability to provide culturally and linguistically appropriate care. Programs mentioned include medical Spanish classes, English as a second language classes, computerized and in-person diversity appreciation/sensitivity training, and in-services provided by community members and/or staff members of particular cultural or ethnic groups. For example, one southern hospital's pharmacist provides classes for physicians on herbal remedies commonly used by certain patient populations, how the remedies are prepared, and what their side effects are. A few other site visit participants discussed their hospitals' emphasis on training that teaches staff how to work with an interpreter. One hospital focused its efforts on teaching physicians how to work with interpreters and how doing so can allow them to provide better care, while interview participants at another hospital told us they provide all staff with online training on how to work with interpreters.

Many hospitals also mentioned less formal methods for developing staff knowledge about cultures and languages present in the hospital. These activities are part of a larger strategy aimed at enhancing staff ability to provide culturally and linguistically appropriate care by educating and exposing them to cultures other than their own. Some of the less formal activities discussed involve cultural fairs, including ethnic dancing and costumes, diverse cafeteria menus, websites for sharing information on cultures common in the community, and reading clubs or weekly reading selections focused on specific cultures or language groups.

Figure 6-E. Programs Addressing Provision of Culturally and Linguistically Appropriate Care by Staff Category (Aggregate)

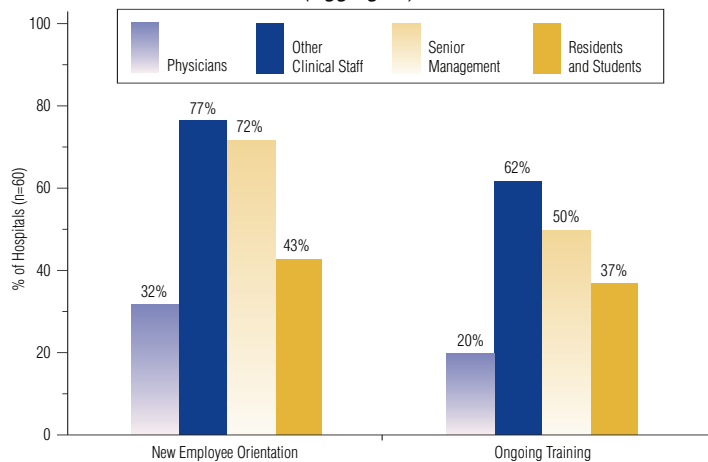


Table 6-D. New Employee Orientation Programs that Address the Provision of Culturally and Linguistically Appropriate Care Delivery

| | Stratified N=30 | Judgment N=30 |
|---------------------------------|--------------------|------------------|
| Physician | 23% | 40% |
| Nurses and other clinical staff | 70% | 83% |
| Senior management | 63% | 80% |
| Residents and students | 30% | 57% |

Table 6-E. Ongoing Training Addresses the Provision of Culturally and Linguistically Appropriate Care Delivery

| | Stratified N=30 | Judgment N=30 |
|---------------------------------|--------------------|------------------|
| Physician | 20% | 20% |
| Nurses and other clinical staff | 50% | 73% |
| Senior management | 37% | 63% |
| Residents and students | 23% | 50% |



Recommendations and Observations Related to Domain Three: Workforce

3-1. Hospitals should engage staff in dialogues about meeting the needs of diverse populations.

These dialogues can help to identify common needs and inform the development of practices and systems to meet these needs.

3-2. Hospital staff should be provided ongoing in-service training on ways to meet the unique needs of their patient population, including regular in-services on how and when to access language services for patients with limited English proficiency.

Informed by hospital dialogues, practices that have been found to be useful for meeting patients' unique needs should be shared with staff throughout the organization. For example, one department may have developed an innovative way to address a unique cultural belief that can facilitate care provision in other departments. There are also several reports of promising practices⁵⁷ that highlight ways to address both cultural and linguistic needs. Hospitals may also want to share their learned practices with each other and then develop a local network of evolving knowledge.

3-3. Accrediting bodies should require continuing education and training that supports the provision of culturally and linguistically appropriate care.

For example, hospital staff should be trained regularly on the hospital's mechanism for providing language services. Hospital staff should also be trained on the best ways to meet the needs of the hospital's population in the context of the resources that are available to them.

3-4. More research is needed to measure and understand the benefits of increased racial, ethnic, and linguistic concordance of hospital workforces and their patient populations.

The National Standards for Culturally and Linguistically Appropriate Services in Health Care recommend that hospitals make efforts to increase the diversity of their workforce as a means to better mirror the patient population.⁵⁸ We need to know that workforce and patient concordance truly makes health care services more culturally and linguistically appropriate. Better measures of the impact of this concordance (and conversely the impact of discordance) are needed to support these efforts.

“Native Americans want to take their children down [to the reservation] to bury them and if there is a premature death before 20 or so weeks... We had Dr. [name omitted] talk about the cultural needs of these people and how important it is for them to take the remains with them. [He was] very helpful in making that happen for us.”

—Leadership Session participant, midwest region hospital



3-5. Research is needed to develop measures of the impact of cultural competency training programs for hospital staff on patient care.

While there is no national standard or certification for guiding the provision of cultural competence training, several training programs exist. Unfortunately, there is limited information about their effectiveness. Measures could focus on staff attitudinal and behavioral change using responses from staff focus groups or satisfaction surveys. Measures could also focus on the availability of language services and the frequency of use of such services.

“Early on, we had staff interested in learning a second language. We spent a lot of money to try to train these staff but found it very difficult. The amount of time it takes to get staff to a point that they can dialogue proficiently is long, and we did not have a great deal of success. But we have provided medical terminology for those [staff] who [already] have Spanish language skills.

*—Human Resource Session participant
southern Region*



CHAPTER 7: DOMAIN FOUR: PATIENT SAFETY AND PROVISION OF CARE



Our fourth domain centers on the actual provision of care and processes that impact its quality and safety. Key areas of this domain include assessment of patients' cultural and

linguistic needs, the informed consent process, the continuum of care, patient education, and the consideration of patient health beliefs, needs, values, and patient safety. Results reported for domain four will touch upon all these areas.

Assessment of Patient Needs

From diagnoses to treatment plans, the patient care process hinges on the identification and understanding of patient needs. Similarly, the provision of culturally and linguistically appropriate care depends on an accurate assessment of a patient's cultural and linguistic needs. As shown in Figure 7A, when asked about identifying cultural and linguistic needs of patients at admission or registration, all sample hospitals reported having a mechanism to identify linguistic need. Fewer, but still a majority, reported having a mechanism to identify the cultural needs of patients (78%). Almost no difference exists between the samples regarding the reporting of a mechanism to identify cultural needs or linguistic needs (Tables 7-A and 7-B).

Nearly all participating hospitals (92%) identified the initial assessment as their mechanism for identifying the cultural and linguistic needs of patients. Hospitals were given the opportunity to report additional mechanisms for identifying patient cultural and linguistic needs; however, no other mechanisms were reported. Many site visit interview participants confirmed that cultural and linguistic needs of patients are determined during the initial assessment. Some participants also revealed specific elements of the assessment that staff use to determine patient needs, sometimes involving the judgment of individuals other than the patient. For example, one

Figure 7-A. Hospital Has Mechanisms to Identify Cultural and Linguistic Needs of Patients (Aggregate)

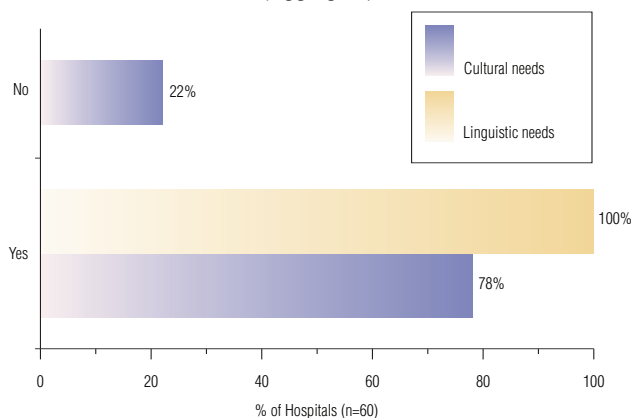


Table 7-A. Hospital has a Mechanism to Identify the Cultural Needs of Patients

| Stratified n=30 | Judgment n=30 |
|-----------------|---------------|
| 80% | 77% |

“I think from a nursing perspective anyway, it certainly is very much a consideration from the time the patient comes in here. Is there anything we need to know? That we need to modify in our care? Our approach? Or whatever, based on their cultural background and their wishes. That’s the key. That we are going to adhere to the patient’s wishes.”

—Leadership Session participant,
southern region hospital



participant at a midwest hospital told us, “We might identify them by clothing, a dialect they speak, whatever.” Several other participants at different hospitals identified the patient’s family as a good source of information about their particular needs. Yet another participant at a different midwest hospital revealed that staff sometimes make their own judgments about patients’ language needs because they are uncomfortable asking patients for this information. The participant explains, “We have a lot of people who are nervous about asking what language people speak—[staff] just listen to what they’re saying and then try to determine what their language is and then they call an interpreter—we have a list of languages for them to determine this, but I’m not sure most people use those.”

Informed Consent

Informed consent is an essential component of the health care process and must be an interactive exchange between patient and provider.⁵⁹ Each hospital must build supports into the informed consent process that account for patients’ cultural and linguistic needs in order to facilitate information flow regarding risks, benefits, and alternative treatment options from the patient to the provider and from the provider back to the patient. Most participating hospitals indicated on the Pre-Visit Questionnaire that their informed consent processes address patient language (93%) and literacy (65%) needs (Figure 7-B). However, only one third of sample hospitals reported that their informed consent processes take patient cultural needs into account. We were surprised to discover that, of those hospitals reporting the attention to cultural needs in their informed consent processes, the majority were stratified sample hospitals (Table 7-C).

Informed consent processes were the topic of many site visit discussions, during which several administrative participants mentioned how difficult it can be to establish informed consent processes that address patient cultural and linguistic needs. One participant at a northeast

Table 7-B. Hospital has a Mechanism to Identify the Linguistic Needs of Patients

| Stratified n=30 | Judgment n=30 |
|-----------------|---------------|
| 100% | 100% |

Figure 7-B. Informed Consent Process Addresses Cultural/Linguistic Needs (Aggregate)

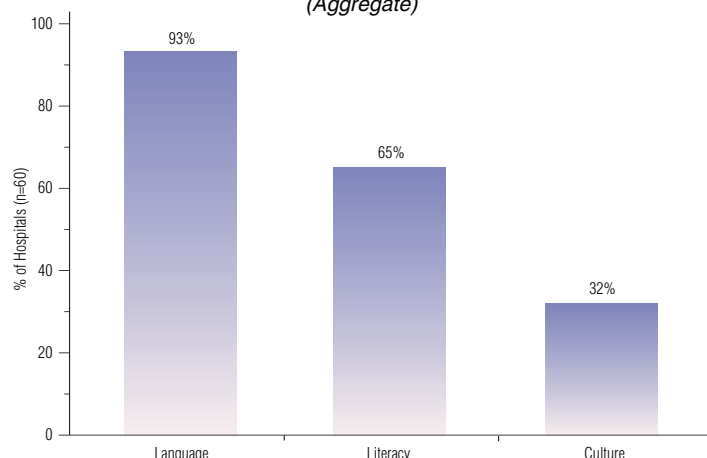


Table 7-C. Hospital’s Informed Consent Process Takes into Consideration:

| | Stratified n=30 | Judgment n=30 |
|----------|-----------------|---------------|
| Culture | 40% | 23% |
| Language | 87% | 100% |
| Literacy | 63% | 67% |



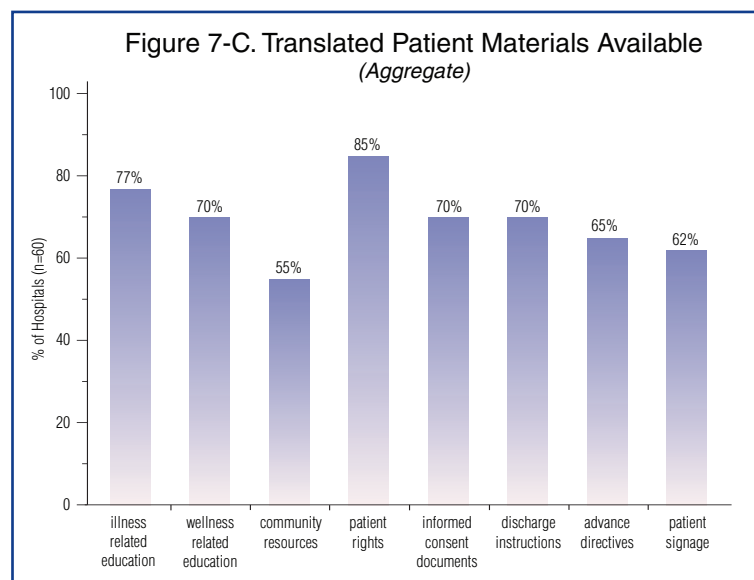
region hospital shared with us some of the ways in which their hospital must address certain consent situations: “Given the large number of languages we [serve], we often wind up having an oral consent rather than a written consent process or given some of the limited literacy profiles, some kind of video consent form.” Other hospitals indicated that consent is always obtained through the use of an interpreter; however, in some cases, the respondent indicated that the interpreter was brought in to sight translate the consent form. This method of on-the-spot translation can pose problems, particularly if the sight translation does not also include an interpreted dialogue between the practitioner and the patient.⁶⁰

Culture can also impact the informed consent process. A patient’s religious beliefs, cultural practices, as well as his or her past experiences can impact the trust needed for informed consent. An African American physician leader at a western region hospital told us a story that exemplifies the challenge of obtaining trust. This physician leader explained a situation in which his African American patient refused to consent to a needed surgery. He explains, “It didn’t matter that I was black myself; this patient didn’t trust me in the white coat. The Tuskegee experience is not over for many African Americans, and we need to be sensitive to that.” Between 1932 and 1972 the United States Public Health Service conducted an experiment on African American men in which the treatment for syphilis was deliberately withheld.

Patient Education

Hospitals frequently rely on written materials to educate patients. Because hospitals are serving more patients who don’t speak English, the need for translated documents is increasing. Many hospitals have worked to provide these resources in the form of patient education materials translated into the languages spoken by their patients. Ninety-three percent of participating hospitals indicated that translated materials are available to patients and their families.

As shown in Figure 7-C, the most commonly reported translated materials are patient rights documents, followed by illness-related education, wellness-related education, informed consent documents, and discharge instructions. More judgment hospitals have translated these documents than stratified hospitals for all



“Even when you go through interpreter services, it is difficult to fully comprehend the connection between the non-bilingual staff and the non-English speaking patient. From a consent perspective, that is an issue. If there is a physician who is explaining and there has to be feedback to make sure that the patient fully understands what is transpiring, that is a challenge.”

—CEO, western region hospital



categories (Table 7-D). Often when asked about the languages into which documents are translated, hospitals only have translated versions in one language. This may be because they only have one other commonly encountered language. In other instances, cost and availability are impeding factors.

Comments about the process for obtaining translated documents related the difficulty in finding someone to translate and the concern the once translated, the document may have lost its meaning. Translation can be costly. One participant at a southern region hospital told us, “The time involved initially in translating our teaching sheets was costly, but now so many of your computer programs can take something and translate it into Spanish on the computer, but we have to have someone go back through it because it doesn’t read very well. You just have to be careful. We worked with the university... they did the initial review and then we looked at trying to get ... a healthcare provider who also spoke that language to look through and say ‘that doesn’t make sense’ or ‘that doesn’t have the same intent.’ That was very laborious.”

Some of the hospitals in our sample have overcome the cost and resource burden of translating written educational materials and forms by starting collaboratives with other hospitals or health care networks. Through these collaboratives, hospitals have been able to pool their financial and staff resources. Review of site visit data reveals that 25% of our sample hospitals use some type of computer program to translate a portion of their documents. The programs most commonly mentioned were Micromedex® Carenotes™ and Krames. Interestingly, neither of these named programs actually provide computer translation software.

In addition to translated patient education materials, several hospitals provide patient education classes in different languages targeted to specific populations.

Table 7-D. Translated Materials Available to Patients and their Families

| | Stratified n=30 | Judgment n=30 |
|----------------------------|----------------------------|--------------------------|
| Illness-related education | 67% | 87% |
| Patient rights information | 70% | 100% |
| Informed consent documents | 50% | 90% |
| Wellness-related education | 57% | 83% |
| Discharge instructions | 63% | 77% |
| Community resources | 40% | 70% |
| Advance directives | 43% | 87% |
| Patient signage | 40% | 83% |

However, one hospital that provided Spanish childbirth classes, staff reported frustration because the classes had limited attendance. Hospital staff with patients to find out why they weren’t attending the classes and learned that it was because the classes were held on weekday evenings, when many of the patients or their spouses worked. By rescheduling the classes to a Sunday afternoon they were able to increase attendance and better prepare their patients for childbirth. This demonstrates that planning for classes in different languages needs to include an understanding of the logistical and social needs of the patient.



Continuum of Care

Patient care is rarely confined to a single location and a sole provider; rather it involves a variety of individuals in a variety of locations across the continuum of care. Communication of patient information across that continuum is integral to ensuring all patient care is culturally and linguistically appropriate. Information garnered about patients' needs and preferences must be shared between caregivers so that all can be aware of specific needs at any given time. Over half of sample hospitals indicated they have mechanisms to share information about cultural (55%) or linguistic (80%) patient needs across the continuum of care. There was little difference between the samples for sharing information about cultural needs (Table 7-E), but as shown in Table 7-F, 25% more judgment sample hospitals than stratified reported having mechanisms to ensure information about linguistic needs accompany the patient throughout the continuum of care.

Of those hospitals indicating they have mechanisms to communicate patient culture and language information across the continuum of care, the most common mechanism identified was a flag in the patient record (Figure 7-D). The next most common response was "other," for which comments frequently cited the plan of care as the mechanism for communicating patient needs, but other mechanisms included handoffs/verbal reports, specific locations within the patient chart (e.g., the face sheet, interpreter notes, etc.), and stickers on the spine of charts.

Table 7-E. Hospital has a Mechanism to Ensure that Information about Cultural Needs Accompany the Patient throughout the Continuum of Care

| Stratified n=30 | Judgment n=30 |
|-----------------|---------------|
| 50% | 57% |

Table 7-F. Hospital has a Mechanism to Ensure that Information about Linguistic Needs Accompany the Patient throughout the Continuum of Care

| Stratified n=30 | Judgment n=30 |
|-----------------|---------------|
| 67% | 93% |

"I can't say that there is a mechanism [for communicating a patient's cultural and linguistic needs across the continuum of care], and if there is, I probably don't know about it. We are so small, we are so dependent on people picking up the phone and calling when the need is there; them knowing who the associates are who can help and then calling them directly, so it doesn't follow directly with the patient. Maybe in the medical record, it might. But is there a form? Not to my knowledge.

—Cultural and Linguistic Service session participant, Western region hospital



Understanding Health Beliefs, Needs, and Values

A clear understanding of a patient's cultural context is indispensable to a provider when attempting to practice culturally and linguistically appropriate care.⁶¹ This includes understanding a patient's health beliefs and values and any needs that stem from those beliefs including spiritual beliefs, folk remedies, traditions or rituals, complimentary and alternative medicines, level of health literacy, socioeconomic status, and epidemiologic implications for treatment. In an effort to better understand what our sample hospitals do to help providers give culturally competent care by meeting patients' cultural needs, we asked them first, if they address patients' cultural needs, and second, what methods they use to do so. More than half of sample hospitals reported having written patient care policies that address cultural services (Figure 7-E), and there was no variation between the samples (Table 7-G). We find this very interesting. While more than half of our sample hospitals reported having written policies, we cannot be sure how this question was interpreted, nor can we be sure what these written policies included. It may be that these issues are not specifically addressed in policies, or perhaps they are incorporated into other policies, such as those for the provision of language services, where we saw more variation between samples (refer to Chapter 8: Domain Five: Language Services).

Figure 7-D. Mechanisms for Communicating Patient Information Through Continuum of Care (Aggregate)

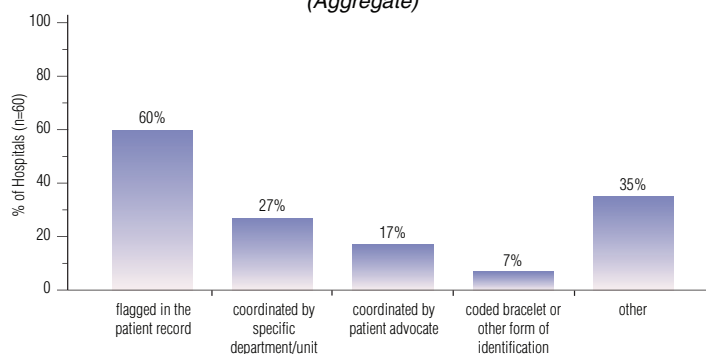


Figure 7-E. Written Patient Care Policies - Cultural Services (Aggregate n=60)

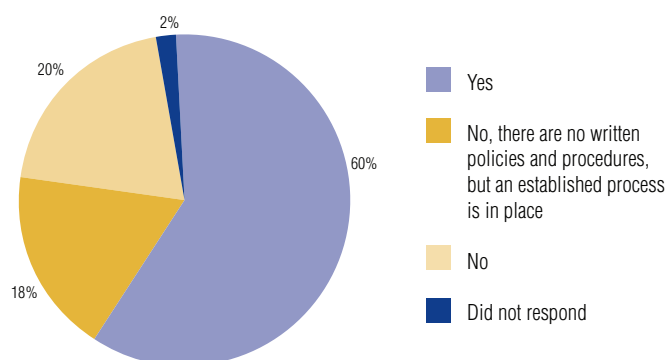


Table 7-G. Written Patient Care Policies and Procedures Address the Provision of Culturally and Linguistically Appropriate Services in Patient Care

| | Stratified n=30 | Judgment n=30 |
|-------------------|-----------------|---------------|
| Cultural services | 60% | 60% |



Nearly all hospitals indicated they address the cultural needs of patients through religious, dietary, and psychosocial methods (Figure 7-F). Fewer hospitals indicated they address culture through health literacy and complimentary medicine, and far fewer engaged cultural brokers, traditional healers, and folk remedies to meet the cultural needs of patients. Differences between samples indicate the only substantial variation is within use of cultural brokers; more than twice as many judgment sample hospitals as stratified hospitals reported utilizing cultural brokers (Table 7-H).

These data support site visit interview data, as many interview participants commented on their use of pastoral care services and hospital chaplains as cultural resources. In fact, several hospitals sought pastoral leaders in the surrounding community to aid in understanding the beliefs, practices, and needs of their patients. Additional methods for addressing patients' cultural needs include consulting bicultural staff members and interpreters, and physically changing the patient environment such as moving furniture, changing room numbers, and installing culturally specific accoutrements like Native American hogans (traditional homes used by the Native Healers for ceremonies) and Sabbath elevators (elevators that automatically stop at every floor so a button does not have to be pushed during the Sabbath).

Meeting patients' cultural needs does not occur without challenges, as many cultural norms do not coincide with those of Western medicine. Several participants cited as cultural challenges the struggle to accommodate large families visiting or staying with hospitalized patients. Working in situations where patients defer to a spouse or family group for decision-making was another challenge. One participant at a western region hospital said, "If there are patriarchal cultures there are struggles when the patient isn't the cultural head of the family, and the father or the son doesn't want you to tell the grandma

Figure 7-F. Hospitals Addressing Cultural Needs of Patients (Aggregate)

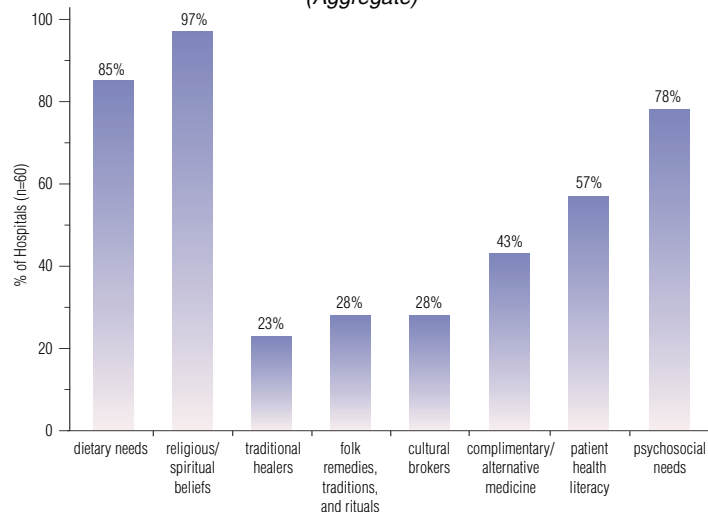


Table 7-H. Hospitals that Address the Cultural Needs of Patients

| | Stratified n=30 | Judgment n=30 |
|--------------------------------------|--------------------|------------------|
| | 97% | 100% |
| How cultural needs are addressed: | | |
| Religious and spiritual beliefs | 97% | 97% |
| Dietary needs | 83% | 87% |
| Psychosocial needs | 80% | 77% |
| Patient health literacy | 57% | 57% |
| Complimentary/alternative medicine | 40% | 47% |
| Cultural brokers | 17% | 40% |
| Folk remedies, traditions, & rituals | 30% | 27% |
| Traditional healers | 23% | 23% |



that she has cancer. That comes into, ‘we can’t tell you [father or son] what she has until we tell her,’ so that really is a struggle there, especially with HIPAA.”

Other challenges we heard relate to certain cultural or religious diets, stoicism with regard to pain, herbal remedies that patients don’t consider “medication,” the practice of vigorously rubbing a coin on the body as a means of healing (the resulting welts can be interpreted as a sign of abuse), particular practices and beliefs surrounding death, and perceived safety threats such as lighting candles under beds or not removing sacred threads and jewelry before surgery.

Generally, hospitals that were presented with these challenges found ways to address them in a manner that was considerate of the patient and family belief without compromising medical treatment. For example, the cultural tradition of tying a thread around the wrist to ward off spirits can be accommodated even in surgery by using surgical tape to cover the threads around the wrist instead of cutting and removing it. Other hospitals were able to accommodate the Gypsy tradition of lighting a candle under the bed by using a battery powered flashlight instead of a candle.

One final challenge some participants emphasized is how to develop an understanding of patients’ cultures without stereotyping them. One participant at a southern region hospital said, “The concern ...for us sometimes, is when you categorize people in one of those boxes, sometimes it becomes more stereotypical than anything else. And how you become, how you’re able to meld that together so that you are recognizing the person while appreciating a sense of background. Because some of the information we have seen out there and information that has been presented under cultural competencies or things like that are a much more stereotypical...”

“I think what I find most challenging is not the language barrier but the way people speak of and understand their human experience—that is in terms of cultural traditions, experiences...”

—*Cultural and Linguistic Service session participant, midwest region hospital*

“Obviously patients from other cultures like Navajo have their own way of healing. When they are diagnosed with an illness and they don’t accept the diagnosis, it could be from their perspective, a different illness. Navajo don’t recognize diabetes; instead they would attribute it to something else. As a patient you’ll then have two illnesses...the needs for the patient are to take a holistic approach, so both can be integrated.”

—*Cultural and Linguistic Service session participant, Western region hospital*



Patient Safety

Issues of patient safety permeate all areas of care provision. Recognizing the importance of both language and culture in providing safe care to diverse patients, we queried our sample hospitals about ways in which they have identified and addressed this link. Twice as many sample hospitals reported identifying a direct relationship between patients' linguistic needs and patient safety issues as reported a direct relationship between patient safety and patients' cultural needs (Figure 7-G). Equal numbers of judgment and stratified sample hospitals reported identifying safety issues related to linguistic issues, but there was a 17% difference between judgment and stratified for identification of safety issues related to culture (Table 7-I). Safety issues related to language may be easier to recognize than those related to culture. Judgment hospitals, which we might expect to be more sensitive to cultural issues, may be more attuned to the link between culture and safety.

When the link between patient safety, language, and culture was discussed during site visits, only a few hospitals indicated that they had been able to quantify this connection. However, there is value in being able to do so, as one northeast region hospital demonstrated. They indicated that they stratified their adverse event data by language and found that there were clusters of adverse events in patients with English as a second language. The ability to demonstrate the link between language and safety has sensitized this hospital to the challenges of providing care to persons of limited English proficiency. Lack of consistent patient-level data such as primary language, race, and ethnicity, along with health information systems' limitations and limited awareness have inhibited study of the patient safety connection to culture and language.

One hospital recognized the safety implications related to medication self-administration. This hospital served many individuals who were Navajo with varying

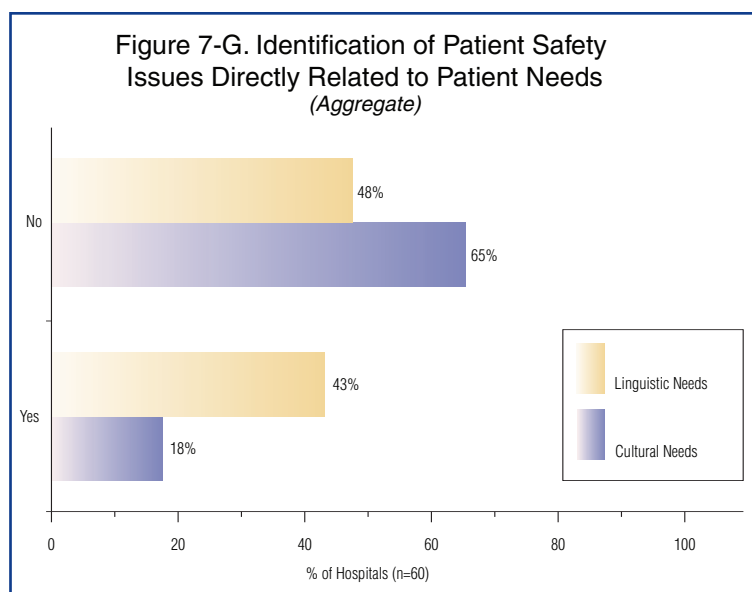


Table 7-I. Hospitals that have Identified Patient Safety Issues Related to Culture or Language

| | Stratified n=30 | Judgment n=30 |
|----------|-----------------|---------------|
| Culture | 10% | 27% |
| Language | 43% | 43% |

degrees of English proficiency and literacy. As a method to instruct patients on when to take the medication, the hospital printed stickers with the sun and moon to indicate day or night and used small dots to indicate dosage. These accommodations have improved patient understanding and improved medication compliance, though at the time of the site visit, the hospital had only recently implemented the practice and had limited data to demonstrate effectiveness.

Staff from a hospital in the midwest region told us during the leadership session that they improved their Emergency Department flow by increasing language services and by working to better understand the community. They found that patients were able to



communicate better with the Emergency room physicians (via trained interpreters and bilingual staff); thus, they were better able to understand their care instructions, including instructions to make follow up appointments at the ambulatory care clinic. Over time, the leadership staff found that patients were less likely to utilize the Emergency Department for non-emergent needs and more likely to make appointments with ambulatory clinics.

Recommendations and Observations Related to Domain Four: Patient Safety and Provision of Care

4-1. Hospitals should formalize their processes for translating patient education materials, including patient rights and informed consent documents, into languages other than English and evaluating the quality of these translations.

- As part of a formalized process, hospitals should establish a central “authority” within the hospital for coordinating the translation of documents, facilitating quality control, and minimizing duplication of similar documents across hospital departments.
- Hospitals may choose to collaborate with other health care providers to translate basic health education materials into other languages and share the costs thereof.
- Documents need to be translated in a manner that conveys accurate and culturally appropriate information.
- Quality controls should be in place to assure the accuracy and meaningfulness of the translation. Quality controls may include user focus groups or engagement of community representatives to assess the accuracy, meaning, and context of translated documents. Some hospitals may choose to use translation companies perform this service.⁶²

4-2. Health care interpreters should be used to facilitate communication during all informed consent processes involving patients with limited English proficiency, and cultural brokers should

be used as a resource when a patient’s cultural beliefs impact care. Practitioners need to be mindful that informed consent is a process, not a one-time event. A person’s cultural beliefs about health can have an impact on his or her understanding of proposed treatments and can impact the trust necessary for truly informed consent. Increased effort toward trying to understand how the patient understands his or her illness allows the practitioner to tailor the information provided in a manner that the patient will best understand.

- Hospitals may have a number of resources available to them to assist in cultural brokering. Some of these resources include hospital chaplains, hospital language service departments and interpreters, and nursing staff who have been trained in transcultural nursing.
- Qualified interpreters should be used to bridge the communication gap during health care encounters involving patients with limited English proficiency. Qualified interpreters often are also able to assist in cultural brokering.
- Adequate accessibility to interpreters requires leadership support; training for staff and medical staff on how to work effectively with an interpreter; a user-friendly system to access interpreter services; and a cadre of qualified interpreters.
- Qualified interpreters can function in-person or remotely (via telephone or video). They can be bilingual staff already employed by the hospital in other roles, or they can be hospital-employed or contract interpreters. Qualified interpreters are distinguished by assessment of their competency and language proficiency, and they have been trained in the practice of interpreting in a health care setting (see definition of “qualified interpreter” in Chapter One).

4-3. **Hospitals should take advantage of the internal and external resources available to educate them on cultural beliefs they may encounter.** Hospitals can learn about internal and external resources by conducting focus groups with patients, consulting



with professional chaplains, engaging community organizations and places of worship, and conducting focus groups with staff, particularly those who may be from the communities and populations served by the hospital.

4-4. Once a patient's race, culture, ethnicity, language, and religion have been determined, hospital staff and medical staff should be made aware of the tendency toward stereotyping in order to avoid making assumptions about patients.

Cultural competence is not meant to represent a complete understanding of each ethnic, religious, and linguistic culture. Rather, the practice of cultural competence is more akin to the practice of patient-centered care, whereby the practitioner works to understand the patient's needs from the patient's perspective.⁶³ Asking open-ended questions of the patient to better understand how the patient is experiencing his or her illness or condition is important to understanding the whole patient and being able to meet individual needs.

4-5. Patient safety and quality improvement leaders need to have dialogues with language services coordinators, diversity officers, and pastoral care workers about issues relating to culture and language that can impact patient safety. While language and culture are known to impact the safety and quality of care, conversations about patient safety initiatives seldom address these issues. The worlds of patient safety and culturally and linguistically appropriate care need to meet in order to begin the integration of language services and the impact of culture into patient safety activities.

4-6. Expand the Joint Commission National Patient Safety Goal #13⁶⁴ to specifically address diverse populations, particularly those with language and communication barriers. This National Patient Safety Goal addresses the need to “encourage patients’ active

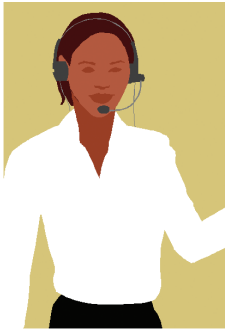
involvement in their own care as a patient safety strategy” and “define and communicate the means for patients and their families to report concerns about patient safety and encourage them to do so.” As part of this goal, accredited organizations should be required to consider the cultural, linguistic, educational, and literacy implications of patient engagement.

4-7. Collection and analysis of adverse event data by language, race, and ethnicity should be undertaken and be standardized as a means to support patient safety initiatives. National adverse event databases should seek the reporting of these demographic data. There exists a preliminary understanding of the impact language can have on patient safety,⁶⁵ but more data are needed to understand the scope of the problem and associated factors.

4-8. More research is needed to evaluate the quality and safety impact of diversity and cultural competence training provided to health care workers. While many hospitals provide cultural competence/diversity/sensitivity training to their staff, there is little evidence of its impact on the provision of care. No common understanding exists regarding the components of effective training on these issues (see Recommendation 3-5). A metric is needed to measure the effectiveness and impact of the various cultural competence/diversity/sensitivity training programs. The resulting data could help to refine training to meet the needs of health care workers and increase the willingness of hospitals to provide the resources necessary to support this training.



CHAPTER 8: DOMAIN FIVE: LANGUAGE SERVICES



This domain explores how hospitals are providing language services. Areas we focus on are how the hospitals organized the structure of these services, what services were utilized by the hospitals, whether or not hospitals evaluated the services, and, if so, how.

Organizational Supports for Language Services

Aside from the legal and regulatory requirements for the provision of language services, hospitals have a more compelling need to communicate effectively with patients in order to provide care safely. As reported in Chapter 4, all judgment sample hospitals have a designated multicultural or linguistic department, service, or office while only 27% of the stratified hospitals have this structural support. These departments are frequently the nucleus around which language services are coordinated. Many hospitals designated an individual to serve as a language service coordinator. In some hospitals these positions were full-time, while in other hospitals the language service coordinator also served another function in the organization. Generally, all hospitals with large interpreter services programs had a language service coordinator.

Ninety percent of sample hospitals indicated on the Pre-Visit Questionnaire that they have written patient care policies regarding the provision of linguistic services (Figure 8-A). Only 2% indicated that they did not have written policies, and the remaining 8% did not respond to the question. As shown in Table 8-A, the margin of difference between stratified and judgment hospitals was minimal (6%), which is interesting since we might expect a much larger margin. Few

Figure 8-A. Written Patient Care Policies - Linguistic Services
(Aggregate n=60)

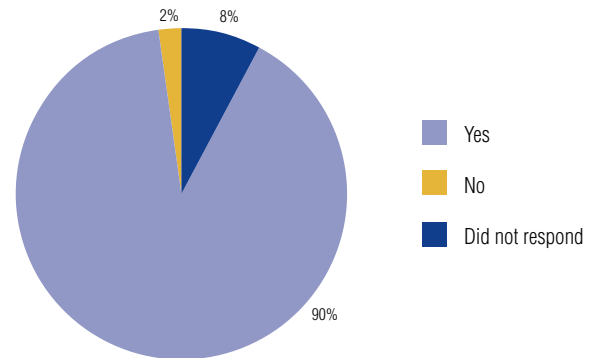


Table 8-A. Does the Hospital have Written Patient Care Policies and Procedures for the Provision of Language Services?

| | Stratified n=30 | Judgment n=30 |
|-----|--------------------|------------------|
| Yes | 93% | 87% |

hospitals shared their written policies with researchers during site visits, so an accurate description of the policies cannot be made. However, on several occasions hospitals that indicated that they have written patient care policies on the Pre-Visit Questionnaire were not certain during interviews that the policy was written.



Provision of Language Services

Figure 8-B shows that the linguistic service most commonly available in sample hospitals is the telephone interpreter, followed closely by bilingual staff. Of the hospitals that provide language services through bilingual staff, just over half (53%) train and/or assess them.⁶⁶ Interestingly, many of the hospitals that train or assess their bilingual staff are also hospitals that employ hospital interpreters. Other language service mechanisms such as hospital-employed interpreters, contract interpreters, or volunteer interpreters were provided by less than half of the hospitals sampled. In addition, it is important to note that very few hospitals relied solely on one of these mechanisms to provide language service; instead, most of them used a combination of mechanisms to meet patient needs.

Differences between our samples regarding the availability of language services were not unexpected. We expected our judgment sample hospitals to have more advanced methods for language services, such as hospital employed interpreters and contract interpreters, and compared to the stratified sample, they do. However, as identified in Table 8-B, our findings grossly under represent the availability of hospital-employed interpreters and contract interpreters when compared with findings from the recent Health Research and Educational Trust (HRET) and National Health Law Program (NHLP) collaborative investigation of language services in US hospitals.⁶⁷ This discrepancy may be attributed to our small sample size. We also speculate that there may be unidentifiable differences between the studies in how we defined hospital-employed interpreters. Respondents to the national survey may have also misinterpreted the term used to identify hospital interpreters (“staff interpreters”) to mean dual role staff. Another possibility is that hospitals report higher numbers than they actually have available for fear of Title VI sanctions.

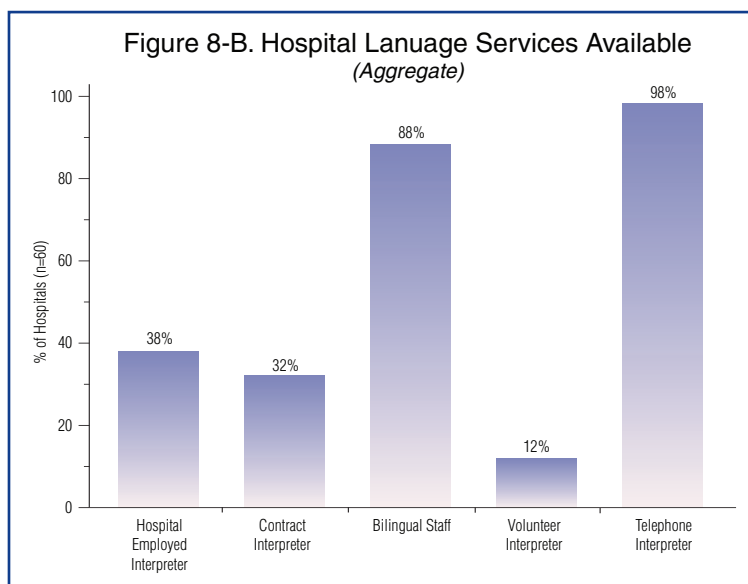


Table 8-B. Language Services Available in HLC Sample Hospitals Compared to National Survey Results

| | HLC Stratified n=30 | HLC Judgment n=30 | HRET/ NHLP Study ^a n=861 |
|-------------------------------|------------------------|----------------------|--|
| Hospital Employed Interpreter | 17% | 60% | 68% ^b |
| Contract Interpreter | 17% | 47% | 65% ^c |
| Bilingual Staff (Dual Role) | 90% | 87% | 78% ^d |
| Volunteer Interpreter | 17% | 7% | ----- |
| Telephone Interpreter | 97% | 100% | 92% |

^a Hasnain-Wynia R, Yonek J, Pierce D, et al. *Hospital Language Services For Patients with Limited English Proficiency: Results from A National Survey*. Health Research and Educational Trust; National Health Law Program; 2006.

^b For this comparison, we used the data from the Hasnain-Wynia category “staff interpreters.”

^c We averaged the Hasnain-Wynia categories for “independent freelance interpreters” and “external interpretation agencies” to compare to our contract interpreter category.

^d We averaged the Hasnain-Wynia categories for “bilingual clinical staff” and “bilingual non-clinical staff” to compare to our bilingual staff category.



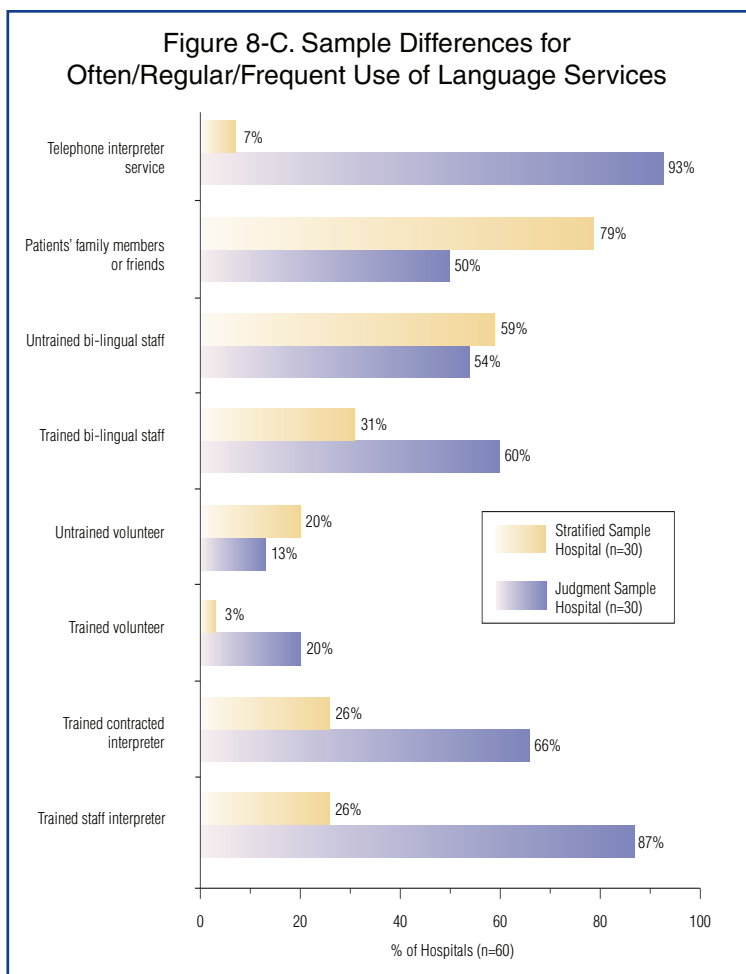
Pre-Visit Questionnaire data provided us with information on the frequency of use of the available mechanisms for language services. Figure 8-C shows that, as expected, judgment sample hospitals reported using trained staff interpreters, trained contract interpreters, trained volunteers, and trained bilingual staff more than stratified sample hospitals. However, there was little difference between sample hospitals regarding the frequent use of untrained bilingual staff to provide language services; over half of the hospitals in both samples reported using untrained bilingual staff often, regularly, or frequently. Also of note is the stratified sample hospitals' infrequent use of telephone interpreter services, despite the relative absence of hospital-employed interpreters and trained contract interpreters at most of these hospitals.

Use of Family Members to Interpret

The use of family members, particularly minors, to serve as interpreters for medical encounters is highly discouraged by many authoritative sources.⁶⁸ Several studies have shown that the use of family members or other ad hoc interpreters⁶⁹ are more likely to misinterpret information, omit or add information, or insert their own values or judgments into the conversation.⁷⁰ While the use of family members is not firmly prohibited by Title VI, it is not recommended.⁷¹ Hospitals could find themselves at risk by relying on family members to interpret since there is no way to determine the competency of the family member nor is there a way to make sure no conflict of interest exists between the family member and the patient.

Interview participants at more than one-third (40%) of our sample hospitals told us that they would use a family member to interpret. Of these, participants at eight hospitals told us that the use of a family member to interpret was one of the *preferred* mechanisms for communication with LEP patients (although no hospital indicated the family as the *only* preferred mechanism). With one exception, hospitals that preferred the use of

Figure 8-C. Sample Differences for Often/Regular/Frequent Use of Language Services



family to interpret over other language service options were stratified sample hospitals. In light of what we learned from interviews, we considered our Pre-Visit Questionnaire data. These data showed how frequently hospitals reported they used available language services. We were surprised to find that 50% of the judgment hospitals reported using family members or friends either often, regularly, or frequently.

Site visits provided us with insight into why family members would be used with such frequency. Some hospitals qualified the situation in which they would use a family member to interpret. Some examples include “I would use a family member if I had the patient’s permission,” or “I would only use a family member to interpret non-medical information.”



During site visits we learned that many practitioners use family because they don't have time to wait for the hospital interpreter or telephone service. This was commonly mentioned to us as a challenge. We also discovered that in some hospitals there was limited awareness of both availability of language services and risks associated with using family members to interpret. One physician told us, "This [language issue] is becoming more common. We have a few Bosnian Serbs in town; most have kids who do a pretty good job of interpreting."

We also discovered that not all hospitals took a clear stance on the issue of using family members. Only one quarter of sample hospitals indicated they discourage staff from this practice or have established policies against it, except in an emergency or as a last resort. Hospitals from the judgment sample were more likely to have hospital-employed interpreters, contract interpreters, and trained and/or assessed bilingual staff. However, judgment sample hospitals did not report that they firmly discouraged or had policies against family members interpreting any more than stratified hospitals. Few hospitals reported never using patients' family members and friends to interpret.

Evaluation of Hospital Language Services

Many respondents indicated they rely on patient satisfaction surveys to evaluate the effectiveness of language services. However, many of these surveys are not translated into languages other than Spanish, and even when they are translated it was reported to us that hospitals often have difficulty receiving them completed. Other hospitals have recognized that reliance on patient satisfaction surveys is not an effective evaluation of language services and have decided to compare frequency of language service use to frequency of language service need.

Training and Assessment of Interpreters

Although just over half of sample hospitals indicated that they are assessing bilingual staff and interpreter ability to understand and communicate patient and medical information into languages other than English, almost as many hospitals indicated they are not, or they did not respond to the question (Figure 8-D). Hospitals did not indicate the type of assessments being administered, nor the content or source of assessments. Almost twice as many judgment sample hospitals assess their interpreter and bilingual staff competency in the target language (Table 8-C; Figure 8-D). Even so, 30% of judgment hospitals are not assessing the competency of their

“One of the things I used to use as a gauge of effectiveness was the length of the interpretation [encounter] “One of the things I used to use as a gauge of effectiveness was the length of the interpretation [encounter]. [But] it could [be a long encounter because it was] a complicated interpretation. On the other hand, [a long encounter] could also be an indication that the person or the process we're using isn't as effective as it could be. So, I used to look at length of interpretation, I know we track that, but we don't really have a good way of tying that to effectiveness.”

—*Cultural and Linguistic Service session participant, western region hospital*



interpreters and bilingual staff. The risk of communication errors is likely greater when the person used to interpret has not been assessed for language competency.

While there are currently no national standards for competency assessment of health care interpreters, we did learn during site visits that some tools for assessment are being used. Some hospitals have used Berlitz, an international language organization, to assess the language proficiency of individuals used to interpret. Other hospitals have relied on the testing services provided by Language Line University and other telephonic interpreting companies. Several hospitals indicated that they only use “certified” interpreters; however, it was not clear what the certification entailed since there is no national certification for health care interpreters at this time. Some of these hospitals may have been in states that have state certification of medical interpreters or they could have been referring to certification for legal interpreting or certification programs developed by vendors such as Language Line or Bridging the Gap.

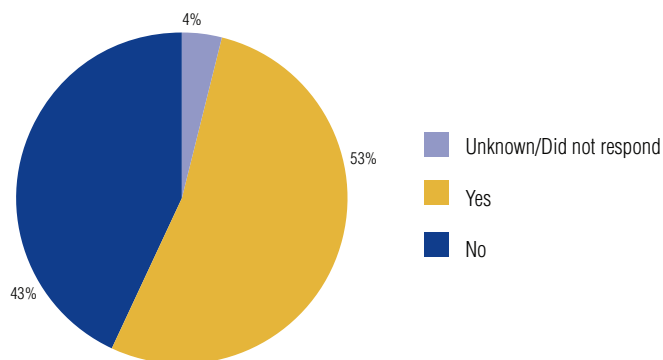
We learned from some interview participants that they are challenged not only by assessing their interpreters’ target language proficiency, but also by finding interpreters who are proficient in English. In some cases, bilingual staff are able to speak directly to patients in languages other than English, but are limited in their ability to communicate well in English which impairs their effectiveness as interpreters. Several hospitals told us that they were providing English as a Second Language classes for their staff because this was an issue.

During site visits, we queried about hospital’s training programs. However, the terms “assessed” and “trained” were not always distinguishable in the site visit data. We are able to determine which hospitals indicated training or assessment, but cannot definitively determine hospitals that only trained or only assessed unless it was specifically stated. We are also not able to

Table 8-C. Are Interpreters and Bilingual Staff Given Special Competency Assessments on their Ability to Understand and Communicate Patient and Medical Information?

| | Stratified n=30 | Judgment n=30 |
|-----|--------------------|------------------|
| Yes | 37% | 70% |

Figure 8-D. Interpreter/Bilingual Staff Target Language Competency Assessed
(Aggregate n=60)



determine the definition of training for each hospital that reported offering it.

Recommendations and Observations Related to Domain Five: Language Services

5-1. Hospitals should consider establishing written policies regarding the provision of language services. Such a policy should address what language services are available; how to access the services; what to do if a patient refuses a service; and provide guidance regarding situations in which the policy may not apply (for example, in social conversations). This policy should be shared



with all staff at orientation and regularly thereafter. The hospital should review its policy regularly to determine whether it continues to meet the needs of the hospital's limited English proficient population. This review should involve consideration of community data, aggregate patient demographic data, and other data that demonstrate the need for interpreter services.

5-2. Hospitals should implement policies that do not permit the use of family members, particularly minors, for interpreting during medical encounters, except in the case of an emergency when no other option is available.

While some patients may initially be more comfortable with a family member as an interpreter, the hospital has no way of knowing the competency of these individuals, nor can the hospital be sure that the family member has the patient's best interests in mind. Family members are not objective and in some situations, such as dealing with a dying loved one, the family member may be under stress and not have the necessary faculties to communicate effectively in two languages. Minors pose an additional challenge to the encounter because they may not have the cognitive or emotional maturity to function in the role of interpreter.

5-3. Hospitals should assess both English and target language proficiency and require or provide training on the practice of health care interpreting for all individuals used to interpret.

The practice of interpreting is a specialized skill that requires extensive knowledge of at least two languages, including medical terminology in both languages, and an understanding and adherence to ethical and professional practice standards. Not all bilingual individuals are equipped to be health care interpreters. Health care interpreters need to be familiar with hospital policies, particularly those related to confidentiality of information and patient rights. Having a trained health care interpreter on staff can facilitate communication between patient and provider with a lesser chance of error than with an unqualified interpreter. Organizations such as the

National Council on Interpreting in Health Care⁷² can provide guidance to hospitals that are trying to improve the quality of their interpreter programs.

5-4. Hospitals should consider incorporating language service programs into their safety and quality efforts by using process improvement structures and tools.

In order to begin to meet the goal of effective communication for all patients, hospitals need to begin to integrate the provision of language services into their efforts to improve overall quality and safety. This can be done by setting achievable objectives and using practical tools to improve care.

5-5. Policymakers need to initiate a national dialogue respecting a national certification program for interpreters in health care.

A recently-released report funded by The California Endowment outlines the current state of national certification and steps needed to establish a national certification program in the future.⁷³ A national certification could provide a common understanding of the skills, experience, and training needed to be a health care interpreter. While national certification would not solve issues regarding the provision of language services in languages of limited diffusion, it could support health care interpretation as a profession that requires training and experience and thus minimize the use of unqualified interpreters.

5-6. The impact of different forms of health care interpretation on health care quality and patient safety need to be quantified.

While there is agreement that communication is essential to safe and high quality health care, generally, hospital staff have little awareness that some mechanisms used for interpreting are less safe than others. While it may be logical to some that not all bilingual individuals have the skills to interpret, others fail to recognize the complexities of language interpretation. Persuasive evidence needs to be developed to convince the health care field that more stringent requirements are needed for language services.



CHAPTER 9: DOMAIN SIX: COMMUNITY ENGAGEMENT



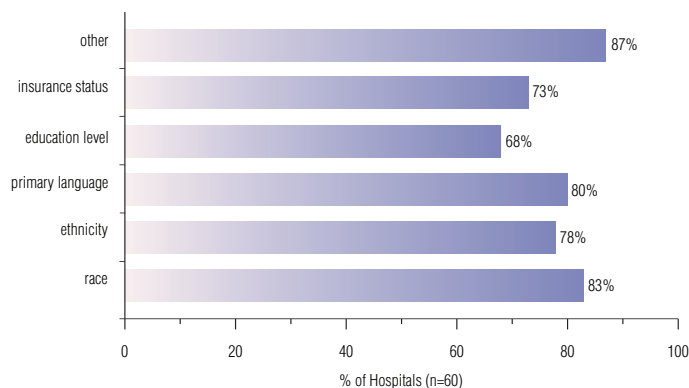
Our sixth and final domain focuses on hospital efforts to engage their communities. One important element of the community engagement domain is an assessment of the community's demographics (including age, gender, educational, socioeconomic, racial, ethnic, cultural, and linguistic composition). Outreach activities that may increase diverse populations' use of hospital services through education and tailoring of services to meet specific population needs is another important element. Data reported for this domain include hospital assessment of community needs and outreach activities.

Assessment of Community Needs

A strategic approach that integrates an understanding of community needs with community collaboration can improve a hospital's provision of culturally and linguistically appropriate care, thereby increasing quality for diverse populations and potentially reducing healthcare disparities.⁷⁴ Hospitals must understand the communities they serve, including how socio-cultural beliefs impact patient health and perceptions of health and health care, in order to develop effective health care options. A starting point may be an assessment of the demographic composition of the community. Although a basic assessment of this kind cannot provide in-depth comprehension of socio-cultural beliefs and perceptions, it can provide hospitals with insight into areas and populations that warrant development of greater understanding.

In order to understand what demographic information sample hospitals are using to determine the composition and potential needs of their community, we asked them to identify which types of community data they use from a list of basic characteristics.⁷⁵ The most frequently cited type of community data used was "other" (Figure 9-A). Although none reported what

Figure 9-A. Community Cultural and Linguistic Demographic Data Used by Hospital (Aggregate)



“We just recently did a focus group where we actually went in and met with populations- Hispanic women and Asian women- and we set those up with the Asian community center and Hispanic community center. We had an outside facilitator facilitate discussion with the groups. We had 15 women, all different [ages], all different abilities to communicate. We wanted to know, what are their challenges in terms of accessing health care? We’re also using that data to help us with [the new center] that we’re building so we can better meet their needs. We heard things that were not just about the hospital. We heard things about physicians, about interpreters, about differences in health care perception.”

—Cultural and Linguistic Service Session participant, midwest region hospital



“other” types of community data they are using. In addition to “other” data used, the majority of sample hospitals indicated they use community demographic data on race, primary language, ethnicity, insurance status, and education level. There was little difference between the judgment and stratified samples in the demographic data they reported using (Table 9-A). Slightly more judgment sample hospitals indicated using community data within each demographic category from our list with the exception of education level. Slightly more stratified hospitals reported using education level than judgment sample hospitals. Eighty-seven percent of all sample hospitals reported using these data to inform the design and improvement of patient services and community outreach.

Sample hospitals assess and understand their communities’ needs in other ways, as well. One hospital meets annually with Native American leaders from nearby reservations to discuss their communities’ needs and what services are or would be effective in meeting those needs. Another hospital meets quarterly with their Amish community’s church leadership to gauge that community’s health care needs and the appropriateness of hospital services provided to them. Several other hospitals described partnerships their pastoral care departments have established with community religious leaders to assess and meet the religious needs of patients during hospitalization. Other hospitals have convened focus groups with community members or organized panels of community representatives to answer staff questions. One hospital in particular provides “dinner with a doctor” every quarter. Dinner is provided and a mutual exchange of information is facilitated between doctors and community members about needs, services, and general health education.

Community Outreach

Establishing collaborative relationships with community entities can provide hospitals with detailed information on issues such as community members’ health-seeking

Table 9-A. Demographic Information about the Community Used to Inform Cultural and Linguistic Services

| | Stratified n=30 | Judgment n=30 |
|------------------|----------------------------|--------------------------|
| Race | 77% | 90% |
| Ethnicity | 70% | 87% |
| Primary language | 73% | 87% |
| Education level | 73% | 63% |
| Insurance status | 67% | 80% |

“I personally take a lot of pride in the community outreach. I spend a lot of hours out doing some of those screenings and talking with people, actually sharing what I know about medicine and health care as well as getting the name of our hospital out and increasing people’s knowledge. [Individuals from different] cultures have very different opinions on what’s appropriate in health care. By getting out into the community, [we’re] showing them that maybe something they’ve always just lived with might not be quite what they should accept.”

—Leadership Session participant, western region hospital



practices and resources like ethno-medical healers, which can help hospitals tailor interventions to the communities they serve.⁷⁶ A majority of our sample hospitals reported they conduct cultural and linguistic community outreach activities, although slightly more hospitals indicated these outreach activities are cultural in nature, rather than linguistic (Figure 9-B).

Hospitals establish relationships with a variety of organizations to address cultural and linguistic issues (Figure 9-C). Most common for judgment sample hospitals are relationships with colleges/universities and faith-based organizations (Table 9-B). Faith-based organizations were most common for the stratified sample. More judgment hospitals had relationships with all types of community organizations.

We also wanted to know the types of cultural and linguistic community outreach activities in which our sample hospitals are engaged. Again, we asked them to select from a list the types of community outreach activities that relate to culture and language (Figure 9-D). Well over half of sample hospitals reported they engage in community education events, development of educational materials, organizational partnerships, and event sponsorships. Conversely, less than half of sample hospitals reported cultural and linguistic outreach activities for marketing or with ethnic media sources. Sample hospitals indicating “other” wrote in activities such as health fairs, community breakfasts, membership on advisory boards, and television programming in languages other than English. As shown in Table 9-C, more judgment sample hospitals reported engaging in our list of activities than stratified hospitals, although the difference was greater for some categories (e.g. event sponsorship) than others (e.g. marketing).

Figure 9-B. Hospitals Conducting Cultural/Linguistic Community Outreach (Aggregate)

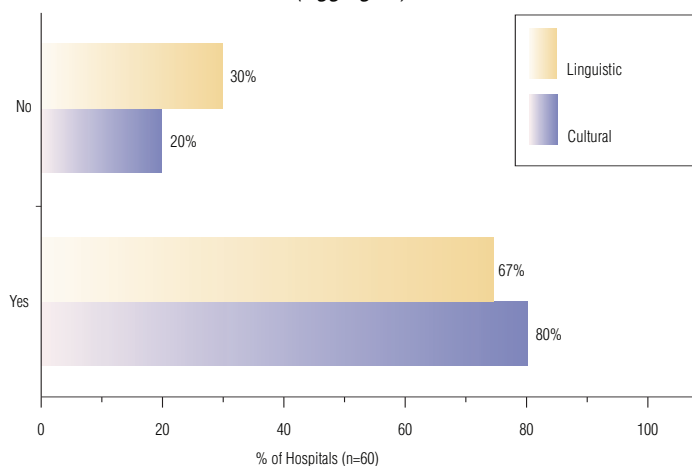
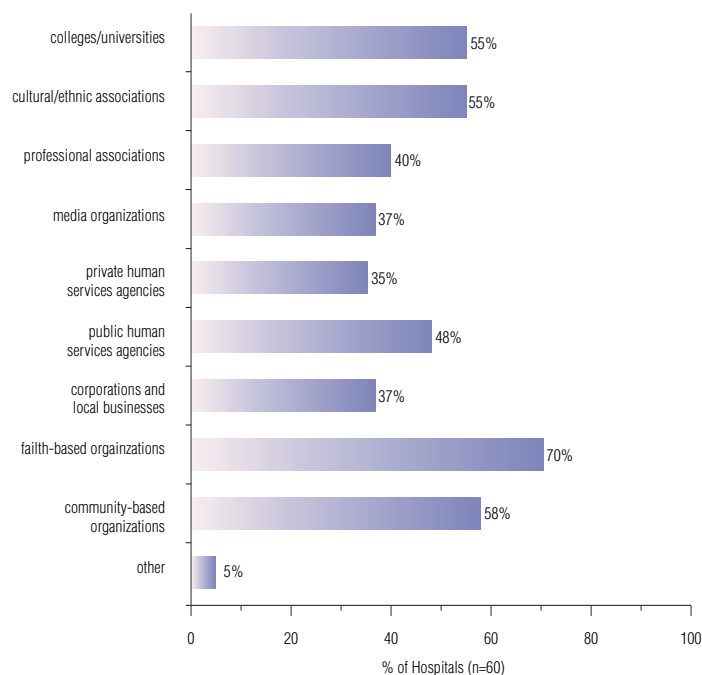


Figure 9-C. Types of Community Organizations Hospitals Engage to Address Cultural/Linguistic Issues (Aggregate)





These Pre-Visit Questionnaire data support what we learned during site visit interviews. Many hospitals told us about a variety of health fairs in which they participate with other local organizations. Some of their community education efforts are targeted at specific ethnic groups, language groups, and disease groups like diabetes and asthma, based on the communities' needs. Other sample hospitals indicated they are tapping local resources to provide interpreter services. They are also working with both public and private agencies to meet their communities' transportation needs. Additional hospital outreach activities discussed during site visits include collaborating with culturally and linguistically diverse communities on plans for emergency preparedness, plans to reduce health threats like tuberculosis, dehydration, and smoking cessation. One northeast hospital developed a smoking cessation program targeted to the Native American population that "built trust between the leadership of the tribe and the hospital" and demonstrated that both were "working for the same thing."

Recommendations and Observations Related to Domain Six: Community Engagement

6-1. Hospitals should make use of the community resources available through community networks, collaborations, and partnerships, including the involvement of community members from diverse cultures and language groups on formal boards and in hospital planning processes. Many hospitals may be using community level data to inform cultural and linguistic service development; however, the active involvement of community members can provide insight into understanding the data that are collected. Drawing upon these insights in a collaborative manner can build trust within the community and provide a sense of investment in hospital services by community members.

Table 9-B. Types of Organizations with which Hospitals Have Developed Relationships to Address Cultural and Linguistic Issues

| | Stratified n=30 | Judgment n=30 |
|-----------------------------------|----------------------------|--------------------------|
| Colleges/universities | 33% | 77% |
| Cultural/ethnic associations | 37% | 73% |
| Professional associations | 30% | 50% |
| Media organizations | 30% | 43% |
| Private human service agencies | 33% | 37% |
| Public human service agencies | 47% | 50% |
| Corporations and local businesses | 27% | 47% |
| Faith-based organizations | 63% | 77% |
| Community-based organizations | 50% | 67% |

Table 9-C. Types of Community Outreach Related to Culture/Language

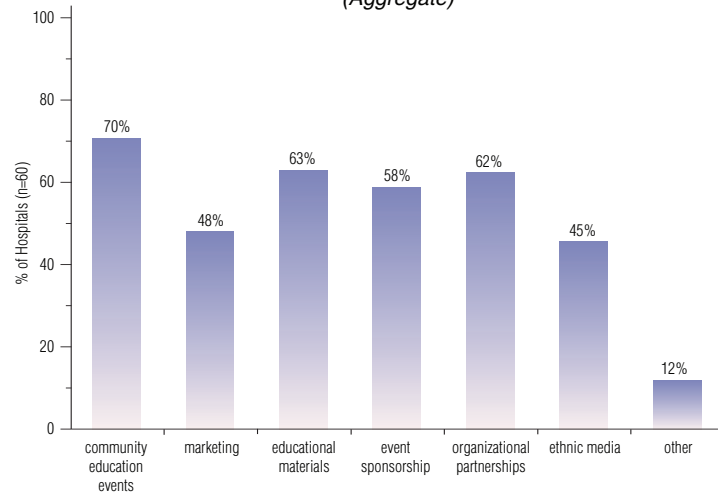
| | Stratified n=30 | Judgment n=30 |
|-----------------------------|----------------------------|--------------------------|
| Community Education Events | 57% | 83% |
| Marketing | 47% | 50% |
| Educational Materials | 47% | 80% |
| Event Sponsorship | 40% | 77% |
| Organizational Partnerships | 47% | 77% |
| Ethnic Media | 33% | 57% |



6-2. Hospitals should consider partnering with local ethnic media to promote better understanding of available hospital services and appropriate routes for accessing care among all community members.

Diverse communities often receive information from sources other than the “mainstream” media. Tapping into ethnic newspapers, television news programs, and radio stations with public service announcements about available services, particularly preventive care services, can spread important information to groups of people who otherwise may not be reached. Some interview participants indicated that their emergency rooms were sometimes crowded with individuals who could have been treated through alternate means, but who were not aware of available services.

Figure 9-D. Types of Community Outreach Related to Culture/Language
(Aggregate)



“The Alzheimer Association of [this] county is an organization that has approached us, and they want to do more within the Latino community. We’re working on a partnership to be able to offer educational seminars outside of this community for the Spanish-speaking community where Alzheimer’s is often an issue that is not addressed.”

—Cultural and Linguistic Service session participant, western region hospital



CHAPTER 10: SO WHAT DOES THIS MEAN?

A Discussion of the Findings



The findings in this report represent a snapshot of how some hospitals across the nation are providing services to diverse patients. To our knowledge, a qualitative study of this

kind has not previously been conducted. We believe that the information in this report contributes to the knowledge needed to improve health care provided to diverse populations.

Limitations

There are several limitations that should be noted when considering the findings of this report.

Sample Size

First, the small size of our sample and our sampling methods do not allow for generalization of study findings to the larger hospital universe. Our hospital sampling criteria biased the sample toward hospitals with more advanced programs for culturally and linguistically appropriate care, and those hospitals serving highly diverse communities. Although we did attempt to include hospitals located in minimally diverse counties, these hospitals comprise no more than 5% of our total sample. As a result, findings may not accurately gauge activities or services undertaken by all US hospitals to provide culturally and linguistically appropriate care. Additionally, the small sample size precluded our ability to make reliable statistical comparisons between the judgment and stratified samples.

Self-reported data

Second, the data are self-reported and subject to variation in accuracy based on respondents' level of knowledge and possible intentional deception. Although we made great efforts to divorce this study from the typical standards and accreditation work of The Joint Commission, the presence of our organization's name, reputation, and course of business may have influenced respondents to

intentionally inflate or exaggerate their hospital's culturally and linguistically appropriate activities or services. Likewise, respondents may have felt compelled to comment on matters even though their knowledge of the subject was limited or inaccurate.

Definitions of terms

While we attempted to be as clear as possible while developing the Pre-Visit Questionnaire, we did not provide a definition of terms to respondents, thus leaving our terms open for interpretation. During site visits we were better able to discern the actual provision of services through the interview process. However, for purposes of comparison between samples, we relied primarily on Pre-Visit Questionnaire data, except for language service data which was compared from both the Pre-Visit Questionnaire data and the site visit data. This was an important lesson learn and we recommend that future research aimed at understanding issues related to language and culture ensure that all terms are clearly defined. This will not only enhance the accuracy of data collected, but will facilitate comparisons between studies.

Patient perception is missing

While this report reflects the perceptions of hospitals, administrators, and clinicians, it fails to reflect the perceptions of the patients who receive services at the sample hospitals. We used our hypothetical patient, Juan Lopez, as a proxy for the patient experience at each hospital, however, that analysis is still underway and those data are not included in this report. This report provides detail of the organizational perspective on the issue, while future reports will emphasize the "experience" of Juan Lopez and highlight the perspectives of specific clinicians. Future work would benefit from inclusion of actual patient perspectives and true experiences and we encourage researchers to work to gain a better understanding of the patient experience.



Discussion

Despite the limitations, there are several observations worth noting. Since each of our samples were unique (one being a more randomized sample, while the other selected based on a prerequisite of advancement in the area of culturally and linguistically appropriate care provision), we expected each sample to behave differently (exhibit different services and perspectives on the issue of culturally and linguistically appropriate care).

We wanted to know what characterized the sample as a whole, but were also interested in any unexpected areas in which the samples behaved the same. We reviewed all reported data to determine activities that characterized approximately 75% or more of the hospitals from each sample as well as activities that characterized 25% or fewer of the hospitals from each sample. We also identified data elements that showed a 10% or less margin of difference between the samples.

We wanted to be able to make some statements about the activities that hospitals were engaged in that were not potentially the result of our sampling method. As identified below, there are several activities that the majority of hospitals (stratified and judgment) are doing to address issues related to language and culture. While not necessarily representative of all hospitals, it does provide us insight into what we might expect from the larger universe of hospitals.

Approximately 75% or more of ALL sample hospitals (n=60):

- Are collecting patient race, primary language, and religion data.
- Are collecting race data for staff.
- Have mechanisms to identify cultural needs of patients.
- Have a mechanism for linguistic needs (100% of hospitals).
- Have informed consent process that take into consideration patient linguistic needs.

- Address cultural needs through religious/spiritual services, dietary services, and psychosocial services.
- Have written patient care policies and procedures for the provision of language services.
- Have bilingual staff and telephone language services available.
- Use race and primary language data about the community to inform cultural and linguistic services.

As we can see from the data above, the majority of hospitals are engaged in several activities to address patient language and culture needs. These data don't tell us the effectiveness of these activities, but they do tell us that many hospitals are thinking about these issues and developing systems to meet diverse needs.

We also wanted to know which activities were not frequently engaged in. We found that the majority of hospitals in our sample are not using the patient demographic data that they collect to stratify quality measures and few are addressing cultural competence through the human resources policies and use of traditional healers. Below is information from our review of activities that were engaged in by 25% or fewer hospitals in each sample.

Approximately 75% or more of ALL sample hospitals (n=60) do NOT:

- Stratify quality measures by race, ethnicity, primary language, education level, and insurance status.
- Have *written* human resource policies regarding the cultural competence of staff.
- Provide ongoing training to physicians that addresses the provision of culturally and linguistically appropriate care.
- Address patients' cultural needs through the use of traditional healers.
- Identify patient safety issues related to patient culture.
- Use trained or untrained volunteer interpreters often/regularly/frequently.



The hospitals in our judgment sample were selected because they had been identified as more advanced in the provision of culturally and linguistically appropriate care. We therefore expected that our samples would respond differently to the majority of our questions. Shown below are data elements that showed a 10% or less margin of difference between the samples.

Little or no difference¹ between samples (Stratified n=30/ Judgment n=30):

- There was no difference for written human resource policies for cultural competence (23%) and little difference for linguistic competence of staff (27%/30%).
- There was little difference between samples for consideration of literacy in informed consent processes (63%/67%).
- There was little difference between samples for mechanisms to ensure information about cultural needs accompany the patient throughout the continuum of care (50%/57%).
- There was no difference between samples for written patient care policies and procedures addressing the provision of culturally appropriate services (60%).
- There was little difference in the frequency of how sample hospitals addressed the cultural needs of patients via different techniques or services with the exception of the use of cultural brokers (See Table 7-H in Chapter 7).
- There was no difference in the identification of patient safety issues related to language (43%).
- There was little difference in written patient care policies and procedures for the provision of language services (93%/87%). Surprisingly, the difference was slightly higher for the stratified sample.
- There was no difference between samples for having policies against the use of family except as last resort or emergency situation (16%).

Findings that really surprised us:

- More than twice as many (33% v. 13%) stratified hospitals collect patient education level data than judgment hospitals.
- Even though more judgment hospitals were collecting more patient demographic data than stratified hospitals, less than one quarter of them were using the data to stratify quality measures.
- Only 7% of stratified hospitals reported that they use the telephone often/regularly/frequently, while the telephone was often the only “professional” mechanism available.
- 50% of judgment hospitals reported using family members often/regularly/frequently even though more than half of them have hospital employed interpreters and other mechanisms available.
- Only 70% of judgment hospitals and only 37% of stratified hospitals provide competency assessments for bilingual staff used to interpret and hospital employed interpreters.

When we look at the practices engaged by the hospitals in this sample against practices that have been identified as desirable, such as the National Standards for Culturally and Linguistically Appropriate Services (CLAS), we realize that we still have a way to go. There may be a gap between current practice and the ideal set forth by the CLAS standards. We found that the hospitals in our study were generally further in the efforts to address language issues than they were to address culture issues. This may not be surprising since language is a more tangible issue to address.

Providing Culturally and Linguistically Appropriate Care is Challenging

Hospitals identified many challenges related to providing care to culturally and linguistically diverse patient populations. The most frequently cited challenges related to language and staffing. Hospitals often reported finding it difficult to find staff with the desired cultural or linguistic competency and some



indicated that there are challenges with having a diverse staff. Cultural issues were also commonly cited as a challenge. All but six hospitals reported financial challenges related to serving diverse populations. We could not find anything common among the hospitals that did not indicate financial challenges.

Analysis of our data revealed three main areas worthy of highlight due to their importance in patient safety: the provision of language services, the process for obtaining informed consent, and the collection and use of patient-level demographic data. These areas are discussed in detail below.

Language Services

Our findings suggest that systems for the provision of language services in hospitals across the country may still be developing. The majority of hospitals had mechanisms to identify the linguistic needs of patients and written policies on the provision of language services. However, many did not provide ongoing training for staff on accessing language services nor did they assess the competency of interpreters and bilingual staff used to interpret. Few had policies in place regarding the use of family members as interpreters, and family members were frequently used to interpret.

The National Standards for the provision of Culturally and Linguistically Appropriate Services in Health Care recommend that family members not be used to interpret during healthcare encounters.⁷⁷ As a first preference, these standards recommend direct communication by a practitioner who is fluent in the language of the patient and English.⁷⁸ However, it is unrealistic for many hospitals to be fully staffed with bilingual employees in all areas of the hospital. Most hospitals will need to rely on an interpreter at some point of contact with a non-English speaking patient. In these cases, interpreters must be assessed for their proficiency in both the target language and English. In addition to language proficiency, interpreters need to be trained

on and demonstrate an understanding of the techniques, ethics, and cross-cultural issues related to interpreting.⁷⁹

In an effort to increase the use of appropriate language services, more attention may need to be focused on promoting training programs for interpreters. It was our observation that many hospitals may not be aware of available resources for training interpreters. The National Council on Interpreting in Health Care (NCIHC) is one resource that hospitals can tap into. While NCIHC does not provide training, it has developed a code of ethics and a set of professional practice standards for health care interpreters.⁸⁰ These tools can be used to provide guidance for setting competency expectations for individuals used to interpret.

We also learned that many hospitals are providing translated patient education materials, including patient rights and informed consent documents to their patients in languages other than English. Certainly the most commonly available translation was Spanish, but we also saw documents translated into less diffuse languages such as Russian, Arabic, and Haitian Creole. When asked about the process for translating these documents, interviewees provided us with a variety of responses. Some hospitals have their documents translated in-house by members of the interpreter staff or other bilingual staff. Other hospitals indicated that they use computer translation programs. However, many interviewees who named specific computer programs identified those that do not actually translate documents, but instead offer a pool of generic patient education materials in English and Spanish. We believe that hospitals are making efforts, but likely need to develop the quality and uniformity of their systems for translation.

Informed Consent

Most hospitals indicated that they take patient linguistic needs into account during the informed consent



process. While many clinical staff interviewees indicated that they “always use an interpreter for informed consent,” many others indicated that “our informed consent form is translated into Spanish” without acknowledging the use of an interpreter to facilitate dialogue about the condition and proposed treatment with the patient.

We recognize that this situation is probably not unique to persons with limited English proficiency. Anecdotal evidence of problems with informed consent is abundant. The use of practices such as “teach back” is one way to begin to improve the informed consent process through a determination of comprehension during a specific encounter. However a more comprehensive approach to meeting the cultural and linguistic, literacy, and other confounding needs of patients is essential to the creation of a health care system that supports informed care throughout the care process.

Several stories exist that highlight the effect of inadequate informed consent. One example is that of a Muslim man who refused chemotherapy treatment for stomach cancer because he believed that the only way to receive the chemotherapy was to be attached to “a pump” which would have interfered with his ability to pray. His physician did not understand that his aversion to the chemotherapy had to do with his need to pray. This misunderstanding delayed his treatment precious months.

Collection and Use of Patient Demographic Data

Accurate, consistent, and systematic collection of data on patient race, ethnicity, and primary language is a key component of efforts to reduce health disparities. The majority hospitals in our study had inconsistent methods for collecting these data, which is consistent with other studies.⁸² Our findings reflect the need for uniform collection mechanisms. Implementation of a uniform framework for the collection of data on patient race, ethnicity, and primary language, such as

the framework proposed by Hasnain-Wynia and Baker,⁸³ can improve data collected by hospitals allowing more accurate evaluations of programs aimed at improving care to minority populations.

We cannot conclude why many of the hospitals in our sample had inconsistent methods for collecting these data. Perhaps systems were in place but not utilized; perhaps staff were not trained on methods to accurately collect data from patients; or perhaps systems and staff training were both missing. Regardless, these data are needed by hospitals to monitor quality and needed by researchers to measure effectiveness of interventions aimed at reducing disparities. In addition, the findings from these studies are needed to inform appropriate policy development.

It is worth noting that very few of our hospitals reported that they use data on race, ethnicity, and primary language to improve the quality of care. More than 4,100 hospitals currently report on measures as part of the Hospital Quality Alliance. Linking demographic data with these quality measures would allow hospitals to identify disparities in care and monitor interventions.^{84, 85}

As discussions surrounding health information technology advance, the issue of patient-level demographic data collection needs to be considered. Hospitals are increasingly reliant on electronic medical record systems. These systems can provide improved access to patient data across the continuum of care and can improve access to information needed for quality improvement activities. However, if the development of these systems fails to consider collection of patient race, ethnicity, language, and other important identifiers, we will be missing vital information necessary to help improve the quality and safety of care.



Bringing It Home: What does this Mean for The Joint Commission?

The Joint Commission embarked on this study to better understand the issues related to the provision of culturally and linguistically appropriate services in hospitals. The need for this understanding was driven, in part, by a desire to evaluate Joint Commission standards and survey processes that address culturally and linguistically appropriate services. Over the last several years, Joint Commission staff have maintained a document that crosswalks Joint Commission standards to the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Because Joint Commission standards are in many ways less stringent than the CLAS standards, the latter document has served as a tool for identifying areas in which Joint Commission standards may be improved. Although many of the observations we made during the HLC study lead us to believe that current hospital activities do not fully meet the CLAS standards, we believe many of these activities also do not consistently meet current Joint Commission standards. Examples of specific Joint Commission standards that may often fall short of full compliance in accredited hospitals include those related to informed consent, effective communication, and patient involvement in care.

So what should the Joint Commission do?

We recommend that the Joint Commission establish a written position on the provision of culturally and linguistically appropriate care. This statement should address the parameters for “effective communication” (standard RI.2.100); the use of family members to provide interpretations; the types of training and competencies expected of individuals who are used to interpret; expectations for ongoing education of staff when the hospital serves a highly diverse patient population; the essential documents that require quality controlled translation into languages other than English; and translation of this issue into The Joint Commission’s National Patient Safety Goals. Such a statement would provide the basis for further elaboration or refinement of relevant Joint Commission standards and also provide guidance for the future training of Joint Commission surveyors.



CHAPTER 11: ENDNOTES

Executive Summary

- ¹ Several Cultural Competence Self Assessment tools have been developed. One tool that may be useful was developed by Andrulis, Delbanco, Avakian, & Shaw-Taylor, titled *Conducting a Cultural Competence Self-Assessment*. Available at: <http://erc.msh.org/mainpage.cfm?file=9.1g.htm&module=provider&language=English>
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Chapter 2

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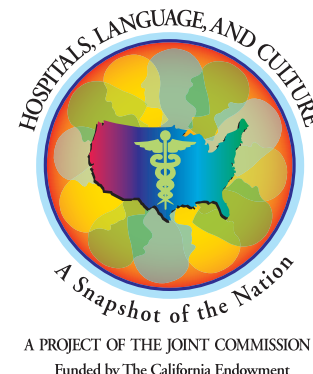
Appendix A

| Demographic Sampling Groups for Stratified Sample and Number of Counties Sampled for Each | |
|--|-----------|
| Counties w. 50 pct or > non-English speaking | 1 |
| Counties w. 15 – 50 pct non-English speaking | 2 |
| Counties w. 10 pct pt or > increase in non-English speaking | 2 |
| Counties w. 75 pct or > non-white | 2 |
| Counties w. 25 to 75 pct non-white | 2 |
| Counties w. > 75 pct white, non-Hispanic | 3 |
| Counties w. 75 pct or >Hispanic | 2 |
| Counties w. 25 to 75 pct Hispanic | 3 |
| Counties w. 20 pct or > foreign born | 2 |
| Counties in CA | 4 |
| Metro area Population 250,000 or greater | 7 |
| TOTAL COUNTIES SYSTEMATICALLY SELECTED | 30 |



Appendix B: PRE-VISIT QUESTIONNAIRE

Research has shown that limited understanding of information provided in English to non-English-speaking patients can influence the quality of health care provided, as measured by both patient satisfaction and health outcomes (Youdelman, 2002, and Weech-Maldonado et. al, 2003). Providers' limited sensitivity to the dynamic effects of culture can have a similar effect. A project funded by The California Endowment, *Hospitals, Language, and Culture: A Snapshot of the Nation* (HLC) will gather data from a sample of hospitals to discover the challenges hospitals face in addressing patients' cultural and linguistic needs, explore how hospitals address these needs, and share both conclusions and promising practices with the field.



The questionnaire takes approximately 30 minutes to complete and is divided into five sections that focus on patient care and services, management and administration, human resources, community engagement, and data collection and evaluation. Completion of the questionnaire may require contributions from staff within your organization. Potential contributors may include staff from human resources, community affairs, clinical services, administration, and quality assurance. Please follow these guidelines when completing your questionnaire:

- Provide responses to all questions in the questionnaire. If you cannot provide a response, please make a note in the comments area.
- Answer honestly based on your hospital's services and administration. This is a baseline inquiry and there is no right or wrong answer.
- Spell out any acronyms you may use.
- There is space for additional thoughts and comments for each specific question, and space for any additional comments in the area provided at the conclusion of the questionnaire.
- Review the questionnaire for completeness prior to submission.

Hospitals, Language, and Culture uses the Office of Minority Health (OMH) definition of culturally competent healthcare: **“services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations.”** OMH also states: “Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter.” In some contexts, “culture” includes gender, sexual orientation, and disability. **For the purposes of this project, “culture” refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. “Translation” refers to the conversion of written communication from one language to another, while “interpretation” refers to the conversion of spoken communication from one language into another.**

This questionnaire was developed based on input from the HLC Technical Advisory Panel, and based on research of other studies. In particular *The Cultural Competence Self-Assessment Protocol for Hospital Systems* (Andrulis et al.), *Serving Diverse Communities in Hospitals and Health Systems* (NAPH), *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (Betancourt et al.), *Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies* (OMH), and *A Diversity and Cultural Proficiency Tool for Leaders* (AHA).



PATIENT CARE AND SERVICES

Hospitals, Language, and Culture uses the Office of Minority Health (OMH) definition of culturally competent healthcare: “services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations.” For the purposes of this project, “culture” refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. “Translation” refers to the conversion of written communication from one language to another, while “interpretation” refers to the conversion of spoken communication from one language into another. Please answer the following questions honestly based on your hospital’s services and administration. Remember, this is a baseline assessment and there is no right or wrong answer.

1. Does the hospital have written patient care policies and procedures that address the provision of culturally and linguistically appropriate services in patient care?

| Cultural Services | Linguistic Services | |
|--------------------------|----------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> | No |
| <input type="checkbox"/> | <input type="checkbox"/> | No, there are no written policies and procedures, but an established process is in place |

Comments:

2. Does the hospital have mechanisms to identify cultural and linguistic needs of patients upon admission or registration?

| Cultural Needs | Linguistic Needs | |
|--------------------------|--------------------------|-----|
| <input type="checkbox"/> | <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> | No |

- a. If yes, please check all mechanisms that apply:

- ☐ information included on admission forms
- ☐ addressed in initial assessment and documented in medical record
- ☐ other _____

Comments:



Appendix B: PRE-VISIT QUESTIONNAIRE

3. Does the hospital address the cultural needs of patients?

☐ Yes

☐ No

a. If yes, please check all techniques and services that apply:

☐ dietary needs

☐ traditional healers

☐ cultural brokers

☐ patient health literacy

☐ psychosocial needs

☐ religious and spiritual beliefs

☐ folk remedies, traditions and rituals

☐ complimentary/alternative medicine

☐ other _____

Comments:

4. Does the hospital's informed consent process address:

Culture

Language

Literacy

☐

☐

☐

Yes

☐

☐

☐

No

Comments:

5. Does the hospital have mechanisms to ensure that information about cultural and linguistic needs accompany the patient throughout the continuum of care?

**Cultural
Needs**

**Linguistic
Needs**

☐

☐

Yes

☐

☐

No

a. If yes, please check all that apply:

☐ flagged in the patient record

☐ coordinated by patient advocate

☐ coordinated by specific department/unit (please specify) _____

☐ coded bracelet or other form of identification

☐ other _____

Comments:



Appendix B: PRE-VISIT QUESTIONNAIRE

6. Does the hospital have mechanism(s) for the provision of language services?

| Never | Seldom | Often | Frequently | Regularly | N/A | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | trained staff interpreter |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | trained contracted interpreter |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | trained volunteer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | untrained volunteer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | trained bi-lingual staff |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | untrained bi-lingual staff |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | patients' family members or friends |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | telephone interpreter service |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Comments:

7. Are written translated materials available to patients and their families?

☐ Yes ☐ No

a. If yes, please check all that apply:

- ☐ illness related education
- ☐ wellness related education
- ☐ community resources
- ☐ patient rights
- ☐ informed consent documents
- ☐ discharge instructions
- ☐ advance directives
- ☐ patient signage
- ☐ other _____

Comments:



MANAGEMENT AND ADMINISTRATION

Hospitals, Language, and Culture uses the Office of Minority Health (OMH) definition of culturally competent healthcare: “services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations.” For the purposes of this project, “culture” refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. “Translation” refers to the conversion of written communication from one language to another, while “interpretation” refers to the conversion of spoken communication from one language into another. Please answer the following questions honestly based on your hospital’s services and administration. Remember, this is a baseline assessment and there is no right or wrong answer.

8. Does the hospital specifically develop formal plans to meet the cultural and linguistic needs of patients?

| Cultural Needs | Linguistic Needs | |
|---------------------------|-----------------------------|-----|
| <input type="checkbox"/> | <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> | No |

a. If yes, please check the types of plans that apply:

| | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> strategic | <input type="checkbox"/> budget |
| <input type="checkbox"/> business | <input type="checkbox"/> other _____ |

Comments:

9. To what degree are your efforts to provide culturally and linguistically appropriate services driven by laws and regulations?

- ☐ very strongly
- ☐ strongly
- ☐ somewhat
- ☐ not strongly
- ☐ not at all
- ☐ not applicable

Comments:



Appendix B: PRE-VISIT QUESTIONNAIRE

10. Does the hospital allocate operating funds for cultural and linguistic services?

**Cultural
Services**

☐

**Linguistic
Services**

☐

Yes, there is a specific line item or dedicated budget devoted to these services

☐☐

Yes, but it is incorporated in another line item or budget

☐☐

No

Comments:

11. Does the hospital have an established multicultural or language services department, project, or office?

☐ Yes

☐ No

Comments:

12. Does the hospital have *executive level* staff with direct responsibility for managing cultural and linguistic competency plans and initiatives?

**Cultural
Competency**

☐

**Linguistic
Competency**

☐

Yes

☐☐

No

a. If yes, please list his/her title(s):

Comments:

13. Is the patient population's cultural and linguistic diversity part of the criteria for choosing governing board members?

**Cultural
Diversity**

☐

**Linguistic
Diversity**

☐

Yes

☐☐

No

Comments:



HUMAN RESOURCES

Hospitals, Language, and Culture uses the Office of Minority Health (OMH) definition of culturally competent healthcare: “services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations.” For the purposes of this project, “culture” refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. “Translation” refers to the conversion of written communication from one language to another, while “interpretation” refers to the conversion of spoken communication from one language into another. Please answer the following questions honestly based on your hospital’s services and administration. Remember, this is a baseline assessment and there is no right or wrong answer.

14. Does the hospital have a plan to recruit and retain a diverse administrative and clinical workforce that meets the cultural and linguistic needs of the patient population being served?

☐ Yes ☐ No

Comments:

15. Does the hospital have written human resources policies regarding cultural and linguistic competency of staff?

| Cultural Competency | Linguistic Competency |
|--------------------------------|----------------------------------|
|--------------------------------|----------------------------------|

| | | |
|--------------------------|--------------------------|-----|
| <input type="checkbox"/> | <input type="checkbox"/> | Yes |
|--------------------------|--------------------------|-----|

| | | |
|--------------------------|--------------------------|----|
| <input type="checkbox"/> | <input type="checkbox"/> | No |
|--------------------------|--------------------------|----|

| | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | No, there are no written policies and procedures, but an established process is in place |
|--------------------------|--------------------------|--|

Comments:



Appendix B: PRE-VISIT QUESTIONNAIRE

16. Which of the human resources development programs listed below address the provision of culturally and linguistically appropriate care delivery for which types of staff members and leadership:

| New Employee Orientation | Ongoing Training | Competency Assessment | |
|---|-----------------------------|----------------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | physicians |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | other clinical staff (nurses, social workers, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | non-clinical (patient advocates, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | administrative |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | facilities (food service, maintenance, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | senior management (managers, support staff, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | governing body |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | residents and students |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

a. Is participation in any of these activities mandatory?

☐ Yes ☐ No

b. Are interpreters and bi-lingual staff given special competency assessments on their ability to understand and communicate patient and medical information in languages other than English?

☐ Yes ☐ No

Comments:

17. Does the hospital collect data on the racial, ethnic and/or linguistic composition of the staff?

| YES | NO | |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | race |
| <input type="checkbox"/> | <input type="checkbox"/> | ethnicity |
| <input type="checkbox"/> | <input type="checkbox"/> | primary language |

a. If yes to any of the above choices, how are the results used? Please check all that apply.

| | |
|---|---|
| <input type="checkbox"/> recruitment | <input type="checkbox"/> cultural activities, brown bags and special events |
| <input type="checkbox"/> retention | <input type="checkbox"/> partnerships with professional organizations |
| <input type="checkbox"/> outreach materials | <input type="checkbox"/> college partnerships, recruitment, or scholarships |
| <input type="checkbox"/> program funding | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> internal affinity groups | |

Comments:



Appendix B: PRE-VISIT QUESTIONNAIRE

18. Is the hospital able to use employee feedback and ideas to develop cultural and linguistic services, policies and programs?

☐ Yes ☐ No

Comments:

COMMUNITY ENGAGEMENT

Hospitals, Language, and Culture uses the Office of Minority Health (OMH) definition of culturally competent healthcare: “services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations.” For the purposes of this project, “culture” refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. “Translation” refers to the conversion of written communication from one language to another, while “interpretation” refers to the conversion of spoken communication from one language into another. Please answer the following questions honestly based on your hospital’s services and administration. Remember, this is a baseline assessment and there is no right or wrong answer.

19. Does the hospital conduct community outreach programs related to culture and/or language?

| Culture | Language | |
|--------------------------|--------------------------|-----|
| <input type="checkbox"/> | <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> | No |

a. If yes, please check all that apply:

| | |
|--|--|
| <input type="checkbox"/> community education events | <input type="checkbox"/> marketing |
| <input type="checkbox"/> educational materials | <input type="checkbox"/> event sponsorship |
| <input type="checkbox"/> organizational partnerships | <input type="checkbox"/> ethnic media |
| <input type="checkbox"/> other _____ | |

Comments:



Appendix B: PRE-VISIT QUESTIONNAIRE

20. Has the hospital established relationships (formal or informal) with organizations in the community to address cultural and linguistic issues?

☐ Yes ☐ No

a. If yes, please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> colleges/universities | <input type="checkbox"/> cultural/ethnic associations |
| <input type="checkbox"/> professional associations | <input type="checkbox"/> media organizations |
| <input type="checkbox"/> private human services agencies | <input type="checkbox"/> public human services agencies |
| <input type="checkbox"/> corporations and local businesses | <input type="checkbox"/> faith-based organizations |
| <input type="checkbox"/> community-based organizations | <input type="checkbox"/> other _____ |

Comments:

21. Does the hospital use cultural and linguistic demographic information about the community?

YES **NO**

- | | | |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | race |
| <input type="checkbox"/> | <input type="checkbox"/> | ethnicity |
| <input type="checkbox"/> | <input type="checkbox"/> | primary language |
| <input type="checkbox"/> | <input type="checkbox"/> | education level |
| <input type="checkbox"/> | <input type="checkbox"/> | insurance status |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

a. Is this data used to inform the design and improvement of patient services and community outreach?

☐ Yes ☐ No

Comments:



DATA COLLECTION AND EVALUATION

Hospitals, Language, and Culture uses the Office of Minority Health (OMH) definition of culturally competent healthcare: “services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations.” For the purposes of this project, “culture” refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. “Translation” refers to the conversion of written communication from one language to another, while “interpretation” refers to the conversion of spoken communication from one language into another. Please answer the following questions honestly based on your hospital’s services and administration. Remember, this is a baseline assessment and there is no right or wrong answer.

22. What patient specific information does the hospital document related to culture and language?

Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> race | <input type="checkbox"/> education level |
| <input type="checkbox"/> ethnicity | <input type="checkbox"/> religion |
| <input type="checkbox"/> patient’s primary language | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> primary language of patient’s family | |

a. What is the racial and ethnic breakdown of your patient population? Please check all that apply and include percentages where available. (Office of Management and Budget classifications used.)

- | | |
|----------------------------------|--|
| <input type="checkbox"/> _____ % | White (not Hispanic/Latino) |
| <input type="checkbox"/> _____ % | Black or African America (not Hispanic/Latino) |
| <input type="checkbox"/> _____ % | American Indian or Alaska Native |
| <input type="checkbox"/> _____ % | Asian and Native Hawaiian |
| <input type="checkbox"/> _____ % | other Pacific Islander |
| <input type="checkbox"/> _____ % | Hispanic or Latino |
| <input type="checkbox"/> _____ % | Other _____ |

b. What are the primary languages of your patient population? Please check all that apply and include percentages where available.

- | | |
|----------------------------------|------------------------------|
| <input type="checkbox"/> _____ % | American Sign Language |
| <input type="checkbox"/> _____ % | Chinese (Mandarin/Cantonese) |
| <input type="checkbox"/> _____ % | English |
| <input type="checkbox"/> _____ % | French/French Creole |
| <input type="checkbox"/> _____ % | Hmong |
| <input type="checkbox"/> _____ % | Khmer (Cambodian) |
| <input type="checkbox"/> _____ % | Korean |
| <input type="checkbox"/> _____ % | Polish |
| <input type="checkbox"/> _____ % | Portuguese |



Appendix B: PRE-VISIT QUESTIONNAIRE

- ☐ _____% Russian
☐ _____% Spanish
☐ _____% Vietnamese
☐ _____% other

Comments:

23. Does the hospital:

| Collect | Analyze | Act On |
|----------------|----------------|---------------|
|----------------|----------------|---------------|

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Patient satisfaction data related to cultural, linguistic, and/or diversity issues? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Grievance and complaint data related to cultural, linguistic, and/or diversity issues? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Outcomes data related to cultural, linguistic, and/or diversity issues? |

Comments:

24. Does the hospital stratify quality improvement and outcome measures by demographic information?

Please check all that apply.

| Quality Improvement | Outcome Measures |
|--------------------------------|-----------------------------|
|--------------------------------|-----------------------------|

- | | |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> race |
| <input type="checkbox"/> | <input type="checkbox"/> ethnicity |
| <input type="checkbox"/> | <input type="checkbox"/> primary language spoken |
| <input type="checkbox"/> | <input type="checkbox"/> education level |
| <input type="checkbox"/> | <input type="checkbox"/> insurance status |
| <input type="checkbox"/> | <input type="checkbox"/> other _____ |

Comments:



Appendix B: PRE-VISIT QUESTIONNAIRE

25. Does the hospital use an electronic medical record system?

- ☐ Yes, the medical record system is entirely electronic
- ☐ Yes, but the medical record system is a hybrid of paper and electronic records
- ☐ No

Comments:

26. Has the hospital identified any patient safety issues directly related to patient cultural and linguistic needs?

| Cultural Needs | Linguistic Needs | |
|--------------------------|--------------------------|-----|
| <input type="checkbox"/> | <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> | No |

a. If yes, please describe the safety issues:

Comments:

CONCLUSION

Please share any additional thoughts or comments:

Thank you for completing the Pre-Visit Questionnaire. An HLC staff member will contact you to confirm receipt of the completed questionnaire. In the meantime, please contact Erica Galvez at (630) 792-5956 or egalvez@jcaho.org should you have questions.



Appendix C: SITE VISIT PROTOCOL

SITE VISIT PROTOCOL

(Administrative Interviews only)

Visit Purpose:

Hospitals, Language, and Culture is designed to collect information from 60 hospitals across the nation about the challenges that they are experiencing providing care and services to culturally and linguistically diverse populations and how they are addressing these challenges. Due to the identified health care disparities among racial and ethnic minorities that persist, current policies and practices may not be sufficient. The Joint Commission on Accreditation of Health Care Organizations wants to better understand the challenges that hospitals are facing related to this issue and how they are addressing these challenges so appropriate guidance in the form of promising policies and practices can be disseminated to hospitals and providers across the country.



Data will be collected during each of five separate sessions. The sessions are structured to involve staff that play particular roles in the provision of care to diverse populations.

The sessions are:

- 1.) **CEO Session (45 minutes):** This session is an individual structured interview with the organization CEO, President, or administrator. The session is led by an interviewer who will engage the CEO in a series of questions focusing on the challenges the hospital faces in providing care to diverse populations, and how the hospital strives to address these challenges. The interviewer will be accompanied by a notetaker and the session will be tape recorded, with the express permission of the CEO.
- 2.) **Leadership Session (45 minutes):** This session is a group interview with three members of the hospital's management team. Participants may include an administrative leader (other than the CEO), a clinical leader (such as nurse executive or medical staff president), and a leader with the responsibility for quality improvement and/or patient safety activities. The session is led by an interviewer who will pose a series of questions about the challenges related to providing care to a diverse population that they see the hospital face. The interviewer will be accompanied by a notetaker and the session will be tape recorded, with the express permission of the participants.
- 3.) **Cultural and Linguistic Services Session (45 minutes):** This session is a group interview with the individual who is in charge of diversity programs or language services and the person who is in charge of community relations. The session is led by an interviewer who will pose a series of questions about the challenges faced by the hospital as they try to meet the needs of diverse populations. Specifically, this session will look at the specifics of providing language services in the organization, determining and meeting community needs, and coordinating these services throughout the hospital. The interviewer will be accompanied by a notetaker and the session will be tape recorded, with the express permission of the participants.
- 4.) **Human Resources Session (30 minutes):** This session is a group interview with the director of human resources and the individual(s) responsible for staff training. The session is led by an interviewer who will pose a series of questions about the challenges related to training staff on diversity issues, culturally and linguistically appropriate care, and determining competence. The interviewer will be accompanied by a notetaker and the session will be tape recorded, with the express permission of the participants.



Informed Consent

Informed consent will be obtained from staff who agree to participate in this study. Staff will be made aware that hospitals are identified by ID number and no staff names or other identifying information will be collected. In addition, the information collected from staff will not be provided directly to hospital leadership or staff outside the session. In order to maintain this level of confidentiality any persons other than session participants, including site visit liaisons, will not be permitted to observe site visit sessions unless they are an actual participant in the session.

We have been granted a waiver of signed informed consent in order to protect staff identity, however, site visit researchers will record verbal consent from all participants at the beginning of each session.

SESSION: CEO

Interviewee: CEO

Length of Session: 45 minutes

INTERVIEW QUESTIONS for CEO SESSION:

Leadership Awareness and Commitment

1. ****How long have you been in your current position? How long with organization?**

1.) ****What has been the biggest change in your patient population mix over the last 5 years?**

(This can be anything; it does not have to be specific to Culture & Language.)

If related to Culture & Language—go to 2a ; If not related to Culture & Language—go to 2.

2.) *****(If the change is not of a cultural or linguistic nature)* has the hospital noticed any changes in the cultural or linguistic needs of the patient population?**

a. *(If there has been a change in the cultural or linguistic needs):* **what has your organization done to respond to this change?**

b. *(If there has not been a change in the cultural or linguistic needs of the patient population):* **has the hospital ever experienced this sort of change, and if so how did they respond in the past?**

3.) ****What are the major challenges you have faced providing services to non-English speaking patients? Probe on Awareness, Response, and effectiveness of response:**

a. ****Have you discovered any challenges that relate more to a patient's culture rather than their language?**

**** These are key questions that MUST be asked ****



Appendix C: SITE VISIT PROTOCOL

- 4.) I understand that executive level staff *do/do not* have direct responsibility for managing cultural and linguistic competency plans and initiatives. (PVQ 12) What is the **title** of the person with specific responsibility for culture and linguistic issues and activities? *(Please note: if CEO is not able to answer this, ask again in the leadership session) Probe on scope of person's responsibility and types of C&L issues that the person deals with, how does this information get to executive level staff.*
- 5.) I understand that your hospital's efforts to provide culturally and linguistically appropriate services are *strongly – not applicable* driven by laws and regulations. (PVQ 9) (if at all,) Which laws are those? (if not applicable,) what drives your Cultural & Linguistic services?
- a. Are there any additional incentives beyond law and regulation that drive Culturally & Linguistically appropriate services. What are these?

Governing Body and Board Activities

- 6.) I understand the *cultural and linguistic* diversity of the patient population *is/is not* part of the criteria for choosing governing board members. (PVQ 13) ****To what extent does the governing board reflect the community you serve? Your patient population** *(if different from community served) Probe: How are governing board members selected?*
- 7.) **To what extent is Culture & Language a board priority?**
- a. **Why or why not?**
- b. **Is there a particular committee of the board that has a mandated responsibility to address Cultural & Linguistic issues?**
- c. **How often are Cultural & Linguistic services, or issues, an item on a board agenda and what is addressed?**

Hospital Strategic Plan

- 8.) I understand that the hospital addresses *cultural and linguistic* needs of patients in its *strategic/budget/business* plans. (PVQ 8) Can you explain how these plans address cultural and linguistic needs? (or Where are these needs addressed?) Can you give specific examples? *Probe: Are there any other patient-level issues that are addressed in the strategic plan? What about less formal plans? What about plans for staff training or recruitment??*
- 9.) **What, if any, have been the fiscal consequences of providing Cultural & Linguistic services?** *To what extent has your provision of such services improved your hospital's market position and financial strength?*



QI and Data Collection

- 10.) I understand that the hospital *collects, analyzes, and/or acts on* QI/PI data related to culture, language, or diversity. (PVQ 23) How does the hospital use QI/PI and patient satisfaction data to plan for and improve Culture & Language activities?
- 11.) ****At present or recently, what if any specific QI/PI priorities have been aimed at this issue?**
- 12.) ****How is adverse event data collected?**
 - a. **Does this information include a mechanism for recording the patient's language needs and whether or not an interpreter was provided?**
 - b. Is incident report data reviewed and is the information shared with staff?

Successes and Needs

- 13.) ****What effort or initiative related to Culture & Language are you most proud of?**
- 14.) ****What do you think could give your Culture & Language efforts the greatest boost?**
(*probe on unmet needs*)
- 15.) **** Is there anything else you would like to add or any questions that you have for us?**
Probe: Are there any questions that you think I should have asked that I didn't?

SESSION: Leadership

Interviewees:

1. Management leader;
2. Clinical leader; and
3. Person with a quality or patient safety orientation.

Length of Session: 45 minutes

INTERVIEW QUESTIONS for LEADERSHIP SESSION:

Leadership Awareness and Commitment

- 1.) ****What has been the biggest change in your patient population mix over the last 5 years?**
(*This can be anything; it does not have to be specific to Culture & Language.*)

If related to Culture & Language—go to 2a ; If not related to Culture & Language—go to 2.



- 2.) **** (If the change is not of a cultural or linguistic nature) has the hospital noticed any changes in the cultural or linguistic needs of the patient population?**
- a. *(If there has been a change in the cultural or linguistic needs): what has your organization done to respond to this change?*
 - b. *(If there has not been a change in the cultural or linguistic needs of the patient population): has the hospital ever experienced this sort of change, and if so how did they respond in the past?*
- 3.) ****What are the major challenges you have faced providing services to non-English speaking patients? Probe on Awareness, Response, and effectiveness of response:**
- b. ****Have you discovered any challenges that relate more to a patient's culture rather than their language?**
- 4.) I understand that executive level staff *do/do not* have direct responsibility for managing cultural and linguistic competency plans and initiatives. (PVQ 12) What is the **title** of the person with specific responsibility for culture and linguistic issues and activities? *(Please note: if CEO is not able to answer this, ask again in the leadership session) Probe on scope of person's responsibility and types of C&L issues that the person deals with, how does this information get to executive level staff.*
- 5.) I understand that your hospital's efforts to provide culturally and linguistically appropriate services are *strongly – not applicable* driven by laws and regulations. (PVQ 9) (if at all,) Which laws are those? (if not applicable,) what drives your Cultural & Linguistic services?
- b. Are there any additional incentives beyond law and regulation that drive Culturally & Linguistically appropriate services. What are these?

Hospital Strategic Planning and Finance

- 6.) I understand that the hospital addresses *cultural and linguistic* needs of patients in its *strategic/budget/business* plans. (PVQ 8) Can you explain how these plans address cultural and linguistic needs? (or Where are these needs addressed?) Can you give specific examples? Probe: *Are there any other patient-level issues that are addressed in the strategic plan? What about less formal plans? What about plans for staff training or recruitment??*
- 7.) What, if any, have been the fiscal consequences of providing Cultural & Linguistic services? To what extent has your provision of such services improved your hospital's market position and financial strength?



QI and Data Collection

- 8.) I understand that the hospital *collects, analyzes, and/or acts on* QI/PI data related to culture, language, or diversity. (PVQ 23) How does the hospital use QI/PI and patient satisfaction data to plan for and improve Culture & Language activities?
- 9.) ****At present or recently, what if any specific QI/PI priorities have been aimed at this issue?**
- 10.) ****How is adverse event data collected (this would be data related to culture or language as they may relate to a sentinel event)?**
- a. Does this information include a mechanism for recording the patient's language needs and whether or not an interpreter was provided?

Communication throughout the organization

- 11.) How aware do you believe hospital employees are of the hospital's commitment to and expectations for culturally and linguistically appropriate services? How do you know what their level of awareness is?
- 12.) ****What departments have been “positive role models” in incorporating culture and language services and sensitivity into their operations?** (14a should help probe on WHY) *Have you noticed any differences in how different departments or staff respond to these issues? What practices have they adopted that you think are especially effective and might be replicated by others?*

Community Engagement

- 13.) I understand that the hospital has established relationships with organizations in the community such as: *colleges, professional associations, private human services agencies, public human services agencies, corporations and local businesses, community-based orgs, cultural and ethnic associations, media orgs, faith-based orgs, other.* (PVQ 20) ****What types of activities does the hospital engage in with these organizations?** *Probe: How does your relationship with these organizations help improve health care for patients with cultural or linguistic needs?*

Successes and Needs

- 14.) ****What effort, initiative, or program relating to Culture & Language within this organization/facility are you most proud of?**
- 15.) ****What do you think would give your Culture & Language efforts the greatest boost?** (*probe on unmet needs*)
- 16.) **** Is there anything else you would like to add or any questions that you have for us? Probe: Are there any questions that you think I should have asked that I didn't?**

**** These are key questions that MUST be asked ****



SESSION: Cultural and Linguistic Services

Interviewees:

- 1.) Head of Cultural & Linguistics Department (internal component)
- 2.) community relations person (external component – someone who works with the patient population outside the hospital and can speak to the community's image of the hospital), or patient advocate, and
- 3.) Pastoral Care (optional, but preferred)

Length of Session: 45 minutes

QUESTIONS FOR C&L SERVICES SESSION:

- 1.) (Warm-up) ****What is each respondent's title, responsibility within or related to the hospital, and tenure in that position?**

Assessing and Meeting Patient Needs

- 2.) ****How does the hospital determine the cultural and linguistic needs of each patient?**
(probe on where and when this happens over the hospital stay and whether or not the process is standard)
- 3.) ****How does the hospital determine if the needs of each patient are met?** *(Again probe on whether or not the process is standard)*
- 4.) ****What are the challenges that you see staff faced with when providing services to culturally and linguistically diverse patients?** *(Probe on cultural issues e.g. religion and spirituality, health beliefs, food preferences, etc. and probe specifically on language issues—eg communication, need for language services, etc))*

Communicating With Patients

- 5.) (Pre-visit Question #6) ****How do staff communicate with non-English speaking patients?**
If the hospital does not provide language services ask: Are there times when you feel disadvantaged by not having access to language services for non-English speaking patients?
- 6.) ****To what extent do you feel that all staff understand how to access language services?**
To what extent are all staff comfortable doing this? Committed to doing this?
- 7.) How do you assess the effectiveness of language services in improving communication between providers and limited English proficient (LEP) patients?
- 8.) (If/When) you use interpreters how is their competency assessed? *Probe: Do you provide training? What type of training? How long is the training?* Is the competency and training the same for bilingual staff who are used to interpret? How do you ensure the accuracy of the interpretation?



- 9.) I understand that the hospital uses *flags in patient records, coordination by patient advocate, coordination by specific dept/unit, coded bracelets or other forms of id* to ensure that information about a patient's *cultural or linguistic* needs accompany them throughout the hospital. (PVQ 5) *How does the hospitals system for communicating language needs work? How do you monitor its success or failure? What challenges do you face in making it work better? Under what circumstances might information about a patient's need for an interpreter or language service be communicated across departments in a different manner?*
- 10.) **** How long does it take to get language services to the patient so that they can be used to facilitate communication? Are there differences dependent upon the language needed? On other factors (e.g. time of day, department, length of encounter)?**
- a. ****To what extent do you believe the hospital's leadership supports the provision of linguistic services? Can you give an example? Is it the same for cultural services? Can you give an example?**
- b. I understand that the hospital has established relationships with organizations in the community such as: *colleges, professional associations, private human services agencies, public human services agencies, corporations and local businesses, community-based orgs, cultural and ethnic associations, media orgs, faith-based orgs, other.* (PVQ 20) ****What types of activities does the hospital engage in with these organizations? Probe: How does your relationship with these organizations help improve health care for patients with cultural or linguistic needs?**

Successes and Needs

- 11.) ****What effort, initiative, or program relating to Culture & Language within this organization/facility are you most proud of?**
- 12.) ****What do you think would give your Culture & Language efforts the greatest boost?** *(probe on unmet needs)*
- 13.) ******Is there anything else you would like to add or any questions that you have for us?** *Probe: Are there any questions that you think I should have asked that I didn't?*



SESSION: Human Resources

Interviewees:

- 1.) Human Resources Director
- 2.) member of training staff

Length of Session: 30 minutes

QUESTIONS for HUMAN RESOURCES SESSION:

- 1.) (Warm-up) **** What is each respondent's title, responsibility within or related to the hospital, and tenure in that position?**
- 2.) I understand that you *do or do not* collect information about the *racial, ethnic, linguistic* characteristics of your staff. (PVQ 17) What do you do with this information? How is it used?
 - a. *Is it aggregated and why (or why not)?*
 - b. *Is the information broken down by different staff categories, such as physicians, nurses, administration, etc.?*
- 3.) In what specific ways do your human resources policies take into account diverse cultural backgrounds of staff? (*e.g.: recognizing holidays and religious observations?*)
- 4.) ****I understand that the hospital tries/does not try to recruit and retain a diverse staff that is able to meet the cultural and linguistic needs of the patient population. (PVQ 14) How does the human resources department do this? What are some of the recruitment and retention strategies used? If no, why not? (probe on barriers to doing this) Do your staff recruitment strategies for staff differ than those for physicians?**
- 5.) ****Is effectiveness in working with diverse clients and staff an element of performance evaluations? In what way? (probe on rewards for high performance in this area)**
- 6.) I understand that the hospital *uses/does not use* employee feedback to develop cultural and linguistic services, policies and programs. (PVQ 18) What issues related to cultural and linguistic services or needs (diversity) have been identified by employees? *How is this feedback solicited and collected? What actions have been taken to respond to the feedback?*
- 7.) ****How does the hospital monitor changes in the racial/ethnic composition of the community?**

How do you get access to that information? What do you do with this information?



8.) ****How is staff trained about cultural and linguistic issues common in the patient population?**

*How comprehensive is the training you provide? What is the frequency and duration of the training?
Have you assessed whether the training is effective? What have been the results of your assessments?
How could the training you provide be improved?*

9.) **** (If/When) you use interpreters how is their competency assessed? Probe: Do you provide training? What type of training? How long is the training? Is the competency and training the same for bilingual staff who are used to interpret? How do you ensure the accuracy of the interpretation? To what extent and how do interpreters get trained on cultural issues?**

10.) **What difficulties have you faced in finding contract or temporary employees (e.g. nurses) with what you consider an adequate level of competence in cultural and linguistic diversity issues? How have you dealt with this?**

Successes and Needs

11.) ****What effort, initiative, or program relating to Culture & Language within this organization/facility are you most proud of?**

12.) ****What do you think would give your Culture & Language efforts the greatest boost?**
(probe on unmet needs)

13.) ****** Is there anything else you would like to add or any questions that you have for us?**
Probe: Are there any questions that you think I should have asked that I didn't? Are there any training resources that you have used that you would like to share with us?



Appendix D:

Cultural Competence Frameworks Used to Inform the Development of the HLC Research Framework

Betancourt, Green, Carrillo, and Ananeh-Firempongⁱ:

1. Organizational Cultural Competence—promoting minorities to positions of leadership, recruitment.
2. Systemic Cultural Competence—eliminating barriers to care, ability to monitor and improve quality of care.
3. Clinical Cultural Competence—enhancing awareness, providing methods to elicit, negotiate, and manage the information.

National Public Health and Hospital Instituteⁱⁱ

Six Domains:

1. Executive Leadership
2. Culturally and Linguistically Competent Care
3. Organizational Infrastructure
4. Staff development and training
5. Language/Interpreter Services
6. Community Relations and Outreach

Andrulis, Delbanco, Avakian, and Shaw-Taylorⁱⁱⁱ

1. Ethnic/Cultural Characteristics of staff/organization
 - Board, staff, patient, community profiles
 - Healthcare organizational recognition of diversity needs

2. Healthcare organization approaches to accommodate diversity needs and attributes
 - Diversity training
 - Human resource programs
3. Healthcare organization links to community served as well as patient and staff diversity initiatives
 - Healthcare organizational links to community
 - Organizational adaptation to diversity
 - Database systems and data development
 - Language and communication needs of patients and staff
 - Business strategies attracting patients from diverse cultures

The Lewin Group^{iv}

Domains*:

1. Organizational Values
2. Governance
3. Planning and monitoring/evaluation
4. Communication
5. Staff Development
6. Organizational Infrastructure
7. Services/interventions

*Indicators for each domain include indicators of structure, process, and output.

ⁱBetancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep.* 2003 July-Aug;118(4):293-302.

ⁱⁱMartinez EL, Cummings L, Davison LA, et al. *Serving Diverse Communities in Hospitals and Health Systems: From the Experience of Public Hospitals and Health Systems.* Washington, DC: The National Public Health and Hospital Institute; 2004.

ⁱⁱⁱAndrulis DP, Delbanco T, Avakian L, Shaw-Taylor Y. *The Cultural Competence Self-Assessment Protocol.* Washington, DC: The National Public Health and Hospital Institute; 1999.

^{iv}The Lewin Group, Inc. *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile.* The Health Resources and Services Administration. US Department of Health and Human Services; 2002.



Appendix E: RESEARCH FRAMEWORK DOMAINS AND FOCUS AREAS

DOMAIN ONE: LEADERSHIP

Focus Area: Leadership Awareness

1. The hospital's leadership is aware of the extent and nature of cultural and linguistic diversity in the patient population that they serve and trends in diversity in the surrounding community.
2. The hospital's leadership is aware that the extent, nature, and trends in cultural and linguistic diversity have an impact on the care and services that are provided at their hospital.
3. The hospital's leadership is aware that regulatory requirements (such as Title VI), mandates and national standards (such as CLAS and JCAHO) exist and are applicable to their hospital.
4. The hospital's leadership is aware that C&L services (*activities*) are essential to the delivery of quality healthcare.

Focus Area: Leadership Commitment and Motivation

5. C&L services are part of the management agenda.
6. The organization has a designated individual with leadership responsibility for C&L activities.
7. The leadership has a mechanism to communicate its C&L related activities and initiatives, policies, procedures, and other information and resources to providers and staff throughout the organization.
8. The hospital's leadership interacts with the surrounding communities in order to understand and meet the health needs of the communities.

Focus Area: Governance

9. The makeup of the governing body is reflective of the patient population served.
10. C&L services is part of the governing body agenda.
11. The governing body sees oversight of C&L services as its responsibility.

Focus Area: Strategic Planning and Finance

12. The hospital's strategic plan addresses Cultural and Linguistic services (*activities*).
13. The hospital's leadership utilizes (*QI/PI, patient satisfaction, community demographic*) data to inform the development of strategic initiatives to address C&L issues.
14. The hospital designates funds to support C&L services. (*Such as language programs, Community outreach, diversity training, recruitment, etc*)

DOMAIN TWO: QUALITY IMPROVEMENT AND DATA USE

Focus Area: Patient-Level Data Collection

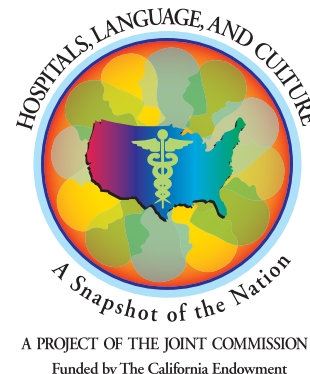
1. The hospital collects patient-level cultural and linguistic demographic data (such as race, ethnicity, primary language of patient and family, socioeconomic, literacy, and education level data)
2. The hospital has a mechanism to assure the accuracy of the patient-level data.

Focus Area: Community-level Data Collection

3. The hospital collects community-level demographic data (such as racial, ethnic, socioeconomic, educational, and linguistic data.)

Focus Area: QI Initiatives Addressing Cultural and Linguistic Services

4. The hospital has specific QI initiatives aimed at improving care to culturally and linguistically diverse patient populations and their families.





Focus Area: Analysis of Data to Improve Care to Diverse Populations

5. The hospital analyzes patient-level demographic data to understand the population served.
6. The hospital stratifies QI measures by race, ethnicity, and primary language.
7. Data from QI studies is used to identify health care differences in race, ethnicity, gender, language, and other demographic variables.
8. Data from QI studies is used to plan for and improve care provided to C&L diverse populations.
9. The hospital compares patient-level demographic data to community-level demographic data in order to discern variations in utilization.

Focus Area: Information Systems Support QI and Data collection

10. The hospital's database systems can link patient demographic information (such as race, ethnicity, language) with other data (such as patient satisfaction and outcomes).

DOMAIN THREE: WORKFORCE

Focus Area: Recruitment

1. The hospital has and implements strategies for recruitment of diverse staff members.

Focus Area: Retention

2. The hospital has and implements strategies for retention of diverse staff members.
3. The hospital has employee incentives, rewards, and sanctions related to cultural and linguistic competence in the workplace.

Focus Area: Development and Training

4. Hospital orientation includes training on diversity issues and culturally and linguistically appropriate provision of care.

5. The hospital provides ongoing training on diversity issues and culturally and linguistically appropriate provision of care.
6. Clinical and medical staff are trained on how to access and utilize language services.
7. Interpreters and other staff are trained to understand and respond to ethnic and cultural traditions (e.g. death and dying rituals, involvement of the family, dietary preferences, etc.).
8. In hospitals that are affiliated with health professional teaching programs (such as medical schools, nursing schools, and schools of public health), there is an effort to interact with the teaching program to share information about providing services to meet the diverse cultural and linguistic needs of patients.

Focus Area: Competence and Skills

9. Staff (including medical staff and leadership) is evaluated on an ongoing basis for their ability to provide culturally and linguistically appropriate care.
10. The hospital has identified the training skill set necessary for medical interpretation.
11. The hospital has a system for ensuring the quality of language services through competence of interpreters and translators and bilingual staff used as interpreters and translators.

Focus Area: Workforce Demographics

12. The racial, ethnic, and linguistic composition of the hospital administration, administrative, ancillary and clinical staff, and medical staff is identified.
13. The hospital uses data to conduct ongoing assessments of workforce needs as they relate to the community and population changes.

Focus Area: Employee Perception

14. Employee surveys or focus groups measure employee perception of hospital policy and practice related to diversity.



DOMAIN FOUR: PATIENT SAFETY AND PROVISION OF CARE

Focus Area: Assessment

1. The hospital has a mechanism at each point of access to identify cultural and linguistic needs of patients and their families.

Focus Area: Informed Consent

2. The process for informed consent, including informed consent documents and patient education materials, take into consideration patient culture, language, and literacy.
3. The hospital employs a mechanism to facilitate informed consent among culturally and linguistically diverse patients.

Focus Area: Continuum of Care

4. The hospital has a mechanism to ensure effective patient navigation through the various points of contact within the hospital. (For example, signage, patient navigators, trained security and information desk personnel)
5. The hospital has a mechanism to communicate patient care C&L needs at different points of contact within the hospital.
6. Appropriate language services are accessible and used across the continuum of care.
7. Discharge planning practices take into consideration issues such as language, health literacy, access, child care, family support, cultural beliefs, and practices.
8. The hospital has a strategy that it implements to accommodate diverse cultural health beliefs and practices.

Focus Area: Patient Education

9. Patient education is provided in a manner that is not rushed and accommodates learning styles, cultural beliefs and practices, language needs, and family involvement.

10. Patient and family education materials are tested for readability for patients of various reading levels and languages.
11. Patient and family education materials are available in the languages most frequently spoken by patients and families.

Focus Area: Understanding Health Beliefs, Needs, and Values

12. The following are considered when providing patient care:
 - Pastoral services, spiritual beliefs, and the impact on treatment
 - Folk remedies, traditions, and rituals practiced by the patient
 - Complimentary and alternative medicine
 - Patient socioeconomic status
 - Patient health literacy
 - Psychosocial needs
 - Epidemiologic implications for treatment
13. Hospital staff views the provision of culturally and linguistically appropriate services as a part of patient safety.

DOMAIN FIVE: LANGUAGE SERVICES

Focus Area: Structure of Service Provision

1. The hospital designates a portion of its budget for language services and obtaining essential translated documents.
2. The hospital has a designated department or division to provide language services.
3. The hospital has written policies and procedures for the provision of language services.
4. The hospital has technology in place to support language services.

Focus Area: Language Services Utilized

5. The hospital has systems in place to provide interpreter services.



6. The hospital has systems in place to have essential documents translated.
7. The hospital has systems in place for signage in the appropriate languages.
7. The hospital has a system in place for providing patients notification about their right to interpreter (LANGUAGE) services.

Focus Area: Evaluation of Language Service Provision

8. The hospital evaluates its language service provision to ensure appropriateness.
9. The hospital evaluates its language services provision to ensure timeliness.
10. The hospital evaluates its language services provision to ensure that services are available throughout the hospital at all points of contact.
11. The hospital evaluates the effectiveness of and patient satisfaction with language services.
12. Interpreters are assessed regularly for competence.
13. Translated materials are edited or reviewed for accuracy and literacy level prior to dissemination.

DOMAIN SIX: COMMUNITY ENGAGEMENT

Focus Area: Assessment

1. The hospital conducts periodic assessments of community and patient needs, including language, literacy, and culture.
2. Assessments include a component that specifically measures the need for culturally and linguistically appropriate services.
3. The hospital monitors the demographics of the community to track changes in gender, racial, ethnic, and linguistic diversity.
4. Demographic data is used for strategic and outreach planning.

Focus Area: Outreach Activities

5. The hospital has a community relations team that includes at least one community representative and is reflective of the diversity of the patient population. The hospital undertakes special marketing initiatives to expand services to the diverse populations in the community.
 - Advertising
 - Recruitment drives
 - Meetings with ethnic/cultural business groups
 - Meetings with ethnic/cultural neighborhood groups and community organizations
 - Other
6. The hospital has developed special services to address specific needs/desires of the ethnic/cultural/linguistic communities.