



One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations

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Participating Hospitals

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EXECUTIVE SUMMARY



Racial and ethnic health disparities are linked to poorer health outcomes and lower quality care. Language and cultural issues can have a significant impact on these disparities when not addressed by health care organizations [1]. As the diversity of our nation continues to grow, hospitals are encountering more patients with language and cultural barriers [2]. The multiplicity of languages, dialects, and cultures can be overwhelming to hospitals and their staff. The *Hospitals, Language, and Culture* (HLC) study set out to better understand how the challenges associated with cultural and language (C&L) barriers are being addressed at 60 hospitals across the country.¹

The goal of this report is to build upon *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings (HLC Report of Findings)* [3] to provide a framework for hospitals to develop and employ practices for meeting diverse patient needs. There is no “one size fits all” solution, and the road map to organizational cultural competence is unique for each hospital. While this report does not provide all of the answers for meeting the needs of diverse patient populations, it can help organizations overcome some of the challenges they face when providing safe, quality health care in an increasingly complex system. Chapter 8: Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool contains a tool that hospitals and other health care organizations can use to promote discussion around their current practices and guide efforts to address the C&L needs of the populations they serve.

Methodology

Purposive sampling was used to select the 60 hospitals in this study. Data were collected during one-day site visits at each hospital. Each site visit consisted of a series of semi-structured interviews with CEOs, administrative and clinical leaders, human resources staff, and C&L services staff such as chaplains, interpreters, and community outreach managers. “Promising” practices were identified as those practices that appeared to be effective

for improving cultural competence within hospitals and/or directly meeting the C&L needs of diverse patient populations as reported by interview participants. These practices were reviewed by the HLC Technical Advisory Panel. The practices were then reviewed to identify common themes. Together, the four themes that emerged constitute a framework that provides a systemic method for hospitals to think about how they provide health care that is culturally and linguistically appropriate.

A Framework for Establishing Practices to Meet the Needs of Diverse Populations

The thematic framework presented is derived from *current practices* that hospitals are employing to provide care and services to their diverse patient populations. As the themes are based on practices that HLC study hospitals are already carrying out, organizations may find, as they read this report, that they are already implementing some of these same practices. Additionally, as hospitals likely face many of the same challenges and constraints in meeting the needs of diverse populations, there may be some practices within each theme that organizations can establish without allocating substantial resources. However, each individual practice is not meant to be a stand-alone solution. A range of practices spanning all four themes must be adopted in a systemic manner that is aligned with patient needs and organizational resources. While the practices identified in this report were implemented in hospitals, many of them may be relevant to other health organizations.

Theme 1: Building a Foundation Establishing a foundation of policies and procedures that systemically support cultural competence is a crucial component of meeting the needs of diverse patient populations. The role of leadership is inherent to these types of activities — leadership support is required to recognize, prioritize, and often drive efforts that establish policies and procedures to improve care and to better meet patient needs.

¹ For more information on the *Hospitals, Language, and Culture* study, including the *HLC Report of Findings*, please visit www.jointcommission.org/PatientSafety/HLC.



EXECUTIVE SUMMARY

Integrating C&L considerations into organizational policy and procedure requires a demonstration of commitment. Without an organizational commitment to cultural competence and subsequent action at the policy and procedure level, these initiatives can often be overshadowed by other organizational priorities. In order to resolve challenges such as lack of funding and resources for C&L services, it is important for organizations to clarify their commitment to providing culturally competent care by creating a supportive infrastructure of policies and procedures that help staff put these ideals into action.

Theme 2: Collecting and Using Data to Improve Services The collection and use of community- and patient-level data is essential to developing and improving services in health care, including services developed to meet the needs of diverse patient populations. Instituting practices to systematically collect data allows the effectiveness and utilization of C&L services to be monitored, measured, and evaluated. This can be useful for planning so that services can be designed to meet the specific needs of the organization.

While many hospitals across the United States already collect community- and patient-level data, few hospitals have developed systems for using them to guide service development and improvement. A thorough understanding of the need for C&L services, dependable information regarding the use of those services, and the usefulness of those data to improve C&L services can all contribute to a hospital's ability to identify and monitor health disparities and provide safe, quality health care to culturally and linguistically diverse patients. The data collected may also be used to inform short- and long-term organizational planning, help develop C&L-specific services and programs, and identify limitations in staffing and resources that collaborative partnerships may alleviate.

Theme 3: Accommodating the Needs of Specific Populations Accommodating the needs of specific populations includes practices aimed at providing safe, quality

care and decreasing health disparities for particular populations in the service community. Accommodations targeted to the needs of specific populations evolve as hospitals search for solutions to the challenges of providing care to their diverse patients.

To ensure organizations meet changing staff and patient needs, the development of services and activities tailored for specific populations should be a continuous process. While the practices outlined in this chapter show positive steps toward the delivery of culturally and linguistically appropriate care, they also indicate the complicated reality of the long road ahead. Although knowledge, field experience, and technology have improved the delivery of C&L services, hospitals need to consider the balance between convenience, cost, patient safety, and quality.

Theme 4: Establishing Internal and External Collaborations Collaborative practices encompass those that bring together multiple departments, organizations, providers, and individuals to achieve objectives related to culturally and linguistically appropriate care. Within each hospital, different stakeholders should be brought together to develop, implement, evaluate, and improve initiatives aimed at meeting the needs of diverse patients. External collaborations can help hospitals engage their community and share information and resources.

Collaboration, whether internal or external, may provide new avenues for hospitals currently undertaking cultural competence initiatives. There is no doubt that collaboration needs to play a role in all the practices outlined in this report. Building active relationships with cultural brokers, traditional healers, chaplains, religious leaders, and other individuals may enhance and extend the hospital's existing C&L services. While collaborative efforts come with their own challenges, building partnerships that bring together the champions of culturally and linguistically appropriate care has the potential to move the entire field forward.



Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool

The self-assessment tool can be used to engage members of the organization in discussions about the needs, resources, and goals for providing the highest quality care to every patient served. The tool is intended to address the main issues that emerged from the HLC study, and the questions are designed to promote discussion around an organization's need to improve or expand current C&L services.

The authors hope that this report will be a useful guide for hospitals and other health care organizations to develop and improve practices that address the needs of diverse patients. The framework presented in this report can help organizations assess their current practices and take action to provide high quality care to the populations they serve in order to achieve optimal patient outcomes.



CHAPTER 1: *Introduction*

Racial and ethnic health disparities reflect poorer health outcomes and lower quality care. Language and cultural issues can have a significant impact on these disparities when not addressed by health care organizations [1]. As the diversity of our nation continues to grow, hospitals are encountering more patients with cultural and language (C&L) barriers [2]. The multiplicity of languages, dialects, and cultures can be overwhelming to hospitals and their staff. The *Hospitals, Language, and Culture* (HLC) study set out to better understand how the challenges associated with C&L barriers are addressed at 60 hospitals across the country. The findings demonstrate that there is much work to be done to address C&L barriers, particularly in the areas of language access services, informed consent and related patient education processes, and the collection and use of patient demographic data [3].

The health care environment of today presents many challenges — for health care organizations, individual practitioners, patients, and families. Health care organizations are challenged to meet legal, regulatory, and accreditation standards, improve health care outcomes and safety among their patients, and respect bottom lines. Individual practitioners are challenged by time and financial restrictions as well as the impact these restrictions have on their ability to provide the best care to all patients. Lastly, patients and their families face challenges navigating the complex health care system, asking the right questions, and providing the right information so they can participate in their health care [4, 5].

The goal of this report is to build upon *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings (HLC Report of Findings)* to provide a framework for developing and employing practices for meeting the needs of diverse patients. This report will outline a framework of four themes that reflect concepts the authors believe contribute to culturally and linguistically appropriate care. This framework is further discussed in Chapter 3: A Framework for Establishing Practices to Meet the Needs of Diverse Populations. The meaning of each theme is then explored in greater depth in chapters 4 through 7. Themes are exemplified by practices that illustrate how hospitals are currently putting

these ideas into action. However, each individual practice is not meant to be a stand-alone solution. A range of practices spanning all four themes must be adopted in a systemic manner that is aligned with the needs of patients and the resources of the organization.

Why Is It Important to Meet the Needs of Diverse Patients?

It is well recognized that communication is essential to quality care and patient safety. Direct communication can be inhibited by primary language barriers, hearing or vision impairment, literacy, culture, cognitive limitation, intubation, or disease. Individuals whose care is inhibited due to a communication barrier or a lack of sensitivity to a cultural belief may be at risk for poor outcomes [6, 7]. Data reported to The Joint Commission demonstrate that communication is the most common underlying root cause of sentinel events [8]. In addition, a study conducted by Woolf et al. (2004) determined that miscommunication plays an important role in medicine [9].

The financial benefit of providing C&L services is difficult to measure. Previous studies have attempted to quantify financial benefit, but none have demonstrated an undeniable return on investment [10-12]. However, if we understand and accept that effective communication is inextricably linked to language, culture, and health literacy, then it becomes clear that addressing these issues plays a significant role in improving quality and safety, resulting in a positive cost-benefit ratio [13].

A Framework for Establishing Practices to Meet the Needs of Diverse Populations

In order to decrease health disparities, hospitals need to take action to understand the needs of their patient populations and employ practices that help address those needs. This report presents a framework for organizations to use when considering the practices they utilize to meet the diverse needs of their patients. Four themes emerged from practices in the HLC data. First, we recognize the importance of **building a foundation** (chapter 4) of organizational policies and procedures that can support

CHAPTER 1: *Introduction*



practices to reduce disparities in care. The second theme, **collecting and using data to improve services** (chapter 5) recognizes the importance of using data to identify needs, evaluate services, and improve care provided to diverse patients. The third theme, **accommodating the needs of specific populations** (chapter 6), states that organizations will need to target efforts to meet diverse C&L needs. The fourth theme involves **establishing internal and external collaborations** (chapter 7) to identify needs, share resources, and work together to meet the needs of populations served. These four themes serve as the structural backdrop for this report and for the tool in Chapter 8: Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self Assessment Tool.

Support for Practices in this Report

The HLC study did not conduct evidence-based studies for the practices identified in this report, but many of the practices reflect recommendations, guidelines, and performance measures from other reports and the current literature. As applicable, practices are mapped to a series of consensus-based performance expectations that support effective communication from the Ethical Force Program found in the American Medical Association's report *Improving Communication — Improving Care: How Health Care Organizations Can Ensure Effective, Patient-Centered Communication with People from Diverse Populations* [14]. In addition, practices are mapped to the federal Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care [15], recommendations from the *HLC Report of Findings* [3], and The Joint Commission's public policy white paper "What Did the Doctor Say?:" *Improving Health Literacy to Protect Patient Safety* [16]. These supporting references are included throughout the report.

How to Use this Report

While this report does not provide all of the answers for meeting the needs of diverse patient populations, it can help organizations overcome some of the challenges they face when providing safe, quality health care in an increasingly complex system. The authors hope this report will inspire ideas for addressing diverse needs and encourage

organizations to work together to evaluate new and existing practices as a means of continued improvement.

One of the goals of the HLC study has been to provide the field with information that is useful and relevant to improve care for diverse patient populations. This report accomplishes this task not only through sharing current ideas and practices from hospitals that participated in the HLC study, but by creating a self-assessment tool that hospitals and other health care organizations can use to help them develop, implement, evaluate, and improve their systems for addressing the care they provide to meet the needs of diverse patients. The self-assessment tool is presented in chapter 8, along with suggested uses for the tool within organizations.

Terminology

The following two terms are used frequently throughout this report. Additional terms are defined in the glossary (appendix B).

cultural competence: the ability of health care providers and organizations to understand and respond effectively to the cultural and language 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 [17].

culturally and linguistically appropriate services: health care services that are respectful of and responsive to cultural and language needs [15].



CHAPTER 2: *Methodology*

The framework described in this report is based on information collected during interviews with individuals working in a variety of hospitals across the country. Hospital sampling and data collection methods are discussed in detail in *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings (HLC Report of Findings)*; therefore these two methodological components are revisited only briefly below [3].

The HLC study was approved by The Joint Commission contracted institutional review board, Independent Review Consulting, Inc., and the institutional review boards of several participating hospitals.

Hospital Sample

Sixty hospitals from 32 states participated in the HLC study. Half of the participating hospitals ($n = 30$) were selected using 1990 and 2000 United States Census and American Hospital Association data. Counties that satisfied specific size, language, nativity, and racial and ethnic population criteria were randomly selected; hospitals within selected counties were then recruited for study participation. The other 30 hospitals were hand-selected by the project team to ensure that hospitals making a concerted effort to address the cultural and language (C&L) needs of their patients were included in the study. These hospitals were either self-nominated or nominated by a member of the project team or Technical Advisory Panel (TAP) who had first-hand knowledge of their efforts.

Data Collection

A one-day site visit was conducted at each participating hospital between September 2005 and March 2006 by HLC project staff and members of a trained research team. Two individuals conducted each site visit (a trained interviewer and a trained note-taker), one of whom was always a project staff member. Each site visit consisted of a series of semistructured interviews with hospital administrative staff and a separate series of interviews with floor staff that have direct patient contact on a regular basis. This report reflects only the information gathered during hospital administrative interviews.

Administrative interviews consisted of a single-person interview with each hospital CEO, and leadership, human resources, and C&L services group interviews, consisting of three hospital staff members from each area. Participants were engaged in dialogues about the challenges their hospitals face when providing care to culturally and linguistically diverse patients, how they are able to overcome those challenges, and what they perceive to be the strengths and weaknesses of their current systems for providing culturally and linguistically appropriate care.

Data Analysis

The study began with the following research question: *Are there promising practices that are helpful to and can be replicated by other hospitals?* Two researchers independently identified and coded promising practices in administrative interview transcripts that appeared to be effective for improving cultural competence within organizations and/or directly meeting the C&L needs of diverse patient populations as reported by interview participants. Qualitative research software NVIVO 2.0 (QSR International, Victoria, Australia) was used to code and store transcripts. Because the HLC study was not able to measure or validate the effectiveness of practices discussed during interviews, the researchers developed an independent set of criteria to assess each coded practice. Coded practices had to meet at least one of the following criteria to remain a promising practice:

1. The practice is reported to benefit the quality or safety of patient care as evidenced by at least one of the following:
 - Improved patient satisfaction
 - Reduction in medical errors/risks
 - Improved staff competence
 - Improved access to language services
 - Facilitation of the continuity of care
2. The practice is reported to respond to a challenge or need in an innovative manner.
3. The practice is reported to improve the hospital's market position or financial status while benefiting the quality or safety of patient care.



The same two researchers jointly reviewed each practice to determine whether it sufficiently met one or more criterion; 163 practices were identified through this process.

Technical Advisory Panel Survey Members of the project's TAP² completed a survey to classify each of the 163 practices as promising or not promising based on the criteria used by HLC staff, in addition to their own professional expertise. Twenty-four surveys were disseminated; 15 completed surveys were returned. Practices that were identified as promising by at least 60% of respondents who answered each question were considered eligible for this report. After applying this criterion, 118 practices (72% of the original pool) were identified.

Development of themes Based on the large number of promising practices identified by the TAP survey, study personnel determined that a detailed discussion of these practices was not possible and thus the original research question was no longer appropriate. Therefore, the research question was modified to: *What common themes exist among the practices identified as promising?* The 118 promising practices were subsequently assessed for common themes and patterns; four major themes emerged from this analysis.

Major Themes from the Framework for Establishing Practices to Meet the Needs of Diverse Populations:

1. Building a foundation
2. Collecting and using data to improve services
3. Accommodating the needs of specific populations
4. Establishing internal and external collaborations

Together, these themes constitute a framework that provides both an overarching context for each practice, and a systemic method for hospitals to think about how they provide health care that is culturally and linguistically appropriate. The four themes are discussed in detail in chapters 4 through 7. Due to space constraints and a desire to emphasize the thematic framework of this report rather than practices alone, a subset of the 118 promising practices is presented. Only salient practices that project staff members believe can be replicated in most hospitals regardless of size, resources, and patient population are discussed.

Challenges and Limitations

Due to the abundance of practices initially identified as promising, the length of the TAP survey deterred some TAP members from participating. Survey length may have also affected TAP members' ability to thoroughly review practices listed toward the end of the document. As a result, practices near the end of the survey may have had a smaller likelihood of being identified as promising by TAP members due to their placement in the survey rather than their comparative merit.

Additionally, none of the practices described in this report were measured, tested, or validated by HLC project staff. Inclusion of a practice in this report does not imply, nor is it intended to imply, that there is inferential, empirical evidence of its effectiveness.

² The TAP consists of professionals from the health care field with expertise in language and culture. A list of TAP members can be found on page 5.



CHAPTER 3: *A Framework for Establishing Practices to Meet the Needs of Diverse Populations*

Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings (HLC Report of Findings) presented a research framework consisting of six domains: leadership, quality improvement and data use, workforce, provision of care and patient safety, language services, and community engagement. The research framework was based upon *recommendations and existing frameworks from the literature* for providing culturally and linguistically appropriate care and was used to develop the research protocol and interview questions for the HLC study.

The current report presents a framework for establishing practices to meet the needs of diverse populations. As this framework is based upon data collected from the HLC study, it is inherently related to the research framework. While it addresses many of the same issues as the research framework, the framework presented here provides a new perspective.

This thematic framework was derived from the *current practices* that hospitals are employing to provide care and services to diverse patient populations.³ In comparison to existing frameworks in the literature — which are often developed to reach the ideals of culturally and linguistically appropriate care — the framework in this report is based upon practices that hospitals are currently implementing. As each of the following themes is based upon current practices, organizations may find that they are already implementing some of the practices discussed within these themes. Additionally, as hospitals likely face many of the same challenges and constraints in meeting the needs of diverse populations, there may be some practices within each theme that organizations can establish without allocating substantial resources. To help engage members of health care organizations in discussions about the needs, resources, and goals for providing safe, quality care, chapter 8 presents a series of self-assessment questions organized by the same four themes.

³ The methods for developing the HLC research framework are outlined in chapter 3 of the *HLC Report of Findings*; the process for developing the thematic framework presented in this report can be found in Chapter 2: Methodology.

Building a Foundation

Organizational policies and procedures can provide a supportive base for meeting the needs of diverse populations. Establishing a foundation of policies and procedures that systemically support efforts to meet the diverse needs of patients can help elevate the priority of these issues within the organization, drive additional efforts, and draw support from staff. The role of leadership is inherent to these types of activities — leadership support is required to recognize, prioritize, and often drive efforts that establish policies and procedures for improving care to better meet patient needs.

Hospitals are developing supportive infrastructures for cultural competence by incorporating cultural and language (C&L) considerations into mission, vision, and value statements; organizational planning; and hospital-wide policies. These high-level initiatives are supported by assigning responsibility for C&L initiatives and infusing cultural competence into organizational systems such as recruitment processes and budget systems. C&L considerations are included in patient care through processes for tracking patient needs, providing staff with the tools to address these needs appropriately, developing processes for incorporating interpreters into the continuum of care, and developing systems for providing written materials in understandable formats. Integration of C&L issues into organizational policy and procedure requires a demonstration of commitment. Without an organizational commitment to cultural competence and subsequent action at the policy and procedural level, these initiatives can often be overshadowed by other organizational priorities.

Collecting and Using Data to Improve Services

The collection and use of community- and patient-level data is essential to developing and improving services in health care, including services developed to meet the needs of diverse patient populations. Hospitals are collecting and reviewing data to assess community and patient needs, monitor the use of C&L services, identify areas for expansion or improvement of services, and identify any disparities in patient care. Instituting practices to systematically collect data allows the effectiveness and utilization of C&L

CHAPTER 3: *A Framework for Establishing Practices to Meet the Needs of Diverse Populations*



services to be monitored, measured, and evaluated. This can be useful for planning so that services can be designed to meet the specific needs of the organization.

It is important to collect and review demographic data to assess both community and patient needs before determining which C&L services are most appropriate to implement. Additionally, it is critical to track how often these services are used to better evaluate an organization's current C&L services. Some of the services that may be monitored include language services, religious and spiritual care services, and special dietary requests that are cultural in nature. To support C&L services, data collected before, during, and after provision can be used to identify areas for service improvement or expansion. While many hospitals across the United States already collect such data, few hospitals have developed systems for using their demographic data to guide service development and improvement. Analyzing data from different sources and stratifying data by various factors can help organizations strengthen their C&L services and address disparities in care for diverse patients.

Accommodating the Needs of Specific Populations

Culturally competent initiatives targeted to specific populations can help reduce disparities in service provision and care. Hospitals are developing practices to meet the language, cultural, and health literacy challenges of specific populations within their service community. As part of these initiatives, hospitals are integrating the concept of culturally competent care into staff training and education. Hospitals are providing staff with training that encompasses a range of activities from self-study educational materials to interactive group learning sessions. To create an environment that is inclusive of all patients, hospitals have modified or altered various aspects of their physical space, programs, and services. Other ways hospitals are better serving diverse populations are by offering services that allow patients to more easily navigate the health care system and educating patients to empower them to advocate for their own care.

Some centralized programs have also emerged as a means of addressing the specific needs of populations that may consist of a significant percentage of patients. These types of programs have been created largely in response to diverse cultural and religious needs. Accommodations targeted to the needs of specific populations evolve as hospitals search for solutions to the challenges of providing care to their diverse patient populations. To ensure that organizations continue to meet staff and patient needs, the development of services and activities tailored for specific populations should be a continuous process.

Establishing Internal and External Collaborations

Developing partnerships within hospitals and with external organizations can provide a means for undertaking practices within the other themes. Hospitals are bringing together diverse stakeholders, collaborating with other organizations to share information and resources, and pooling existing resources with other organizations to implement C&L initiatives by creating new materials and services. Within each hospital, different stakeholders should be brought together to develop, implement, evaluate, and improve initiatives aimed at meeting the needs of diverse patients.

External collaborations with other hospitals or health care organizations can help hospitals better address challenges such as limited resources and high costs for developing new materials and programs. Hospitals are also making use of community resources to help recruit and train a more diverse workforce, bridge cultural or religious barriers, and raise patient awareness of hospital services and available public programs related to the continuum of care. Resources and programs that may benefit from collaboration include staff training in cultural competence, language services, signage and written materials available in multiple languages, and resources for patients who speak languages not commonly encountered by the hospital.



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Practices that help hospitals build a foundation for meeting the needs of diverse patients include any practices within an organization which are codified and set as official processes, or which are a part of an organization's general practices, operations, and/or culture. The role of leadership is inherent to these types of activities — leadership support is required to recognize, prioritize, and often drive efforts that establish policies and procedures that improve care to better meet the needs of diverse populations. Establishing a foundation of policies and procedures that systemically support efforts to meet the diverse needs of patients can help elevate the priority of these issues within the organization, drive additional efforts, and draw support from staff.

Developing a Supportive Infrastructure for Cultural Competence

A commitment to culturally competent care can be reflected at the highest level by incorporating these ideals into an organization's guiding principles, organizational planning, and hospital-wide policies. These types of high-level activities can help hospitals develop a cohesive message about meeting the needs of diverse populations and better communicate this vision to staff, patients, and the public.⁴ As exemplified by hospitals in the study sample, a number of different opportunities exist for incorporating cultural competence into system-wide practice.

It Starts with a Mission As a hospital's policies, procedures, and overall practice are often driven by its mission, vision, or values, organizations may want to incorporate a commitment to cultural competence in these guiding principles, especially in the mission statement. Review of the mission statements of the 60 study hospitals revealed

⁴ Literature in the field has supported the development of an organizational infrastructure to serve as the foundation for and reinforce initiatives that help better meet the needs of diverse patient populations. As the CLAS standards mention, "Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services" (CLAS Standard 8). In addition to having this infrastructure in place, as the *HLC Report of Findings* recommends, "Hospital CEOs and other hospital leaders should make their commitment to culturally and linguistically appropriate care highly visible to hospital staff and patients" (Recommendation 1-2). Similarly, *Improving Communication — Improving Care* advises that "the workforce [be] knowledgeable about leadership commitment" (Content Area 1, Performance Expectation 6.1).

Make the Mission Actionable

Interviews with hospital staff revealed that it is vital to operationalize guiding principles into actions or processes throughout the organization. Members of the TAP supported this sentiment with such comments as "This could be promising if there were real initiatives to address this," and "In theory, this should drive all leadership behavior." Hospital staff concurred with these ideas, with a CEO from a northeastern hospital stating, "It's one thing to put it in a mission and vision statement and plaster it on the wall and to say we serve all people in the community regardless of ethnicity or race; it's another thing to actually do it." While it is an important step forward for hospitals to express their commitments to cultural competence in their organization's guiding principles, the mere statement is empty without turning these words into supporting actions, procedures, services, and resources.

The distinction between making a statement and turning that statement into action was quite evident in interviews with hospital staff. For example, one CEO from a southern hospital mentioned the importance of their mission statement to the provision of cultural and language (C&L) services, noting, "We call it our community benefit strategy. In the early '90s we created a new mission — provide health and medical services to meet [the needs] of the community we serve. It is based on a strategy of improving health status. . . . The board pushed the hospital to really live the mission/vision." Although this particular hospital's mission statement does not include language referring directly to cultural competence, they have operationalized their mission of "meet[ing] the needs of the community [they] serve" into actions that include the implementation of C&L services. As this hospital exemplifies, statements of commitment to meeting the needs of diverse populations in an organization's guiding principles must go hand in hand with operationalizing those commitments into supporting hospital practices.

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that only one hospital, located in the west, directly referenced the term *cultural competence*. Although other hospitals did not directly mention cultural competence in their mission statements, many had vision or value statements that referred to “vulnerable populations,” “underserved populations,” “diverse populations,” or “diverse needs.” Hospitals seem to be using a variety of terms to refer to their commitment to meeting the needs of diverse populations. While it can be argued that a verbal commitment to serving the needs of “vulnerable” or “diverse” populations is not equivalent to providing “culturally competent care,” it is important to recognize that hospitals are making strides by including cultural competence issues at high administrative levels and mentioning them in their organization’s mission, vision, or values statements.

Making Cultural Competence a Part of Organizational Planning Hospitals can integrate cultural competence into their organizational planning. As hospitals in the HLC study demonstrated, one way to integrate these needs into organizational planning is to use the Office of Minority Health’s National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care as a blueprint to guide equitable care [15].⁵ One TAP member shared from personal experience, “This practice has yielded good results for us program-wide. [We have] used CLAS as a vehicle to achieve a national diversity agenda and organizational mission.” While the CLAS standards are neither exhaustive nor prescriptive in how organizations should provide culturally and linguistically appropriate care, they present a starting point or a general framework, outlining distinct areas in which hospitals should have systems or processes in place to address patient needs.

Hospitals can use other standards and frameworks from the literature to guide organizational planning. Other resources include The Joint Commission’s standards,⁶ the

HLC research framework from *Exploring Cultural and Linguistic Services in the Nation’s Hospitals: A Report of Findings (HLC Report of Findings)* [3], and performance expectations from AMA’s Ethical Force report *Improving Communication — Improving Care: How Health Care Organizations Can Ensure Effective, Patient-centered Communication with People from Diverse Populations* [14].

Developing Policies for Cultural Competence Policies offer an additional vehicle to clearly communicate the organization’s commitment to cultural competence and equitable care to staff.⁷ The study findings suggest that many staff are not aware of ways to meet the needs of diverse patients and are sometimes not aware that it is part of their responsibility. Organizational policies articulate to staff the “dos” and “don’ts,” but are limited in their ability to provide guidance beyond that. Despite these limitations, policies can help ensure that staff recognize the importance of culturally and linguistically appropriate care to the organization and to patient care as well as their role in upholding those ideals.

“We don’t say [using CLAS standards to guide planning is] the be-all, end-all. What we are saying, however, is that consistent with the system’s goal to provide an equitable experience, [CLAS] is a blueprint that helps us know what to target, what to focus on. We wouldn’t know [otherwise]. We [would] know by what people tell us about their experiences, but we wouldn’t have a more formalized approach for doing it if we hadn’t found the standards.”

—CEO from a
northeastern hospital

⁵ Integrating cultural competence into organizational planning is an important step toward meeting the needs of diverse patient populations. *Improving Communication — Improving Care*, for example, advises that “the organization’s written strategic and operational plans address identifying and appropriately meeting the communication needs of communication-vulnerable populations” (Content Area 1, Performance Expectation 1.0).

⁶ The Joint Commission’s standards have been mapped to the CLAS Standards in a document available at www.jointcommission.org/PatientSafety/HLC/.

⁷ The role of organizational policies that support cultural competence has been recognized in the literature. *Improving Communication — Improving Care* suggests that “the organization has policies that address the communication needs of communication-vulnerable populations and that place these needs in the context of other organizational needs and priorities” (Content Area 1, Performance Expectation 4.0).

Several HLC study hospitals mentioned that organizational policies reinforce cultural sensitivity in the provision of care. In some cases, this included punitive measures that would be taken if violations occurred, such as removal of staff or mandatory facilitation of a peer discussion group on cultural sensitivity.⁸ While policies may provide a definitive means of addressing the needs of diverse patients, they are not a substitute for education or a means for monitoring compliance. Staff awareness and cultural competence should be built upon a shared desire to understand and meet the needs of patients, rather than a means of avoiding punishment.

In addition to general staff behavior, organizational policies can lend support for hospital procedures such as the use of professional health care interpreters. Several of the hospitals in the study mentioned that their organizations refrain from the use of family, minors, or other untrained individuals as interpreters, although staff interviews revealed that many of them face challenges when handling situations in which patients bring a family member or friend and prefer this individual over the hospital-provided interpreter. Hospital policies may play a significant role in addressing such challenges by communicating to staff a clear, universal procedure for navigating this type of situation. Any organizational policies should be accompanied by staff training (see Chapter 6: Accommodating the Needs of Specific Populations).

Integrating Culture and Language into Organizational Systems

Incorporating the ideals of cultural competence into planning processes, guiding principles, and policies is a strong starting point for cultural competence; the infusion of these principles into organizational systems is the next logical step. For the purposes of this report, organizational systems encompass processes that are at a higher level in the organization than the direct delivery of patient care.

⁸ Having specific actions tied to the violation of policies on respect or cultural sensitivity is supported by *Improving Communication — Improving Care*, which recommends that “the organization has a protocol for identifying and responding to members of its workforce who communicate with individuals in ways that lack respect, compassion or socio-cultural sensitivity” (Content Area 5a, Performance Expectation 4.0).

What is a Professional Health Care Interpreter?

The “interpreters” referred to within this report are considered professional, trained, and evaluated interpreters, not simply bilingual individuals. The National Council on Interpreting in Health Care defines a professional health care interpreter as “an individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to a code of professional ethics” [18]. Interpreters can be on-site interpreters; interpreting services could also be provided via telephone or video.

Recruiting and Sustaining a Diverse Workforce

Hospitals can prioritize diversity within recruitment and hiring processes in order to incorporate cultural competence considerations at the workforce level.⁹ Some hospitals reported efforts to increase the ethnic and/or language concordance between their staff and patient population. As a human resources staff member from a midwestern hospital stated, “We advertise in local neighborhood papers for certain positions, and participate in job fairs. There is one [job fair] focused on Latinos. Nurse recruitment is a big issue everywhere — bilingual nurses get the red carpet treatment.”

Once hospitals recruit a diversified staff, they must also consider how they will maintain their workforce,¹⁰ which presents its own set of challenges. A midwestern hospital transformed its obstetrics workforce from a branch consisting entirely of male doctors to a bilingual department with more female than male physicians over the course of seven years. This practice subsequently increased their patient population. As the CEO of the hospital noted,

⁹ Practices that help organizations diversify staff through their recruitment and hiring processes is addressed by CLAS Standard 2: “Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.”

¹⁰ To help formalize processes around maintaining a diversified staff, *Improving Communication — Improving Care* suggests that the organization have “a written plan that includes goals and policies for maintaining a workforce that meets the needs of the populations it serves — especially its communication-vulnerable populations” (Content Area 4, Performance Expectations 1.0).



“The environment is different from most other hospitals. There is a hospitality focus. [This hospital’s staff] needs to deal with patients [and] their cultural demands; therefore, people choose this hospital for its approach to [obstetrics].”

Recruiting a diversified workforce does not come without challenges. A lack of resources for undertaking these types of recruitment efforts was cited by hospitals as one of the major challenges they face. The competitive environment of recruitment can pose additional challenges for sustaining a diverse workforce. As the aforementioned CEO said, “Other hospitals are stealing the staff [we have] trained.”

Some hospitals are resolving the issue of sustaining a diverse workforce by providing financial incentives. A member of leadership from a western hospital noted, “We have put waivers on some positions so that only people who are bilingual can be hired for that position. We also pay our staff to interpret. It [provides] incentives [for] staff to work on these skills so that they can get additional pay.” It is important to keep in mind that any staff used to interpret should be trained and assessed in both the target language and English. Hospitals can provide incentives for staff members who are currently or who become professional interpreters. Some hospitals mentioned that they are not sure how to start recruiting more diverse staff. As hospitals try to address these challenges, some have targeted ethnic media outlets to aid their recruitment efforts. Collaboration with other entities such as community organizations or academic institutions may provide additional resources and opportunities (see Chapter 7: Establishing Internal and External Collaborations).

Creating a High-Level Task Force Hospitals felt it was important to establish a high-level task force to drive initiatives and take responsibility for diversity-related issues within the organization.¹¹ While having any organizational committee or entity driving its diversity initiatives is valuable, the committee’s recognition by hospital leadership is key to its influence in effecting change within the hospital.

The practice suggested here is to have a task force that operates at a *high level*, which means taking responsibility for and driving initiatives around cultural competence. As C&L service staff from a midwestern hospital said, “When we started a small committee, we only had a core group of dedicated people. Then, [from] 1995 to 1996, [the hospital] decided to revise the delivery of care with managed care [and] realized that profitability was related to providing C&L service. The committee became more of a strategic team. . . . No hospital can do an adequate job unless it formulates a high-quality task force group. A committee just can’t do it, but once we were at the system-wide task force level, we were able to get ‘clout.’” As this example shows, creating a task force that has the power to influence planning and organizational-level change is a substantial undertaking that requires the active participation of a number of stakeholders from throughout the organization, including leadership. Involving high-level managers and organizational decision makers may help move initiatives forward. While the hospital in this example is part of a system, the high-level task force can be implemented in independent organizations. The important piece of this practice is assembling a group that will lead and take responsibility for meeting the needs of diverse patients. This may help streamline activities and drive outcomes. Ideally, this high-level task force would consist of a multidisciplinary group of members with diverse backgrounds (see Chapter 7: Establishing Internal and External Collaborations).

Structuring Supportive Budget Systems for Culturally and Linguistically Appropriate Care Another crucial element needed to support cultural competence within an organization is the establishment of internal budget systems that support culturally and linguistically appropriate care.¹² This is especially important given that the majority of HLC study hospitals — ninety percent — mentioned a lack of funding as a challenge for C&L services. When asked what would give C&L services the greatest boost, respondents overwhelmingly stated “more money” or “reimbursement for interpreter services.” Some of these financial challenges can be overcome through

¹¹ *Improving Communication — Improving Care* states, “At least one individual or committee has as one of its charges a focus on addressing the specific needs of communication-vulnerable populations” (Content Area 1, Performance Expectation 5.1).

¹² Budget systems that promote the use of language services is supported by the *HLC Report of Findings*: “Financial incentives should be created to promote, develop, and maintain accessibility to qualified health care interpreters” (Recommendation 1-4).

external funding sources, including reimbursement through Medicaid and State Children’s Health Insurance Program (SCHIP) programs, joint collaborations, and grant funding.¹³

While these sources may address funding issues overall, it is equally important to examine the internal budget systems, which may inadvertently create barriers. While there is no ideal universal budget system for the provision of language services, hospitals are finding different ways to remove such financial barriers. One midwestern hospital has centralized its budget for interpreter services so that the use of interpreter services is no longer budgeted and charged to individual departments. Although this was a relatively new practice at this hospital at the time of the study, its results were promising. A C&L service staff member remarked, “[It is] amazing how [the centralization] has changed the resistance to using interpreters.” As budget systems may create a considerable disincentive to utilizing C&L services, hospitals should consider how these fundamental systems may impact the services they provide. Staff should not be inhibited to use C&L services to meet patient needs. Even if budgets for these services are not centralized, monitoring patient needs and utilization of C&L services (see Chapter 5: Collecting and Using Data to Improve Services) may help organizations evaluate the effectiveness of their current systems or processes.

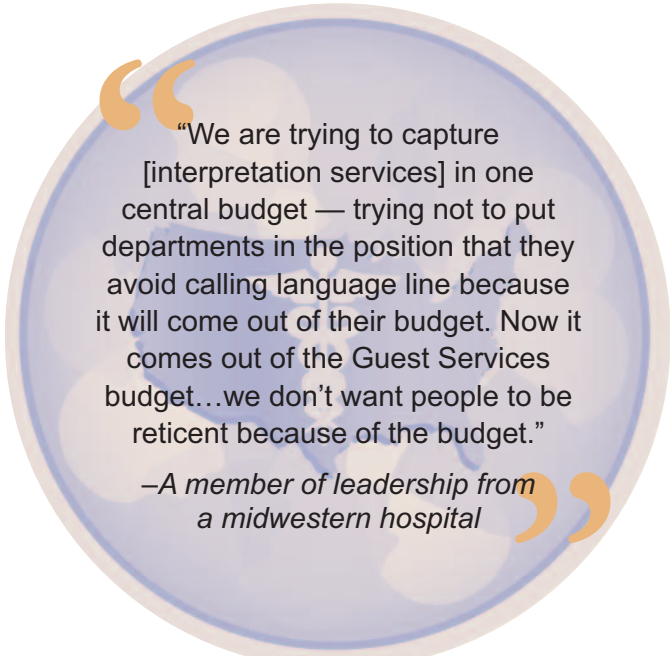
Integrating Cultural Competence into Patient Care

Changes in patient care are necessary to complement cultural competence at the organizational planning and systems levels. These practices include any processes that hospitals use to identify patients’ diverse needs, to match these needs to appropriate services, and to effectively communicate with patients throughout the provision of care.

Tracking Patient Needs One important component of caring for diverse populations is providing staff with the necessary tools to easily collect information on patient needs.

This information may include the patient’s age, gender, race/ethnicity, primary spoken and/or written language, religion, sexual orientation, disabilities, cultural needs, dietary needs, and health literacy level. The data can serve multiple purposes and will help inform staff of the patient’s communication needs throughout the health care encounter. Additionally, on the aggregate level, these measures may serve as one way for hospitals to track demand for language services, such as interpreters or other language access services (see Chapter 5: Collecting and Using Data to Improve Services). Hospitals utilized a wide range of tracking systems, such as the use of stickers or other flagging devices in the chart indicating the need for language services; direct documentation in the patient record; a patient summary face sheet including categories for language barriers, physical constraints, etc.; and color-coded armbands that identify the different languages spoken by a patient.

While a wide variety of tracking systems exist, the need for consistency in using these systems is paramount. One member of C&L services from a midwestern hospital noted that although their electronic record system includes a field for recording a patient’s C&L needs, a challenge they continually face is that the field is not mandatory. Despite the fact that this hospital has made notable efforts to establish a process for identifying patient needs, it is unclear how effective these systems will be without consistent documentation. Additionally, although the initial



“We are trying to capture [interpretation services] in one central budget — trying not to put departments in the position that they avoid calling language line because it will come out of their budget. Now it comes out of the Guest Services budget...we don’t want people to be reticent because of the budget.”

—A member of leadership from a midwestern hospital

¹³ To provide health care organizations with more information on reimbursement models, the Access Project and the National Health Law Program (NHLP) released the *Language Services Action Kit*, available at www.accessproject.org/adobe/language_services_action_kit.pdf.

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identification of patient needs is important, organizations should keep in mind that all of a patient's C&L needs may not have been captured in that first assessment. Patient needs should subsequently be documented over time as they are identified in order to provide both effective hand-off and patient-provider communication.

Determining Appropriate Language Services As with systems for tracking patient needs, hospitals developed a variety of tools, including decision trees and charts to help guide staff through the decision process of selecting appropriate language services and present information for accessing those services.¹⁴ These tools give hospitals an additional opportunity to communicate to staff any related policies or procedures regarding C&L-specific services. By clearly communicating these procedures and giving decision-making tools to staff, hospitals can increase the likelihood that staff will access the appropriate services more consistently.

These tools are meant to complement and reinforce — not replace — other communication, education, and training activities. For example, one of the challenges mentioned by hospital leadership is that staff may not be using the telephone interpreter service as much as they should. While staff may not be aware of this service or the appropriate situations in which hospital procedure dictates its use, hospitals should not overlook other factors that may contribute to the problem. In this case, the low rate of telephone service use may be linked to the staff's perception or ease of use of the telephone service, cost issues, environmental barriers, or low-quality equipment. In order to address such challenges, hospitals should communicate directly with staff and provide tools that streamline procedures. One approach in this example would be to collect data on the utilization of telephone services and in-person interpreters as well as the costs associated with those services (see Chapter 5: Collecting and Using Data to Improve Services). These data can then be coupled with feedback from staff to reconcile any C&L-specific service issues.

14 Providing staff with information on accessing appropriate services is addressed by *Improving Communication — Improving Care*, “The workforce knows, or has access to information outlining, the primary contact person or office for interpretation services, workforce development, communication training and other relevant communication issues” (Content Area 1, Performance Expectation 6.2).

Incorporating Interpreters into Patient Care As many of the hospitals shared, interpreters can facilitate patient-provider communication throughout the continuum of care.¹⁵ For example, in addition to providing services during the patient-provider encounter, hospitals utilized interpreters throughout a patient's visit, from the admission process to explaining their rights and through the duration of laboratory tests.

Interpreters can be used to facilitate pre-visit scheduling and logistics. One northeastern hospital, for example, developed a partnership between their Interpreter Department and doctors' offices within the area. To streamline this process, interpreters would schedule and attend visits with the patient as well as call before outpatient visits to ensure that patients knew where to go. Utilizing interpreters to help with scheduling and logistics in this way can help alleviate navigational burdens and potentially reduce the number of no-shows for office visits.

Translating Written Materials While the practices discussed so far have primarily revolved around oral communication and the use of interpreter services, C&L considerations are applicable to all points of communication with patients, including any printed materials.¹⁶ Examples of printed patient materials that hospitals may need to provide in multiple languages or in plain language include informed consent forms, educational materials, written instructions, navigational signage, and medication information. HLC study hospitals developed systems for providing medication information and prescription labels in a patient's primary language. Hospitals may also consider using symbols to bridge barriers presented by health literacy. A western hospital, for example, used symbols on medication labels to communicate instructions for taking medications to patients. Hospitals should keep in mind

15 Joint Commission standards require that organizations provide “interpretation (including translation) services as necessary.” In addition, as recommended in the *HLC Report of Findings*, “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” (Recommendation 4-2).

16 Joint Commission standards require that “written information provided is appropriate to the age, understanding, and, as appropriate to the population served, the language of the patient.”

that any written materials that are translated should be evaluated in order to ensure that the intended information is accurately conveyed.

Hospitals are making strides in providing written materials in multiple languages. Despite these successes, hospitals continue to struggle to provide materials in languages they encounter less frequently. As resources are often limited, this may be another area in which collaboration with other organizations may provide supplemental resources (see Chapter 7: Establishing Internal and External Collaborations). To help hospitals with these types of initiatives, available resources include the Agency for Healthcare Research and Quality's (AHRQ) report, *Is Our Pharmacy Meeting Patients' Needs?*, which guides hospitals through conducting a health literacy assessment of their pharmacy and patient needs [19].

Which Written Materials Need to be Translated?

Written information is difficult to classify as “vital” or “nonvital,” and some documents may include both vital and nonvital information. However, examples of vital and nonvital written materials include:

Vital:

- Consent and complaint forms
- Information about free language assistance programs or services
- Notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services
- Intake forms that may have important consequences

Nonvital:

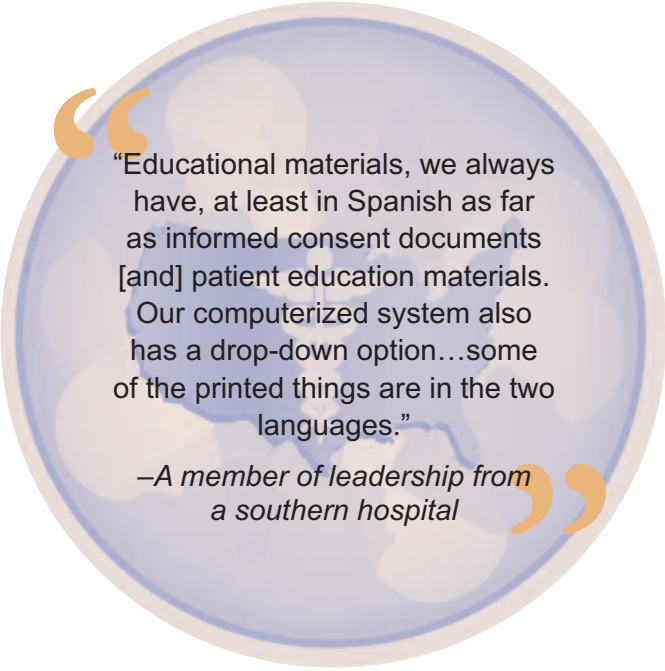
- Menus
- Third-party documents, forms, or pamphlets distributed as a public service
- Large documents such as enrollment handbooks (although vital information contained within these documents may need to be translated)

Source: Office for Civil Rights [20]

Conclusions

Building an infrastructure by developing hospital policies and procedures that support cultural competence is a crucial component of meeting the needs of diverse patient populations. Integrating C&L considerations into organizational policy and procedure requires a demonstration of commitment. Without an organizational commitment to cultural competence and subsequent action at the policy and procedure level, these initiatives can often be overshadowed by other organizational priorities. One of the most prominent challenges identified by HLC study hospitals is the constant competition between C&L services and other hospital priorities, which often results in a lack of financial and other resources for C&L services. Another common challenge is a lack of clarity in organizational communication to staff regarding the importance of cultural competence and identifying who, ultimately, is responsible for providing culturally competent care.

In order to resolve these challenges, it is important for organizations to clarify their commitment to providing culturally competent care by creating a supportive infrastructure of policies and procedures that help staff put these ideals into action. The self-assessment questions provided in chapter 8 can help hospitals and other health care organizations further explore the types of policies



“Educational materials, we always have, at least in Spanish as far as informed consent documents [and] patient education materials. Our computerized system also has a drop-down option...some of the printed things are in the two languages.”


—A member of leadership from a southern hospital

CHAPTER 4: *Building a Foundation*



and/or procedures that will support their organizations in better meeting the needs of diverse patient populations. Other resources, such as the California Health Care Safety Net Institute's *Straight Talk: Model Hospital Policies and Procedures on Language Access* and the Georgetown National Center for Cultural Competence's *Cultural and Linguistic Competence Policy Assessment*, can provide additional guidance as hospitals work to build their supportive foundation of policies and procedures [21, 22].

While these types of policies and procedures are important, they are only one of the building blocks and should be accompanied or supported by data collection and evaluation (chapter 5), accommodations to patient needs (chapter 6), and internal and external collaborations (chapter 7). For example, data collection on patient needs and community demographics is crucial to developing strategic initiatives, determining staff recruitment targets/staff-patient concordance goals, and developing patient-centered visits and communications. Data are needed for continually evaluating or monitoring of the effectiveness of these policies and procedures once they are in place. Remember that while policies and procedures that support cultural competence are vital to meeting the needs of diverse population, they make up only one component of the framework.



“I think the biggest challenge is making certain that staff and employees [practice] cultural sensitivity. This is a people business and as much as the CEO might issue an edict. . . . [cultural sensitivity] does not happen unless you invest in your employees.”

—CEO from a western hospital”



CHAPTER 5: *Collecting and Using Data to Improve Services*

The collection and use of data is essential to improving health care services, including those services developed to meet the needs of diverse patient populations.¹⁷ Instituting practices to systematically collect data allows the effectiveness and utilization of cultural and language (C&L) services to be monitored, measured, and evaluated. These practices can be useful for planning and designing services to provide safe, quality care and decrease health disparities.

Assessing the Need for C&L Services

As there is no “one size fits all” plan for providing culturally competent care, each organization must assess its needs and resources and plan accordingly. Before determining which C&L services are most appropriate to implement, it is important to collect and review data to assess community and patient needs.

Collecting Community-Level Data Demographic information about the service area population is essential to an organization’s ability to fully appreciate and accommodate the needs of its community.¹⁸ Data collected at the community level provide insight into populations that actively use hospital services as well as groups that may need targeted outreach to increase access and interaction with the organization. Demographic data may include a variety of

Examples of Demographic Data to Collect

- Age
- Cultural needs*
- Dietary needs*
- Disability*
- Gender
- Health literacy level*
- Primary spoken and/or written language
- Race/ethnicity
- Religion
- Sexual orientation*
- Socioeconomic status

* denotes demographic variables that may be collected on the patient- and patient population-levels only

characteristics such as age, gender, race/ethnicity, primary spoken and/or written language, religion, health literacy, and socioeconomic status.

Identifying different populations within the community allows an organization to respond to changing demographics, changing health needs, and the changing market. Among the many benefits of understanding the service community, several hospitals reported an increase in market share as a result of their efforts to reach out to the community and respond to the community’s health needs.

“Collection of data is critical. Data shows you who your population[s] [are] and what languages these populations speak. Further [scrutiny] of the data allows the facility to see what services they are most apt to seek. It allows the facility to develop staff training based on their cultures as well as medical risks and tendencies. Data allows [human resources] to conduct an annual comparison of employee mix to community and patient load. If the patient data does not proportionately match the community data, then the facility must ask if there is a reason why that population is not accessing services. What is missing from the services or are their needs even addressed?”

—HLC TAP member

17 Support for the systematic collection and analysis of data and its use in quality improvement can be found throughout the current literature. The *HLC Report of Findings* recommends that hospitals “implement a uniform framework for the collection of data on race, ethnicity, and language” and that “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” (Recommendations 2-1 and 2-6). Several national standards also require the collection of community- and patient-level data, including CLAS Standard 11, “health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area,” and Joint Commission standards require that medical records contain “the patient’s language and communication needs.”

18 As mentioned in *Improving Communication — Improving Care*, organizations should collect “population-level information about its communication-vulnerable populations and their communication needs” (Content Area 2, Performance Expectation 4.0). In addition, it is recommended that “the organization works with community and advocacy groups that service its community to collect information about new and emerging racial, ethnic and language populations” (Content Area 2, Performance Expectation 4.1).



Some hospitals collected community-level data by performing a community health needs assessment. Community health needs can be assessed through various methods, including conducting public forums, surveys, or focus groups with members and leaders in the community [23]. In addition, data are available regarding racial and ethnic disparities in health care that hospitals can use to better understand the community they serve. Data on age, gender, race/ethnicity, primary spoken and/or written language, religion, socioeconomic status, and other demographic characteristics can be accessed from several sources, such as state, county, and municipal departments of health; national census figures; and United States Department of Education statistics. One hospital convened a steering committee to review demographic data from the community to determine community health needs and plan for appropriate services.

Collecting Patient-Level Data Collecting data on age, gender, race/ethnicity, primary spoken and/or written language, religion and other demographic characteristics during patient encounters can help organizations monitor which populations currently seek C&L services and what services should be provided in the future.¹⁹ In order to make sure that the appropriate data are collected, organizations may ask patients open-ended questions such as, *Is there anything else about you, your cultural background, or your family that we should know that might help us provide the best quality care for you?* Questions such as these allow unique patient-level information to be captured and addressed.

It is important, of course, to ensure that the data are accurate and systematically collected. As discussed in Chapter 4: Building a Foundation, several hospitals have implemented policies to identify and track a patient's language needs throughout the continuum of care, though few are

able to confidently state that this information is collected consistently. Race and ethnicity data are often more difficult to collect. The current classification of the Office of Management and Budget (OMB) does not identify categorization of ethnicity beyond “Latino/Hispanic” or “non-Latino/Hispanic” [24]. This is insufficient when organizations serve large populations that do not identify themselves among the existing OMB classifications. In addition, collecting this information can prove to be sensitive both to patients and to the staff who are asked to collect it.

Notes on Collecting Race and Ethnicity Data

The Health Research and Educational Trust Disparities Toolkit (www.hretdisparities.org) is a free, valuable resource that provides recommendations and guidelines to facilitate the process of collecting race and ethnicity data [25]. Included in the toolkit are training guidelines and scripts for staff to use when collecting these data from patients.

“We have been doing research on the internet not only on census data but education data [as well] . . . The [steering] committee will look at that and say, ‘Here’s what our services looked like this year for our patients; these are the major languages we interpreted, here are some of the difficulties we had, here’s what our community demographics look like—does it match up?’ . . . We are going to do this on an annual basis by looking at internal and external data to see how we are doing and [whether] our services are structured correctly.”

—C&L services staff from a northeastern hospital”

¹⁹ *Improving Communication — Improving Care* states that “when possible, information on an individual’s race and ethnicity is collected directly from the individual,” and that an “organization ensures that information on how individuals need to communicate is collected, including primary language” (Content Area 2, Performance Expectations 2.1, 3.0, and 3.1). CLAS Standard 10 requires health care organizations to “ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated.”



CHAPTER 5: *Collecting and Using Data to Improve Services*

A northeastern hospital collected and used data on race, ethnicity, and primary language to strengthen patient-centered care and staff recruitment processes, and to compare clinical outcomes. As C&L services staff said, “[We’re] making the commitment as an organization to collect race- and ethnicity-related data. Along with that comes the country of birth and primary language. It’s opened up a lot of opportunities for us to see how can we take that information and make sure that it continues with the patient throughout his/her stay here, and also how can we use that information internally to strengthen or enhance some of our patient-centered care [and] our recruitment processes.” This hospital plans to incorporate these demographic data into their strategic and business plans to better serve their community. This practice may also be extended to include data on religious or spiritual preferences, as these data are also important for assessing the need for C&L services.

Other hospitals are using patient focus groups to gather information regarding patient needs.²⁰ A HLC TAP member in support of this practice said, “Focus groups are . . . a way to collect data, but instead of relying on surveys, which have a very low rate of return for the limited English proficient (LEP) population, you get your data from the source, provided you can get enough patients to participate.”

Monitoring C&L Service Utilization

To better evaluate an organization’s current C&L services, it is critical to monitor how often the services are used.²¹ Collecting data is one way to measure the frequency of C&L service provision. Some of the services that may be monitored include language services,


religious and spiritual care services, and special dietary requests that are of a cultural nature.

Collecting Data on C&L Service Use Providing language services is essential to meeting the communication needs of diverse patient populations. Collecting data on how often language services are used allows an organization to quantify usage, justify a need for the services, and strengthen financial and staff support to provide those services. Hospitals measured language service use by documenting the frequency of interpreter encounters during patient care. Interpreter encounters can be documented in a variety of ways, depending on an organization’s policies, such as directly in the medical record or in interpreter logs that are maintained by the interpreter services department. Documentation may also include interpreter scheduling databases, given that the organization has an electronic system to plan and track encounters. The type of language service used may also influence how usage data are collected. For example, records containing information on the use of telephone interpreting services may be kept by individual departments rather than in a centralized location.

Documenting interpreter encounters may also be useful for the analysis of sentinel events. As communication issues have been reported as the root cause of over 60% of sentinel events [8], collecting data on interpreter encoun-

20 *Improving Patient Care — Improving Communication* encourages hospitals to convene focus groups on a “regular basis to get feedback on the perceptions of care and communication needs of communication-vulnerable populations” (Content Area 5, Performance Expectation 6.3).

21 CLAS Standard 4 requires that “health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.” The *HLC Report of Findings* also recommends that “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” (Recommendation 4-2).



“We tell them exactly what the documentation needs to be. We tell them the language or preferred method of communication and the type of communication assistance whether it was a telephonic, backup language bank employee, or speech impaired.”

—C&L services staff from a northeastern hospital



ters can provide additional information. One southern hospital had an adverse event reporting system that included data on patients' language needs and whether or not an interpreter was provided. The appropriate documentation of language services, combined with an adverse event reporting system that connects interpreter information with event details, can provide further insight into the effectiveness or weaknesses of specific interpreting methods and provide data for future studies.

One caveat of documenting interpreter encounters to monitor language service use is that documentation should be mandatory throughout the organization. Sporadic or inconsistent data collection may inadvertently diminish the importance of providing language services, based on an underestimate of the frequency of use or an inaccurate representation of the need for language services. Organizations are encouraged to develop system-wide policies to require the routine documentation of interpreter encounters throughout the continuum of care (see Chapter 4: Building a Foundation).

Organizations may also consider extending the practice of documenting interpreter encounters to address other C&L services. Documenting patient encounters with religious and spiritual care providers can help organizations measure the frequency of use for such services. It is also useful to document information regarding patient dietary preferences so that these preferences can be considered as care is provided. For example, if the patient has specific dietary preferences such as vegetarian, kosher, or halal, these should be documented so hospital services can be adapted to accommodate the patient's specific needs (see Chapter 6: Accommodating the Needs of Specific Populations).

Building Upon C&L Service Utilization Data

Quantifiable language service provision data can also contribute to studies beyond merely understanding how often patients use language services. For example, with the practice of documenting interpreter encounters as a model, data regarding the frequency of language service use may serve as a foundation for inquiries into the effectiveness of interpreter services, the allocation of resources, clinical outcomes for diverse populations, and patient satisfaction studies. A number of staffing issues may also

emerge from these data, including the need for education and training to increase awareness of the availability of language services, to ensure that the services are accessed and provided correctly, and to address compliance problems with organizational policies or procedures for data collection. Data on interpreter encounters and language service use may also promote changes in staff recruitment that alleviate workload concerns.

Using Data to Improve C&L Services

Data collected before, during, and after the provision of C&L services can be used to identify areas for service improvement or expansion. Analyzing data from different sources and stratifying it by various factors can help organizations strengthen their C&L services and address disparities in care for diverse patient populations.

Establishing a Baseline of C&L Services Before hospitals can evaluate C&L service improvements, it is important to assess the organization's commitment to providing services to diverse patients and establish a baseline of the services provided.²² A midwestern hospital hired a

“[We] do root cause analysis, [and] the language issues that come up in root cause analysis are interpretation issues. Was [the information] adequately interpreted? Do we really know what was interpreted? One of the things we've done to assist with that is we now have interpreters sign on [forms] that [identify that] they have interpreted for [patient] care, especially on consents.”

—CEO from a western hospital

²² CLAS Standard 9 advocates that “health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.”



CHAPTER 5: *Collecting and Using Data to Improve Services*

consulting firm to conduct a comprehensive diversity audit across multiple categories, including supplier diversity, building accessibility, policies, education programs, communication, and marketing. According to the hospital's CEO, "[It gave] us a baseline on how we were [doing] in those categories. We could see, compared to the industry, that we are not doing too bad, or [that] we have a long way to go. . . . We had our results given to our executives, which we prioritized and said, 'Okay, based on all of that information, we have to work on *this*.' So we set some priorities."

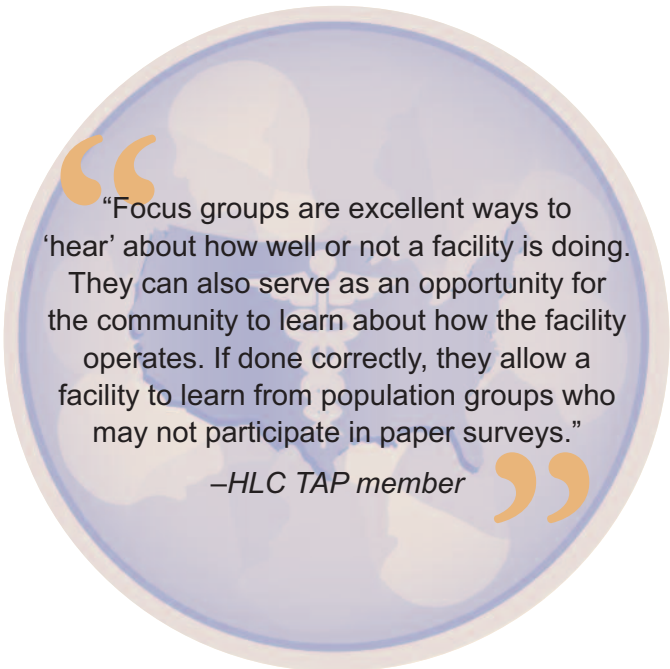
Obtaining Patient Feedback Collecting patient feedback data following the provision of C&L services allows an organization to evaluate those services from the patient perspective. Patient feedback data can help hospitals determine the effectiveness and appropriateness of their C&L services or suggest additional services. Several HLC study hospitals collected and reviewed patient complaint and/or patient satisfaction data to identify issues that could be better addressed by their C&L services. One caveat to this practice is that patient complaint and satisfaction data are often collected through paper surveys, and organizations may need to conduct focus groups or adapt their written data collection tools to accommodate C&L needs.²³ Community resources and leaders may also be helpful in both obtaining and assisting in the analysis of patient feedback (see Chapter 7: Establishing Internal and External Collaborations).

A northeastern hospital obtained patient feedback through informal patient interviews with staff managers to identify patient care issues as a way to collect data to improve care and C&L services. In some cases, bilingual staff interpreted during patient interviews. The potential wealth of data obtained from direct interaction with patients can be used for many purposes and provides an invaluable patient perspective on existing and much-needed services.

Stratifying Data As mentioned earlier, collecting accurate data regarding patient age, gender, race/ethnicity, primary spoken and/or written language, religion, and other

demographic characteristics can help organizations better assess the need for C&L services. In addition, these data can be used in the analysis of service and technical quality measures (including clinical outcomes) and adverse events as a way to separate and stratify results by demographic category.²⁴ Organizations are encouraged to use the demographic data they collect to identify disparities in the care and services provided for diverse patients.

Stratifying data by demographic variables can help hospitals pinpoint areas in which patients from specific populations need targeted services or programs. For example, a southern hospital stratified their patient outcome data by primary language, and the results prompted the organization to translate patient education materials into other languages to improve clinical outcomes for patients whose primary language was not English. Other hospitals stratified adverse event data by primary language, or stratified their performance and quality indicators by race and ethnicity. Using data to better understand how certain populations receive care can also inform the way organizations examine their core measures.



“Focus groups are excellent ways to ‘hear’ about how well or not a facility is doing. They can also serve as an opportunity for the community to learn about how the facility operates. If done correctly, they allow a facility to learn from population groups who may not participate in paper surveys.”

—HLC TAP member

23 As stated in CLAS Standard 13, “Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.”

24 The *HLC Report of Findings* suggests that the “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” (Recommendation 4-7). *Improving Communication—Improving Care* further advises that “the organization [cross-link] demographic information with clinical quality measures” (Content Area 2, Performance Expectation 6.0).



Although *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings (HLC Report of Findings)* advocates using technology as a tool to facilitate data stratification,²⁵ there were no practices identified in this study that specifically addressed the use of information systems to stratify data. As this report focuses on the current practices performed in hospitals around the country, one possible explanation for the absence of technology-based practices may be a lack of resources and technological infrastructure available in the present environment. However, it is also possible that organizations that have the technology in place do not use their data to the fullest potential. Given the national attention to developing and applying standards for health information technology and electronic medical records, hospitals must support the inclusion of race, ethnicity, and language as minimum, mandatory fields for the collection of C&L-related data. Data systems that support the collection and facilitate the use of these data will allow hospitals to refine their quality, performance, and outcome measures in order to improve C&L services.

Conclusions

This chapter highlights various considerations when developing or evaluating current practices to collect and use data to improve C&L services. While many hospitals across the United States already collect these data, few hospitals have developed systems for using them to guide service development and improvement. The self-assessment questions provided in chapter 8 were developed to generate ideas and discussion about identifying the types of data to collect, existing databases that can be used, methods for collecting the data, and ways to use the data to improve services.

A thorough understanding of the need for C&L services, dependable information regarding the use of those services, and the usefulness of those data to improve C&L services can all contribute to an organization's ability to identify and monitor health disparities and provide safe, quality health care to culturally and linguistically diverse patients. The data collected may also be used to inform short- and long-term organizational planning (see Chapter 4: Building a Foundation), help develop C&L-specific services and programs (see Chapter 6: Accommodating the Needs of Specific Populations), and identify limitations in staffing and resources that collaborative partnerships may alleviate (see Chapter 7: Establishing Internal and External Collaborations).

“We’ve begun to break down not just who the patients are, but we’ve also begun to look at patient care issues [and] overall performance and quality indicators. . . .

We’ve just started in the last year to break that down into different cultures or ethnicities to see if there are any differences there and draw correlations to see why one population has a longer length of stay. Are there resource issues? Socioeconomic levels? Are there resources available to them after discharge? . . . [Can we] maybe change the way we treat patients [as we go] forward?”

—A member of leadership
from a southern hospital

“The performance improvement cycle starts with cycle thinking. . . . How do you know if you’re providing good services or not? What data do you have that shows that you’re doing what you want to do and you’re not providing services you want to provide? If you’re not meeting your goals, then you move into the next part of performance improvement which is planning, planning for improvement.”

—A member of leadership from
a western hospital

²⁵ The *HLC Report of Findings* recommends that “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” (Recommendation 2-5).



CHAPTER 6: *Accommodating the Needs of Specific Populations*

Accommodating the needs of specific populations includes practices aimed at providing safe, quality care and decreasing health disparities for particular populations in the service community.²⁶ Although all the practices mentioned in this report can help hospitals care for their diverse patients, the majority of practices reported by health organizations have a macro-level approach. In contrast, this chapter focuses on micro-level practices designed to meet the challenges of certain populations. The practices included also relate to other themes in this report, but are placed in this chapter because they best reflect the organizational efforts that directly address the language, cultural, and health literacy issues of specific populations.

Promoting Staff Awareness through Training, Dialogue, and Support

In order to provide safe, quality health care for all patients, it is essential to integrate the concept of culturally competent care into staff training and education as a means toward quality improvement.²⁷ One of the challenges hospitals reported is a lack of awareness among staff regarding the importance of cultural and language (C&L) issues and how they affect patient care. To address this challenge, hospitals are providing staff with training that encompasses a range of activities, from self-study educational materials to interactive group learning sessions.

Training to Support Effective Communication The role of effective communication in patient safety has been well documented in the current literature [13]. Organizations can highlight the importance of communication throughout the continuum of care by training staff to improve their communication skills with patients.

26 CLAS Standard 1 states, “Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.”

27 The *HLC Report of Findings* recommends that “hospitals should engage staff in dialogues about meeting the needs of diverse populations” and “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” (Recommendations 3-1 and 3-2). CLAS Standard 3 requires that “health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.”

By building awareness of how communication contributes to patient safety and setting expectations for effective communication at all levels of the organization, hospitals may be able to diminish resistance to C&L initiatives and make effective communication a customary part of their overall services.

Some organizations may elect to start their training efforts with high-level staff to ensure leadership buy-in for C&L-related activities. One northeastern hospital developed a senior-level training session that had a “focus on communication as the cornerstone to patient safety and discusse[d] negative outcomes correlated to [limited English proficient] and non-English speakers.” Hospitals may gain stronger organizational support for C&L initiatives if members of leadership champion efforts for better communication between staff and patients.

Another way to enhance communication with patients is to provide staff education on how to work with a professional health care interpreter during medical encounters.²⁸ It is important to acknowledge that professional health care interpreters are a key component of the medical team and have abilities that extend beyond facilitating communication between patients and providers. Given that interpreters have received the appropriate training, they may also be used as cultural brokers to lend insight into cultural practices and beliefs and identify potential cultural conflicts.²⁹

A number of hospitals provided staff with language courses such as English as a Second Language, accent reduction, and one-day elementary medical language classes. While such courses may alleviate some specific communication barriers staff members may have, they do not provide a means of bridging language barriers

28 As mentioned in the *HLC Report of Findings*, “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” (Recommendation 4-2).

29 Guiding principles and competencies for cultural brokering programs are outlined in *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs*, available at www.culturalbroker.info/index.html.



between staff and patients. Staff should be cautioned not to rely upon elementary second-language skills to communicate with patients; instead, the use of professional health care interpreters is vital to avoiding patient-provider miscommunication.

Several of the hospitals that provided staff language classes reported that the classes were offered only to specific clinical staff, such as physicians. Hospitals should keep in mind that the ability to communicate effectively is important for all staff, as it is not only physicians who interact and communicate with patients during the health care encounter.

Training to Support Cultural Competence In addition to addressing the importance of effective communication, hospitals should also consider providing staff training around cultural competence and sensitivity.³⁰ While it is equally important to train on effective communication, training to support cultural competence serves a distinct function.

Hospitals reported that staff education supporting cultural competence took many forms, including staff in-services, online resources, sessions with guest speakers, and specific cultural-focused classes. Topics varied from cultural traditions and rituals to the roles of traditional healers and faith in the health and healing process. At one southern hospital, for example, pharmacists lead training sessions for physicians on types of herbal remedies they may encounter with their patient population. As C&L services staff described, “Our doctors have learn[ed] to become aware of different herbal preparations and some of the various mixtures, and they are aware of some of the medical side-effects of these mixtures. They have a wealth of experience in asking and assessing what patients are taking.” As a result, physicians may be better able to both collect a more accurate assessment of what their patients are taking as well as have a more complete understanding of the impact these remedies may have on their patients’ health. Staff training that supports cultural competence may also include gaining knowledge and skills for addressing cross-cultural encounters, such as being aware of biases and tendencies for stereotyping.

Staff turnover is expected in hospitals, and it is important to develop ongoing training to maintain a consistent staff commitment to culturally competent care. A number of teaching hospitals worked with their training programs to formalize cultural competency training and incorporate it into their residency programs. As a member of leadership from a western hospital described, “We [have] a three-year curriculum that includes topics on various cultures. In particular, we talk about Hispanic, Vietnamese, and Middle Eastern culture[s], teach[ing] [staff] about various aspects of [patients’] cultural needs, and use actual patient cases to [illustrate] needs.”

Cultural Competence Learning Modules

A number of learning modules related to cultural competence are available online including the Health Resources and Service Administration’s *Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency* (www.hrsa.gov/healthliteracy/training.htm) [26], and the Office of Minority Health’s *A Physician’s Practical Guide to Culturally Competent Care* (cccm.thinkculturalhealth.org) [27].

“[We] do cultural competency training for two reasons. We have a very diverse staff and want to develop cohesion between them, and the more understanding that we can create, the better the services will be. We try to train staff on the patient populations we serve. We don’t do enough of it and frankly we don’t do enough research to understand what culturally sensitive care is.”

—CEO from a western hospital

³⁰ Support for cultural competence training may increase when there is clearer evidence of its effect on patient care. According to the *HLC Report of Findings*, “More research is needed to evaluate the quality and safety impact of diversity and cultural competence training provided to health care workers” (Recommendation 4-8).



CHAPTER 6: *Accommodating the Needs of Specific Populations*

Providing Staff with Educational Materials and Tools

HLC study hospitals used self-study materials and tools to educate staff about C&L issues. Resource books on different cultures were often reported, and a number of hospitals developed visual aids such as cards for staff to use to communicate with patients. As a member of leadership from a midwestern hospital described, “We don’t necessarily have an interpreter at the bedside 24 hours a day for every day of the hospitalization so there’s a lot of time where the nurse has to use his or her skills to talk with that patient [and] communicate basic daily needs. You can do that very simply through pictures, and you can show them [text] in their language. . . . It’s just something for day-to-day to get by.” While these types of cards may be a relatively inexpensive resource for staff and may feature many of the issues commonly encountered by patients, such tools are far from exhaustive, only scratching the surface of individual patient issues and making the health care conversation fairly one-sided. As hospitals and their staff use various resources, they must remember that these are not substitutes for formal language training and/or quality language services.

Online applications such as intranets have also provided a new channel for hospitals to disseminate information similar to that included in cultural resource books. One C&L services staff member from a midwestern hospital noted, “We’ve tried to direct more and more staff to the diversity intranet, . . . [which provides] resources and information to them. We have a couple of links on that site that give them immediate translation of written materials as well. So, we’re trying to keep it updated and make it easy to use at the bedside. The intranet site has been a really excellent tool because so many people are looking for something quick.”

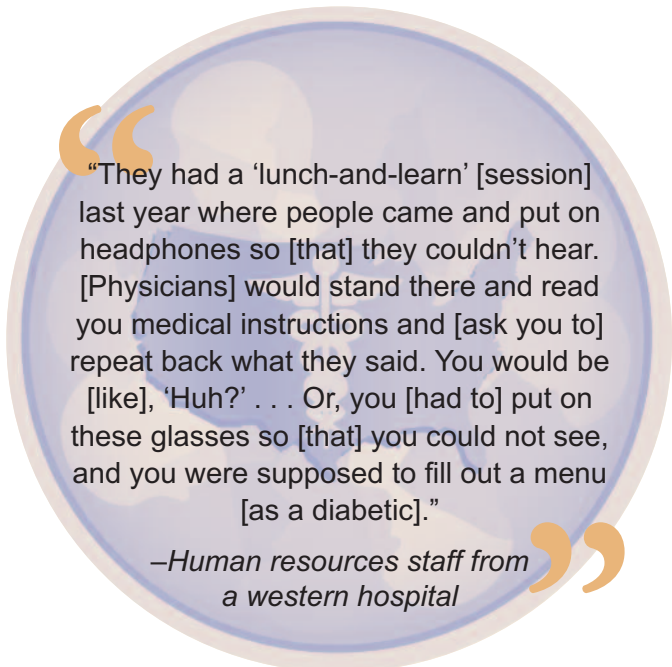
Hospitals should be aware that stand-alone self-study materials can increase the likelihood of stereotyping, given that only generalized descriptions of various populations and cultures may be available in resource books or visual aids.³¹ Educational materials such as these

should not be a substitute for group trainings that give staff an opportunity to interact and openly discuss cultural diversity issues.

Hospitals can better understand different staff perspectives and possibly identify other issues that need to be addressed through in-person sessions that facilitate staff dialogues. The importance of culturally competent care extends beyond the limited English proficient (LEP) population and can address communication issues that affect populations with physical disabilities. One hospital developed hands-on role-play activities to provide staff the opportunity to experience the perspective of hearing- and vision-impaired patients.

Using Technology to Support Communication

Technological aids can be used to increase the efficiency and efficacy of interpreting services. Dual handset telephones have reduced the inconvenience of passing a phone back and forth between provider and patient or using the speakerphone feature during telephone interpreting encounters. One northeastern hospital reported using hands-free headset technology, and a member of their leadership said, “We have made broader and better use of phone-based translation services over the last five years. We have become a little more adept in using those services through hands-free telephonic headsets. . . . Pre-admission,



“They had a ‘lunch-and-learn’ [session] last year where people came and put on headphones so [that] they couldn’t hear. [Physicians] would stand there and read you medical instructions and [ask you] repeat back what they said. You would be [like], ‘Huh?’ . . . Or, you [had to] put on these glasses so [that] you could not see, and you were supposed to fill out a menu [as a diabetic].”

—Human resources staff from
a western hospital

31 The *HLC Report of Findings* cautions that “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” (Recommendation 4-4).



histories, and pre-examinations can be done by our personnel who are wearing hands-free sets so they can do physical examinations with patients and have telephonic interpretation at the same time. If you need someone to breathe deeply while you examine the solid organs in the abdomen, you can do that and have your hands available and do what you need to do. That type of technical help has been very useful.”

One caveat to using the telephone for providing interpreter services is that the interpreter misses nonverbal communication between the patient and provider. Hospitals may want to define, through organizational policies or procedures, which situations are appropriate for telephonic interpreting and which require direct interaction [28].

Technology has also enhanced distance interpreting through the use of video medical interpreting. The video component adds another level of information to distance interpreting, as interpreters are able to better see nonverbal behaviors communicated by patients and staff. In some hospitals, video medical interpreting has improved the efficiency of in-house interpreters by eliminating travel time from one patient to the next. Video medical interpreting services provided by external vendors can also alleviate the demand for in-house interpreters without sacrificing the information obtained from nonverbal cues.

Notes on Technology

Any technological upgrades may come with a sizable price tag so it may be worthwhile for hospitals to experiment and pilot the use of these technologies to look at a cost-benefit ratio. Although each organization is unique, a possible proxy for this process would be to solicit and share information with other organizations until more robust research can be conducted in the field. Hospitals should also consider staff needs and any anticipated barriers to using new technology. While technologies in interpreting are promising, organizations should keep in mind that it is not the technology alone that enhances care, but rather the way it is used by hospital staff to better communicate and meet patient needs.

Creating an Environment that Meets Specific Patient Needs

In order to meet the needs of diverse patient populations, hospitals are developing or modifying existing services to provide safe, quality care to the specific populations they serve. These accommodations have involved alterations to various aspects of the hospital’s physical space, programs, and services to create an environment that is inclusive of all patients.

Enhancing the Hospital’s Physical Space Hospitals are undertaking numerous efforts to create a physical environment that supports the diversity of their patient population.³² The physical environment includes everything from the layout of waiting areas and waiting rooms to navigational signage and decor. One midwestern hospital discovered that providing culturally competent care requires an assessment of the hospital’s entire environment from the patient perspective. As diverse patient populations may contain groups other than LEP patients, hospitals should consider all perspectives when providing care.

“We’ve done a series of audits of our space, where people just go and sit in a waiting area and see what happens. Or, [they] do a visual assessment. If countertops are really high and you’re sitting in a wheelchair, how accessible is that? So, there’s been a very concerted effort around the environment. As we have done remodeling of patient care units, [and] as we’ve done remodeling of other spaces, it’s with an eye toward how welcoming we are to all people.”

—C&L services staff from a midwestern hospital

³² In *Improving Communication — Improving Care*, the AMA’s Ethical Force Program advises organizations to create “a physical environment that facilitates communication by fostering a feeling of welcome and comfort for individuals from communication-vulnerable populations” (Content Area 5a, Performance Expectation 1.0).



CHAPTER 6: *Accommodating the Needs of Specific Populations*

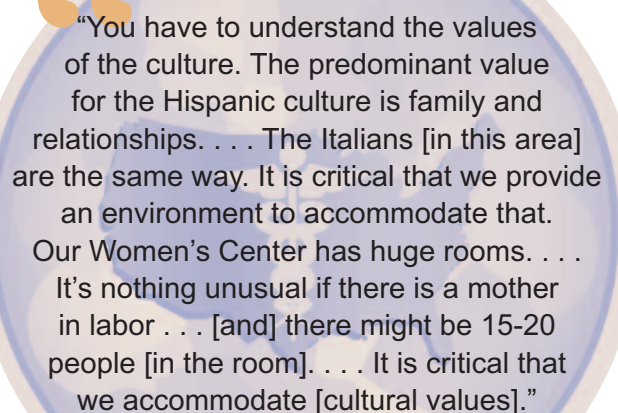
Another significant component of an inclusive environment is the presence of directional signage and other critical postings in a format that is appropriate and accessible.³³ However, achieving a patient-friendly environment encompasses more than just having bilingual signage; health literacy levels should also be taken into account. As a member of leadership from a western hospital remarked, “It’s just being sensitive to people in general. . . . Hospitals are like mazes to some people. They can’t find [where they need to go], even with great signage — it’s hard for them to interpret some signs.” To meet both literacy and language needs, hospitals may consider using universal health care symbols³⁴ or focus some attention on training those at initial points of contact, such as information desk representatives, to be sensitive to and inclusive of diverse patients.

Beyond redesigning the elements of an existing physical space, an inclusive environment may also require structural additions. Some hospitals are making adjustments to accommodate the needs of both patients and staff. As a CEO from one northeastern hospital commented, “We have actually opened up a mosque, which is interesting for a Lutheran institution. . . . [We] work[ed] with the Imams in the community and with our physicians. We have quite a number of physicians [and patients] who are Muslim, and because they needed to pray during the day, there needed to be a spot to do it.” This practice reflects a structural modification targeted to a specific population and illustrates the importance of engaging community leaders to improve hospital services for patients and staff.

As hospitals consider changes to their physical space, data collection will play a key role in understanding the needs of patient populations and/or staff, and as the previous example illustrates, collaboration may play a role in designing and implementing solutions. Understanding the underlying values of patients’ cultures is essential to providing safe, quality care.

Adapting Services to Address Cultural Beliefs Some hospitals are altering or expanding existing services to address the cultural beliefs of their patients.³⁵ These types of adjustments are made on a case-by-case basis and cannot always be planned, nor can they be reflected in an organization’s policies and procedures. Organizations should make an effort to be responsive to patients’ cultural needs and preferences.

While some practices may result in significant changes to hospital services, other situations can be resolved fairly simply. A midwestern hospital relocated a female Muslim patient to a different unit to accommodate her cultural preference for a female provider. At a northeastern hospital, the CEO discussed how staff found ways to show their respect for beliefs among the Chinese community: “You know [how some] people have a superstition [about] the number 13? In the Chinese culture, it is [around the number] four, so we do not put Chinese patients on the fourth floor or do anything with the number four. . . . You have to be responsive to that sort of [cultural belief].”



“You have to understand the values of the culture. The predominant value for the Hispanic culture is family and relationships. . . . The Italians [in this area] are the same way. It is critical that we provide an environment to accommodate that. Our Women’s Center has huge rooms. . . . It’s nothing unusual if there is a mother in labor . . . [and] there might be 15-20 people [in the room]. . . . It is critical that we accommodate [cultural values].”

—A member of leadership
from a western hospital

33 As required by CLAS Standard 7, “Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.”

34 The *Hablamos Juntos* project of the Robert Wood Johnson Foundation developed and tested a set of universal health care symbols that is available at www.hablamosjuntos.org.

35 The *HLC Report of Findings* recommends that “hospitals should take advantage of the internal and external resources available to educate them on cultural beliefs they may encounter” (Recommendation 4-3).



As a human resources staff member from a midwestern hospital described, “We had a patient who wore a [culturally symbolic bracelet,] and she had to have surgery. While we were trying to be attentive to the western philosophy of medicine, we didn’t realize that there were other things going on. Someone realized later that they could put tape over the [bracelet,] in the [operating room] to maintain sanitation but also make the place more welcoming for all people who have different practices.” Although this resolution seems simple, it took initiative on the part of hospital staff to respect the patient’s beliefs and find an acceptable compromise that was mutually beneficial.

Other hospitals mentioned adapting their food service programs, such as developing a halal kitchen and menu or having their kitchen blessed by local religious leaders. Developing menus that are more attuned to the cultures of patient populations is not solely a food preference issue. Food may play a role in specific traditions, as one CEO from a northeastern hospital noted: “We had a sizable Korean population of women who were delivering their children here, and then all of a sudden, they disappeared. Why is that? Well, in the Korean culture, the birth of the child and the care of the mother necessitate the serving of seaweed soup to the mother post-delivery. Who would know that unless you figured out why they were not coming back? So we learned the hard way that . . . serving the seaweed soup was [part of] their culture.” This example emphasizes the need to learn about and better understand the community served. If this organization had not taken the initiative to reach out to the Korean community, it would have not discovered a simple accommodation to reconnect with this population.

Hospitals have also found the need to adapt direct patient care services. In order to meet the needs of their Somali population, one CEO from a midwestern hospital described the need to add to their workforce, “For the Somali [population,] we have a doula in our [obstetrics] department. Somalis have a very different perspective about gynecologic and reproductive health than [Western medicine]. [The doula] is kind of like an advocate in labor — someone who’s trained to know — not to be a physician extender but [rather] a patient extender.”

Helping Patients Manage Their Care

Another way hospitals are better serving diverse populations is by offering services that allow patients to more easily navigate the health care system.³⁶ Hospitals are also providing patients with education and training to help them take responsibility and advocate for their own health.

Navigating the Health Care System Patient navigation programs are designed to eliminate barriers and delays to diagnosis and treatment through one-on-one contact [29]. Patient navigators may assist patients with numerous issues, ranging from insurance to logistics (e.g., appointment scheduling, transportation) to cultural beliefs to education. Navigators are typically members of the community served, are knowledgeable about the health care system, can communicate effectively with patients and their families, and collaborate with external partners to coordinate follow-up and support services [30].

One western hospital used a patient navigator model targeted to immigrant populations that integrates cultural mediation, community engagement, patient navigation, case management, interpreting, and provision of care.

“We had an organ procurement [issue, in which] the spiritual leader could not leave the room. [The patient’s culture believes] the soul doesn’t depart without them....but [it’s] very unusual to have anybody else in the operating room during that particular procedure. But all the right people were notified, and all the arrangements were made, and we were able to do that, to accommodate them, because we knew how important it was for the family and everyone else involved.”

—A member of leadership from a midwestern hospital

³⁶ *Improving Communication — Improving Care* advises organizations to have “programs to help communication-vulnerable populations navigate the health care system to appropriately use health care resources” (Content Area 5, Performance Expectation 2.0).



CHAPTER 6: *Accommodating the Needs of Specific Populations*


A member of the leadership from the same hospital said, “[T]hese navigators have a capacity to do complex case management, as well as education [and] some public health work, because they can bridge clinical encounters, go out to the community, and talk about the implications for the communities — kind of a public health vehicle.” However, hospitals are cautioned that the implementation of a patient navigator program may require organizations to define boundaries between the roles of patient navigators and professional interpreters. If navigators will be used to interpret during medical encounters, they should be assessed for language proficiency in English and the target language.

Providing Patient Education and Training Patients must have the appropriate education and training to make informed decisions, actively participate in, and manage their care.³⁷ Hospitals employed several practices to educate patients in their primary language. Spanish interpreters have specifically been used in obstetrics (OB) and neonatal intensive care units to assist patients with discharge instructions, which resulted in decreased revisits to the emergency room. According to the leadership at a western hospital, “[We] recognized there [were] a large number of moms and babies returning to the hospital after discharge. In investigating that, [we] realized that the problem was that they weren’t understanding the information that they were being sent home with. . . . [Now] if you go up to OB, you will find everything you can possibly imagine. Information can be communicated correctly so that [new parents] can leave the hospital and know how to care for that baby and know how to care for themselves. . . . There was just an absolute decrease in the number of returns we had of new moms and babies coming back. It was a simple solution to what could just turn out to be a disaster if [patients] don’t have the right info.”

In an effort to meet both the educational and cultural needs of the patient population, hospitals may also alter how they provide education to account for traditional customs. A member of leadership from a northeastern hospital described, “[After childbirth,] the mother had been discharged. What was needed was for her to come back and

receive some training and education about how to care for the baby. She was not able to come back because of this cultural practice — to rest for 30 days — so [the husband] was going to come in her place. Our practice was that mom comes in and receives that education, so we realized that we needed to . . . reevaluate our own practices.” The organization subsequently modified their post-childbirth training to engage the father, thus accommodating the mother’s need to rest for the allotted time period following labor.

Using Technology in Patient Instruction and Education Some hospitals have used technology to distribute patient education, including online education via streaming video technology in sign language for deaf and hard of hearing patients as well as language translation software to provide educational and discharge materials in patients’ primary languages. Hospitals have used the internet or an organizational intranet to create patient education materials in multiple languages. At a western hospital, human resources staff discussed their use of electronic patient education software to create documents that meet language needs, “[F]or the nursing side, we have a patient education [computer] program. [It has] whatever topic you want to teach to your patient to take home and to read. It comes predominately in English and Spanish. . . . There are up to ten languages provided for certain topics.”



“One of the programs we have [includes] case managers that go into the community and areas particularly where we have non-English speaking individuals and are really case finders/case managers, where they can work with those populations and encourage them to seek care when needed.”

—CEO from a western hospital

³⁷ Joint Commission standards require that patients receive “education and training specific to the patient’s needs and as appropriate to the care, treatment, and services provided.”

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Hospitals should remember that although technology is a more convenient or efficient channel to convey information, it is the quality of the message and materials that will ultimately determine whether the needs of patients are being met. With online translation tools, hospitals should remind their staff that language translation software provides literal translations, and therefore, they should have written policies about the editing process that is required to verify the accuracy of the translation.³⁸ Without professional translators to edit electronically translated documents, the danger is very real that incorrect information could be conveyed to patients, compromising patient safety and care.

Notes on Language Translation Software

Organizations should be aware that although language translation software and online translation tools can make some processes more efficient, these resources may only provide information in one direction, such as tools that only provide instruction. When such programs are used alone, there is no way for health care providers to ascertain the level of patient understanding or respond to patient concerns and questions. Hospitals may consider supplementing the use of electronically translated patient education documents with professional interpreters to facilitate communication between patients and providers.

Establishing Centralized Programs that Meet Specific Needs of Large Populations

For large populations that may comprise a significant number of patients, it may be necessary to develop centralized programs within an organization to implement system-wide services that address specific patient needs. These types of programs are often created in response to diverse cultural and religious needs.

Developing Culturally Centered Programs Hospitals have developed formalized programs built around the unique

cultural needs of the patients they serve. In some instances, hospitals designed culturally centered programs to help bridge cultural barriers in the understanding of health and healing. For example, one western hospital faced challenges when reconciling ideas between practices in Western medicine and the traditional healing practices of the American Indian population they serve. A C&L services staff member described, “In Native medicine there’s no diabetes. The illness a patient carries has another diagnosis in Native medicine . . . so then as a patient, you will have two illnesses, [one diagnosed by Western medicine, and another diagnosed by Native medicine]. . . . The practitioner, physician, and nurses have to have some general understanding about the cultural belief and the legal issues so that they teach [patients] accordingly — or provide medications accordingly.” This hospital formally established a Native medicine program and a Traditional Healing Committee that worked to integrate traditional healing practices into the Western medicine practiced in the hospital to better serve their American Indian community.

In other cases, culturally centered programs provided services that better recognized the distinct needs of various groups. One midwestern hospital developed a tele-psychiatry program to better serve the needs of their deaf and hard of hearing patients. A C&L services staff member pointed out, “We have a psychologist/psychiatrist who

“In psychiatry, we have culturally focused units —Spanish-focused, gay-focused, Asian-focused. We have had waivers on positions that would require a person to go through specific classes before being hired for [one of these] positions. This model in psychiatry has worked well, [and] it is a big attractor for staff to work here.”

—CEO from a western hospital

³⁸ As recommended by *Improving Communication — Improving Care*, organizations should ensure that “translations from English are independently evaluated and checked for accuracy” (Content Area 5b, Performance Expectation 8.1).



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speaks sign language and through video streaming gives appointments to people over their home computer. . . . [They provide] mental health and behavioral health sessions [and] consults.”

Similarly, a western hospital created a culturally focused psychiatric unit that accommodates several populations in their service community. Culturally centered programs need to be supported by targeted recruitment and cultural competency training, and the cultural competency training that this program’s staff completes is both ongoing and evaluated for efficacy. As described by a human resources staff member, “We have certain things such as mandatory cultural competency testing. We require that all of our staff have at least one training . . . and monthly unit-based updates. I think where [we see results] is around patient relationships.”

Developing Religious or Spiritually Centered Programs

Along with meeting the cultural needs of patients, hospitals have established programs to meet various religious and spiritual needs of patients.³⁹ A human resources staff member from a western hospital noted, “One thing that has been identified on the patient side was more support, spiritually . . . [The hospital] started a program a year ago, and the employees are volunteering to give their skills to help. Thirty-five percent of our patients are Catholic, so we wanted to meet that need. When [patients] are in the hospital, [they feel] a need to be connected with their faith. What we found is that we have far more employees willing to help with religions [in addition to Catholicism]. We took [these 60 volunteers] through a six-week training on praying in other religions.” A northeastern hospital addressed the religious needs of their population by expanding their annual child remembrance services to include four different religions.

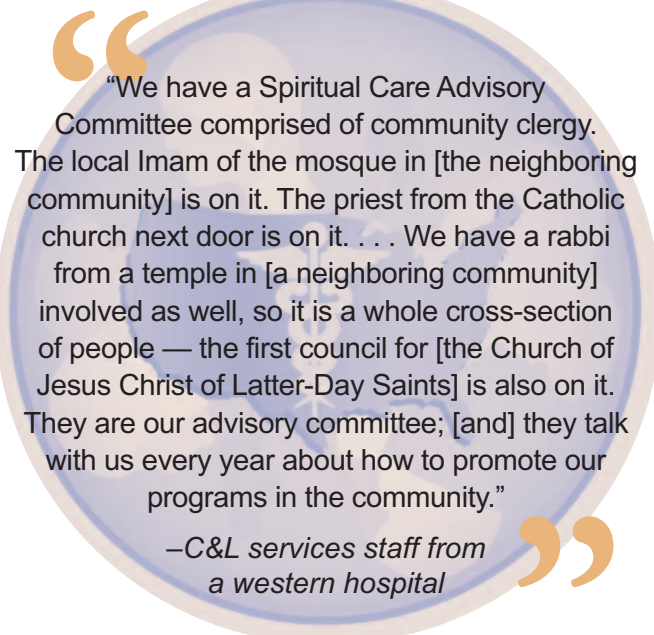
Twenty percent of hospitals reported that they had developed interfaith chaplaincy programs comprised of leaders from a variety of different religious groups. In some instances, these religious leaders not only provide consul-

tation services to patients, but offer guidance as a group on how the hospital can engage their community.

Spiritually or culturally centered committees can play an important role in the development of centralized programs. In addition to the use of focus groups, as described in the Chapter 5: Collecting and Using Data to Improve Services, these committees can inform the development and implementation of such centralized programs.

Conclusions

Accommodations targeted to the needs of specific populations evolve as hospitals search for solutions to the challenges of providing care to their diverse patients. To ensure organizations meet changing staff and patient needs, the development of services and activities tailored for specific populations should be a continuous process. While the practices outlined in this chapter show positive steps toward the delivery of culturally and linguistically appropriate care, they also indicate the complicated reality of the long road ahead. Although knowledge, field experience, and technology have improved the delivery of C&L services, hospitals need to consider the balance between convenience, cost, patient safety, and quality. Chapter 8 includes a self-assessment tool hospitals and other health care organizations can use to evaluate their current C&L services with respect to the specific populations they serve.



“We have a Spiritual Care Advisory Committee comprised of community clergy. The local Imam of the mosque in [the neighboring community] is on it. The priest from the Catholic church next door is on it. . . . We have a rabbi from a temple in [a neighboring community] involved as well, so it is a whole cross-section of people — the first council for [the Church of Jesus Christ of Latter-Day Saints] is also on it. They are our advisory committee; [and] they talk with us every year about how to promote our programs in the community.”

—C&L services staff from a western hospital”

³⁹ *Improving Communication — Improving Care* advises that “the organization’s scheduling of communication and educational events [be] sensitive to relevant religious and cultural observances” (Content Area 5a, Performance Expectation 6.0).

CHAPTER 6: *Accommodating the Needs of Specific Populations*



As organizations create services and resources for specific populations, these initiatives will likely include elements of Chapter 4: Building a Foundation, Chapter 5: Collecting and Using Data to Improve Services, and Chapter 7: Establishing Internal and External Collaborations. As a member of C&L services from a midwestern hospital described, “[The doula program] came out of dialogue with women from the community that we were able to bring in [to] talk about their birth practices [and] our birth practices. . . . We had a series of three luncheons. We literally sent vans out to go pick women up and bring them here to have a dialogue. It was as informal as that. It [developed] into the doula program that we [now] have.” As this example shows, elements of each theme can contribute to the development of programs that accommodate the needs of specific populations.

“We have had to modify some of our policies with respect to religious preferences. We have a population of Jehovah’s Witnesses who use our facility and who do not believe in blood transfusions [during] surgery, so our medical staff have created some policies for bloodless surgeries with the Jehovah’s Witness leadership within the community to make certain that we are consistent with the guidelines that they have set up.”

—CEO from a western hospital”



CHAPTER 7: *Establishing Internal and External Collaborations*

Collaborative practices encompass those that bring together multiple departments, organizations, providers, and individuals to achieve objectives related to culturally and linguistically appropriate care. Collaborative partnerships, both internal and external, can provide a conduit for undertaking the practices outlined in Chapter 4: Building a Foundation, Chapter 5: Collecting and Using Data to Improve Services, and Chapter 6: Accommodating the Needs of Specific Populations. Collaborations can help hospitals engage their community, share information and resources, and improve the care they provide.

Working Together within the Hospital

Within each hospital, different stakeholders should be brought together to develop, implement, evaluate, and improve initiatives aimed at meeting the needs of diverse patients.⁴⁰ For this reason, when implementing any of the practices outlined in the previous chapters, diverse individuals across the organization should be involved, representing a range of different departments, positions, professional levels, racial/ethnic backgrounds, etc.

Establishing a Cultural Diversity Committee Involving staff from across the organization throughout the development and implementation of culturally competent care is essential to helping identify all the needs to be addressed and to provide feedback on solutions to meet those needs. Along these lines, among the most common practices reported by participating hospitals is the establishment of a Cultural Diversity Committee comprising administration, management, and employees. Some of these committees also included members of the community or patient population. These groups are often tasked with providing mentorship, education, information sharing, and other activities related to offering cultural and language (C&L) services.

⁴⁰ *Improving Communication — Improving Care* suggests, “Regular evaluations include talking to workforce members, community liaisons and individuals from communication-vulnerable populations about both positive and negative aspects of the organization’s communication programs and strategies” and “the organization responds to the results of evaluations by having leaders, workforce members community members, and individuals from the populations it serves work together to develop solutions and make changes to plans, policies, procedures and educational programs” (Content Area 6, Performance Expectations 1.2 and 8.0).

Bringing Stakeholders Together Beyond the Diversity Committee While bringing together a diverse committee or task force is important, interdepartmental collaborations should not be exclusive to specialized “diversity groups.” These types of collaborations could be utilized to implement any of the practices outlined in the previous chapters. By gathering a diverse group of stakeholders to work together on projects and tasks related to cultural competence, the varying perspectives that this type of group can give will help guide organizations through various steps in the process. First, in defining issues, they can provide insight and identify specific needs to be addressed. Second, they can guide implementation as there may be existing resources within each department that can be pooled together or existing processes that can serve as a template. Third, they will play an important role in pilot testing, evaluating, and providing feedback for refining programs and materials. Having feedback from multiple groups at a pilot stage may help refine processes, identify any areas that require tailoring, and reveal any critical gaps or lagging processes. Despite the benefits that these types of interdepartmental collaborations can bring, they do not come without their challenges. Bringing together such varying departments, perspectives, personalities, and cultures can cause points of disagreement to surface, which may generate tension. However, as contentious as these discussions may become, they may also help alleviate existing tensions among these

Bringing Diverse Stakeholders Together to Form a High-Level Task Force

The practice of bringing diverse stakeholders together can add another level to the idea of the high-level task force introduced in Chapter 4: Building a Foundation. The importance of the task force described in chapter 4 is that it is charged with the responsibility of driving cultural competence. The Cultural Diversity Committee brings together diverse stakeholders from throughout the organization to discuss and implement C&L-related initiatives. These two practices are not mutually exclusive. Ideally, a C&L-related task force or committee would be comprised of diverse, multidisciplinary stakeholders and hold the power and responsibility to oversee and drive initiatives.



groups as they have an opportunity to voice their opinions, hear from others, and work toward a common goal.

Building Bridges with Other Hospitals

External collaborations — with other hospitals or health care organizations — are equally important.⁴¹ As hospitals find ways to share their resources with each other, they may be able to better address challenges such as limited resources and high costs for developing new materials and programs. Resources and programs that may benefit from collaboration include staff training in cultural competence, interpreter services, signage and written materials available in multiple languages, and resources to patients who speak languages not commonly encountered by the hospital.

Sharing Existing Resources Many hospitals around the country provide care to patients with similar needs and face common challenges in providing culturally and linguistically appropriate care to diverse populations. While each hospital is unique, they may share a common need for resources, which can bring organizations together to avoid “reinventing the wheel” each time they take on C&L-related activities. In some cases, sharing existing resources can help resolve issues related to time, finances, and staff.

For example, as part of a grant they received, one western hospital reported creating a web site for sharing information about the different cultures that are common to their geographical area. As the CEO of the hospital commented, “We can get information [about] a variety of patient populations and present it to [staff] in a way that they understand.” While the development of this web site is worth mentioning, what is more interesting about this example is that the organization took this project a step further by sharing it with other hospitals that serve similar communities. Since its development, this web site has been used by other hospitals across the country and continues to receive support from grant funding. By sharing resources this way, hospitals may find new methods of filling gaps in their own materials and programs. Alternatively, this type of sharing may also help hospitals develop materials they do not have the resources to produce on their own.

However, sharing existing materials can also require overcoming any organizational “red tape” that may prevent this type of collaboration. Additionally, although hospitals may be able to contribute to a common pool of resources that meet several needs and are available in a variety of languages, there will still be gaps, and existing materials may not be adequate.

Pooling Resources Together Bringing together the resources of multiple hospitals to create new materials that meet the needs of diverse patient populations is one potential way to fill persistent gaps in existing materials. One midwestern hospital collaborated with a group of area hospitals to produce a set of translated materials for use among the group. As a member of leadership from this hospital, “[The] hospitals all together received grant funding and developed a web site that is accessible to all hospitals [and which] has translated materials in multiple languages on all of the basic health care needs.” This hospital also reported taking part in a collaborative to create a cultural competency index that addresses the health care needs of 50 or 60 ethnic groups in addition to 25 or 30 cultural belief systems. The index provides links to translation services and resources for patient health information and education materials. Since its initial development, this particular hospital has posted this index on their intranet.

“We are part of a local collaborative, where six or seven different health care systems have come together and said, ‘We don’t all need to translate all of our diabetic and education information into these six or seven languages. Why don’t you take on doing half of those, and we’ll do half of those, and let’s take our letterhead off of that information.’ We can use that information across the system.”

—Human resources staff from a midwestern hospital”

⁴¹ Recommendation 4-3 from the *HLC Report of Findings* supports this idea: “Hospitals should take advantage of the internal and external resources available to educate them on cultural beliefs they may encounter.”



CHAPTER 7: *Establishing Internal and External Collaborations*

By pooling resources to create materials in this way, hospitals are essentially creating better tools that they can all use. As a human resources staff member noted, “[By working together,] we can make sure that the information is accurate, but we can [also] be more effective with the information we have.”

If hospitals can find other health care organizations that have similar needs or serve a similar mix of patients, they can come together to create tools or translate existing materials to better serve their patients. However, in some cases, it may be difficult to find a hospital with similar needs, or there may be organizational barriers or restrictions to jointly developing, owning, and sharing materials. Working with other hospitals and health care organizations is a great step forward, but collaborative opportunities can be expanded by involving other disciplines, groups, and the community in general.

Engaging the Community

Involving the community and making use of external resources can help hospitals take steps toward developing a more diverse workforce, bridging cultural barriers, and becoming a more active part of the community.⁴²


Community Partnerships to Create a More Diverse Workforce Collaboration with academic institutions and training programs has the power to provide a comparable opportunity for hospitals that are not affiliated with health professional teaching programs to establish potential sources for recruiting and training a more diverse workforce.⁴³ In *Exploring Cultural and Linguistic Services in the Nation’s Hospitals: A Report of Findings (HLC Report of Findings)*,

⁴² Practices that engage the community have been recommended by both the *HLC Report of Findings* — “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” (Recommendation 6-1) — as well as CLAS Standard 12: “Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.”

⁴³ *Improving Communication — Improving Care* recommends, “The organization partners with educational institutions and other community organizations to achieve workforce goals and enhance services, especially for communication-vulnerable populations” (Content Area 4, Performance Expectation 3.0).

the research framework suggests that “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” [3]. This type of opportunity is not exclusive to hospitals affiliated with health professional teaching programs. One western hospital mentioned that they are participating in a foreign nurse program with a local community college. As a member of their human resources staff said, “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.” Programs such as these have the potential to provide hospitals with a more diverse workforce. As the CEO remarked, “Our hope, our desire, is to hire many more bilingual staff members.”

One issue to keep in mind with retraining foreign-born staff is that literacy and language competency need to be assessed in both the target language and English. As one TAP member suggested, this practice could be improved if coupled with English as a Second Language classes for the nurses being recruited and retrained.



“We are working with [a] county hospital. We want to be able to share our resources, [especially for] the [less common] languages we see like Arabic, Croatian, etc.”

—C&L services staff from
a western hospital



Partnerships among hospitals, local training programs, and academic institutions are not limited to retraining foreign-born medical staff. Hospitals should consider reaching out to any local programs that provide training in bilingual medical interpretation, giving students the opportunity to complete an internship or shadow professional healthcare interpreters. Alternately, if these types of programs do not currently exist in the community, local colleges or training programs can work together with hospitals to establish partnerships to develop and train bilingual staff. Obviously, developing new training programs requires both time and money, which can be difficult to find, but a number of partnerships have made available the structure of their programs as well as some lessons learned, upon which hospitals can draw [31-33].

Additionally, partnerships should not be limited to colleges and secondary education institutions. A western hospital mentioned working with a local high school to financially support high school students who want to go to college for health care interpreting. As many high school students are unaware of such opportunities, it is important to reach out to the community and establish relationships with local schools. However, one TAP member commented, “Few colleges offer medical interpretation as a career,” so this type of collaboration may not always be an option. Therefore, hospitals should supplement their recruitment efforts with ongoing training of existing bilingual staff.

Using Community Leaders to Bridge Cultural Barriers To better address cultural or religious health beliefs, hospitals can develop relationships and collaborate with cultural or religious leaders in the community to meet patients’ needs. One western hospital, for example, discussed their cooperative relationship with a local American Indian medicine man. Through such partnerships, traditional healers are on hand to provide guidance to patients and staff on how to bridge gaps between traditional and Western medicine.

The practice of developing partnerships with traditional healers is not limited to any particular culture. A shaman, for example, may help bridge cultural barriers for Southeast Asian populations, or a curandero may help address the needs of patients of Mexican descent. However, these part-

nerships should not be exclusive to traditional healers. As many patients may have cultural needs related to religious beliefs, hospitals should develop relationships with local religious leaders and institutions to provide resources and guidance for serving patients with specific needs. The National Center for Cultural Competence’s *Sharing a Legacy of Caring: Partnerships Between Health Care and Faith-Based Organizations* may help organizations explore the potential benefits and barriers to developing these types of collaborations [34]. In addition, hospital chaplains often serve as cultural brokers, helping hospitals address patients’ cultural needs. While these partnerships may help fill existing gaps in a hospital’s C&L-related services, they can also present major challenges. As one TAP member mentioned, this type of collaboration, such as allowing traditional ceremonies to be performed at the hospital, may require a change in organizational policies. Staff training on accessing these services and understanding their role in the provision of culturally competent care may also be required.

Becoming an Active Member of the Community

Engaging the community also involves reaching out to community members and raising awareness of services available at the hospital. These activities can include such strategies as advertising and recruitment drives; however, community interaction can consist of activities that are considered more grassroots. One southern hospital, for

“We go to [high school] job fairs. Having a bilingual recruiter helps us a lot with these efforts [because] they can influence the ideas that some students may have about getting into health care or nursing. We just had a scholarship for education aimed at vulnerable populations. By [receiving] that, [students] are committ[ed] to com[ing] back here and work[ing] for us.”

—Human resources staff from
a western hospital

example, shared that they hired a Hispanic staff person to work with lay health educators in the Hispanic community to educate community members on how to use the hospital. A western hospital mentioned that they have made formal efforts to talk to the community and inform them about the various services the hospital provides. This type of outreach can both raise awareness of available services and provide a means of establishing organizational commitment and a level of trust within the community.

As hospitals reach out to their communities, they should also consider ways in which they can provide avenues for making community services more cohesive.⁴⁴ To do this, hospitals need to identify the various services that their patients may encounter throughout the continuum of care. One northeastern hospital, for example, trains their interpreters to raise awareness of public assistance programs and the State Children’s Health Insurance Program (SCHIP) to help with hospital reimbursement. A CEO from a western hospital mentioned that their web site includes, “a lot of other programs that . . . provide non-health care support—food coupons [and] other types of temporary housing assistance that we can provide to patients when we need to.” Alternatively, hospitals can also provide resources on local adult learning programs for patients with limited health literacy skills.⁴⁵ These efforts may help hospitals develop relationships to revise existing materials or create new materials that not only meet patients’ language needs but also their health literacy needs.⁴⁶

⁴⁴ *Improving Communication — Improving Care* recommends that a health care organization work “with its community partners to facilitate communication outside of clinical encounters, emphasizing the needs of communication-vulnerable populations.” Once this partnership is established with the community, the AMA’s Ethical Force Program suggests that they “work together to identify resources, services and assets available within the community to aid in communicating about health and health care, especially for communication-vulnerable populations” (Content Area 3, Performance Expectations 3.1 and 3.2).

⁴⁵ *Improving Communication — Improving Care* suggests that “the organization [work] with the populations it serves and community organizations to help improve health literacy” (Content Area 5c, Performance Expectation 7.0).

⁴⁶ Recommendation III from “*What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety*” suggests that health care organizations “refer patients with low literacy to adult learning centers, and assist them with enrollment procedures” and “encourage partnerships among adult educators, adult learners, and health professionals to develop health-related curricula in adult learning programs, and conversely . . . assist in the design of patient-centered health care services and interventions.”

Conclusions

Collaboration, whether internal or external, may provide new avenues for hospitals currently undertaking cultural competence initiatives. There is no doubt that collaboration needs to play a role in all the practices outlined in this report. For example, as hospitals develop C&L-related organizational policies and procedures, leadership should engage and bring together stakeholders from multiple departments in order to understand the environment (supports, constraints, etc.) in which current procedures are being carried out (see Chapter 4: Building a Foundation). Collaboration may also have implications for data collection (see Chapter 5: Collecting and Using Data to Improve Services) as hospitals may find external organizations that they can work with to collect community-level data. Additionally, partnerships with external organizations may increase access to resources that supplement the services provided by the hospital (see Chapter 6: Accommodating the Needs of Specific Populations). Building active relationships with cultural brokers, traditional healers, chaplains, religious leaders, and other individuals may enhance and extend the hospital’s existing C&L services. While collaborative efforts come with their own challenges, building partnerships that bring together the champions of culturally and linguistically appropriate care has the potential to move the entire field forward. The self-assessment questions provided in chapter 8 can help hospitals and other health care organizations further explore opportunities for internal or external collaborations for better meeting the needs of diverse patient populations.

“[The director of community outreach and interpreter services] has taken a step with the interpreters — that they should not just function within the four walls of the hospital; they should actually be out in the community. . . . This hospital, through its interpreter services and other services as well, has truly gone out and has mined the intelligence that’s out in the community — the epidemiology that’s out in the community, the different religious groups, and people living in the community — and said, ‘How can we best react to that?’”

—CEO from a northeastern hospital”

CHAPTER 8: *Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool*



Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings (HLC Report of Findings) showed us a snapshot of 60 hospitals at different points of the cultural competence continuum [3]. It also confirmed that hospitals are challenged to meet the diverse cultural and language (C&L) needs of the patients they serve. Until evidence-based practice standards for cultural competence are developed, hospitals must continue to meet these diverse needs as best they can.

Hospitals are complex institutions, each with unique demographic, regional, historic, and financial contexts. In order for C&L practices to be effective, they should be designed to meet the needs of the organization and its patients. It is our hope that this report and the self-assessment tool contained in this chapter will help hospitals and other health care organizations tailor initiatives to provide culturally and linguistically appropriate care.

The Self-Assessment Tool

Site visits for the *Hospitals, Language, and Culture* (HLC) study brought together individuals at each hospital for focused discussions about how care is being provided to patients from culturally and linguistically diverse backgrounds. The interview sessions were exploratory, allowing participants to share their experiences and challenges in meeting C&L needs. We found that bringing staff together to dialogue about how their organization was meeting these needs was informative not only for the study, but for participants as well. Hospital staff often found themselves viewing these issues from a new perspective and generating new ideas for approaching these situations.

The self-assessment tool at the end of this chapter can be used to guide these types of discussions and engage members of the organization in conversations about the needs, resources, and goals for providing the highest quality care to every patient served. The tool consists of questions, generally open-ended, that are built around the concepts outlined in chapters 4 through 7. The questions are not evaluative, and there are no right or wrong answers. The

tool is designed to help hospitals and other health care organizations discuss and explore current C&L practices in order to identify potential gaps and areas for improvement. We believe that the tool presented here will stimulate these moments of discovery and help staff see their C&L services in the context of the organization as a whole.

How to Use the Tool

The goal of this tool is to engage diverse staff members from different sectors of the organization to come together and explore how they are currently addressing patients' C&L needs. The benefit of the tool is that it allows organizations to think broadly about how they meet the needs of diverse patient populations and consider how processes may be improved upon to reflect the organization's focus on achieving optimal patient outcomes and reducing health disparities.

Bringing People Together Organizations will likely find different ways to use the self-assessment tool. Some organizations may decide that they wish to bring together a multidisciplinary group or create a high-level task force — as described in Chapter 4: Building a Foundation and Chapter 7: Establishing Internal and External Collaborations — to go through the self-assessment questions. Another option is to bring together smaller groups, drawing from different organizational levels or disciplines. Some organizations may decide to appoint either a team or individual to spearhead the process. It may also be useful to have a group facilitator help guide discussions and give members of the group an opportunity to provide input.

Bringing people together to explore C&L issues can be a useful way to share information and ensure that everyone is on the same page. In addition, individual interviews can provide details and enrich the information collected. Organizations may consider using a combination of methods to conduct their self-assessment. While some organizations may choose to complete their assessment in a one-day session, others may prefer a series of shorter meetings.



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Methods for Conducting Self-Assessment

- Focus groups
- In-services
- Lunch meetings
- Seminar series
- Small-group interviews
- Staff retreat
- Targeted interviews

Choosing Participants Regardless of which method is used, it will be important to collect information from a range of staff representing different disciplines and levels. A diverse group of stakeholders will bring varying experiences with C&L issues to the table and provide a more well-rounded view of how the organization is currently meeting the needs of diverse patients.

Potential Participants

- Chaplain
- Chief executive officer
- Chief medical officer
- Chief nursing officer
- Chief operating officer
- Community members
- Dietary services
- Diversity officer
- Financial assistance/billing staff
- Human resources director
- Information technology staff
- Intake staff
- Language services coordinator
- Medical staff
- Nursing staff
- Patient advocates
- Patient safety officer
- Patients and families
- Quality improvement officer
- Recruiter
- Risk management officer
- Social services
- Staff/clinical educator

Beyond Self-Assessment

Self-assessment should be a continuous process. Once an organization has explored the practices that it has in place to meet C&L needs, these practices should be monitored and evaluated. The HLC study found that some hospitals developed practices to meet specific C&L needs, but sometimes they did not achieve the desired results. For example, a hospital may have a contract with a telephone

interpreting service, but discover that staff do not use it. To understand why this disconnect occurs, the organization should determine what factors contribute to the underuse of the service — perhaps staff is unaware that the service is available or is not comfortable using it.

We encourage organizations to have frequent dialogues about the practices that are employed, including how the practices are being evaluated. Asking questions such as *Are the practices meeting their intended aims? How effective are these current practices? How well are they fitting in with other hospital processes/services? Are there any barriers that still need to be addressed? What improvements can be made? Have the practices resulted in any unintended consequences?* should be a continuous part of ongoing organizational improvement.

Organizations may also consider conducting a self-assessment in conjunction with a gap analysis of current practices, using resources such as the recommendations of the *HLC Report of Findings* and the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

As health care organizations plan for new C&L practices, it is important that they understand the desires and needs of their staff. Consideration for the preferences of the staff who utilize these services is one way to encourage the effective implementation of new practices. In addition, new services should be easy to use and impose minimal delay to care and treatment [35].

This report does not provide a step-by-step guide to becoming culturally competent. The road map to cultural competence is unique for each organization, and there is no “one size fits all” solution. As shown by HLC study hospitals, motivators and journeys toward cultural competence are distinct. It is our hope that this report can help organizations tailor their initiatives to meet the unique needs of their diverse patient populations.



Self-Assessment Tool

We provide this self-assessment tool to help organizations evaluate the way they currently provide care and services to diverse patient populations. The tool is intended to address the main issues that emerged from the *Hospitals, Language, and Culture* (HLC) study, and the questions are designed to promote discussion around the need to improve or expand current initiatives to meet patients' cultural and language (C&L) needs. The questions are organized by four key themes: Building a Foundation, Collecting and Using Data to Improve Services, Accommodating the Needs of Specific Populations, and Establishing Internal and External Collaborations.

Building a Foundation

Developing a Supportive Infrastructure for Cultural Competence

1. How does our leadership currently support the provision of culturally competent care?
2. In what ways does our mission statement or other guiding principles (e.g., vision, values) reflect an organizational commitment to providing culturally competent care?
3. How have we operationalized our commitment to the provision of culturally competent care into organizational actions, procedures, services, and resources?
 - How do our C&L services reflect an understanding of the needs of the population?
 - What resources (e.g., financial, staff) have we dedicated to C&L activities?
 - o Which internal resources have been identified to support C&L activities and improve patient-provider communication?
 - o Which external resources have been explored to provide or pay for C&L activities and improve patient-provider communication?
4. In what ways have we used the National Standards for Culturally and Linguistically Appropriate Services (CLAS) or other guidance⁴⁷ to incorporate cultural competence into organizational planning?
5. Which organizational policies and procedures, if any, set expectations for staff for providing culturally and linguistically appropriate care?
 - Do we have policies and/or procedures that address the following:
 - o Reinforcing the importance of cultural sensitivity and effective communication in the provision of care
 - o Supporting the use of professional health care interpreters
 - o Discouraging the use of family, minors, or other untrained individuals as interpreters
 - o Suggesting which types of language services are appropriate for certain situations (e.g., on-site, telephone, video)
 - o Requiring the use of language services throughout the continuum of care
 - o Resolving or mediating any cross-cultural conflicts that may arise
 - What training have staff received regarding these policies and procedures and how to abide by them?
 - How is compliance with these policies and procedures monitored?

Integrating Culture and Language into Organizational Systems

6. Which of our organizational goals support staff diversity?
 - What are our strategies for staff recruitment?
 - What are our strategies for staff retention?

⁴⁷ Other guidance may include the United States Department of Justice's *Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance* [36], United States Department of Health and Human Services' *Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations* [37], and the American College of Healthcare Executive, American Hospital Association, Institute for Diversity in Health Management, and National Center for Healthcare Leadership's *Strategies for Leadership: Does Your Hospital Reflect the Community It Serves, A Diversity and Cultural Proficiency Assessment Tool for Leaders* [38].



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7. Which members of our organization are responsible for coordinating C&L initiatives?
 - In what ways does leadership support those in charge of C&L initiatives?
8. Is there a dedicated staff position for coordinating C&L initiatives?
 - o What are the position's specific responsibilities?
 - o Does this position report to an executive in the organization?
 - Is there a high-level task force that coordinates C&L initiatives?
 - o Who serves on the task force?
 - o How many members are internal or external to the organization?
 - o Are there a range of staff levels and disciplines represented?
 - o How often does the task force meet?
 - o How does the task force review policies and procedures to ensure they address the diverse needs of patients and staff?
 - o How does the task force support efforts for ongoing cultural competence training for staff at all levels?
 - o What is the process for implementing task force recommendations?
9. What types of financial systems are in place to remove barriers to using C&L services?
 - How do we budget funds for the provision of culturally appropriate services?
 - o How do we budget funds for the provision of language services?
 - o Can we manage costs by cancelling/rescheduling interpreter appointments when patients cancel/reschedule appointments?

Integrating Cultural Competence into Patient Care

10. Are we effectively using staff across disciplines to provide culturally and linguistically appropriate care?
11. What formal systems do we have for identifying patients' C&L needs?
 - Have we determined the first points of contact at which C&L needs are best identified?
 - How do staff handle phone calls from patients with language needs?
 - How does the phone system handle calls from patients with language needs (e.g., automated system, operator)?
 - How do we ensure that information regarding C&L needs follows the patient throughout the continuum of care?
12. What tools are provided to staff to determine the appropriate language services?
 - What resources are available to identify language needs (e.g., "I Speak" cards, telephone interpreting services)?
 - What training have staff received to understand and use the resources available to identify language needs?
13. What tools and resources are available to staff to help them meet patients' cultural needs?
 - How are staff made aware of these tools?
 - What type of training have staff received to help them meet the unique cultural needs of the patient population?
14. How are staff made aware of the availability of C&L services?
 - Are interpreter services incorporated at the patient care level to ensure visibility?
 - What type of training have staff received regarding the appropriate use of C&L services?
15. What type of training have staff received regarding how to access C&L services?
 - Are staff aware of the regulatory requirements, mandates, and national standards regarding the provision of language services?
 - What internal materials are available on how to access C&L services during hours, after-hours, and for certain departments (e.g., the emergency room)?
 - How are C&L services accessed (e.g., on-site interpreters, contract interpreters, telephone or video language services, chaplain, religious and spiritual services, dietary services, etc.)?

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16. What type of training is required for those providing language services?
- If using staff to interpret:
 - o Is there a policy that ensures staff are proficient in English and the target language, including relevant medical terminology?
 - o Is there a policy that ensures staff understand the role of the interpreter, Health Insurance Portability and Accountability Act (HIPAA) and confidentiality issues, and interpreter codes of ethics and standards of practice?
 - o Are there requirements for ongoing testing and training?
 - o Have guidelines been developed for dual-role interpreters?
 - If using an outside vendor for language services:
 - o Are there standards for training and competency that agency interpreters have to meet?
 - o Does the hospital ensure that outside vendors comply with hospital policies and procedures related to such issues as language proficiency, the role of interpreters, HIPAA, confidentiality, ethics, and standards of practice?
 - o How do we ensure that contract interpreters are meeting those standards?
17. What types of written materials (e.g., informed consent, medication information, discharge instructions) does our organization create or have translated into patients' primary languages?
- Are professional translators used to translate materials?
 - Is there a formal quality review process for these materials?
 - Is there a central repository for translated documents to minimize duplication and control the quality of the documents?
 - How are health literacy and cultural issues addressed by written materials?
 - Are other options available for patients with low literacy or low health literacy skills (e.g., video or audio instructions)?
 - What is the process for tracking print materials for revisions and updates?

Collecting and Using Data to Improve Services

Assessing the Need for C&L Services

18. How have we assessed the C&L needs of the community?
- What type of community-level demographic data do we collect (e.g., age, gender, race/ethnicity, primary spoken and/or written language, socioeconomic status, religion, health literacy level, etc.)?
 - o How often are these data collected?
 - o Are these data self-reported?
 - o Do staff in all departments/care units have access to these data?
 - What methods do we use to collect data from the community?
 - o Have we conducted individual interviews and/or focus groups with community leaders, patients, and local businesses?
 - o Are there other data regarding community demographics that we can access?
19. How have we assessed the C&L needs of our patients?
- What type of patient-level demographic data do we collect (e.g., age, gender, race/ethnicity, primary spoken and/or written language, religion, sexual orientation, disabilities, cultural needs, dietary needs, health literacy level, etc.)?
 - How do we ensure the accuracy of the data?
 - o Do we collect data directly from our patients?



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- o Are staff trained on the best way to obtain data in a manner that is respectful to the patient and comfortable for the staff?
 - o Has the organization utilized tools such as the Health Research and Educational Trust (HRET) Toolkit for collecting data on race, ethnicity, and primary language to aid their data collection efforts?
 - What are our policies and/or procedures that address the systematic collection of data?
20. How are these data used to create C&L initiatives?

Monitoring C&L Service Utilization

21. How are cultural issues incorporated into patient care?
- How often do cultural issues have an impact on patient care?
 - Do staff consider religious and spiritual beliefs, cultural beliefs, folk remedies, traditions, rituals, and alternative medicine when providing care?
 - What skills do staff have to explore patients' perspectives including cultural and religious beliefs related to health, illness, and treatment?
 - Do staff document situations in which cultural issues arise?
 - o Do chaplains record encounters with patients?
 - o Are dietary considerations regarding culture and/or religion recorded?
22. How are language issues incorporated into patient care?
- Is there formal documentation of interpreter encounters?
 - o Where is the encounter documented (e.g., interpreter log, patient's medical record)?
 - o Is the type of interpreter documented (e.g., on-site, telephone, video)?
 - o Is there a policy for documenting interpreter encounters?
 - o Are staff educated on the importance of documenting interpreter encounters?
 - Are encounters documented when an interpreter has been offered but has been refused by a patient?
 - o Is there a policy for documenting the refusal of interpreter services?
 - o Are staff educated on the importance of documenting the refusal of interpreter services?
 - Are the different forms of interpreters (e.g., on-site, telephone, video) evaluated for efficiency, cost, and quality?
23. How are data regarding the use of C&L services reviewed and compared to the C&L needs identified through demographic data collection?

Using Data to Improve C&L Services

24. What is the baseline for the C&L services we currently provide?
- Can we use this baseline to compare our progress as we improve C&L services?
25. How do we measure the quality of our C&L services?
- What systems are in place to collect feedback from patients and staff?
 - Are we asking the right questions to obtain information regarding the care we provide to patients with C&L needs?
 - How do we obtain feedback from patients with language needs?
 - o Do patient satisfaction surveys include questions about C&L services?
 - o Is there a mechanism in place to translate written surveys and patient responses?
 - o Are focus groups and patient interviews used to obtain patient satisfaction data?
 - Are our patients satisfied with the communication services, resources, and tools provided to them?
 - How are these data used to improve C&L services?

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26. How are data used to identify disparities in health care and improve C&L services?
- Are data regarding outcomes, performance and quality indicators, adverse events, etc., stratified by demographic variables?
 - Which demographic variables are used to stratify data?
 - Is there an information system in place to link demographic data to other information to facilitate analysis?
 - Are these results used to improve the C&L services provided for diverse populations?

Accommodating the Needs of Specific Populations

Promoting Staff Awareness through Training, Dialogue, and Support

27. How does staff training address the importance of effective communication in the provision of care?
- Does training address the roles that language, literacy, and culture play?
 - Are these issues addressed during orientation and ongoing training?
 - Are staff provided training on how to access available resources to meet the C&L needs of patients?
 - Are they trained to access on-site interpreters, telephone, or video interpreters?
 - What type of training have staff received on how to work with interpreters?
28. How are staff educated on the unique C&L needs of the patients served?
- Do staff receive cultural competence training?
 - When does training occur?
 - Is the training required or optional?
 - How often is training provided (e.g., during orientation, annually to all staff)?
 - What issues are addressed in the training?
 - Who provides the training?
29. What educational materials and tools are staff provided regarding the C&L issues of the service community?
- Are there any online applications or intranet resources that provide cross-cultural information?
 - Do staff have an opportunity to dialogue about the cultures and languages encountered?
 - Are staff required to demonstrate competency regarding the use of C&L resources and tools?
30. How can technology enhance or better facilitate existing language services?
- Are staff trained to properly use telephone or video medical interpreting services?
 - Is the appropriate equipment present in patient rooms (e.g., speakerphone, dual handset telephones, video equipment)?
 - Are speech output devices and/or bilingual communication boards made available to supplement language services?

Creating an Environment that Meets Specific Patient Needs

31. What aspects of the physical environment have been evaluated to determine whether they meet specific patient needs?
- Is signage readable, in appropriate languages, and available throughout the organization?
 - Is it easy for patients to identify and access the organization's entry points?
32. What changes have we made to the physical environment that support patient diversity?
- Are there rooms available for special patient needs such as prayer, family conferences, and individual consultations?
 - Do we have patient rights and responsibilities documents translated into our most dominant languages and posted in clear view of all major entry points?
 - Have we considered ways to accommodate patients with large families?



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33. How have we adapted our patient care services to incorporate cultural beliefs?

- Is there a need to modify visitation hours to accommodate patient needs?
- How can we adjust our policies and procedures to accommodate cultural considerations?
- Do our dietary menus reflect our commitment to diversity and culturally competent care?

Helping Patients Manage Their Care

34. What programs do we have that help patients understand and navigate the health care system?

- Do we have educational resources that explain the health care system?
- What mechanism is in place for patients to ask questions about the health care system?
- Are staff available to assist patients with insurance, payment, and logistical issues?

35. What types of patient education and training do we provide that help patients make informed decisions and actively participate in their care?

- Does our in-house pharmacy translate prescription and warning labels into the most common patient languages?
- Do discharge instructions take into account such factors as a patient's language, health literacy, cultural beliefs, access, child care, family support, etc.?
- How can technology be used as a tool to provide patient education?
 - Are electronically translated patient education materials assessed for accuracy?
- Are patients given an opportunity to ask questions regarding their instructions?
- How are patients assessed for comprehension of their instructions (e.g., asked questions, teach-back processes)?

Establishing Centralized Programs that Meet Specific Needs of Large Populations

36. What culturally centered programs have been developed to address the needs of our larger populations?

- Are there any current programs that could be more culturally focused?

37. What programs have been built around religious and spiritual beliefs?

- Is our chaplaincy service diverse and inclusive of multiple religions?

Establishing Internal and External Collaborations

Working Together within the Hospital

38. How are activities and initiatives related to culturally competent care being coordinated within our organization?

- How are we involving different stakeholders from across the organization to collaborate in C&L efforts?
 - Committees may consist of:
 - Staff (clinical and administrative leadership, nursing, medical staff, pastoral care, interpreting services, social work, human resources, patient safety/risk management, quality improvement staff, cultural brokers, community outreach/marketing, etc.)
 - Patients
 - Community leaders
 - Religious leaders
- Do stakeholders represent varying perspectives within the organization (including various departments, positions, professional levels)?
- Do stakeholders represent the varying perspectives within the community (e.g., cultures, religions)?
- What activities are stakeholders overseeing?
 - How are these C&L activities being centrally coordinated?
- How are stakeholders addressing patient and/or staff concerns related to C&L issues?

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Building Bridges with Other Hospitals

39. What existing resources can we share with other organizations or local, state, and national associations?
- Are there best practices related to implementing culturally competent care that we could share with other organizations?
 - Are there any lessons learned from implementing culturally competent care that would be useful to share with other organizations?
 - What types of information would we like to learn from other organizations?
 - What resources are available that other organizations can share with us?
 - What organizations or types of organizations do we want to share information or resources with?
40. What resources or materials do we want to develop in collaboration with other organizations?
- Are there specific types of resources we want to develop with other organizations (e.g., a multi-hospital interpreter network, educational resources, or translations of vital documents such as consent forms, complaint forms, patient rights information, intake forms, etc.)
 - Which languages should we target?
 - Which hospitals or other health care organizations should we collaborate with?

Engaging the Community

41. How many community representatives are involved in our C&L-related committees?
- On what other committees would having community representatives be helpful?
 - Do the community representatives currently involved provide perspectives of the diverse needs of the populations we serve?
42. What opportunities have we identified to partner with educational institutions to recruit and train a diverse workforce?
- What opportunities are available for training current staff?
 - What types of recruitment opportunities are available in the surrounding community?
 - What incentives are we providing to recruit and train a diverse, bilingual staff?
 - Are there opportunities for developing a future diverse workforce?
43. Which community resources exist that could help us better meet C&L needs?
- What community organizations or networks can we collaborate with to help bridge cultural barriers?
 - What religious leaders or chaplains have we developed relationships with to meet patient needs?
 - Are there traditional healers within the community to whom we can reach out?
 - How have we trained staff to be aware of and access these external resources?
44. How have we reached out to the community and/or facilitated access to both internal and external services?
- Are patients aware of the community programs or services available that relate to patients' continuum of care?
 - Are there public assistance programs that we could help patients become more aware of as part of their overall care?
 - What adult learning programs could we partner with to help with issues of health literacy?



Appendix A: Endnotes

1. Smedley BD, Stith AY, Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press; 2002.
2. Hasnain-Wynia R, Yonek J, Pierce D, Kang R, Greising CH. *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*. Chicago, IL: Health Research & Educational Trust and the National Health Law Program; 2006.
3. Wilson-Stronks A, Galvez, E. *Hospitals, Language, and Culture: A Snapshot of the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals A Report of Findings*. Oakbrook Terrace: The Joint Commission; 2007.
4. Brashers DH, Stephen M, Neidig JL. The Patient Self-Advocacy Scale: Measuring patient involvement in health care decision-making interactions. *Health Commun*. 1999;97-121.
5. Marelich WD, Murphy, DA. Effects of empowerment among HIV-positive women on the patient-provider relationship. *AIDS CARE*. 2003;15:475-481.
6. Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. Jan 2003;111(1):6-14.
7. Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care*. Apr 2007;19(2):60-67.
8. The Joint Commission. *Root Causes of Sentinel Events 2006*. Available at: http://www.jointcommission.org/NR/rdonlyres/FA465646-5F5F-4543-AC8F-E8AF6571E372/0/root_cause_se.jpg. Accessed February 19, 2008.
9. Woolf SH, Kuzel AJ, Dovey SM, Phillips RL Jr. A string of mistakes: the importance of cascade analysis in describing, counting, and preventing medical errors. *Ann Fam Med*. Jul-Aug 2004;2(4):317-326.
10. Jacobs EA, Shepard DS, Suaya JA, Stone EL. Overcoming language barriers in health care: costs and benefits of interpreter services. *Am J Public Health*. May 2004;94(5):866-869.
11. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res*. Apr 2007;42(2):727-754.
12. Brach C, Fraser I. Reducing disparities through culturally competent health care: an analysis of the business case. *Qual Manag Health Care*. Summer 2002;10(4):15-28.
13. Schyve PM. Language differences as a barrier to quality and safety in health care: The Joint Commission perspective. *J Gen Intern Med*. 2007 Nov;22 Suppl 2:360-1.
14. American Medical Association, The Ethical Force Program. *Improving Communication — Improving Care: How Health Care Organizations can Ensure Effective, Patient-Centered Communication with People from Diverse Populations*. Chicago, IL: Ethical Force Program, American Medical Association; 2006.
15. United States Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington, DC: HHS; 2001.
16. The Joint Commission. *What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety*. Oakbrook Terrace, IL: The Joint Commission; 2007.

Appendix A: Endnotes



17. Adapted from Cross et al., 1998 and US Department of Health and Human Services, Office of Minority Health, 2000. Available at: www.ahrq.gov/about/cods/cultcompdef.htm. Accessed December 19, 2006.
18. National Council on Interpreting in Health Care. *The Terminology of Health Care Interpreting: A Glossary of Terms*. Washington, DC: National Council on Interpreting in Health Care; 2001. Available at: www.hablamosjuntos.org/pdf_files/TheTerminologyofHealthCareInterpreting.pdf. Accessed on February 19, 2008.
19. Jacobson KL, Gazmararian JA, Kripalani S, McMorris KJ, Blake SC, Brach C. *Is Our Pharmacy Meeting Patients' Needs? A Pharmacy Health Literacy Assessment Tool User's Guide*. (Prepared under contract No. 290-00-0011 T07) AHRQ Publication No. 07-0051. Rockville, MD: Agency for Healthcare Research and Quality; October 2007.
20. United States Department of Health and Human Services, Office for Civil Rights. *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. Washington, DC: HHS;2003:68 Fed. Reg. At 47311-47323.
21. Paras M. *Straight Talk: Model Hospital Policies and Procedures on Language Access*. Oakland, CA: California Health Care Safety Net Institute; 2005.
22. Georgetown National Center for Cultural Competence. *Cultural and Linguistic Competence Policy Assessment*. Available at: www.clcpa.info/. Accessed February 21, 2008.
23. University of Kansas, Work Group for Community Health and Development. *Conducting Concerns Surveys*. Available at: ctb.ku.edu/en/tablecontents/section_1045.htm. Accessed February 19, 2008.
24. Executive Office of the President, Office of Management and Budget (OMB), Office of Information and Regulatory Affairs. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Federal Register Notice. Washington, DC: Executive Office of the President; October 30, 1997. Available at: www.whitehouse.gov/omb/fedreg/1997standards.html. Accessed February 19, 2008.
25. Hasnain-Wynia R, Pierce D, Haque A, Hedges Greising C, Prince V, Reiter J. *Health Research and Educational Trust Disparities Toolkit*. Chicago, IL: Health Research & Educational Trust; 2007. Available at: www.hretdisparities.org. Accessed February 19, 2008.
26. United States Department of Health and Human Services, Health Resources and Services Administration. *Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency*. Available at: www.hrsa.gov/healthliteracy/training.htm. Accessed on February 22, 2008.
27. United States Department of Health and Human Services, Office of Minority Health. *A Physician's Practical Guide to Culturally Competent Care*. Available at: ccm.thinkculturalhealth.org/. Accessed on February 22, 2008.
28. Kelly N. Telephone interpreting in health care settings: some commonly asked questions. *The ATA Chronicle*. June 2007. Available at: www.atanet.org/chronicle/feature_article_june2007.php. Accessed on February 19, 2008.
29. Freeman HP, Muth BJ, Kerner JF. Expanding access to cancer screening and clinical follow-up among the medically underserved. *Cancer Pract*. 1995;3:19-30.



Appendix A: Endnotes

30. Freeman HP. A model patient navigation program. *Oncol Issues*. 2004 Sept/Oct;19:44-46.
31. Central Nebraska – Area Health Education Center, Inc., Hablamos Juntos. *Developing a Medical Interpreting Training Program*. Fresno, CA: Hablamos Juntos; 2005. Available at: www.hablamosjuntos.org/resource_guide_portal/pdf/13Training_Program-CNAHEC.pdf. Accessed February 19, 2008.
32. Hablamos Juntos. *Educational Partnerships for Interpreter Training: An Hablamos Juntos Initiative*. Fresno, CA: Hablamos Juntos; 2005. Available at: www.hablamosjuntos.org/resource_guide_portal/pdf/12Training_Program_Profile_091405.pdf. Accessed February 19, 2008.
33. National Linguistic & Cultural Programs (NLCP), Kaiser Permanente. Health Care Interpreter Certificate Program [webpage]. Available at: www.kphci.org/. Accessed February 19, 2008.
34. National Center for Cultural Competence. *Sharing a Legacy of Caring: Partnerships Between Health Care and Faith-Based Organizations*. Washington, DC: Georgetown University Child Development Center; 2001.
35. Regenstein M. Measuring and improving the quality of hospital language services: insight from the Speaking Together collaborative. *J Gen Intern Med*. 2007; 22(Suppl 2):356-9.
36. United States Department of Justice, Coordination and Review Section, Civil Rights Division. *Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance*. Washington, DC: DOJ. Available at: www.lep.gov/selfassesstool.htm. Accessed February 19, 2008.
37. United States Department of Health and Human Services, Office of Minority Health. *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. Washington, DC: HHS; 2005. 1-253.
38. American College of Healthcare Executives, American Hospital Association, Institute for Diversity in Health Management, National Center for Healthcare Leadership. *Does Your Hospital Reflect the Community it Serves?: A Diversity and Cultural Proficiency Assessment Tool for Leaders*. Chicago, IL: American Hospital Association; April 2004. Available at: www.aha.org/aha/content/2004/pdf/diversitytool.pdf. Accessed February 19, 2008.
39. Adapted from Cross T, Bazron B, Dennis K, Isaacs M. *Towards a Culturally Competent System of Care* (Volume I). Georgetown University Center for Child and Human Development, Washington, DC; 1989. Available at: <https://www.omhrc.gov/templates/browse.aspx?lv1=2&lv1ID=107>. Accessed December 12, 2006.
40. Jezewski MA. Cultural brokering in migrant farm worker health care. *West J Nurs Res*. 1990 Aug;12(4):497-513. Jezewski MA, Sotnik P. *Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign-born Persons*. Buffalo, New York; 2001.
41. Adapted from *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs*. Developed for the National Health Service Corps Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services by National Center for Cultural Competence, Georgetown University Center for Child and Human Development. Spring/Summer 2004.
42. Adapted from Sampson A. *Language Services Resource Guide for Health Care Providers*. The National Health Law Program and the National Council on Interpreting in Health Care. October 2006.
43. The Joint Commission. *The Joint Commission Standards for Hospitals*. Oakbrook Terrace, IL: The Joint Commission; 2008.

APPENDIX B: *Glossary*



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. Bilingual staff includes those who serve in a dual role, providing interpreter services for the hospital in addition to their primary position.

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 [39].

cultural broker: an individual who bridges, links, or mediates 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 [40]. Cultural brokers can also be medical professionals who draw upon cultural and health science knowledge and skills to negotiate with the patient and health system toward an effective outcome [41].

cultural competence: the ability of health care providers and health care organizations to understand and respond effectively to the cultural and language 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 [17].

culturally and linguistically appropriate services: health care services that are respectful of and responsive to cultural and language needs [15].

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 [39].

curandero: a traditional folk healer in some Latin American cultures dedicated to curing physical and/or spiritual illnesses.

disparities: racial and ethnic differences in health care that are not attributable to other known factors [1].

doula: an individual who assists with labor and after childbirth.

effective communication: a critical component to the patient's understanding of the informed consent process, participation in his or her care, understanding of all information provided to him or her, and ability to fulfill the responsibilities related to his or her care. In order for communication to be effective, the information provided must be complete, accurate, timely, unambiguous, and understood by the patient.

halal: dietary laws which regulate the preparation of food in accordance with Muslim principles and techniques.

Imam: a Muslim religious leader; prayer leader of a mosque.

interpreter/interpretation/interpreting: an *interpreter* is a person who renders a message spoken/signed in one language into one or more languages. The practice of *interpreting* is distinguished in this report from translating to include only spoken/signed language. *Interpreting* refers to the process of *interpretation*; *interpreter* refers to the person who is providing the interpretation [42].

language services: for purposes of this report, language services refers to those mechanisms used to facilitate communication with individuals who do not speak English and those who are deaf or hard of hearing. These services can include in-person interpretation using a professional health care interpreter, bilingual staff, or remote interpreting systems such as telephone or video medical interpreting. Language services also refer to processes in place to provide translation of written materials or signage.

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 [20].



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National Standards on Culturally and Linguistically Appropriate Services (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 [15].

professional health care interpreter: an individual with the appropriate training and experience to interpret with consistency and accuracy and who adheres to a code of professional ethics [18].

sentinel event: an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase *or the risk thereof* includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome [43].

shaman: a member of certain tribal societies who acts as a medium between the natural and supernatural world.

telephone interpreting: interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through speakerphones or headsets. 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 [18].

translator/translation/translating: a *translator* is a person who converts written text in one language into another language. *Translation* is distinguished from interpretation to refer to written language [42].

video medical interpreting: interpreting carried out 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 via a television monitor. The interpretation is relayed to the principal parties by speakerphone or through headsets. Two-way interactive television can also be used so that the other parties can interact with the interpreter as though face-to-face [18].

For more information about the *Hospitals, Language, and Culture* study, please visit www.jointcommission.org/PatientSafety/HLC/ or email hlc-info@jointcommission.org.