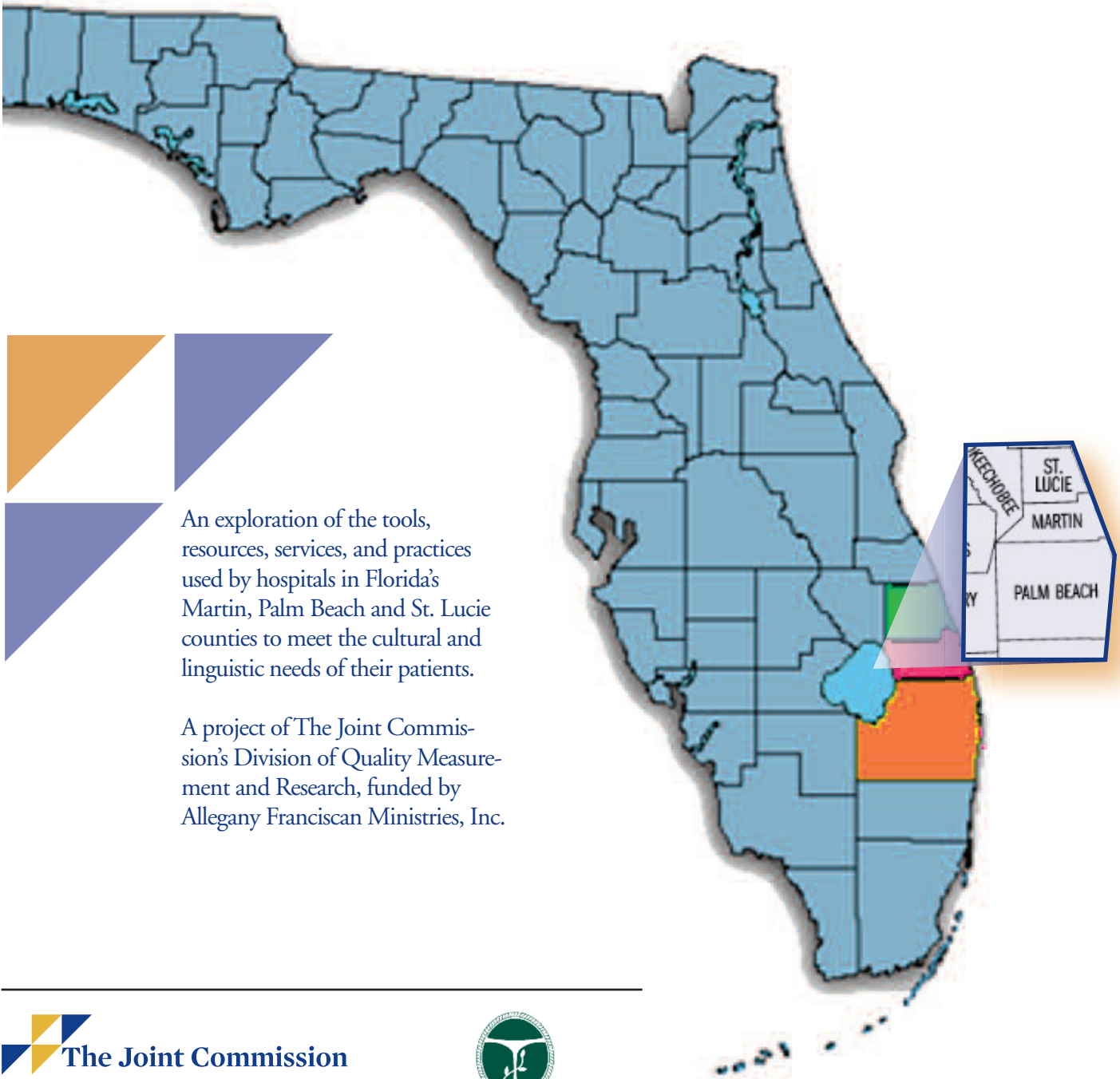


Cultural and Linguistic Care In Area Hospitals



An exploration of the tools, resources, services, and practices used by hospitals in Florida's Martin, Palm Beach and St. Lucie counties to meet the cultural and linguistic needs of their patients.

A project of The Joint Commission's Division of Quality Measurement and Research, funded by Allegany Franciscan Ministries, Inc.

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Project Staff:

Nancy Kupka, DNSc, MPH, RN
Brette Tschurtz
Amy Wilson-Stronks, MPP, CPHQ
Erica Galvez, MA

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Joint Commission Staff:

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Graphic Design:

Bill Bullerman

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Technical Advisory Panel Members:

Mary Bishop, MSN, RN, CNAA, FACHE
Chief Nursing Officer
Jupiter Medical Center

Davide Carbone
CEO
St. Mary's Medical Center

Corinne Danielson, MPH, CHES
Center Director
Sari Asher Center for Integrative Cancer Care

Lance DeLaruelle, MPA, FHFMA
Vice President, Business Services
Bethesda Healthcare System

Julio Mariaca
Program Director, Language Access
Glades Initiative

Jill Sheppell
Project Coordinator
Martin County Children's Services Council

Andrea Stephenson, MBA, MHS
Special Project Consultant
Strategic Partners Consulting

Executive Summary

Effective patient-provider communication is fundamental to safe, high quality, patient-centered health care. However, effective communication can be inhibited by a number of factors, including language and culture barriers. As the diversity of our nation continues to grow, it is increasingly challenging for hospitals and health care providers to ensure that they effectively communicate with their culturally and linguistically diverse patients.¹

In order to advance effective communication, many hospitals are implementing new policies, procedures and practices to address language and cultural barriers. Despite these efforts, many patients' language and culture needs continue to go unmet or are addressed inappropriately by healthcare providers.²

The goal of this study was to establish a baseline of the culturally and linguistically appropriate care currently provided by hospitals in our study group. This information can inform the development of interventions and tools aimed at improving the cultural competence and linguistic services available in these hospitals.

Methodology

Purposive sampling was used to select fourteen hospitals in Florida's Palm Beach, St. Lucie, and Martin Counties. Data were collected via two questionnaires. The administrative questionnaire consisted of questions related to the availability of cultural and linguistic resources and services at each study hospital. A follow up staff questionnaire was designed to identify which of these cultural and linguistic services staff were aware of, which they preferred to use and why. Study participants were asked to submit any policies, procedures, training, or educational materials related to the provision of culturally and linguistically appropriate care. Data were analyzed and supporting materials were reviewed and catalogued.

Findings

It was evident that hospitals in our study group are providing a variety of tools, resources, and services to meet their patients' cultural and linguistic needs. However, there appears to be several inconsistencies and gaps between what language tools, services, and resources hospitals are providing and what resources and practices staff actually use. Our data suggest that staff were not always aware of the availability of language tools and resources, and even when they were, did not use these tools and resources frequently. A large majority of staff responding to the survey still use "someone accompanying the patient" to communicate with LEP patients, despite evidence that this practice contributes to miscommunication and serious medical errors, and is highly discouraged by several legal and regulatory bodies^{3 4} In addition, the large majority of study hospitals utilizing bilingual staff as interpreters are not testing the competency of these staff.

Because none of the hospitals in the study group asked staff to evaluate the cultural and language access resources provided to them, and since the hospitals are not collecting the necessary data about the utilization of provided services, there is no way for them to determine the use or effectiveness of the tools and resources they are providing.

Summary and Recommendations

Providing culturally and linguistically appropriate care is challenging, as there are many barriers to overcome, even for those hospitals with well-established language programs. Hospitals in our study can improve the cultural and linguistic care they provide by:

1. *Addressing the practice of using ad hoc interpreters*⁵. This report discusses the potentially negative consequences of utilizing family members and friends as interpreters. The Office for Civil Rights issued policy guidance for Title VI compliance in 2004 that states LEP persons must be notified of the availability of free interpreting services, and the services must not require interpretations by family or friends.⁶ Bilingual staff serving in dual roles as interpreters may fall under the category of “ad hoc” if their competence to provide interpretation has not been assessed. The *Speaking Together Collaborative*⁷ found that formal training in medical interpreting along with assessment for language fluency were considered important attributes of high quality interpreters. Interpreting is a skill, and hospitals cannot rely on self reported lists of bilingual staff, but need to have a more formal mechanism to identify trained and (in the future) certified interpreters.
2. *Disseminating information to hospital staff regarding how and when to access available resources*. Even though this study found that many cultural and linguistic tools and resources are in place for our participating hospitals, orientation appears to be the primary, and sometimes the only method for communicating the availability of these resources to staff. Another lesson learned from the *Speaking Together collaborative*⁸, and confirmed by this study, is that just providing the services doesn’t guarantee they will be utilized⁹. Getting the word out to staff on a regular basis about available services, and when to use them, is an important step in making sure the patients who need these services will receive them.
3. *Collecting patient population data that can be used to plan for, and evaluate, the language and cultural services they provide to their patients*. The majority of hospitals in our study group are not collecting the appropriate data to assess their needs and usage for language access. In addition, other than tracking incident reports, hospitals are not monitoring the effectiveness of the services they are providing. Assessing each individual to determine their race, ethnicity, and language needs is an essential first step toward ensuring effective health care communication. And data collected at the hospital level are useful for assessing the quality of hospital-provided services¹⁰. One of the largest barriers most health systems face in improving quality and reducing disparities is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time¹¹. Hospitals can not begin to understand how to improve their language and cultural services until they understand the need for them. A comprehensive data collection and use analysis is beyond the scope of this study, but as advances are made in health information systems, consideration should be given to the integration and alignment of race, ethnicity and language data into all hospital information systems and using this data for service planning and to make improvements.

The findings from this study should help hospitals develop and improve practices that address the cultural and linguistic needs of their patients.

Introduction

Effective patient-provider communication is fundamental to safe, high quality, patient-centered health care; however, many factors can impact the effectiveness of communication. Some of these factors include language, culture, and health literacy. As the cultural and linguistic diversity of the US continues to grow, it is increasingly challenging for hospitals and health care providers to ensure that they effectively communicate with their culturally and linguistically diverse patients¹².

Background

In 2001 the US Department of Health and Human Services Office of Minority Health published the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.¹³ These standards were designed as a way to correct inequities that currently exist in the provision of health services and to make services more responsive to the needs of all patients.¹⁴ (See appendix 1: CLAS standards). The release of the Institute of Medicine's (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*¹⁵ in 2003 further catapulted the issue of health disparities and culturally and linguistically appropriate health care into the national spotlight. While many of the recommendations in the IOM report mirrored recommended practices in the CLAS standards, the health care field's readiness to engage was uncertain. With funding from The California Endowment, The Joint Commission engaged in a landmark national study to better understand how hospitals across the nation were addressing the challenge of meeting the increasingly diverse needs of their patient populations. Findings from the study concluded that there is a gap between current practice and the ideal set forth by the CLAS standards and the recommendations made by the IOM. However, the study also identified many promising practices and set forth several practical recommendations to move the hospital field forward¹⁶

More recently, efforts to better understand these issues have resulted in action on the part of several national quality organizations. The National Quality Forum (NQF) has endorsed 45 practices to guide healthcare systems in providing care that is culturally appropriate and patient centered¹⁷, The National Committee for Quality Assurance (NCQA) has published model practices to guide healthcare systems in providing multicultural care¹⁸, and The Joint Commission (TJC) has added to its multiple standards that support culturally and linguistically appropriate care¹⁹ through the adoption of new requirements for patient-centered communication in hospitals. These requirements were developed as part of a larger initiative, supported by The Commonwealth Fund, to increase quality and safety through effective communication, cultural competence, and patient- and family-centered care.²⁰

In addition to recommended practices and standards, a number of legal and regulatory requirements have been established in an effort to improve patient-provider communication and reduce health care disparities. Section 601 of Title VI of the Civil Rights Act of 1964, 42 USC 200d, provides that "no person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."²¹ The Office for Civil Rights issued policy guidance for Title VI compliance in 2004 that states

LEP persons must be notified of the availability of free interpreting services, and the services must not require interpretations by family or friends.²²

Why Is This Important?

Many patients find conversing with health care providers, reading health-related materials, or taking an active role in their own health care decisions challenging. Such communication challenges are particularly difficult for patients with limited English proficiency, frequently resulting in patient-provider misunderstandings and incomplete information regarding diagnoses,²³ treatment plans,²⁴ medication instructions,²⁵ medical histories,²⁶ and symptom complaints.²⁷ Communication breakdowns have been observed to contribute to adverse events,^{1 28} diminished health care quality, and low patient satisfaction.^{29 30}

In order to comply with legal and regulatory requirements, and to promote high quality care and patient safety, many hospitals are implementing new policies, procedures, and practices to address language and cultural barriers. Despite these efforts, many patients' needs continue to go unmet or are addressed inappropriately by healthcare providers.³¹ The literature has consistently demonstrated that language access services, including interpreters and translators, are essential to addressing many of the diverse communication needs of LEP patients.³² The use of professional interpreters has been shown to improve patient satisfaction, decrease rates of miscommunication and improve access to health care for LEP patients.³³ Most staff, however, are not trained to work with interpreters and have received little or no education in language or cultural issues as they relate to clinical care.^{34 35}

Language access resources, such as professional interpreters, telephone or video interpreters and translated documents are infrequently used or not available,³⁶ and healthcare providers continue to rely upon "ad hoc" interpreters, such as family members and friends, and untrained bilingual staff, despite evidence that this practice contributes to miscommunication and serious medical errors, and is highly discouraged by several legal and regulatory bodies^{37 38}

In addition to understanding the importance of utilizing professional interpreters during the clinical encounter for effective communication, it is necessary to understand the cultural differences that may contribute negatively to patient-provider communication. Intercultural communicating requires "not just an exchange of words (spoken sound and conventional symbols) but also an exchange of *shared meanings*."³⁹ This communication can be difficult when the participants are from different racial and cultural backgrounds. Interpreters and bilingual staff need to translate both the words and the "shared meaning", based from a cultural knowledge, in order to be communicate effectively.⁴⁰

Understanding why staff prefer to use one language service or tool over another is essential to ensuring that patients' linguistic and cultural needs are met. Establishing a baseline of the culturally and linguistically appropriate care currently provided by hospitals' can help inform the development of interventions and tools aimed at improving their cultural competence and linguistic services. This study was designed to address the following research questions:

¹ An adverse event is defined as any 'unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.' (Aspen 2004)

1. What services are hospitals providing to address patients' cultural and linguistic needs?
2. Which of these services are hospital staff aware of?
3. Which of these services do hospital staff prefer to use?

Methodology

Study Participants

Setting

As one of the major entry points to the US through its southeastern border, Florida is home to refugees and immigrants from the world over.⁴¹ According to the 2006 US Census Bureau's American Community Survey, Florida has the 8th largest population of individuals over the age of 5 who speak a language other than English at home. The proportion of Florida's 2006 population comprised of these individuals exceeds the national average by 6% (see Table 1) and Florida's proportion of foreign-born individuals exceeds that of the nation by 6.4%.⁴² These proportions also increased more rapidly in Florida than nationally between 2000 and 2006.

Palm Beach, St. Lucie, and Martin Counties, in particular, have become home to a variety of individuals who speak a language other than English at home or who were born outside of the United States. While many of the immigrants residing in these counties are from Cuba and Haiti, others come from far reaching areas such as Bosnia, Serbia, Iran, Vietnam, and Burundi.⁴³ The proportion of the population that is foreign born increased in each of these counties by at least 3% between 2000 and 2006, and the proportion of their populations speaking a language other than English at home increased by at least 1.9% during the same time frame (see Table 1). Although speaking a language other than English at home, or being born outside of the US, does not always determine limited English proficiency, these factors increase the likelihood that individuals may not speak or read English well enough to meaningfully engage in their health care. In addition, they may impact the ability of the individual to navigate the US health care system and western medical culture.⁴⁴

Table 1.

	Foreign born population 2000 ⁴⁵	Foreign born population 2006-2008 (<i>%change from 2000</i>)	Population speaking a language other than English at home 2000 ⁴⁶	Population speaking a language other than English at home 2006-2008 (<i>% change from 2000</i>)
Palm Beach County	17.4%	21.6% (+4.2%)	21.7%	26.0% (+4.3%)
St. Lucie County	10.5%	16.2% (+5.7%)	13.8%	19.7% (+5.9%)
Martin County	8.1%	10.6% (+2.5%)	11.3%	13.6% (+2.3%)
State of Florida	16.7%	18.7% (+2.0%)	23.1%	25.8% (+2.7%)
USA	11.1%	12.5% (+1.4%)	17.9%	19.6% (+1.7%)

Hospitals

All 23 hospitals currently providing acute care, rehabilitation and psychiatric hospital services in Florida's Palm Beach, St. Lucie, and Martin Counties were invited to participate in the study. In order to help with recruitment efforts, and in recognition of the time and effort that would be involved in the study, hospitals were offered a \$500 honorarium for

participation. Participating hospitals were also promised a final report that presented study findings from their hospital and aggregate comparisons to other participating hospitals. An invitation letter describing the study was mailed to the CEO of each of hospital. The letters were followed by a personal phone call from project staff, again inviting the hospitals to participate. A lack of response from the hospital, after three attempts at communication (leaving messages), was interpreted as declining the invitation to participate.

The CEOs of each participating hospital were asked to identify a key hospital staff member to serve as the primary hospital contact (liaison) for project staff. The liaison was responsible for completing an administrative survey and for coordinating data collection activities within their hospital. Project staff asked hospital liaisons to submit demographic information regarding their hospital's ownership / hospital system membership, teaching status, size and aggregate racial, ethnic, and linguistic characteristics of the patient population (if available). Liaisons were responsible for gathering paper or electronic versions of the hospital's written policies related to cultural and linguistic services and for submitting them to project staff. Regular communication with the liaisons and project staff was established via phone and e-mail.

Questionnaire Development and Implementation

Administrative Questionnaire

Development

In order to determine what services hospitals make available to staff to meet the linguistic and cultural needs of their patients, a questionnaire was developed to gather this information from the participating hospitals. Questions were designed to capture information across four broad categories:

1. Cataloging the cultural and linguistic services and resources that hospitals make available to staff.
2. Identifying how hospitals monitor the quality of cultural and linguistic services offered.
3. Categorizing each hospital's written policies and/or hospital administration preferences related to cultural and linguistic services.
4. Describing how the hospital disseminates information about available cultural and linguistic services to staff (including training and education), the frequency with which this information is disseminated, and factors that influence the frequency and method of dissemination.

The questionnaire was developed with input from a technical advisory panel (TAP) that was established and convened with assistance from the Allegany Franciscan Ministries and the Palm Beach County Medical Society. The TAP was comprised of seven individuals with local expertise in the cultural and linguistic services available in the area and also consisted of members from the Palm Beach Medical Society.

The terminology in the questionnaire and response options were constructed by project staff based upon knowledge obtained through previous studies and literature review of available cultural and linguistic tools and resources. Once the draft questionnaire was completed, it was reviewed by the TAP, who were aware of local resources and issues that might impact the response options, and their recommendations were incorporated into the draft questionnaire.

Pilot Testing

The draft questionnaire was pilot tested in three independent hospitals in three different states (Georgia, Illinois, and Missouri). The sites were selected based on professional relationships with colleagues at these hospitals and had no affiliation with the study. The goal of the pilot test was to determine how well the instrument captured the information needed for the study and to identify any potential problems with the items. Pilot testers were asked to complete a short questionnaire about the survey to determine how long it took to complete, what resources or departments within the hospital might need to be accessed to obtain information, and whether or not the questions were clear. This information was used to instruct the hospital liaisons during project training. Based upon pilot testing feedback, the use of the word “multilingual” was changed to “bilingual,” which is more recognizable, and several language selection options were added to capture specific dialects. Once pilot test recommendations were incorporated the questionnaire, it was reviewed again by the TAP for final approval.

The final version of the administration questionnaire consisted of 23 questions, separated into five sections: Hospital Demographics, Language Resources and Services, Culture Resources and Services, Cultural Competence, and Monitoring Quality. The instrument consisted of a combination of yes/no, open ended, and multiple choice questions. The final section requested the liaisons submit any written policies and procedures, training, orientation or education documents, or any other documents which addressed meeting patients’ cultural and linguistic needs.

Implementation

Each of the 14 hospital liaisons was asked to participate in a one-hour webinar to introduce the goals and objectives of the study, describe the liaisons roles and responsibilities, and to discuss research protocols and confidentiality measures (this is discussed in more detail in the staff questionnaire development section). After completing the webinar training, hospital liaisons were sent the administrative questionnaire in a protected electronic document and were asked to return either electronically, by fax or by US postal service. Liaisons were also asked to submit the accompanying documentation (policies, procedures, and training and educational materials) in a format easiest for them. All submitted documents were assigned a code and were stripped of other identifying information to maintain the confidentiality of the hospital. The responses from the administrative survey were compiled and preliminary analysis was performed.

Staff Questionnaire

Development

In order to capture hospital staff preferences and utilization of the tools, resources and services available to meet the language and cultural needs of hospital patients, a second questionnaire was developed to collect this information.

Objectives:

1. Determine hospital staff members’ ability to identify cultural and linguistic services available in their hospital.
2. Describe which cultural and linguistic services staff prefer to use and why.

A preliminary analysis of the responses from the administrative questionnaire was used to inform the questions and response sets on the staff questionnaire. For example, the results of the administrative survey confirmed that Spanish was the most commonly reported language encountered by hospitals in the study group, so it was decided that the staff survey would include a section where staff would be asked whether or not they use certain tools and services for Spanish-speaking patients that they do not use for patients speaking other languages. In addition, because employee orientation was identified as a way of disseminating information by a majority of the administrative questionnaire responses, this was added as a response option in the staff questionnaire regarding how they receive information from their hospital. In order to keep the questionnaire shorter in length, responses from several open-ended questions on the administrative questionnaire were converted into multiple choice options on the staff questionnaire.

To improve response rates, a conscious effort was made to keep the staff survey brief in length. The questionnaire included nine questions designed to capture staff awareness of available tools and resources from a list and to assess the frequency of use for those services or resources. In addition to the resources and tools identified on the hospital survey, staff was also asked about the use of family members or friends to interpret for the patients and how frequently they use them. While this was clearly not a resource provided by the hospital, the literature and previous studies, as well as feedback from the pilot testers, have demonstrated this to be an often used method to communicate with LEP patients. Staff participants were also asked whether or not they were bilingual, and if so, whether or not their competence speaking a language other than English had been assessed.

The staff questionnaire followed a similar review process as the administrative survey. The first draft was sent to the TAP for review and modifications were made. The staff questionnaire included only one open-ended question which asked staff to identify the resource they prefer to use when communicating with LEP patients and why. Other than professional role, staff was asked not to put their name on the survey, and the only identifier was a code which designated from which hospital the survey was returned (Staff survey in Appendix 2).

Pilot Testing

The same three hospitals who participated in the pilot testing of the administrative survey were asked if they would participate in testing the staff survey. Pilot testers were offered a \$250 honorarium in recognition of their contribution. Twenty-five informed consent sheets, twenty-five surveys, and twenty-five prepaid, preaddressed envelopes were sent to the pilot testers, with the distribution protocol. A short feedback form was also included to solicit feedback from the pilot testers about the material. This feedback enabled project staff to make modifications to the survey and to streamline the distribution process. Based upon the feedback provided, several modifications were made. First, all three of the pilot testers reported that the distribution process took more time than was expected. Timelines, therefore, were extended and the liaisons were given eight weeks to distribute the surveys. Pilot testers also requested a process to track responses in order to ensure that the surveys were returned. To protect confidentiality, staff names were not tracked, so an anonymous method for tracking responses was adopted. Each survey included a receipt that could be anonymously returned to the liaisons upon mailing of the survey. Custom sticky notes were

ordered and provided to the hospital liaisons. Pilot testing also led to minor changes to the staff questionnaire and the modifications to the survey distribution process.

Implementation

Staff questionnaires were administered with the assistance of the hospital liaisons. As discussed, each liaison was asked to participate in a one-hour web-based training session, during which they were provided with instructions for questionnaire distribution and received a list of staff to recruit (by professional role). The webinar introduced the liaisons to the goals of the study and to project staff, outlined their responsibilities as liaisons, addressed the proposed recruitment and data collection protocols and included guidelines to ensure the protections of human subjects. The data collection instruments were reviewed, and the collaborative project webpage was introduced. Eleven of the hospital liaisons completed the webinar training (one liaison was representing two hospitals). Two of the hospital liaisons were unable to participate in the webinar. These liaisons received the training materials via email, and the content of the training was discussed with these two individuals by telephone.

The hospital liaison was instructed to recruit up to 100 staff members, categorized by professional role) within their hospital to participate in a staff survey. Both hospital administration and staff were made aware that their participation was voluntary and that they were able to end their participation at any time. A written consent form outlining all risks, benefits, alternatives, measures to ensure privacy and confidentiality, and contact information was given to participants prior to completing the questionnaire. The participants were asked to mark a box indicating that they had been apprised of pertinent project information and their agreement to participate.

In order to be eligible for the staff survey, individuals from the participating hospitals must directly interface with patients on a regular basis. The following categories of staff were identified as potential participants:

1. physicians
2. nurses
3. certified nursing assistants / patient care technicians
4. outpatient pharmacists
5. diagnostic imaging technologists
6. phlebotomists
7. admitting clerks
8. transporters
9. therapists (respiratory, speech, physical, and occupational)
10. dieticians
11. environmental services
12. pastoral care / chaplains
13. switchboard operators
14. billing
15. social workers
16. patient advocates
17. discharge planners
18. interpreters

Because full-time professional nurses constitute the largest health care profession (US Department of Labor, Bureau of Labor Statistics), professional nurses were over-sampled. Hospital liaisons were asked not to recruit more than five staff members for each of the other categories. Staff was asked to identify their profession on the staff survey by checking one of the following six categories:

- a. Physician
- b. Nurse
- c. Other clinical provider (imaging, lab, etc.)
- d. Support services (registration, switchboard, billing, etc.)
- e. Environmental services (dietary, housekeeping, security, etc.)
- f. Other _____

Hospital liaisons were given explicit instructions on how to recruit staff and how to distribute the survey both during the webinar instruction and as written instructions in the mailing with the staff surveys. The specifics of recruitment processes varied between hospitals, but included email blasts to hospital employees, announcements about the project by key hospital personnel during department meetings, posters in hallways or common meeting areas like lunchrooms, and giveaway incentives such as candy bars or certificates for free coffee. All written and verbal invitations to participate in the project contained information about the projects' purpose and the voluntary nature of participation.

Surveys were distributed by the hospital liaisons. A packet of material, containing 100 cover letters, project summaries, informed consent sheets, questionnaires and prepaid-preaddressed return envelopes, and sticky note "receipts" was sent to each of the liaisons. Liaisons were given eight weeks to distribute the questionnaires. Staff confidentially completed the questionnaire, sealed it in the pre-addressed envelope and mailed it back to project staff without returning it to the liaison. Only the questionnaire receipt was returned to the hospital liaison. At the conclusion of the data collection phase, liaisons were asked to report how many surveys they were able to distribute in order to calculate the hospitals response rate.

Confidentiality

Institutional Review Board

Because the study involved collecting information from human subjects through surveys, Institutional Review Board (IRB) approval was sought and granted through Independent Review consulting Inc. (IRC) (100 Tamal Plaza, Suite 158, Corte Madera, CA 94925 (grant # 2008-082).

Data Collection and Storage

Strict privacy and confidentiality standards were maintained with regard to any information that might identify study participants. Information collected from participants included demographic and opinion data. Personal health information was not collected. All collected study data was de-identified and stored separately from the hospital identifiers (e.g. names). Only the hospital liaisons recruiting survey respondents and the principal investigator and coordinator had access to hospital identifiers (no staff identifiers, other than their position in the hospital, was collected). All survey data and policies and procedures were saved using

codes and not associated hospital names. All hospital data presented without identifiers, and individual data provided only in the aggregate.

Data Analysis

The administrative survey responses were compiled and entered into *SurveyMonkey*TM software to determine frequencies and for preliminary analysis and then entered into Excel software for more detailed analysis. Policies, procedures, training materials and educational documents received by the hospitals were cataloged and coded, after removal of all identifying information. All policies and procedures were entered into NVIVO software for thematic review (QSR Nvivo version 7.0.189.1; Copyright QSR International Pty. Ltd). Project staff identified an a priori coding schema for the policy review based on existing literature and knowledge from previous studies. Policies were reviewed independently and coded by project staff to categorize the policies based on the coding schema and to determine additional emerging themes. These components of language access policies were placed into the category “nodes” as a way to catalog and characterize each element using NVIVO software. Counts were conducted as to which of the hospital policies contained the different identified language access elements. After all the policies went through one round of coding, they were coded again by project staff to reach consensus on the appropriate categorization.

A relational database was developed and staff surveys were entered into the database immediately upon return to The Joint Commission. Once all the surveys were entered, frequencies were completed and analyzed in the aggregate and stratified by hospital. Patterns in concordance of services reported by hospital administration and hospital staff were analyzed for individual hospitals and aggregate data was reviewed for observable patterns.

RESULTS

Study Participants

Of the 23 hospitals invited to participate in the study, 14[†] agreed to participate. Three did not respond to multiple communication attempts, and six declined participation. The declining hospitals identified time, lack of resources, and too many competing priorities as the primary reasons for their refusal. Ten hospitals from Palm Beach County (of 18 invited hospitals), two hospitals from St. Lucie County (of three invited hospitals,) and two hospitals from Martin County (of two invited hospitals) were included in the study. 13 of the 14 hospitals in the study sample are acute-care hospitals and one hospital provides long-term care acute.

The average number of licensed beds in our study group was 255 (range 70 – 460). The average number of ED visits was 36,392 (range 20,436 – 56,970) and the average approximate percentage of physicians who are employed by the hospital was 6% (range 0 – 20%). Twelve of the hospitals in our study group were affiliated with a health system and two were not.

Populations Served by Participating Hospitals:

As part of the administrative survey, hospitals were asked “In 2008, other than English, what languages did patients in your hospital identify as the language in which they prefer to receive medical information?” Participants were asked to identify the three most common language preferences in their order of frequency. The most commonly reported language was Spanish. Thirteen of the fourteen hospitals in our study reported this being the most frequently occurring language. Creole or Haitian Creole was reported as the second most commonly encountered languages. There was no agreement on a third most common language. Twenty-three other languages were encountered at participating hospitals at least once in 2008 (see “Languages encountered in 2008” in Appendix 3).

Sources Used for Evaluation of Patient Population Language Needs

Participating hospitals identified tallying of requests for interpreter services (which included requests for on-site interpreters, bilingual staff, or telephone interpreter services) as the most frequently used mechanism for evaluating the language needs of their patient population. This mechanism was utilized by seven of the participating hospitals. Three of the participants utilized a report based on patient language data from the electronic medical record system. Other sources used to evaluate patient population language needs listed by hospitals were reviews of financial assistance records, US Census Data, and reviews of data from patient registration. Three of the participating hospitals indicated that language needs of their patient populations are not routinely evaluated.

[†] One of the participating organizations operated two hospital sites. These were counted as two distinct hospitals because the sites were across town and each had their own ED and other similar services. Another participating organization also operated multiple sites, but was counted as a single hospital for the purposes of the study. This decision was based upon the duplication of services at the two facilities, their physical proximity (located across the street from each other), and the understanding that the sites essentially operated as a single hospital.

Hospital Resources and Language and Cultural Tools and Services

Language Access Resources and Tools

Hospital liaisons were asked to indicate which language tools and resources were provided by their hospitals from a pick list of possible choices. The responses were broken out by interpreter resources (defined as a person who renders a message spoken in one language into a second language, either face to face or remotely) and auxiliary communication tools or aids designed to assist in communication but do not render a message *spoken* in one language into another (Tables 2 and 3).

Table 2: Interpreter resources provided by hospitals in study group

Interpreter Resources Provided	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Telephone Interpreter		X	X	X	X	X	X	X	X	X	X	X	X	X	13
Video Remote Interpreter					X										1
Interpreter (employee of hospital or contract interpreter)	X	X		X							X	X	X	X	7
Bilingual Staff member - designated by hospital like on a list	X		X		X	X		X	X	X	X	X	X	X	11
Bilingual Staff member - not designated by hospital but able to provide interpretive services when necessary			X				X								2
Total	2	2	3	2	3	2	2	2	2	2	3	3	3	3	

Table 3: Auxiliary communication tools or aids provided by hospitals in study group

Auxiliary Communication Aids Provided	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Hand Held communication devices														X	1
"I speak" cards		X			X		X	X	X			X	X		7
Communication Boards					X	X		X	X	X	X	X		X	8
Translated documents	X	X	X		X	X	X	X	X	X	X	X	X	X	13
Bilingual Signage or way finding	X	X			X		X	X	X		X	X	X	X	10
Total	2	3	1	0	4	2	3	4	4	2	3	4	3	4	

If a participating hospital identified that they use bilingual staff members as a resource to communicate with LEP patients, they were asked several questions about these staff. The table below depicts the characteristics of those bilingual staff serving as interpreters (clinical or nonclinical) and whether or not their competence to serve as interpreters has been assessed by the hospital (Table 4).

Table 4: Use of bilingual staff serving as interpreters

Use of Bilingual Staff	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Hospital uses clinical staff to interpret	X		X			X	X	X	X	X	X	X	X	X	11
Hospital uses non-clinical staff to interpret	X					X	X	X	X	X	X	X	X	X	10
Hospital tests competence of bilingual staff													X		1
Hospital intentionally recruits and hires bilingual staff to communicate directly to staff	X						X						X		3

Policies and Procedures for Language Access

Participating hospitals were asked to submit any policies and procedures related to the provision of language services. Policies were reviewed to determine if they addressed certain characteristics related to the provision of language access services and resources. The table below depicts which policy characteristics are present in the policies submitted for review (Table 5).

Table 5: Policy characteristic in language access policies submitted for review

Policy Characteristics – Language Access	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Provision for Language Access Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14
Use of family member or friends as interpreters prohibited or discouraged				X		X	X	X	X		X				6
Waiver required if pt. refuses hospital interpreter				X											1
Information in policy regarding how to or when to access or use interpreters	X	X	X			X	X	X	X		X	X	X		10
List of bilingual staff members able to provide interpretive services maintained by hospital	X					X	X	X	X		X		X		7
Training or education requirements of bilingual staff identified							X	X	X						3
Acceptable wait times for services given															0
Patient notification of rights to LA services addressed in policy				X			X	X	X				X		5
Patient Care policies related to LEP		X	X								X				3

Dissemination of Language Access Information in Study Sample

Hospital liaisons were asked on the administrative survey to describe the ways in which they disseminate information on how to access and use language services to physicians and hospital staff. Possible dissemination methods were given as an example in the text of the question but the response was open-ended. The responses were categorized and are depicted below (Table 6).

Table 6: Methods used by hospitals to communicate how to access and use language services

Dissemination Methods – Language Access	Hospital													Total	
	a	b	c	d	e	f	g	h	i	j	k	l	m		n
Orientation	X		X	X	X		X	X	X		X	X	X	X	11
Shared Intranet		X		X		X				X	X			X	6
Annual updates					X		X				X	X		X	5
Training		X								X	X				3
Printed media															0
Information shared at meetings		X						X	X						3
Signage / placards						X						X	X		3

Cultural Resources and Tools

Hospital liaisons were also asked to provide information the cultural resources and tools are provided in their hospitals to meet patients' needs (Table 7). A pick list of several cultural resources and tools was provided to liaisons from which they could select as many as were available.

Table 7: Cultural resources and tools provided in hospitals in study group

Resource / Tools Provided - Cultural	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Staff members with knowledge of specific cultures or beliefs	X	X	X	X		X	X	X	X	X	X		X	X	12
Volunteers / interns with knowledge of specific cultures or beliefs			X				X	X	X		X		X	X	7
Chaplains / pastoral care			X	X	X		X	X	X		X	X	X	X	10
Access to traditional healers					X										1
Hospital-provided books containing information about different cultures				X	X						X				3
On-line or intra-net materials about specific cultures and their needs	X		X		X					X	X	X			6
Questionnaires or assessments that help identify patients cultural needs		X	X				X	X	X		X			X	7
Special dietary services (kosher, etc.)		X	X	X	X		X	X	X	X	X		X		10
Physical or environmental resources	X	X	X				X			X	X		X		7
Complementary / alternative medicine		X		X	X					X	X				5
Community cultural resources															0
Formal ongoing collaborations				X			X						X		3
Other		X										X			2
Total	3	6	7	6	6	1	7	5	5	5	9	3	6	4	

Policies and Procedures and Educational Materials Related to the Provision of Cultural and Spiritual Care
 The same process of cataloguing and review was followed for the submission of cultural care policies and procedures as for language access policies and procedures. Because most of the policies addressed both cultural and spiritual care together, it was decided to group these policies together. In addition, the table below identifies any educational or other materials submitted related to the provision of cultural and/or spiritual care (Table 8).

Table 8: Policy characteristics and educational materials provided for the provision of cultural care

Policy Characteristics – Cultural and Spiritual	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Cultural and spiritual care addressed		X	X		X	X				X	X			X	7
Accommodation for religious or cultural practices		X	X			X				X	X			X	6
Dietary accommodations		X			X					X	X			X	5
Instructions on how to access and use cultural tools or resources		X	X							X	X			X	5
Information on where to access or refer to outside resources		X	X			X				X	X			X	6
Non-discrimination based on beliefs – policy or provision		X	X		X	X				X	X			X	7
Provision of alternate decision makers		X									X			X	3
Provisions for care at the end of life		X								X	X			X	4
Education and other materials Submitted															
Cultural tools or guides		X	X	X						X					4
Training or educational modules or information (on-line or hard copy)	X	X	X	X						X			X		6
Patient rights brochures		X													1
Diversity brochures		X	X							X	X				4
Orientation materials (case studies, presentations)		X	X	X						X	X		X		6

Dissemination of Cultural Information in Hospitals in Study Sample

Hospital liaisons were asked on the administrative survey to describe the ways in which they disseminate information on how to access and use cultural services. Examples were given, but responses were open ended. Fewer hospitals answered this question for cultural resources than for language access resources. The responses, if provided, were categorized and are depicted below (Table 9).

Table 9: Dissemination methods for cultural resources used by hospitals

Dissemination Methods – cultural resources	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Orientation		X	X	X						X	X			X	5
Shared Intranet											X				1
Annual updates	X										X			X	3
Training										X	X				2
Printed media															
Information upon referral or request					X		X	X	X						4

Monitoring the Quality of Services, Resources, and Practices Aimed at Meeting Patient’s Cultural and Linguistic Needs

The liaisons were asked how they monitor the quality of services, resources, and practices aimed at meeting patient’s cultural and linguistic needs. Several examples of how they might track quality were provided in the text of the question (e.g., incident reports, complaints), but responses were open ended. Hospitals were not asked to break this out into language services and cultural services. (Table 10)

Table 10: Quality monitoring methods for services, resources, and practices provided to meet patients’ cultural and linguistic needs

Quality Monitoring Methods – Language and Culture	Hospital														Total
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	
Incident Report Tracking	X		X	X	X			X	X	X				na	7
Review of Patient Satisfaction reports re: Language and Culture	X							X	X		X	X			5
Review telephone interpreter utilization						X						X			2
Referrals for interpreter reviewed													X		1
Complaints (handled case by case)		X			X					X	X				4
None							X								1
Is Staff asked to evaluate the cultural and linguistic services offered to them?	--	N	N	N	N	N	N	N	N	N	N	N	N		

Staff Utilization of Language and Culture Tools and Services

Staff Survey Response Rates

Staff surveys were received from 608 staff in 12 of the 14 participating hospitals. Due to the very low number of surveys distributed in two of the hospitals in our study sample (0 and 30 surveys respectively), these hospitals were dropped from the aggregate analysis. Two other hospitals were only able to distribute a portion of their surveys (66 and 68). This was reflected in the calculation of the response rate.

Total number of responses: **608**
Percent of distributed staff surveys completed and returned: **54%**

Survey respondents were asked to indicate their professional role in the hospital. As discussed in the methodology section, hospital liaisons were encouraged to target professional nurses when distributing the survey (Table 11). Other than professional role, no identifying information from participants was collected. The liaisons were asked to target nurses, but the range varied (17 – 76% of responses were nurses)

Table 11: Breakdown of Responses by Professional Role in Hospital (n=608)

Role in Hospital	Number of respondents / percentage
Physician	29 / 4.7%
Nurse	287 / 47.2%
Other clinical provider (such as imaging, lab, etc.)	116 / 19.1%
Support services (registration, billing, etc.)	81 / 13.3%
Environmental services (dietary, housekeeping, security, etc.)	18 / 2.9%
Other	71 / 11.7%
No answer	5 / <1%

Staff Awareness of Language Resources and Tools Provided by Hospitals

Staff were provided a pick list of language tools and resources (both interpreter resources and auxiliary communication aids) and asked to check a box if that that tool or resource was available in their hospital for communicating with limited English proficient (LEP) patients. Even though, “Someone accompanying the patient” is not a resource provided by the hospitals, it was one of the options on the pick list. This option was given based on feedback from the pilot test and the acknowledgement from the literature and previous studies that this practice is often utilized. In addition, 17% of all staff responding to the survey indicated that they are bilingual and communicate directly with patients. It was decided not to break this out by hospital, due to the possibility that staff could be identified. In Table 13, the green shading indicates the hospital identified this as tool or resource provided at their hospital. The number in the box is the percentage of staff who identified this as an available tool or resource. A blank box indicates that no staff responded to this option, and a (-) denotes that fewer than 10% of staff marked that box (Table 12).

Table 12: Available language services (in green) versus staff awareness (by hospital)

Resource / Tools Provided	Hospital												Total
	a	b	c	d	e	f	g	h	j	k	l	m	
Someone accompanying the patient	68%	78%	72%	77%	81%	81%	83%	80%	86%	77%	82%	91%	80%
Telephone Interpreter	15%	75%	64%	70%	76%	56%	73%	39%	64%	73%	92%	94%	67%
Video Remote Interpreter		-	-	-	19%		19%			-	-	-	7%
Interpreter (employee of hospital or contract interpreter)	17%	19%	24%	18%	18%	-	20%	14%	11%	22%	22%	37%	19%
Bilingual Staff member - designated by hospital like on a list	49%	42%	64%	27%	32%	38%	44%	41%	32%	34%	45%	91%	42%
Bilingual Staff member - not designated by hospital but able to provide interpretive services when necessary	72%	65%	68%	61%	66%	62%	76%	73%	83%	63%	71%	63%	69%
Hand Held communication devices	-	-	16%	-	-		-			-		-	5%
"I speak" cards	-	12%	20%	-	-		-	-	-	-	16%	-	8%
Communication Boards	-	32%	36%	22%	21%	62%	27%	10%	40%	36%	27%	23%	27%
Translated documents	30%	38%	36%	57%	45%	13%	46%	27%	14%	47%	63%	71%	41%
Bilingual Signage or way finding	-	14%	32%	34%	12%	13%	19%	12%	17%	14%	29%	26%	18%
Number of staff surveys returned for each hospital	47	69	25	44	75	16	63	49	63	73	49	35	608

Green shading = Hospital indicated that this is a resource or tool provided by the hospital

- = Fewer than 10% of staff responded that they were aware of this service.

Frequency of Use for Available Language Tools and Resources

Staff were asked to indicate how frequently they use the resources or services provided by the hospital. Options included “Frequently”, “Sometimes”, or “Never”, but were not defined. It was noted that staff should indicate which tools and resources they used during the actual health encounter (e.g., explaining medical procedures, translating documents, etc.); not for activities of daily living. Only responses for Spanish-speaking patients are presented. The percentage of staff who responded that they use the tool or resource “frequently” is identified below (Table 13).

Table 13: Frequency of Use for Spanish Language Tools and Resources (by Hospital)

Resource / Tools Provided	Hospital												Total
	a	b	c	d	e	f	g	h	j	k	l	m	
Someone accompanying the patient	36%	42%	44%	36%	43%	31%	41%	59%	54%	51%	41%	63%	45%
Telephone Interpreter	-	20%	12%	36%	32%	-	16%	-	-	18%	33%	40%	19%
Video Remote Interpreter					-		-			-			-
Interpreter (employee of hospital or contract interpreter)	-	-	12%	-	-		-	-	-	-	-	26%	-
Bilingual Staff member - designated by hospital like on a list	28%	19%	36%	18%	14%	-	13%	14%	-	14%	16%	46%	20%
Bilingual Staff member - not designated by hospital but able to provide interpretive services when necessary	51%	33%	36%	32%	23%	25%	33%	53%	38%	32%	37%	29%	35%
Hand Held communication devices			12%		-					-			-
"I speak" cards				-	-		-	-	-	-	-		-
Communication Boards	-	-	12%	-	-	19%	-	-	13%	-	-	-	-
Translated documents	13%	15%	24%	25%	27%	-	24%	12%	-	26%	37%	26%	20%
Bilingual Signage or way finding	-	-	16%	18%	-	19%	13%	-	-	-	10%	-	-
Staff who indicated they use their bilingual skills to communicate directly to pts	15%	-	8%	11%	-		-	16%	10%	-	20%	22%	
Number of staff surveys returned for each hospital	47	69	25	44	75	16	63	49	63	73	49	35	608

Green shading = Hospital indicated that this is a resource or tool provided by the hospital
 - = Fewer than 10% of staff responded

Staff Preferences for Communicating with LEP Patients

An open-ended question, “Which resource(s) do you prefer to use to communicate with limited English proficient patients (when you do not speak their language) and why?” was asked. The most common themes for each hospital are listed below (Table 14).

Table 14: Preferences for communicating with LEP patients as identified by staff

	Preferred Communication Methods Reported by staff
Hospital a	Bilingual staff
Hospital b	Telephone interpreter; family or friend
Hospital c	Bilingual staff; family members
Hospital d	Telephone interpreter; bilingual staff
Hospital e	Telephone interpreter; family member; bilingual staff
Hospital f	Family member; bilingual staff member
Hospital g	Family; bilingual staff
Hospital h	Family; bilingual staff
Hospital j	Bilingual staff, family
Hospital k	Family; telephone
Hospital l	Telephone; bilingual staff
Hospital m	Telephone; bilingual staff

Staff Awareness of Cultural Resources and Tools Provided by Hospitals

Staff were provided a pick list of cultural tools and resources and asked to check a box if that tool or resource was available. In Table 16, the green shading indicates that the tool is available (as reported in administrative survey). The number in the box represents the percentage of staff who identified this as an available tool or resource. A blank box indicates that no staff responded to this option, and a (-) denotes that fewer than 10% of staff marked that box (Table 15)

Table 15: Awareness of cultural tools by hospital

Resource / Tools Provided - Cultural	Hospital												Total
	a	b	c	d	e	f	g	h	j	k	l	m	
Staff members with knowledge of specific cultures or beliefs	66%	82%	92%	72%	62%	56%	71%	48%	78%	57%	76%	77%	70%
Volunteers / interns with knowledge of specific cultures	21%	39%	40%	20%	26%	-	22%	12%	19%	21%	29%	31%	24%
Chaplains / Pastoral Care	17%	62%	44%	43%	42%	-	46%	26%	32%	46%	65%	37%	42%
Hospital provided books containing information about different cultures	-	41%	44%	36%	24%	-	16%	-	14%	-	22%	11%	20%
On-line or intranet materials about specific cultures	26%	56%	48%	25%	46%	31%	22%	18%	51%	26%	30%	20%	34%
Questionnaires or assessments that help identify cultural needs	11%	32%	36%	14%	23%	13%	17%	-	22%	22%	24%	20%	21%
Special dietary services	13%	67%	76%	54%	46%	44%	37%	22%	27%	37%	45%	49%	42%
Physical or environmental resources	13%	43%	40%	32%	16%	-	22%	12%	17%	25%	37%	23%	24%
Complementary / alternative medicine	-	17%	-	-	12%	-	-	-	-	-	-	-	-
Community cultural resources	-	-	20%	-	-	-	-	-	-	-	16%	11%	-
Formal / ongoing collaboration	-	23%	32%	16%	14%	-	11%	12%	-	-	29%	11%	14%
Educational opportunities for learning about cultural diversity**	53%	62%	60%	41%	30%	-	31%	20%	22%	25%	45%	34%	36%
Number of staff surveys returned for each hospital	47	69	25	44	75	16	63	49	63	73	49	35	608

Green shading = Hospital indicated that this is a resource or tool provided by the hospital

- = Fewer than 10% of staff responded that they used this service

Staff Frequency of Use of Cultural Resources

Staff were asked to indicate how frequently they use the cultural tools and resources provided by the hospital. Options included “Frequently”, “Sometimes”, or “Never”, but were not defined. The percentage of staff who responded that they use the tool or resource “frequently” is identified below (Table 16).

Table 16: Frequency of use of cultural tools and resources

Resource / Tools Provided - Cultural	Hospital												Total
	a	b	c	d	e	f	g	h	j	k	l	m	
Staff members with knowledge of specific cultures or beliefs	26%	36%	48%	34%	18%	13%	29%	22%	40%	25%	31%	29%	29%
Volunteers / interns with knowledge of specific cultures	-	-	24%	-	-	-	-	-	-	-	-	-	-
Chaplains / Pastoral Care	-	23%	12%	-	12%	-	13%	-	-	15%	43%	14%	14%
Hospital provided books containing information about different cultures	-	16%	24%	14%	-	-	-	-	-	-	-	-	-
On-line or intranet materials about specific cultures	-	19%	12%	-	15%	-	22%	-	-	-	-	-	-
Questionnaires or assessments that help identify cultural needs	-	12%	32%	-	-	-	16%	-	-	-	12%	11%	11%
Special dietary services	-	43%	36%	32%	24%	25%	16%	-	-	12%	18%	23%	19%
Physical or environmental resources	-	19%	-	11%	-	-	-	-	-	-	16%	-	-
Complementary / alternative medicine	-	-	-	-	-	-	-	-	-	-	-	-	-
Community cultural resources	-	-	12%	-	-	-	-	-	-	-	-	-	-
Formal / ongoing collaboration	-	16%	12%	-	-	-	-	-	-	-	16%	-	-
Educational opportunities for learning about cultural diversity**	-	23%	16%	14%	-	-	-	-	-	-	18%	-	-
Number of staff surveys returned for each hospital	47	69	25	44	75	16	63	49	63	73	49	35	608

Green shading = Hospital indicated that this is a resource or tool provided by the hospital

- = Fewer than 10% of staff responded that they used this service

** This resource not listed on administrative survey, so staff concordance cannot be determined.

Dissemination of Information Regarding Language and Cultural Resources– Staff Concordance (n=608)
 Staff were given a pick list to identify how their hospital provides information about how to access and use available language and cultural resources and were asked to check all those that applied. Percentage of staff who identified each method, by hospital, is shown below (Table 17).

Table 17: Percent of staff who identified the different dissemination methods**

Information dissemination methods	Hospital												Total
	a	b	c	d	e	f	g	h	j	k	l	m	
Orientation	51%	57%	60%	45%	50%	44%	43%	20%	54%	38%	55%	58%	48%
Inservices	38%	55%	44%	27%	39%	19%	30%	-	24%	32%	52%	40%	34%
Printed media	11%	42%	36%	32%	41%	-	27%	12%	16%	19%	43%	29%	27%
Intranet	47%	30%	40%	23%	20%	13%	20%	14%	18%	33%	31%	34%	27%
“lunch and learns”	-	12%	36%	16%	20%	-	-	-	-	-	14%	46%	13%
Signage / placards	4%	24%	20%	25%	14%	13%	14%	-	-	-	26%	11%	14%
Other	-	-	-	-	-	-	-	16%	-	-	14%	-	-
No training or education provided	13%	-	-	11%	-	25%	11%	53%	21%	25%	-	14%	16%
Number of staff surveys returned for each hospital	47	69	25	44	75	16	63	49	63	73	49	35	608

** Not broken out by language and culture on staff survey
 - = Fewer than 10% of staff responded that they used this service

Staff Understanding of Available Tools and Resources – Language and Culture

Staff were asked whether or not they had a good understanding of what tools and resources are available in their hospitals (Table 18).

Table 18: Staff have a good understanding of cultural and linguistic resources available to them

Staff understands C & L resources available**	Hospital												Total
	a	b	c	d	e	f	g	h	j	k	l	m	
Yes	83%	77%	84%	68%	66%	56%	57%	37%	51%	48%	84%	71%	64%
No	13%	19%	12%	27%	28%	25%	33%	51%	48%	38%	14%	26%	29%
Number of staff surveys returned for each hospital	47	69	25	44	75	16	63	49	63	73	49	35	608

** Not broken out by Language and Culture on staff survey

Discussion of Findings

The findings in this report illustrate what types of cultural and linguistic tools are being provided by fourteen hospitals in Florida's Martin, Palm Beach, and St. Lucie counties. We believe the information provided in this report identifies several potential areas on which hospitals could focus in order to make efforts and develop interventions toward improving the quality of the culturally and linguistically appropriate care they provide to their patients. As discussed in the methodology section, participating hospitals will receive information comparing their findings to those in the aggregate.

Language Access Findings

What services are hospitals providing to address patients' cultural and linguistic needs? It was evident from our administrative survey data that there is a richness and variety of resources and services provided to meet patients' cultural and linguistic needs. All but one of the hospitals provided telephone interpreter services and all but two used bilingual staff, and more than half provided dedicated interpreters. However, despite the provision of these services, there appears to be a chasm between what language tools, services, and resources hospitals are providing and what resources and practices staff use.

Our data suggest that overall, staff were not always aware of the availability of language tools and resources or if they were aware, did not necessarily use these tools and resources frequently. This finding is consistent with many other studies and explorations that have occurred regarding language services⁴⁷. The results from this study support the idea that even when resources and services are provided by hospitals, it does not guarantee that staff will use these services or that patients will benefit from their availability. Our data demonstrate that though staff appear to be aware of and utilize some of the resources provided by the hospitals, the large majority (80%) of staff responding to the survey use "someone accompanying the patient" (not a resource provided by the hospital) to communicate with LEP patients.

More data is needed to fully understand why staff continue to use someone accompanying the patient, despite the availability of other resources. We know from the literature and from laws and regulations that this is not an ideal practice, yet only six of the hospitals in our study addressed this practice in their administrative policies and or educational documents. Only one of the fourteen hospitals in our study required the use of a waiver if the patient insisted on utilizing this method to communicate. If the majority of our study hospitals do not have a firm position on this practice, it is not realistic to expect staff to avoid it. In reviewing staff comments to try to understand "why" they preferred one method over another, several themes emerged. Ease of use and convenience was a factor in their preferred mode of communication. However, many comments demonstrated the misconception that using family or friends as interpreters is beneficial to patients' because they were more comfortable and thus contributed to the provision of more patient-centered care. These comments suggest that staff are either unaware of the existing recommendations that discourage this practice, or feel that the benefit of using family members or friends outweighs any potential negative consequences.

Because none of the hospitals in our study group asked staff to evaluate the cultural and language access resources provided to them, there is no mechanism for hospitals to

understand this preference or to receive any sort of feedback about the tools and services they provide. Since they are not collecting data about the utilization of provided services, there is also no way for them to determine which tools are being utilized or how effective the utilization is.

Bilingual staff serving in dual roles as interpreters was a resource available in most hospitals in our study sample and staff reported utilizing them more frequently than many of the other available resources. While bilingual staff can be a resource, there can be problems using bilingual staff whose competency and understanding of the profession of interpreting has not been assessed. There is little being offered in the way of training for these staff in our study group and very few staff identified that their competency to serve as an interpreter had been assessed. A more formal mechanism to identify trained and (in the future) certified interpreters should be in place to ascertain that bilingual staff are providing high quality interpretation.

Cultural Resources Findings

It appears that hospitals in our study are providing a number of different cultural tools and resources. Trying to draw conclusions about the frequency of staff use for cultural resources is a little more difficult than for the language services. Based on the professional role of the staff member completing the survey, he or she might not have occasion to use the available cultural resource (for instance, an imaging technologist does not necessarily need to be aware of special dietary services available). Overall, the frequency of use was low, but this does not necessarily mean that these services are inappropriate. Because the hospitals do not ask staff to evaluate the cultural and linguistic services provided to them, there is no way to get a better understanding of which tools and resources are the most helpful.

Monitoring the Quality of Services, Resources, and Practices Aimed at Meeting Patient's Cultural and Linguistic Needs

Hospitals in our study group are not monitoring the quality of services, resources, and practices aimed at meeting patient's cultural and linguistic needs, other than to track whether there is an incident report or complaint.

Hospitals will not be able to evaluate or improve the linguistic and cultural tools or resources they are providing to patients and will not be able to encourage the use of these services by staff if they do not understand how effective and convenient these resources are. More specific information is needed to determine which services would be better utilized by staff. The only way hospitals can get this information is if they collect data to monitor the quality or effectiveness of the services they are providing and to understand the needs of their specific populations.

Summary and Recommendations

While there is a richness and variety of available cultural and linguistic tools and resources provided by hospitals in our study group, there appear to be some inconsistencies and gaps in how these resources are utilized by staff. Individual hospital reports will be provided to participating hospitals so that they may tailor recommendations to specific improvement areas but several overall areas for improvement were identified in the aggregate. Providing culturally and linguistically appropriate care is challenging, and the provision of these services continues to evolve. These findings and recommendations are consistent with many other study findings.⁴⁸

1. The practice of using “ad hoc” interpreters needs to be addressed.

An “ad hoc” interpreter is defined as “an untrained person who is called upon to interpret, such as a family member interpreting for her parents, a friend, a bilingual staff member who is pulled away from other duties to interpret, or a self-declared bilingual individual who volunteers to interpret. These individuals may not have sufficient language capability or knowledge of medical terminology and confidentiality issues to function adequately as interpreters⁴⁹. This report discussed the potentially negative consequences of utilizing family members and friends as interpreters. Hospitals should implement policies and procedures that do not permit the use of family members, or other ad hoc interpreters, particularly minors, for interpreting during medical encounters, except in emergency situations, when no other option is available. Awareness and education for staff regarding this issue might be the first step in reducing this practice.

Bilingual staff serving in dual roles as interpreters may fall under the category of “ad hoc” if their competence to provide interpretation has not been assessed. Very little is being offered in the way of training for these staff and very few have had their competency to serve as an interpreter assessed. The *Speaking Together Collaborative*⁵⁰ found that formal training in medical interpreting along with assessment for language fluency were considered important attributes of high quality interpreters. In addition, research has shown that individuals with exposure to a second language, even those raised in bilingual homes, frequently overestimate their ability to communicate in that language, and make errors that could affect complete and accurate communication and comprehension⁵¹. Interpreting is a skill, and hospitals cannot rely on self reported lists of bilingual staff, but need to have a more formal mechanism to identify trained and (in the future) certified interpreters.

2. Dissemination of information regarding how and when to access available resources needs to be addressed.

Even though many cultural and linguistic tools and resources exist for our participating hospitals, orientation appears to be the primary, and sometimes the only, method for communicating the availability of these resources to staff. “Just because you build it, does not mean they will come”⁵². Another lesson learned from the *Speaking Together* collaborative, and confirmed by this study, is that just providing the services doesn’t guarantee they will be utilized. Getting the word out to staff on a regular basis about available services, and when to use them, is an important step in making sure the patients who need these services will receive them.

3. Patient and population data should be collected to plan for and evaluate the provision of language access and cultural services.

The majority of hospitals in our study group are not collecting the appropriate data to assess their needs and usage for language access. The most popular mechanism for evaluating language needs in our hospitals' was the tallying of requests for interpreter services. This practice might speak to usage, but not necessarily to need. Three of the participating hospitals do not evaluate the language needs of their patient populations at all. In addition, other than tracking incident reports, hospitals are not monitoring the effectiveness of the services they are providing. Assessing each individual to determine their race, ethnicity, and language needs is an essential first step toward ensuring effective health care communication. And data collected at the hospital level are useful for assessing the quality of hospital-provided services⁵³. One of the largest barriers most health systems face in improving quality and reducing disparities is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time⁵⁴. Hospitals can not begin to understand how to improve their language and cultural services until they understand the need for them. A comprehensive data collection and use analysis is beyond the scope of this study, but as advances are made in health information systems, consideration should be given to the integration and alignment of race, ethnicity and language data into all hospital information systems and using this data for service planning and to make improvements.

Limitations and Challenges

As with all studies that rely on self-reported information, this study was subject to variation in data accuracy based on interviewees' level of knowledge (both staff and administrative) and possible deception, intentional or otherwise. Although it was made clear in many different communications that the study was separate from the accreditation work of The Joint Commission, it is possible that the presence of the organization's name and reputation might have resulted in respondents exaggerating or enhancing information about available tools, resources, and services. Because hospital liaisons were responsible for selecting and recruiting staff respondents, it is possible that liaisons selected staff members who they determined to be particularly savvy about cultural and linguistic services, or they may have deliberately selected individuals with no knowledge of services in order to highlight a perceived deficiency in these services. The hospital liaison was responsible for submitting policies, procedures, and training documents, so it is also possible that some available policies, education or information regarding the provision of cultural and linguistic services were overlooked, based on the knowledge level of the liaison.

The staff questionnaire was deliberately designed to be no more than a page, front and back, in order not to overwhelm the respondent and to encourage completion. Because of this, there was only one open-ended question to which staff could expand upon the information given to them. It is possible we could have received more detailed information had the survey length been longer. In some questions, because "Frequently", "Sometimes", and "Never" were not defined, these terms could have been interpreted differently by staff completing the survey.

The small size of our sample is another limitation to this study. Only fourteen hospitals are included in the overall sample, two of which were unable to produce staff survey responses, so these data were not reported. Due to the small sample size, generalization cannot be made beyond Southern Florida.

This study relied on hospital liaisons who took on this role in addition to their additional responsibilities. Thus, focus on this study and/or distribution of the questionnaires could have understandably waned. The hospital liaisons reported challenges that included, availability of staff to recruit, needing additional time to distribute questionnaires, or failure of staff to return the questionnaires.

The terminology used in the staff questionnaire may have been unclear to some survey respondents. While every attempt was made to be as clear as possible, it was not always apparent that staff understood the differentiations among the various designations of “interpreter”. In addition, there appeared to be some interchanging of the words “interpreter” (as defined for the questionnaire as an employee of the hospital or contract employee whose sole responsibility was to interpret) and bilingual staff serving in dual roles.

Summary

The purpose of this study was to establish a baseline of the culturally and linguistically appropriate services provided in hospitals in Florida’s Palm Beach, St. Lucie, and Martin Counties. We believe the results of this study will help inform the development of tools and interventions aimed at improving these hospitals’ cultural and linguistic services. We know from previous studies and from our involvement in this study that providing culturally and linguistically appropriate care is challenging, there are many barriers to overcome, even for those hospitals with well-established language programs. The first step in this journey is to understand the starting point – which we believe this study accomplished. There are many national resources in place to assist hospitals in their efforts to improve the provision of these services. In addition, there are many local and regional resources in place of which hospitals in these three counties could take advantage. The next step is to capitalize on this data and link to these available resources, to create new collaboratives, and perhaps to share resources. Despite the challenges, hospitals attempting to improve their provision of culturally and linguistically appropriate care will be the better for it, with the ultimate winner being the patient.

Endnotes

¹ 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.

² Patek L et al. *Spotlight on: Improving Patient-Provider Communication. A Call to Action*. JONA Volume 39, Number 9, pp 372-376. 2009

³ 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.

⁴ Patek L et al. *Spotlight on: Improving Patient-Provider Communication. A Call to Action*. JONA Volume 39, Number 9, pp 372-376. 2009

⁵ An “ad hoc” interpreter is defined as “an untrained person who is called upon to interpret, such as a family member interpreting for her parents, a friend, a bilingual staff member who is pulled away from other duties to interpret, or a self-declared bilingual individual who volunteers to interpret. These individuals may not have sufficient language capability or knowledge of medical terminology and confidentiality issues to function adequately as interpreters. 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.

⁶ *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons*. Washington, DC. United States Department of Health and Human Services, Office for Civil Rights, 2003. Accessed at: <http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf>.

⁷ 2007 *Speaking Together: Tools for Improving Language Services Delivery*, National Language Services Network. The George Washington University Medical Center. School of Public Health and Health Services. Department of Health Policy.

⁸ Ibid

⁹ Ibid

¹⁰ Ulmer C, McFadden B, Nerenz D (eds) *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Institute of Medicine, Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Washington DC: National Academies of Science, 2009. Accessed in March, 2010 at: <http://books.nap.edu/catalog/12696.html>

¹¹ Ibid

¹² Hasnain-Wynia, R Yonek, J, Pierce D, et al. *Hospital Language Services For Patients with Limited English Proficiency: Results from A National Survey*. Health Research and Educational Trust; National Health Law Program: 2006

¹³ 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.

¹⁴ Ibid

¹⁵ Smedley B, Stith A, Nelson A, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* National Academies Press, Washington DC, 2003.

¹⁶ Wilson-Stronks A, Galvez E. *Hospitals, Language, and Culture: A Snapshot for the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*. Oakbrook Terrace: The Joint Commission; 2007.

Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, and Galvez E One Size Does not Fit All: Meeting the Healthcare Needs of Diverse Populations. Oakbrook Terrace, IL: The Joint Commission; 2008.

¹⁷ National Quality Forum (NQF). *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*. Washington, DC: NQF; 2009.

¹⁸ National Committee for Quality Assurance (NCQA) *Innovative Practice in Multicultural Health Care*, 2008. Available at http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLASInnovativePrac_08.pdf

¹⁹ *The Joint Commission Standards Supporting the Provision of Culturally and Linguistically Appropriate Services, "Hospital, Language and Culture Project*. Accessed at: http://www.jointcommission.org/PatientSafety/HLC/HLC_Joint_Commission_Standards.htm

²⁰ Joint Commission Perspectives®, January 2010, Volume 30, Issue 1 Copyright 2010 Joint Commission on Accreditation of Healthcare Organizations

²¹ Federal Register: August 8, 2003. Volume 68, Number 153, page 47311-47323
From the Federal Register Online via United States Department of Justice, Civil Rights Division. Accessed at: <http://www.justice.gov/crt/cor/lep/hhsrevisedlepguidance.php>

²² *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons*. Washington, DC. United States Department of Health and Human Services, Office for Civil Rights, 2003. Accessed at: <http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf>.

²³ Baker DW, et al. Use and effectiveness of interpreters in an emergency department. *Journal of the American Medical Association*. 1996; 275:783-88.

²⁴ Baker DW, et al. 1996. *Ibid*.

²⁵ 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*. 2003 Jan;111(1):6-14.

²⁶ Flores G, et al. 2003. *Ibid*.

²⁷ Elderkin-Thompson VR, Silver C, Waitzkin H. When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Social Science & Medicine*. 2001; 52:1343-58.

²⁸ Aspden P, Corrigan J, Wolcott J (eds). *Patient Safety: Achieving a New Standard for Care*. Institute of Medicine, Committee on Data Standards for Patient Safety, Board of Health Care Services, Washington, DC: National Academies of Science, 2004, 528.

²⁹ Dohan D, Levintova M. Barriers beyond words: cancer, culture, and translation in a community of Russian speakers. *Journal of General Internal Medicine*. 2007; 22(Suppl 2):300-5.

Richardson LD, Babcock Irvin C, Tamayo-Sarver JH. Racial and ethnic disparities in the clinical practice of emergency medicine. *Acad Emerg Med*. 2003; 10(11):1184-8.

Fadiman, Anne. *The Spirit Catches You and You Fall Down*. New York: Farrar, Straus, and Giroux; 1997.

Collins KS, Hughes DL, Doty MM, Ives BL, Edwards JN, Tenney K. Diverse communities, common concerns: Assessing health care quality for minority Americans. Findings from The Commonwealth Fund 2001 Health Care Quality Survey. March 2002; 25-26.

Davis K, Schoenbaum SC, Collins KS, Tenney K, Hughes DL, Audet AMJ. Room for Improvement: Patients Report on the Quality of Their Health Care. The Commonwealth Fund, April 2002.

Agency for Healthcare Research and Quality. 2008 National Healthcare Disparities Report. Rockville, MD: U.S. Department of Health and Human Services in collaboration with an HHS-wide Interagency Work Group, Agency for Healthcare Research and Quality; AHRQ 2008 National Healthcare Disparities Report (NHDR) mandated by the U.S. Congress (42 U.S.C.299a-1(a)(6)).

³⁰ Derosé KP, Escarce JJ, et al. Immigrants And Health Care: Sources Of Vulnerability. *Health Affairs*.2007; 26(5):1258-1268.

Divi, et al. Language proficiency and adverse events in US hospitals: a pilot study. *International Journal for Quality in Health Care*. 2007; 19(2):60-67.

Cohen et al. Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics*. 2005; 116(3):575-79.

Flores G. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. *Medical Care Research and Review*. 2005; 62(3):255-99.

DeWalt DA, Berkman ND, Sheridan S, et al. Literacy and health outcomes: a systematic review of the literature. *J Gen Intern Med*. 2004; 19(12):1228-1239

Scott TL, Gazmararian JA, Williams MV, Baker DW. Health literacy and preventive health care use among medicare enrollees in a managed care organization. *Med Care*. 2002; 40(5):395-404

Fadiman, Anne. *The Spirit Catches You and You Fall Down*. New York: Farrar, Straus, and Giroux; 1997.

³¹ Patek L et al. *Spotlight on: Improving Patient-Provider Communication. A Call to Action*. JONA Volume 39, Number 9, pp 372-376. 2009

³² Joint Commission Perspectives, February 2008, Volume 28, Issue 2, 2008. Joint Commission on Accreditation of Healthcare Organizations.

³³ Ramirez D, Engel KG, Tang TS. Language interpreter utilization in the emergency department setting: a clinical review. *J Health Care Poor Underserved*. 2008; 19(2):352-362. JONA, Vol. 39, No. 9. September 2009 375

³⁴ 2007 *Speaking Together: Tools for Improving Language Services Delivery*, National Language Services Network. The George Washington University Medical Center. School of Public Health and Health Services. Department of Health Policy.

³⁵ Patek L et al. *Spotlight on: Improving Patient-Provider Communication. A Call to Action*. JONA Volume 39, Number 9, pp 372-376. 2009

³⁶ Ramirez D, Engel KG, Tang TS. Language interpreter utilization in the emergency department setting: a clinical review. *J Health Care Poor Underserved*. 2008;19(2):352-362. JONA, Vol. 39, No. 9. September 2009 375

³⁷ 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.

³⁸ Patek L et al. *Spotlight on: Improving Patient-Provider Communication. A Call to Action*. JONA Volume 39, Number 9, pp 372-376. 2009

³⁹ Johnstone MJ, Kanitsaki O Culture, Language and Safety: Making the Link, *Int J Qual Health Care*. 2006 Oct; 18(5): 383-8. Epub 2006 Sept. 6

⁴⁰ *Ibid*

⁴¹ Florida Department of Children and Families, Refugee Services. Florida's Refugee and Entrant Arrivals: Statistical Reports (1998-2007). Available at: <http://www.dcf.state.fl.us/refugee/publications/>. Accessed December 3, 2007.

⁴² US Census Bureau. American Fact Finder, Florida Fact Sheet. Available at: <http://factfinder.census.gov>. Accessed December 3, 2007.

⁴³ Florida Department of Children and Families, Refugee Services. *Ibid*.

⁴⁴ Agency for Healthcare Research and Quality. 2006 National Healthcare Disparities Report. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; December 2006. AHRQ Pub. No. 07-0012.

Shin HB, Bruno R. Language Use and English-Speaking Ability: 2000. Census 2000 Brief, US Census Bureau: October 2003.

⁴⁵ US Census Bureau. *Ibid*.

⁴⁶ US Census Bureau. *Ibid*.

⁴⁷ Regenstein, Marsha. Measuring and Improving the Quality of Hospital Language Services: Insights from the *Speaking Together* Collaborative. *J Gen Intern Med* 22(suppl 2): 356-9. DOI: 10.1007/s11606-007-0358-2 The George Washington University Medical Center. School of Public Health and Health Services. Department of Health Policy.

⁴⁸ Wilson-Stronks A, Galvez E. *Hospitals, Language, and Culture: A Snapshot for the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*. Oakbrook Terrace: The Joint Commission; 2007.

Hasnain-Wynia, Romana, Cohen A, Restuccia J, Yonek J. "Improving Care for Individuals with Limited English Proficiency: Facilitators and Barriers to Providing Language Services in California Public Hospitals. Safety Net Institute, October 2009. California Endowment.

⁴⁹ 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.

⁵⁰ *Ibid*

⁵¹ 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.

⁵² *Ibid*

⁵³ Ulmer C, McFadden B, Nerenz D (eds) Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Institute of Medicine, Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Washington DC: National Academies of Science, 2009. Assessed in March, 2010 at <http://books.nap.edu/catalog/12696.html>

⁵⁴ *Ibid*

Appendix 1: CLAS Standards

National Standards on Culturally and Linguistically Appropriate Services (CLAS)**

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

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.

Standard 3

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.

Standard 4

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.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

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.

Standard 8

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.

Standard 9

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.

Standard 10

Health care organizations should 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.

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.

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.

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.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

** Taken from the Office of Minority Health website:

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> (accessed 2/12/10)

Appendix 2: Staff Questionnaire

I have read the Informed Consent Information Sheet and agree to participate in this study by completing the survey.

1. What is your role in the hospital? (Please do not write your name)

- a Physician b Nurse c Other clinical provider (imaging, lab, etc.) d Support services (registration, switchboard, billing, etc.)
 e Environmental services (dietary, housekeeping, security, etc.) f Other _____

2. Are you bilingual?

- a Yes What language(s) other than English do you speak? _____ (Please complete questions 3 and 4).
 b No No (please skip to question #5)

3. If you are bilingual, has your language proficiency or competence been assessed by the hospital?

- a No, my competency has not been assessed
 b Yes, my language competence has been assessed (please specify how and when you were assessed) _____

4. If you are bilingual, does your name appear on a hospital list of bilingual staff members designated to serve as interpreters?

- a Yes
 b No

5. Please follow these instructions for Question #5:

STEP 1: In the left hand column, check which resources are available in your hospital for communicating with limited English proficient patients;

STEP 2: For those resources you marked available, please indicate how often you use them; first for **Spanish**-speaking patients and then for **all other languages**;

Please note: We are only interested in those resources that you use for the actual health care encounter (e.g. explaining medical procedures, translating documents, providing discharge instructions, etc), not for the interpretation of activities of daily living.

Resource or Method Available

Frequency of Use

	Frequency of Use					
	Spanish Speaking Patients			All Other Languages		
<input checked="" type="checkbox"/> ← Please check the box if the resource is available	Frequently	Sometimes	Rarely	Frequently	Sometimes	Rarely
a <input type="checkbox"/> Someone accompanying the patient (<i>family member or friend</i>)						
b <input type="checkbox"/> I am bilingual and communicate directly to patients						
c <input type="checkbox"/> Telephone interpreter (<i>Language Line, Cyracom, etc.</i>)						
d <input type="checkbox"/> Video Remote Interpreter						
e <input type="checkbox"/> Interpreter (<i>Employee of the hospital whose primary job is to provide language services</i>)						
f <input type="checkbox"/> Bilingual staff member - formal (<i>Primary job is NOT language services, but is designated by the hospital, (for example, on a list) as able to provide interpreting services</i>)						
g <input type="checkbox"/> Bilingual staff member - informal (<i>Employee is not designated officially by the hospital, but able to provide interpretation services when necessary</i>).						
h <input type="checkbox"/> Hand-held electronic communication device (<i>such as PDA or portable laptop computer</i>)						
i <input type="checkbox"/> "I Speak" cards (<i>cards containing the names of languages in English and the target languages for patients to point</i>)						
j <input type="checkbox"/> Communication boards (<i>physical, written tools containing words, letters, and/or symbols the patients may point to</i>).						
k <input type="checkbox"/> Translated documents						
l <input type="checkbox"/> Bilingual signage / way finding (<i>use of universal symbols, multi-lingual signs, etc</i>)						
m <input type="checkbox"/> Other (<i>please specify</i>) _____						
n <input type="checkbox"/> None						

6. Which resource(s) do you **prefer** to use to communicate with limited English proficient patients (when you do not speak their language) and why?

7. Which additional resources do you have available and do you use to help meet the needs of your patients? Please check all that apply and indicate how frequently you use them

Resource Available

Frequency of Use

<input checked="" type="checkbox"/> ← Please check the box if the resource is available		Frequently	Sometimes	Rarely
a	<input type="checkbox"/> Staff members with knowledge of specific cultures, beliefs, or practices.			
b	<input type="checkbox"/> Volunteers / interns with knowledge of specific cultures, beliefs or practices.			
c	<input type="checkbox"/> Chaplains / pastoral care.			
d	<input type="checkbox"/> Hospital-provided books containing information about different cultures.			
e	<input type="checkbox"/> On-line or intranet materials about specific cultures and their needs.			
f	<input type="checkbox"/> Questionnaires or assessments that help identify patients' cultural needs.			
g	<input type="checkbox"/> Special dietary services (<i>kosher meals / kitchens, flexible meal times to accommodate prayers / religious fasting, etc.</i>)			
h	<input type="checkbox"/> Physical or environmental resources (<i>e.g. Sabbath elevators, prayer rooms, etc.</i>)			
i	<input type="checkbox"/> Complementary / alternative medicine modalities (<i>including folk remedies, acupuncture, traditional healers, etc.</i>)			
j	<input type="checkbox"/> Community cultural resources (<i>please specify _____</i>)			
k	<input type="checkbox"/> Formal, ongoing collaborations or relationships with the community, health care providers, or other entities).			
l	<input type="checkbox"/> Opportunities for learning about cultural diversity such as printed media, intranet, lunch and learns, celebration of cultural events or months).			
m	<input type="checkbox"/> Other (<i>please specify _____</i>)			
n	<input type="checkbox"/> None			

8. Please indicate how your hospital provides information about how to access and use available language and cultural resources (check all that apply):

- a Training /education provided at orientation. b Training / education provided as in-service c Printed media d Intranet
 e "Lunch and learns" f Signage / placards g Other (please specify) _____
 h No training, education or other information is provided

9. Do you think you have a good understanding of what tools and resources are available in your hospital to help meet the cultural and linguistic needs of patients?

- a Yes
 b No

Thank you for taking part in our study.

Appendix 3: Languages Encountered

Languages (other than English) Encountered in the Patient Populations of Hospitals
Participating in the “Cultural and Linguistic Care in Area Hospitals” Study**

American Sign Language
Arabic
Chinese – Mandarin
Chinese – Other
Finnish
French
French Creole
German
Greek
Haitian Creole
Hebrew
Hungarian
Italian
Korean
Mayan languages (Quanjobal, Mam, Popti, and Quiche)
Polish
Portuguese
Russian
Spanish
Tagalog
Vietnamese
Yiddish

** As reported by hospitals in study group.