CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

Introduction, Purpose, and Suggestions for Using the Guide

The Purpose of this Guide: When the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care were published for public comment in the Federal Register on December 22, 2000, health care organizations began to contact OMH and private consultants seeking assistance in implementing culturally and linguistically competent health care services that would meet the new national standards. OMH has supported the preparation of this step-by-step guide to assist health care organizations to create a health care environment that would meet the very real needs and expectations of an increasingly diverse patient/consumer population. Suzanne Salimbene, Ph.D., President of Inter-Face International, a company that works to bridge language and cultural gaps in health care, was awarded a contract to develop the guide.

Availability of Professional Assistance: Users of this guide will be able to express their concerns and ask questions about the implementation of the checklists and instructions. At the end of the guide, there is a user evaluation. The author will answer all questions to the best of her ability, responding personally to the particular institution that has submitted the question. User comments, suggestions and criticisms will be carefully considered in the future editing of each module. All comments are welcomed in an effort to develop a flexible, easy-to-use and practical guide to cultural competence in health care institutions.

How to make most effective use of the guide:

- Designate a single person or committee to be ultimately responsible for institution-wide implementation.
- Read the short introduction to each section of the guide to gain an overview of the purpose and the contents of the checklists or forms.
- Circulate the checklists or forms to the particular person or group most likely to have access to the information requested. Ask that party to choose a responsible person for the completion of the form(s) and/or questionnaire(s) and to establish a deadline for returning the completed form(s).
- When all of the checklists, questionnaires and forms have been returned, read the part of the guide which describes how to best interpret or utilize the information received.
- Choose someone to be responsible for the actual implementation of the goals of that module (i.e. the drafting and tracking of a long-term plan).
- One may wish to form a committee made up of all the individuals responsible for the implementation of each set of goals. This way the committee may meet

regularly to assess the progress in establishing a culturally and linguistically competent organization.

- The above committee should be responsible for compiling the annual self-assessment described in Section #9 of the guide.

Guide Format and Table of Contents

Format

This guide is designed to be practical and easy to use. It contains a minimum of cursive text. The majority of the guide is in the form of downloadable and reproducible "checklists", forms, and syllabi that healthcare organizations can use or adapt to their specific needs. Although these checklists are designed to be used in sequence in their entirety, each section is "self-contained." Institutions not wishing to implement the entire program according to the guide can use individual "steps" or "checklists." The guide presents a suggested order of implementation of the CLAS Standards. Following the section number and the title is the number of the CLAS Standard to which it refers.

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o. Checklist #5: Patient/community access to culturally and linguistically appropriate care

p. Checklist #6: Community involvement, input and support *(CLAS Standard #12)*

Further Reading

3. **Guide to devising a workable strategic plan** *(CLAS Standard #8).*
This section is designed to guide the institution to the creation and implementation of a written strategic plan for initiating and fostering cultural and linguistic competency throughout the organization. The plan helps each organization define long-term and short-term goals and develop specific plans to achieve each goal. The strategic plan covers a 5-year period and suggests some mechanisms for measuring success and reporting upon progress on a yearly basis. It also guides institutions in re-defining and extending goals once the 5-year period has been completed.

List of reproducible forms and instructions:

a. Checklist #1: Setting and articulating cultural competence goals to fit into the organizational mission statement, operating principles and service focus

b. Checklist #2: Developing a 5-year plan

j. Checklist #3: Developing an accountability hierarchy for CLAS and cultural competence leadership throughout the organization

10. **Guide to insuring that patients/consumers receive effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and preferred language** *(CLAS Standard #1).*
"This standard constitutes the fundamental requirement on which all activities specified in the other CLAS Standards are based," as stated in the published version of the CLAS Standards. The term "understandable" refers not only to language, but also to culture. This standard assures care in a language (whether in the preferred language of the patient/client or in English that can be easily understood) and in concepts that are understandable from his or her cultural or religious framework.

List of reproducible forms and instructions:

a. Checklist #1: Improving the "effectiveness" of care

b. Checklist #2: Improving the "understandability" of care and services

j. Checklist #3: Improving the "respectfulness" of care

k. Checklist #4: Developing customer satisfaction questionnaires to assist in evaluating the "effectiveness," "understandability" and "respectfulness" of care and services

l. Checklist #5: Interpreting the results

11. **Guide to promoting diversity throughout the organization** *(CLAS Standard #2)*

Staff diversity is not, in itself, a guarantee of an organization's ability to provide its patients/clients with culturally or linguistically appropriate care and services. It does, however, improve the comfort level of culturally diverse patients. It demonstrates that the organization recognizes and values the members of the patient's ethnic group. According to CLAS Standard #2, diversity is measured not merely by numbers but by an organization's ability to hire and retain a staff that reflects the demographics of the service area. Staff diversity needs to be encouraged and supported throughout all ranks of the organization. While at this time it may not be possible to achieve exact parity between patients and staff at all job levels, a clear demonstration of good faith efforts to develop concise strategies for working toward this goal will be recognized as meeting this standard. (Note: The majority of this section will be the concern and responsibility of the human resources department.)

List of reproducible forms and instructions:

a. Checklist #1: Utilizing patient and staff demographics to evaluate the organization's "Diversity Profile"

b. Checklist #2: Evaluating the organization's efforts to attract and retain minority staff members (Note: Sources for advertising openings to minority applicants for managerial and medical positions)

j. Checklist #3: Evaluating job advancement options and opportunities for minority groups

k. Checklist #4: Developing a plan to improve minority representation throughout the organization

Further Reading

12. **Guide to providing the language access services that have been mandated by Title VI of the Civil Rights Act of 1964** *(CLAS Standards #4, 5 ,6 & 7)* The specific services relating to language access for limited English speaking patients are already required of all organizations receiving federal funds. CLAS Standards #4, 5, 6 & 7, which relate to these provisions, are categorized as mandates rather than recommendations. Good faith efforts to work toward total language access represent an acceptable step in the right direction if they are accompanied by a strategic plan for broadening this access to less populous groups. Multilingual signs, culturally-appropriate translated written documents, and trained medical interpreters in the preferred languages of at least 3 of its primary service population groups may be considered an adequate "starting point." The reproducible checklists aid in the implementation of language services for these primary groups.

List of reproducible forms and instructions:

a. Checklist #1: Informing patients of their right to language assistance

b. Checklist #2: Establishing adequate signage in other languages

c. Checklist #3: Developing appropriately translated patient information and patient education materials for all patients in the service area

d. Checklist #4: Creating an efficient, cost-effective system for medical interpretation

Further Reading

13. Guide to on-going staff training throughout the organization *(CLAS Standard #3)*
This section will assist in the evaluation of current training in cultural and linguistic competence and the development of a plan to ensure that this training becomes an on-going process at the institution. It presents a list of core topics that should be included in training. This list has been subdivided into three levels of competence according to job performance requirements and the amount of contact staff members are expected to have with diverse patients and colleagues.

List of reproducible forms and instructions:

j. Checklist #1: Evaluating current training in cultural and linguistic competence

k. Checklist #2: Planning for on-going training throughout the organization

l. Checklist #3: The three levels of cultural and linguistic competence

Further Reading

14. Guide to the development of positive, participatory and collaborative partnerships with community organizations and support groups of culturally diverse populations in the service area *(CLAS Standard #12)*
These alliances will ensure that each group's health care needs and concerns are met in a culturally appropriate manner.

List of reproducible forms and instructions:

a. Checklist #1: Strengthening ties with communities through contacts with grass root organizations

Further Reading

9. Guide to annual self-assessment and evaluation
This final step in an organization's journey toward cultural and linguistic competence is linked to both the creation of a workable strategic plan and constant revisiting of the institutional audit. These checklists should be repeated each year as a means of evaluating the institution's progress in meeting its goals. It is recommended all yearly self-assessments be saved. They will provide a comprehensive picture of the institution's journey toward cultural and linguistic competence.

List of reproducible forms and instructions:

a. Checklist #1: Annual institutional self-audit

b. Checklist #2: Review of employee and patient grievances and patient satisfaction

c. Checklist #3: Examining and re-evaluating short and long-term goals (Note: Refer to the completed forms of Section #3 of the guide to complete this checklist).

Assessment and evaluation of the effectiveness of the guide

Section #1, An Important Message to Health Care Decision Makers: The Compelling Rationale for Cultural & Linguistic Competency

Changing Health Care Population and Staff

Cultural and linguistic competence has become a necessity for the survival of any healthcare organization. The mainstream White patient and staff populations may soon become minorities. The U.S. Census Bureau predicts that within the next 50 years, nearly one half (48%) of the nation's population will be from cultures other than White, non-Hispanic. Many from these population groups hold health beliefs extremely different from the Northern European beliefs upon which our U.S. health system was founded. This increase will impact both patient and staff demographics. The world views, communication styles, work habits and ethics of culturally diverse staff members will be different from that of primarily White employees. To achieve both customer and staff satisfaction and loyalty, each organization will need to broaden its cultural and linguistic competency.

Culture, Patient Compliance and Health Outcomes

Satisfaction and loyalty contribute to an organization's economic well being. Successful outcomes to medical treatment are strongly influenced by linguistic and cultural access to care. Compliance with treatment, as well as the retention of culturally diverse patients and staff, will impact risk management, the number and outcome of medical malpractice suits and employee grievances. An adaptation of services that are more appropriate to culturally and linguistically diverse patient/client groups will lower the chances of bad outcomes due to miscommunication or misuse of medications and medical advice.

Culture, Access to Care and Health Care Regulating Bodies

Cultural and linguistic competence is now recognized as a major component in the accessibility of health care. Most recently (August, 2001) the Surgeon General's report: *Mental Heath: Culture, Race, Ethnicity* unequivocally stated the need for mental healthcare providers to gain a better understanding of the culture of their patients and the impact of cultural beliefs and practices on a patient's access to and response to care. Appropriate provisions to the language needs of patients were mandated by Title VI of the Civil Rights Act of 1964. All health care organizations that receive federal funds are also required to demonstrate their ability to provide both culturally and linguistically appropriate care and services. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) mentions the need for culturally appropriate care and services eighty seven times in each of its accreditation manuals. The Department of Health and Human Services Office of Minority Health (DHHS-OMH) spent two years in the preparation of the Culturally and Linguistically Appropriate Services (CLAS) Standards. This composite of existing mandates and recommendations regarding the specific needs and objectives of cultural competence in health care, draws together all that has been done, thus far, in achieving these goals. The CLAS Standards are summarized in Appendix I of this section of the guide. These steps by regulatory bodies indicate the direction in which health care is moving. They demonstrate a strong determination on the part of monitoring bodies, to assure access to health care which is linguistically and culturally appropriate to an increasingly diverse patient population.

A Brief Summary of the Culture, Language and Health Care Connection

Culture plays an extremely important role in health care. It determines how one defines health, wellness, illness, youth, and old age. People learn their health/illness and illness prevention beliefs and practices from the culture to which they belong. That culture determines whether or not preventative measures such as periodic check-ups, vaccinations, mammograms, and Pap tests, are taken. It impacts the decision to accept or reject medical advice and/or treatment. Culture also determines how patients expect to be treated by each member of the healthcare organization with whom they interact. Because none of us are immune to culture, it also influences the expectations of caregivers regarding how patients should behave toward one another, their caregivers, and the healthcare system as an institution. See Appendix II of this section for examples.

The Who, What, When and How in Creating & Maintaining a Culturally Competent Health Care Institution

What behaviors, practices, and policies are required to provide culturally and linguistically competent care to an increasingly complex and diverse group of patients? More important, how are the required knowledge, strategies and skills acquired and maintained? Cultural and linguistic competence should become an intrinsic part of each institution's mission. Treatment plans will not be followed or valued by the culturally diverse consumer unless they are both culturally and linguistically appropriate. Each organization needs to become culturally competent at all levels and maintain this standard on a daily basis.

Implementation of CLAS

Implementation of CLAS will include **on-going intervention**. Cultural and linguistic competency requires changes in the basic assumptions and communication styles that each member of the organization has developed over the course of his/her personal and working lifetime. Changes include:

- System-wide interventions to heighten cultural and linguistic awareness and Sensitivity.
- The acquisition of new skills, strategies, and knowledge.
- Consistent support and reinforcement from senior leaders.
- Information seminars about the rules and taboos of population groups in the service area.
- Easy-to-access cultural references for medical staff.
- Staff training on how to effectively utilize medical interpreters.

How to Use this Guide to Enhance the Cultural Competency of an Organization

- Designate a high ranking administrator with decision making power as Director of Diversity (This person may wish to work alone or form a Diversity Council or Committee).
- The Director of Diversity should oversee the implementation of this step-by-step guide. In some cases, he or she should adapt the suggested steps to meet the structure of the organization. This person must have the authority to delegate the

completion of each of the 9 sections to the appropriate person or department in the organization. The checklists or instructions in these sections may also need to be distributed to different persons within that department.

- Follow the steps indicated by the guide in interpreting the results and/or implementing the organizational changes indicated.
- The CEO and other high ranking administrators should demonstrate full support in the creation of any organizational changes recommended by the director and the committee or council.
- Some steps and checklists should be repeated after the implementation of changes as a means of measuring success.
- This initiative should be viewed as a long-term, on-going commitment to developing and maintaining cultural and linguistic competence.

Further Reading:

Brach C, Fraser C: Reducing Disparities through Culturally Competent Health Care: An Analysis of the Business Case. *Quality Management in Health Care* 2002; 10(4):15-28.

Kairys JA, et al: Assessing Diversity and Quality in Primary Care Through the Multimethod Process (MAP). *Quality Management in Health Care* 2002; 10(4):1-14.

Appendix I: CLAS Standards*

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
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.
3. Health care organizations ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
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.
10. 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.
11. 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).
12. 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.
13. 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.
14. 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.
15. 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.
16. 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.
17. 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.

18. 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.

19. 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.

*Office of Minority Health, U.S. Department of Health and Human Services. *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* Rockville: IQ Solutions, 2001.

Appendix II The Culture, Language and Health Care Connection**

Avoiding Stereotypes:
The information presented below offers examples of some of the health beliefs and behaviors that have been attributed to members of several diverse cultural groups living in the United States. It should **never** be assumed that membership in a particular cultural group means that any individual either ascribes to any or all of the belief or behaviors described below. The information provided here is intended to add an additional perspective to the understanding of individuals who may be exhibiting behavior which seems strange or unfamiliar. **Each patient must be assessed as a unique individual, not as a member of a particular group.** The degree to which an individual adheres to the traditional belief system or the behaviors attributed to a particular cultural group depends upon many factors. These include the number of years the person has lived in the United States, the environment in which he or she lives, and the person's level of education and socioeconomic status. Health care institutions and caregivers are cautioned to avoid stereotyping individuals based upon the broad cultural norms described below. This information merely provides a few examples of the many ways in which culture may impact health beliefs, the way a patient may respond to pain, and the different forms of treatment. It should not be taken to imply that all members of a particular group hold to the behavior or beliefs presented. When a patient or a patient's family responds in ways that medical staff find confusing, it is recommended that questions be asked to assess for their adherence to traditional beliefs.

Questions to further assist in cultural assessment can be found in the following articles:

Kleinman, Eisenberg & Good article, "Illness and Care, Clinical Lessons from Anthropology and Cross Cultural Research, Ann. Int. Med., 1978, Feb., 88(2),251-8.

Spector, R. E. Cultural Diversity in Health and Illness (attachment), 6th Edition, Prentice Hall, 2003, Lieberman, et. al. "Woman's Health Care: Cross-Cultural Encounters Within the Medical System" Journal of the Florida Medical Association, August/September, 1997,Vol..81,#1.

Warren B, Capinha-Bacote, J., Munoz C, in Munoz C. Cultural concepts to consider in the care of the ethnically diverse client and family, Ohio Nurses Review 2001.

Salimbene, S., What Language Does Your Patient Hurt In? A Practical Guide to Culturally Competent Patient Care, 2nd Edition, Diversity Resources, to be published Fall, 2004.

Interpersonal Commentary
On the purely interpersonal level, for example, members of the U.S. culture, generally admire "equality" and "informality." Many members of this dominant caregiver population demonstrate caring and compassion by smiling at the patient, patting the patient on the arm, shoulder, or head, and/or addressing the patient by his/her first name. This behavior can be interpreted by members of cultures who use a formal, impersonal

version of the pronoun "you" with anyone who is not a close friend or relative or who address one another in terms of role (e.g. brother, sister, oldest daughter, or aunt) as being impolite and disrespectful. In cultures that believe that a person's soul resides in the head, it can be considered intrusive or even a cause of illness to touch someone on the head without permission. In other cultures, it is impolite to smile at someone one does not know, especially if that person is of a higher status such as a physician or nurse! In the same manner, the behaviors of caregivers who belong to a rather formal culture – or one that is referred to as a "distance" or "non-touch" culture may also be misinterpreted by patients who come from a more informal, "touch" culture such as our mainstream White culture in the U.S. The patient may fail to develop a sense of trust with a caregiver whom they have labeled as "unfeeling" or "unconcerned."

Expectations of Type and Extent of Medical Exam

Culture also determines the patient's needs and expectations regarding the type and extent of the medical exam and treatment. For example, in traditional Chinese medicine, the physician examined the patient by taking the pulse at seven different pressure points and looking at the tongue in several different places. Traditional Chinese physicians rarely resort to an invasive examination or treatment of any kind. Often illness is attributed to an imbalance of *Yin* and *Yang.* Balance is restored by foods or medications of the lesser force. Most traditional medications are taken orally as a liquid or slush. On the other hand, some Latino patients may prefer medications to be given in hypodermic form. In Mexico, medication is often given in hypodermic form and the caregiver always "gives/prescribes something" – even if it is a placebo or a suggestion for a minor change in lifestyle. Failure to give any medication or advice may cause the patient to go away with the feeling that he/she received inferior treatment. Latino patients who follow traditional rules of etiquette expect the caregiver to offer his/her hand in greeting at every office visit. They may also wish to place themselves in the "expert hands" of the physician and not want to share in the decision-making process regarding treatment options. If the physician asks the patient to participate in the choice of treatment plan, the patient may lose confidence in the physician's medical experience and expertise.

Expression of Pain

Research has shown that though the sensation of pain is similar for most populations, there are major cultural differences in the manner in which pain is expressed. Members of some Asian groups, for example, may not exhibit pain behavior and may refuse medication, while members of other groups may cry out when pain should be relatively slight as a means of demonstrating their "delicacy." Although in Mexican culture, loss of self-control is frowned upon, and men are expected to resist outward expression of pain, caregivers in the United States often label Mexican females patients as "crybabies" because they frequently cry-out a great deal during labor. What these caregivers don't understand is that this behavior does not indicate lack of control, and that the "message" intended by the cries is not, "I expect you to do something!" but "I am sharing the pain with you so that I feel it less intensely." In other words, the cultures of different population groups may dictate very different pain behavior so it is important for caregivers to refrain from making assumptions about the meaning of these behaviors based upon the behavioral dictates of their own culture. They should also refrain from

making a generalization about a patient's pain behavior which is based upon the patient's cultural group.

Surgery

There is little surgical tradition in much of Asia. Confucius is believed to have said that the body is only "loaned" to the person while he/she is on earth. Only those who return the body "whole" are allowed to go to heaven. This belief may cause an Asian patient to refuse to consent to surgery that requires the removal of a tissue or body part.

Alternative Medicine

Patients from many cultures may use alternative therapies – either instead of or concurrent with Western treatment. Often these treatments will not harm the patient, but it is important for caregivers to encourage patients to disclose these treatments because some may be harmful, either by themselves or in conjunction with what the physician prescribes. Some traditional treatments are misinterpreted by caregivers. Two popular pan-Asian treatments are "coining" and "cupping." In "coining," a coin or other piece of metal is heated and rubbed on the infected area until red welts appear. In cupping, glass cups are heated until the air is removed and, then, placed on the back or chest. The removal of the cup causes red welts to appear on the skin. Often when these marks are found on women or children, caregivers, not trained to recognize this cultural practice, suspect and report spousal or child abuse.

Culture, Colors and Decor

Culture also molds patient and caregiver perceptions about what the waiting room or clinic should look like and even where certain departments should be located. How would an individual feel, if either labor and delivery or surgery were on the fourth floor, and that person, as do many Asians, associate the number four with death? White has always been the "preferred color" of hospital corridors, waiting rooms, and physician coats. Why? This is because to members of Western European culture, white symbolizes cleanliness, purity, and peacefulness. To many Asian groups, however, white is a color that is reserved for death and funerals!

Culture and the Institution's Bottom Line

As one can see, culture, looked at from these different perspectives, can seriously impact a medical institution's bottom line! It may ultimately determine whether or not members of a particular population group initially choose that healthcare organization as a healthcare provider, are satisfied with their treatment results, and remain loyal patients/clients of that organization. Competency in treating culturally diverse patients will enable an institution to retain a larger service population. When caregivers understand the needs, beliefs and concerns of various cultures in their service area, they can modify care and treatment to make it more appropriate to the particular patient's lifestyle and belief system. Care that does not conflict with a patient's cultural beliefs improves compliance with the taking of medication and recommended lifestyle changes. Patients, too, tend to be more forthcoming in disclosing alternative treatments if they feel that the caregiver will respect, not ridicule, these methods. As a result of greater trust, openness and compliance, the frequency and extent of bad outcomes can be minimized.

Furthermore, legal suits that are the direct or indirect result of bad outcomes caused by miscommunication and mistrust between caregiver and patient can be measurably reduced.

References & Further Reading

Calvillo, E.R., Flaskerud, J.H., "Evaluation of the pain response by Mexican American and Anglo American women and their nurses, "Journal of Advanced Nursing, 1993, 18, 451-459

Galanti, Geri-Ann, Caring for Patientf from Different Cultures, 3rd Edition, 2004, Philadelphia, University of Pennsylvania Press

Helman, C.B., Culture, Health & Illness, 4th Edition, Boston, Butterworth Heinemann

Lipson, J.G., Dribble, S.L., Minarik, P.A., eds. Culture and Nursing Care: A Pocket Guide, San Francisco, UCSF Nursing Press, 1996

Ng, B., Dimsdale, J., Shragg, P, Deutsch, R, "Ethnic Differences in Analgesic Consumption for Post Operative Pain," Psychosomatic Medicine 58: 125-129 (1996)
Suzanne Salimbene, Ph.D. "Methods for Improving Cultural Competence," (203-222) Burns & Northrup, eds., *Guide to Managed Care Strategies, 1999,* Faulkner & Gray New York

Salimbene,S. What Language Does Your Patient Hurt In? A Practical Guide to Culturally Competent Patient Care, Amherst, Diversity Resources, 2000

Weber, S.E., Cultural Aspects of Pain in Childbearing Women, JOGNN, 25(1),1996, 67-72

Section #2, Guide to Conducting and Interpreting the Institutional Audit

General Directions

Do not burden one person with the completion of all of the checklists in this section. Although one person should be responsible for the distribution and collection of the information, the forms should be distributed to the person or department most likely to have the information at hand or most likely to be impacted by the results. Remember, this is an institutional *self-audit*. The information will remain within the organization. It has been developed to assist each individual institution to clarify where it stands on a continuum of cultural competence and what areas of cultural and linguistic competence require the most attention. The more thoroughly the checklists are completed, the greater will be its usefulness in helping the institution plan a more successful implementation of CLAS Standards. (Note: The Census figures will be available for each institution's service area. If the institution does not yet gather official data on its patients' race and ethnicity, estimate the patient demographics. In the future, race and ethnicity might be included on intake forms because this information will provide valuable data about current and future service populations).

What can be learned from Checklists #1 and #2?

1. **Changes in patient demographics (or estimated patient demographics)**
   - **a.** Compare 1990 or earliest record of patient demographics with the most recent demographics
   - **j.** Compute increases and decreases in patients from ethnic groups
   - **k.** Determine whether there are new groups moving into the service area
   - **l.** Use the U.S. Census Bureau predictive figures for 2010 to forecast changes in current patient populations

2. **An estimate of how much each population group believes in the institution's ability to serve them effectively**
   - **a.** Compare the 2000 Census figures (per race and ethnic group) with the patient figures (or estimated patient figures) at the institution
   - **j.** Determine the percentage of the population group that has opted to use the institution
   - **k.** If only a small percentage of the population of any ethnic group in the service area is utilizing the facility, it is possible that the facility does not hold the confidence of that community. To investigate the cause of this lack of confidence, select a person or committee to check the attitudes of the population group toward the institution. This can be done by contacting community leaders and organizations and conducting an informal survey of that group's attitudes about the quality of care provided by the institution.

3. **A comparison of patient demographics with staff demographics**
   CLAS Standard #2 recommends that healthcare organizations work toward developing a balance between staff demographics throughout the organization and

the demographics of the populations that they serve. The replies of Checklists #1 and #2 will allow a comparison of the staff and patient demographic data. While at this time it may not be possible to have an equal balance between the ethnic/racial/cultural backgrounds of patients and staff throughout the country, it is important that the culturally competent organization makes a good faith effort to accomplish this balance within the next decade.

What can be learned from Checklist #3?
This is a checklist that should be filled out by one or more of the top decision-makers. Their answers will help leadership identify the extent of their commitment to the cultural competence initiative. (Note: Should the organization's leadership not be in full support of implementing CLAS, they may wish to postpone this journey. The experience of other organizations has shown that full support of top leadership is necessary for a successful implementation of CLAS. Anything less than full support often results in failure, needless expense, and an unhappy and frustrated lower chain of command and staff).

What can be learned from Checklists #4 and #5?
Checklist #4 will illustrate how easily the institution has made it for culturally diverse patients/consumers to access health services. Checklist #5 will indicate whether or not the institution has incorporated community leadership as a source of information as well as a source to help improve access to care. These checklists will suggest ways in which community leaders might be utilized to build support and improve patient/consumer satisfaction.

What can be learned from Checklist #6?
This checklist will indicate how well the institution currently measures up to the CLAS Standards. The answers will help the institution to identify the strongest and weakest points of cultural competency and decide which issues should be dealt with first.

Section #2, Checklist #1: Present and Future Patient Demographics

Ethnicity of Patients in Service Area	1990 or Earliest Patient Demographics*	2000 or Most Recent Patient Demographics*	Increase/ Decrease of Ethnic Patient Group	2000 U.S. Census Figures for Areas Served**	2010 U.S. Census Forecast Figures for Areas Served**	Expected Increase/Decrease of Ethnic Groups Served
Total White (Non-Hispanic) ***List ancestry of most recent immigrants below (e.g. Polish, Bosnian, Russian*****)**	**Number/Percent**	**Number/Percent**	**Number/Percent**	**Number/Percent**	**Number/Percent**	**Number/Percent**
Total Hispanic ***List ancestry below (e.g. Mexican, Haitian, Cuban)***						
Black (Non-Hispanic)						
American Indian						
Total Asian/Pacific Islander ***List ancestry below (e.g. Chinese, Japanese, Hmong*****)**						
Asian Indian						
Muslim (e.g. Middle Eastern, Pakistani, Others)						
Total patients seen						

*If records of patients' race and ethnicity have not been kept, estimate these demographics.
**See U.S. Census Race/Ethnicity by Community

Section #2, Checklist #2: Present Staff Demographics

Ethnicity of Staff in Institution	Administrators (Managers, Supervisors)	Physicians (MDs, DOs)	Nurses (RNs, NPs, PAs, Techs, etc.)	Clerical Staff	Misc. Staff (Housecleaning, Food)	Total Staff Members	2000 or Most Recent Patient Demographics*
Total White (Non-Hispanic) *List ancestry of most recent immigrants below (e.g. Polish, Bosnian, Russian)	Number/Percent	Number/Percent	Number/Percent	Number/Percent	Number/Percent	Number/Percent	Number/Percent
Total Hispanic *List ancestry below (e.g. Mexican, Haitian, Cuban)							
Black (Non-Hispanic)							
American Indian							
Total Asian/Pacific Islander *List ancestry below (e.g. Chinese, Japanese, Hmong)							
Asian Indian							
Muslim (e.g. Middle Eastern, Pakistani, Others)							
Total of all ethnicities							

*This information is found in **Section #2, Checklist #1**. Either use the 2000 or most recent Patient Demographics or, if these are unavailable, use the 2000 U.S. Census figures for the area served. This column is present to help in the comparison of Checklists #1 and #2.

Analysis of Section #2, Checklist #2

10. How well do the staff demographics match the demographics of the patients served (or estimated demographics)?

Excellent _____ Well _____ Some Improvement Needed _____ Not Well _____

11. At what levels of the staff hierarchy are the majority of the minority employees? (Note: If the organization finds that minority workers are primarily at the lower levels of employment, the Human Resources Department will need to make a strong effort to increase the cultural diversity of the upper level staff.)

Administrators _____ Physicians _____ Nurses _____ Clerical staff _____

Food/Maintenance ____

12. Identify conflicts which have resulted from the mixture and/or non-mixture of culturally diverse employees and patients.

a. List problems that have occurred between staff members who belong to different cultures that impact:

Teamwork _____

Communication _____

Other (_____) _____

b. List problems that have occurred between staff members and patients who belong to different cultures that impact:

Communication _____

Trust _____

Correct Diagnosis _____

c. Review the above list when the organization begins to plan training in cultural and linguistic competence. Make sure that the issues behind these difficulties are addressed in training.

4. Increasing staff diversity and cultural competence

a. A specific strategy to recruit culturally and linguistically diverse administrative, clinical and support staff is being utilized. **Yes No**

j. The retention statistics for these employees are: _____

k. The promotion statistics for these employees are: _____

l. Analyze the promotion and retention statistics.

10) Which group(s) seems to have a lack of retention?

_____

11) Which group(s) seems to have a lack of advance?

_____

m. The institution actively seeks to recruit employees who have received cultural competency training and who have demonstrated cultural as well as job competence. **Yes No**

n. Consider how the organization might build efforts to develop cultural competence into promotion and advancement.

Section #2, Checklist #3: Assessment by Leadership

This checklist is intended to assist top leadership assess their personal commitment to cultural competence. It need not be shared with anyone else in the organization. Experience has shown that a strong positive commitment is necessary for the implementation of CLAS to succeed. This implementation should probably not be started until it becomes a top priority for the highest levels of leadership.

1. I view building a culturally competent organization as a:

____Top Priority ____Priority ____Lesser Priority ____Good, if not costly

10. List at least three specific measures that I, as leader of the organization, have already taken to "walk the talk" or to demonstrate to my management, staff, and the community, my commitment to offering culturally and linguistically appropriate services to diverse patient groups.

a._____

b._____

c._____

11. Is there a specific person or department assigned to promoting diversity or cultural competence? **Yes No**
(If you answered **No**, proceed to #7. If you answered **Yes**, continue with #4.)

12. What is the title of that person or department? _____

13. Does that person or department report directly to me? **Yes No**

14. Has that person or department been given broad decision-making power? **Yes No**

10. In the first column below, list all specific vehicles, which the organization has already implemented to promote items a and b; in the second column list the key element(s) (e.g. training, interpreters, signage or additional staff) of these vehicles. In the third column, indicate **S** for single intervention, **R** for repeated on a regular basis, or **O-G** for on-going interventions.

a. Teamwork among staff of different cultures:

1) _____ _____ ____

2) _____ _____ ____

3) _____ _____ ____

b. Cultural and linguistic competency in serving culturally diverse patients:

1) _____ _____ ____

2) _____ _____ ____

3) _____ _____ ____

11. List at least 3 other measures which I would like our institution to take this fiscal year to promote cultural and linguistic competence.

j. _____

k. _____

l. _____

Section #2, Checklist #4: Evaluation of Current Actions to Enhance Cultural & Linguistic Competence

This checklist is an internal assessment of current practices. It may be helpful to ask or consult with the training department and/or the human resources department to complete this section of the audit.

1. **Organizational Mission Statement:**

_____

_____

_____

a. Staff diversity is mentioned in the mission statement. **Yes** **No**

b. Culturally and linguistically appropriate care is part of the mission statement. **Yes** **No**

2. **Internal Organizational Communications**

j. The need to offer culturally and linguistically appropriate services to diverse populations is frequently mentioned in internal memos, publications and internal computer notices. **Yes** **No**

10) Indicate the number of times this has been mentioned in communications during the past month. _____

2) Indicate the number of times this has been mentioned in communications during the past 6 months. _____

b. The need for cultural awareness and sensitivity to colleagues of different races, ethnicities and cultures is a frequent topic of internal memos, publications and postings on the internet. **Yes** **No**

10) Indicate the number of times this has been mentioned in communications during the past month. _____

11) Indicate the number of times this has been mentioned in communications during the past 6 months. _____

3. **Cultural Diversity Education**

j. An internal course on the cultural beliefs of the specific patient populations is required of all staff. **Yes** **No**
(If answered **No**, proceed to **#3f**. If answered **Yes**, continue with **#3c**.)

k. The departments/individuals required to take the course are:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

c. List the topics covered by the course (e.g. religious/cultural beliefs, proper etiquette such as forms of address and "rules of touching," specific health/illness beliefs and practices and the appropriate treatment modification for a particular patient group).

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

j. Indicate the length of the course in hours. _____

e. Indicate how many times the course is offered per year. _____

f. Specific teambuilding provisions to improve the communication and teamwork between employees of different cultural, language and ethnic groups are provided **Yes No**

13. Community Involvement

The organization regularly works and/or consults with many of the community's cultural, ethnic and religious groups regarding the forms of care and services which should be made available to their members. **Yes No**

14. Other Measures

List all other measures below which the organization *has already taken* as a means of ensuring a culturally and linguistically competent work environment (i.e. Human resources has been instructed to increase the diversity of staff at all levels or cultural competence is used as an indicator of career advancement).

a. _____

b. _____

c. _____

15. Overall Rating

Rate the organization's overall status in cultural competence at this time.

Fully competent ___ Excellent ___ Moderate ___ Needs much improvement ___

Section #2, Checklist #5: Patient/Community Access to Culturally and Linguistically Appropriate Care

This checklist is an internal staff assessment and may be directed to the person(s) responsible for customer care or community relations. This person might be given the responsibility of gathering information from employees in the various departments and objectively determining the effectiveness of these services. It is also possible for individual departments to analyze and evaluate the first three sections listed below.

1. Telephone Services

. List the provisions currently available to assist non-English speaking callers in the first column and the language(s) for which these services are available in the second column.

1) _____ _____

2) _____ _____

3) _____ _____

b. List the type of training/instructions that telephone operators receive to help them appropriately handle calls from non or limited English speaking persons.

1) _____

2) _____

3) _____

2. Patient care

a. Rate the knowledge and open-mindedness of staff physicians and nurses regarding possible health/illness beliefs and practices of the specific patient groups that they may be called upon to treat.

1) Physicians: Excellent ___ Above Average ___ Average ___ Poor ___

2) Nurses: Excellent ___ Above Average ___ Average ___ Poor ___

b. Medical caregivers have been given written guidelines regarding working with patients from other religions, cultures or language backgrounds. **Yes No**

10) These guidelines are distributed via: _____

11) Something is being done to enforce these guidelines. **Yes No**

c. Caregivers have been taught specific strategies for taking an accurate history and physical on culturally and linguistically diverse patients. **Yes No**

These strategies are followed on a consistent basis. **Yes No**

m. Staff have easy access to medical, pharmacological and epidemiological information about specific patient groups. **Yes No**

1) Cultural and/or religious information is also available. **Yes No**

2) This information is made available through: _____

n. Staff have been given lists of possible alternative medications or other measures which might be used by specific patient groups. **Yes No**

o. Staff have been given lists of community leaders who might be helpful in assisting with patients from each culture. **Yes No**

p. Staff are aware of the types of medications, procedures, and/or medical approaches which might be forbidden by cultural and/or religious laws. **Yes No**
This awareness is verified via: _____

q. Caregivers know the dietary and eating habits of patient groups and take these into account when giving patients a special diet or advice concerning food to favor or to avoid. **Yes No**
This information is provided via: _____

3. Physical Environment

a. What are the colors of the walls? _____

b. Studies have been conducted regarding the specific numbers, colors, etc. to use or avoid when working with the specific cultural groups regularly served by our institution. **Yes No**

l. The pictures, decorations, etc. are meaningful and/or soothing to members of other cultures. **Yes No**

m. In the waiting areas, culturally appropriate refreshments, reading materials, etc. are available. **Yes No**

n. Appropriate areas for prayer, contemplation and/or family discussion regarding medical decisions are available to patients and their families. **Yes No**

f. Admissions desk staff, office personnel and triage persons trained to identify and deal with cultural, religious and language differences. **Yes No**

10. Emergency room/Walk-in and Appointment Services

a. Assess language access for the patient populations served. Indicate whether or not forms, signs, patient education materials, and customer satisfaction surveys are offered in the native language of each population group.

k. Assess interpreter access for the patient populations served. Indicate whether or not a full-time, on-site interpreter or some other form of interpreting service (e.g. phone company operator) is utilized for each population group.

Patient Population Groups in the Service Area	Forms (e.g. in-take, billing and consent)	Signs	Patient Education Materials	On-site Interpreters	Other Interpreters (e.g. phone company)

l. The following statements refer to the quality of the on-site interpreters:

1) They are easily accessible to the patients. **Yes No**

2) The majority are professional medical interpreters. **Yes No**

10) The majority are volunteer interpreters. **Yes No**

4) The volunteer interpreters are knowledgeable in medical terminology. **Yes No**

5) The volunteer interpreters receive an orientation/training in medical interpreting. **Yes No**

10) The volunteer interpreters receive compensation (e.g. extra vacation time, yearly bonuses and/or awards) for performing these services. **Yes No**

5. Other services

a. Food

1) Meals are planned around the eating habits and dietary laws of the major patient groups. **Yes No**

2) Family members are permitted to bring certain selected foods to the patient. **Yes No**

b. Visitation

1) Visiting regulations are flexible enough to accommodate the customs of different patient groups. **Yes No**

2) List the visiting hours. _____

12) List the maximum number of visitors allowed at one time. _____

4) Define the term "close family members" as it pertains to visitation regulations.

_____

_____

Section #2, Checklist #6: Community Involvement, Input and Support (CLAS Standard #12)

1. Community Involvement in Improving Accessibility of Care

a. Indicate whether or not community feedback has been sought on the language and interpreter services that the institution provides for each patient population.

b. Indicate whether or not customer satisfaction surveys are provided in the native language of each patient population.

Patient Population Groups in the Service Area	Community Feedback on Forms (e.g. in-take, billing and consent)	Community Feedback on Signs	Community Feedback on Patient Education Materials	Community Feedback on On-site Interpreters	Community Feedback on Other Interpreters (e.g. phone company)	Customer Satisfaction Surveys

2. Utilization of Community Organizations for Input and Support

a. List the important community and/or religious organizations affiliated with each patient population in the service area.

b. Indicate the institution's ability to incorporate feedback from important community and/or religious organizations in the development of a culturally diverse environment.

Patient Population Groups in the Service Area	Important community and/or religious organizations	Direct Contact is established between the healthcare organization and the community organization	A member of the community organization serves on one of the institution's advisory boards and/or committees	Input on how to improve patient satisfaction has been requested from the community organization

3. **List other forms of community group involvement and/or support that the institution is currently engaged in or desires to implement in the future.**

_____

_____

_____

_____

_____

Further Reading

Frusti DK, Niesen KM & Campion JK: Creating a culturally competent organization: use of the diversity competency model. *Journal of Nursing Administration* 2003; 33(1):31-8.

Siegel C, Davis-Chambers E, Haugland G, Bank R, Aponte C & McCombs H: Performance Measures of Cultural Competency in Mental Health Organizations. Administrative Policy of Mental Health 2000; 28(2):91-106.

Section #3, Guide to Devising a Workable Strategic Plan *(CLAS Standard #8)*

This section guides the institution in the creation and implementation of a written strategic plan for initiating and fostering cultural and linguistic competency throughout the organization. The plan helps each organization define its particular long-term and short-term goals and develop specific plans to achieve them. The strategic plan is intended to cover a 5-year period. It suggests some mechanisms for measuring success and reporting upon progress on a yearly basis. It also guides institutions in re-defining and extending goals once the 5-year period has been completed.

Section #3, Checklist #1: Setting and articulating cultural competence goals to fit into the organizational mission statement, operating principles, and service focus

1. Mission Statement

Often the organizational mission statement was formulated prior to demographic changes, which have and will continue to result in increases in diversity of staff and patients. It is recognized that mission statements cannot be re-written each time an institution begins a new initiative. However, cultural and linguistic appropriateness have now become inseparable from quality care, as well as customer and staff satisfaction and retention. While this portion of the guide may not immediately lead to a revision of the mission statement, it will help those involved in the institutional decision-making process to access the impact of cultural and linguistic competence on achieving the mission as it stands today. This exercise may also assist the primary decision-makers in the present and future revisions of individual mission statements.

- **a.** Write the organizational mission statement in the left column below, placing each sentence on a separate line.
- **b.** Analyze each point or sentence. List the ways that this aspect of the mission may impact the access to or quality of care or services provided for culturally or linguistically diverse patients in the blank spaces below each point in the left column.
- **c.** Rewrite or revise each point or sentence in the right column to specifically indicate the organization's commitment to offering that quality of service to culturally diverse populations.

Mission Statement & Analysis	Revisions of Mission Statement
1. _____	1. _____
_____	_____
_____	_____
2. _____	2. _____
_____	_____
_____	_____
3. _____	3. _____
_____	_____
_____	_____
4. _____	4. _____
_____	_____
_____	_____

d. Consolidate the revised points into a comprehensive mission statement which indicates a strong commitment to providing culturally competent employment, patient and staff services, and medical care. _____

_____

_____

e. Submit the analysis and the revised mission statement to the governing board of the institution with a request that they be considered in future examinations of the mission statement.

2. Operating principles

a. Write the organization's operating service principles in the left column below, placing each point or sentence on a separate line.

b. Analyze each point or sentence. List the ways that this aspect of the operating principles may impact the access to or quality of care or services provided for culturally or linguistically diverse patients in the blank spaces below each point in the left column.

c. Examine the operating principles which may inhibit the institution's ability or efforts to provide culturally and linguistically appropriate services to culturally diverse populations or offer less than excellent working or advancement opportunities to culturally and linguistically diverse employees.

m. Revise these principles in the right column to support, rather than inhibit, excellence in management of clients and staff.

n. Discuss the procedures that are necessary to implement these modifications.

Operating Principles & Analysis	Revisions of Operating Principles
1. _____	1. _____
_____	_____
_____	_____
2. _____	2. _____
_____	_____
_____	_____
3. _____	3. _____
_____	_____
_____	_____
4. _____	4. _____
_____	_____
_____	_____

3. Service Focus

a. Analyze the focus of the services offered by the institution.

b. Compare these to the services mandated or suggested by the CLAS Standards.

c. Use the appropriate section of the institutional audit to determine whether the institution's service focus adequately meets the needs of:
1) The current population in the service area
2) The present client/patient population
3) Estimates of the population in the desired service area for 2025

d. Make a list of any services which may become obsolete by 2025.

e. Make a list of any new services which might be needed between now and 2025.

f. Discuss how the institution might begin to modify its focus so that it meets both the CLAS Standards and the expectations of the populations who will be served in the next 20+ years.

Section #3, Checklist #2: Developing a 5-Year Plan

The implementation of CLAS and the creation of a culturally and linguistically competent health care organization and staff involves an **on-going** and **permanent** commitment on the part of the entire organization. Even the initial work involved in meeting the CLAS standards and evolving as a culturally competent health care institution may require 5 years to fully implement. Below are suggestions for creating a workable 5-year plan. The goals and plans set for each 5-year period may be further divided into yearly and, then, into quarterly implementation periods to make it easier to track accomplishments and identify parts of the plan which may need revision. However, please note that both service populations and staff demographics change with time, making it essential to continue to train old and new staff members. Thus, after implementation of this initial 5-year plan, organizations will need to develop another 5-year plan to determine and track continuing projects.

1. Analyze the findings of the Institutional Audit (Review all 6 checklists)

a. Make a list of everything that the institution must do to consider itself a Culturally and Linguistically Competent organization and to be fully in compliance with the 14 CLAS Standards.

b. Link connected areas (i.e. increasing the diversity of staff at all levels, increasing educational opportunity or becoming an organization which is tolerant of differences).

c. In the table below, place the more important problem areas and their connected components in the **To Do** column. Record the staff member or department in charge of implementing the task in the **By Whom** column. Develop a planning timeline for the completion of each step and note the date in the **When** column. In the **Other Considerations** column, the following issues may be considered:

1) Identify those **To Do** actions that are believed to require a substantial budget and those which can be accomplished without much cost to the organization.
2) Identify those actions for which the organization already has the infrastructure and those for which an infrastructure must be created.
3) Identify those actions which only require a one-time intervention and those which require multiple or on-going interventions
4) Identify those actions which seem easy to implement and those which seem difficult to implement.

To Do	By Whom	When	Other Considerations

2. Divide the tasks outlined above into a 5-year implementation plan, using the following criteria:

a. No person or department is burdened with more than one major task or four minor tasks per year

m. Monetary outlay is divided equitably over a 5-year period. (Note: Expenditures for on-going staff training throughout the organization may be greatest during the first year, but a major effort should be made to train some members of each segment of the staff population each subsequent year.)

1) The creation of any new infrastructure is spread out over the 5 year period.
2) One time and on-going interventions are combined each year.

3. Review and revise this 5-year plan at the close of each year.
Determine what goals (i.e. items listed on the "to do list" above) have or have not been met, which costs have been under or over-estimated and how to best and most cost effectively meet the goals set by the Strategic Plan in the future**.**

Section #3, Checklist #3: Developing an accountability hierarchy for CLAS and cultural competence leadership throughout the organization

The achievement of cultural and linguistic competence requires an organization-wide effort. Leadership must set the tone, but every employee must be helped to understand the importance of cooperating with and contributing to these efforts. The manner of gaining the support of the organization as a whole will be discussed in detail in other sections of this guide. Some of the key elements needed for the successful implementation of CLAS are listed below:

1. A **senior diversity/cultural competency leader** (e.g. a Director of Diversity) who is responsible for coordinating these efforts throughout the organization is clearly delineated. This leader's effectiveness is greatly enhanced if he or she reports directly to the CEO and has decision-making power and a budget for building cultural and linguistic competence.

2. The department heads and managers throughout the organization share the responsibility for creating a culturally competent organization and culturally competent staff.

3. The diversity leader guides each department and division to devise short-term goal(s) for each quarter of the year. These goals will reflect areas of need as demonstrated by the findings of the institutional audit. Care must be taken to ensure that each goal can be practically accomplished within each department's budgetary and staff-availability framework.

10. Short reports on the accomplishment of each goal are required. The simple format illustrated below is suggested to make the process more time efficient.

Department:
Quarter (Period):

Goal Description:

Accomplishment Deadline:

Status: **□Complete** **□ Item(s) still to be done**

Details, requests for assistance, etc. (optional):

j. The Diversity Leader compiles this departmental information for use in a yearly report to the CEO.

k. A yearly report of accomplishments in the area of cultural and linguistic competence is distributed to the entire staff and to the community that the organization serves.

Section #4, Guide to insuring that patients/consumers receive effective, understandable and respectful care provided in a manner that is compatible with their cultural health beliefs and preferred language *(CLAS Standard #1)*

"This standard constitutes the fundamental requirement on which all activities specified in the other CLAS Standards are based,"[1]. Because this standard can best be implemented through the implementation of the other 13 Standards, this section of the guide will merely further define the concepts behind the Standard and offer suggestions for evaluating and improving services so that the other 13 Standards are easier to implement. The intent of this Standard "is to ensure that all patients/consumers receiving health care services experience culturally and linguistically competent encounters with an organization's staff."[2] The following definitions of *effective, understandable,* and *respectful* care included in the Final Report[3] are summarized below so that they may be easily referred to in the completion of this section of the guide.

"**Effective health care** is care that successfully restores the patient/consumer to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention and wellness interventions. In order for health services to have a chance of being effective in a patient, the clinician must accurately diagnose the illness, discern the correct treatment for that individual, and negotiate the treatment regimen successfully with the patient."

Culture plays an important role in the provision of effective care and services. The key to implementation of the statement above is the word: *negotiate.* It is not merely enough that the medical diagnosis be made correctly and that a *medically* correct treatment plan devised. If the treatment plan contains recommendations which are either taboo in the patient's religion or culture or if it cannot be made a part of the patient's lifestyle, it may prove ineffective with that patient. Culturally and linguistically appropriate care requires caregiver's to negotiate with the patient regarding the need for a particular treatment plan and work with that patient to make it a part of the patient's conceptual and life frame.

Understandable care focuses on the need for patients/consumers to fully comprehend questions, instructions, and explanations from clinical, administrative and other staff….[It] encompasses not only addressing language differences and ensuring linguistic comprehension but also explaining technical or specialized terminology and concepts and verifying that the patient/consumer understands the content of what is being said. "

For care to be truly "understandable" the concepts as well as the words used orally or in writing must "make sense" in the world view or cultural framework of patient/consumer. C*ulture* gives conceptual meaning to words by shaping how those words are understood..

[1] National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report, March 2001, Washington DC, p. 49
[2] Ibid.
[3] National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report, March 2001, Washington DC, p. 51

For example, should the culture of the patient not include in its world view, joint physician/patient responsibility for decision making, merely asking the patient, in his or her primary language, to participate in decision-making may not constitute "understandable care". The patient may understand the "words" of a phrase such as "You have three treatment options, X, Y and Z, which option do you prefer?" when these words are translated into the patient's native language. However the "custom" of patient sharing in decision-making may not be *understandable*. Culture may cause the patient to interpret the meaning of this utterance as "I am the physician but I do not know what to do."

Respectful care includes taking into consideration the values, preferences, and expressed needs of the patient/consumer and helps to create an environment in which patients/consumers from diverse backgrounds feel comfortable discussing their specific needs with any member of an organizational staff.

Each culture has its own ways of showing respect. Often U.S. caregivers address patients by their first names, because U.S. culture utilizes this informal form of address to indicate friendliness and caring and respectful "equality" to the person addressed. However, to a person from another culture, using the first name may be understood as a demonstration of disrespect by indicating that the speaker views the person as having a lower status. Thus, this first standard recommends that all care to be provided in a manner that is not only linguistically and a culturally appropriate, but in a way that will be interpreted as respectful by the patient/consumer.

Note: The information which was gathered in completing **Section #2, Checklists #1 and #5** can serve as a resource in the completion of this section of the guide.

Section #4, Checklist #1: Improving the "Effectiveness" of Care

1. **Outcomes Statistics**
   Gather and compare outcomes statistics for each group with those of the general or majority population served. (Note: If the organization does not keep statistical records by race/ethnicity, it is highly recommended that it begin to do so. An important indication of an institution's overall cultural competency is statistical comparisons by race/ethnicity of outcomes, repeat presentations, and patient satisfaction. If these records are not kept by the organization, it may not be possible to trace those patients for whom an interpreter was used.) Answer the questions below as a means of assessing the effectiveness of the care currently being offered to each of the population groups served by the organization:

   a. Is there statistically a greater number of unsuccessful outcomes (based on medical or negative customer satisfaction reports) in one population group in comparison with those of other population groups?

   b. Is there statistically a greater number of patients in any or all of the above groups that do not complete treatment than there are with the majority population groups?

   c. Is there a statistically greater number of repeat presentations of the same complaints?

2. **Effectiveness of Care**
   The answers to the above questions are measures of the effectiveness of care. A higher rate of poverty in many culturally diverse patient groups is often given as the major cause of unsuccessful treatment outcomes, failure to complete treatment, or to return with re-occurrences of the complaint. However, while poverty or low literacy may play a role, so may patient perceptions of the quality of care which they are receiving. These perceptions are strongly influenced by culture. It is recommended that institutions take a proactive role in lowering statistical differences in the above by taking steps to improve the effectiveness of care. The following steps are suggested:

   a. Supply clinicians with current information regarding:
   1) Susceptibility of particular ethnic/racial groups to certain diseases
   2) Possible lifestyles and dietary habits which might impact health or make it difficult for patients to follow treatment plans

   b. Improve the ability of clinicians to communicate effectively with their patients directly or via interpreters through:
   10) Training in communication skills (including how to effectively negotiate a treatment plan which the patient will be able and willing to follow)
   2) Training in cultural awareness, understanding and acceptance of beliefs and lifestyles different from their own
   3) Improved interpreter services (See **Section #4, Checklist #2**)

Section #4, Checklist #2: Improving the "Understandability" of care and services

1. Linguistic Comprehension

Linguistic comprehension requires the availability of interpreters who know the language and dialect of the patient, understand medical terminology in both languages and also understand the impact of culture, educational level, and economic status upon the meaning attributed to questions and statements. The patient/client may understand the words the interpreter is saying, but may misconstrue the meaning behind the words unless cultural factors are taken into account. Under OCR Title VI, federally funded institution should take reasonable steps to provide LEP persons with professional medical interpreters and have them be available to assist these patients at *any and all times* the patients are seen. **According to this ruling, every institution receiving federal funds should meet this criterion.** Below is a suggested procedure to help satisfy this ruling quickly and cost effectively.

Start with the 3-5 language groups most frequently served by the institution. (The number will be dependent upon the size of the facility and the diversity of the service area). Institutions should actually employ professional staff interpreters for population groups for which they see 10 or more patients per day. All other language groups served by the institution must also be provided with interpreter services at no cost to the patient. However, these services might be provided through:

a. Prior arrangements for professional medical interpreters to be on call on an "as needed basis"

b. Bilingual staff who have indicated a desire to serve as interpreters and who have met the following criteria (Note: Some monetary or scheduling incentive should be offered to these personnel):

1) Certification through an oral and written test of their knowledge of conversational and medical language in *both* English and the language of interpretation

11) Specific interpreter training (36-42 hours training)

c. A telephone service utilizing trained medical interpreters (Note: Arrangements for this service should be set up in advance of need.)

2. Conceptual Comprehension

Technical and specialized terminology and concepts must be explained to patients/consumers in a manner that is appropriate to their world view, which is often culturally determined or influenced, and their educational level. It is important that caregivers and other staff verify patient/consumer understanding of the content of what is being said. Below are some suggestions for assuring that explanations are understood. (Note: These techniques may be used when communicating directly with the patient or through an interpreter.)

a. When a technical or specialized term is being defined, begin with that term or word. For example, "X is…"

b. The explanation or definition should be given in layman's terms. Whenever possible, relate it to the individual patient/consumer and his or her condition or situation.

n. To verify comprehension, ask the patient/consumer to explain what has been said in his or her own terms. Avoid asking questions which can be answered with a "yes" or "no." Ask questions which the patient/consumer must answer with information which will help determine comprehension.

Section #4, Checklist # 3: Improving the "Respectfulness" of Care

To effectively take into consideration the values, preferences, and expressed needs of the patient/consumer, the health care organization as well as each individual employee must take the time and devote the effort to learning these values, preferences, and expressed needs. It is also important that all direct contact staff understand and follows culturally appropriate rules of etiquette. This knowledge and patience requires training in cultural and linguistic competence. The content of training will be described in detail in Section #7 of this guide. Below are some basic suggestions that can be made available to all staff through internal memos or internet sites:

1. Don't follow "The Golden Rule" when interacting with patients/consumers from another culture. The way one indicates respect for another person is determined by culture. Ways of showing respect in one culture may be interpreted as disrespectful by a member of another culture. Try to learn how the patient/consumer wishes to be treated and treat him/her in that way.

2. Learn the basic etiquette of each of the cultural groups that one is likely to meet.

3. Learn the customary form of greeting. (Note: In many cultures, this will vary according to the age, gender, and social position of the person.)

10. Learn the "polite" forms of address.

11. Learn the rules for touching.

12. Learn the customary distance between individuals when they are talking.

13. Learn whether or not it is considered rude to show the bottoms of one's feet (i.e. crossing one's legs is inappropriate).

14. Learn whether a handshake is expected or is considered inappropriate.

15. Learn one or two words or phrases in the most common languages. Words, such as "Hello," "Good-bye," "Please" and "Thank you" said in the person's language, go a long way in establishing rapport and showing respect.

16. Remember that there is a tremendous diversity even between members of the same culture. Become a keen observer. Try to take the time to ascertain what the patient/consumer's needs and preferences are and act accordingly.

11. Many seemingly culturally diverse persons (especially those of 2nd or 3rd generations) from other cultures are more comfortable with U.S. culture than they are with the culture of their ancestors. Observe each person's behavior and communication style. It is extremely disrespectful so assume, for example, that every Asian or Hispanic

looking person will have difficulty speaking or understanding English or have "strange" beliefs and/or practices.

Section #4, Checklist #4: Developing customer satisfaction questionnaires to assist in evaluating the "effectiveness," "understandability" and "respectfulness" of care and services

10. Assuring Accuracy of Information

A survey will only give accurate information if one asks the "right" questions. In terms of patient/consumer satisfaction, "One size does not fit all." It is common for health care organizations to engage professional survey companies to conduct and evaluate their customer satisfaction surveys. These companies have the ability to not only track the satisfaction records of individual organizations but to bench mark these against the results of other health care organizations. Some of these survey companies also offer the surveys in other languages. However accurate the translations, these surveys often do not accurately track the satisfaction of culturally diverse patients because they are based upon questions which were devised for the original English language version. The origin of the questions typically asked on professionally developed surveys are primarily based upon research into what White Caucasian Americans of Northern European background want and expect from their care provider and the specific criteria by which this group evaluates quality of care. A well-translated version of the survey can measure patient responses to the specific questions that were asked. However, these answers will not necessarily indicate whether or not the culturally and linguistically diverse patient felt that the care received was satisfactory according to the criteria of his/her culture. To measure satisfaction according to these criteria, surveys must be customized to reflect the particular cultural/ethnic group's unique definition of what constitutes satisfactory service. Thus, until professional survey companies begin to utilize culture-specific contents, healthcare organizations may wish to use a less "scientific" approach to measuring the satisfaction of the culturally diverse patient. The following are suggestions on how to devise a more accurate measurement tool: c

a. Approach leaders in each of the cultural communities served (See *CLAS Standard #12* referred to in Section #8 of this guide*).* Ask these leaders for assistance. Tell them that the organization would like their help in providing a better quality of care and services to their community. Form an advisory committee which includes these community leaders.

b. Meet with this group to brainstorm for ideas on improving cultural and linguistic competency. Below is a sample of questions which might be asked.

10) If a member of your cultural, ethnic and/or religious group could choose any healthcare organization, which organization would he/she choose? What elements and services make this organization most desirable?
11) What qualities do many members of your community consider most important in choosing a healthcare organization?
12) How important is it for most members of your community to be provided with an interpreter? How does the availability of interpreter services contribute to patient satisfaction with care? Is having signage in the patient's native language expected or needed by many members of the community?

13) When a member of your group enters a health care facility, how does he/she want to be treated by the person at the front desk or the receptionist? How is courtesy defined or measured within this cultural group? How is politeness measured? How does one show caring and concern?
14) How might a person wish to be addressed and treated by the nurses? (Note: Forms of address may vary according to age and gender.)
15) Is it culturally appropriate to ask members of your community about life support? About organ donation? To explain all the elements of the Patient's Bill of Rights?
16) What are people of your cultural group's typical concerns or needs regarding the hospital room? What criteria might be important in evaluating the quality of the room?
17) What might be the expectations regarding food? At what times might the patient expect to be fed? What types of foods are typical in your cultural community's diet? Are there any foods that are inappropriate or forbidden by certain religious sects within your group? Are there any customs regarding food handlers that the institution should be aware of?
9) What criteria might a patient or the patient's family use to rate the nursing care received (i.e. greeted patient with appropriate title or followed cultural "rules of touching")?
10) What criteria is usually used to rate the care and skill of a physician? How might patients expect the physician to address them and behave toward them?
11) Are there any tests or treatments that some members of the community find inappropriate? Might the length of waiting time for tests and treatments measurably contribute to a community member's evaluation of services received? What other factors in the taking of tests or the administering of treatments might contribute to the patient's satisfaction or dissatisfaction with services?
12) What is most important to members of your community in regards to visitors and family? How many friends and family are likely to come to visit at one time? How might the institution make their visit more pleasant?
13) What might be the patients or the family's greatest concerns regarding the discharge process? How can the institution measure patient satisfaction with and comprehension of the instructions he/she must follow at home?

c. Evaluate the survey form presently used by the healthcare institution to determine the appropriateness and importance of each service to members of the community. This evaluation may offer insight into the accuracy of information gathered about the community thus far. Answers to questions such as the ones suggested above will then guide the institution in determining the actual criteria patients in a particular ethnic community apply when evaluating the care and services provided by the institution. These results may indicate whether it is best to use a translated version of the form currently in use with some additional culture-specific questions, which track differences in values and expectations, or whether it is necessary to develop a separate customer satisfaction survey for each of the cultural groups served.

2. **Translating satisfaction questionnaires into the languages of patient populations**
   After learning something about the heath care expectations of the cultural groups served and their specific definition of quality of care, convert them into survey questions as described above and translate them into the primary language of the patient/consumer. A professional translation service should be used initially, but then have a member of the community "back-translate" (turn the questions back into English) as a means of measuring the accuracy of the translation. Ask this community member if the responses to the survey will give the organization an accurate picture of the patients' satisfaction with care.

   (Note: The surveys prepared for cultural groups who speak and read English as their primary language will not require translation. However, it is recommended that community leaders be consulted regarding the appropriateness of the questions asked and the language used, prior to conducting the survey. Be sure to inquire whether there are any other questions that need to be addressed to accurately measure the satisfaction of this group with the care and services provided.)

3. **Deciding between an oral or a written survey**
   One of the customer survey companies contacted during the preparation of this section stated that it requires all hospital patient satisfaction surveys be mailed to the homes of the discharged patient. While this procedure gives the company a written record of responses, it presents a problem in tracking the satisfaction ratio of lower income patients who tend to move frequently or patients who provide a false address or no address at all. There is also the difficulty of getting patients who are illiterate in their own language or unfamiliar to the use of surveys as a measurement tool to complete these assessments.

   Another customer survey company stated that their surveys are conducted via telephone interviews. While this is an excellent idea, the company was unable to provide information regarding the number of actual languages for which it has this capacity. It should also be noted that some persons might loathe to answer questions posed by an unseen voice or may not have telephones in their homes.

   Each of the methods above require the patient's cooperation after he/she has been discharged from the hospital or has completed out-patient treatment. Many patients may not wish to be reminded of their past illness, thus they fail to respond.

   Because of the difficulties described above, it is recommended that the organization explore the possibility of conducting the survey orally at the time of discharge or at the end of the final office visit. A person instructing the patient about self-care or medication usage might be the best person to administer the survey. An effort should be made to limit the survey to 10 key questions. (Note: The organization may like to identify these as questions that ask about the effectiveness, understandability, respectfulness of care.) The person conducting the survey should be responsible for filling in the patient's responses and making any comments that seem pertinent to the patient's feelings of satisfaction or dissatisfaction with the services received.

Section #4, Checklist #5: Interpreting the results

(Note: Even though it is important to "listen to the voice" of diverse groups, it is essential that no single patient/client is stereotyped because of a last name, the color of skin or some other superficial trait. Oral interviewing can help avoid this by asking the language of choice at the start of the survey. This will not assure against any stereotyping, but may lessen it.)

1. **Tracking within a particular group**

   a. Analyze the results of the surveys by race, culture and ethnicity. Look for patterns (i.e. Are there questions about services for which a number of persons from the same group indicate some degree of dissatisfaction? Is there anything the organization can do to improve patient satisfaction with this service?). If there are questions as to the best way to amend the service, go to the source (e.g. a leader of that community) and ask for suggestions as to how to improve consumer satisfaction.

   b. Modify the services accordingly and track the results of successive surveys.

   c. Keep repeating the process until the survey ratings improve.

2. **Comparing the satisfaction ratios for all the groups served, including White Caucasian non-Hispanic Americans**

   a. Even though the questions asked of each group may differ somewhat, the degree of satisfaction for each group can be compared and measured.

   b. Identify aspects of care that please some groups and not others.

   c. Determine whether or not the institution is meeting the needs of some of the groups served but not the needs of others.

   d. Determine which aspects of care and services can be customized and modified.

Section #5, Guide to promoting diversity throughout the organization *(CLAS Standard #2)*

Staff diversity is not, in itself, a guarantee of an organization's ability to provide its patients/clients with culturally or linguistically appropriate care and services. It does, however, improve the comfort level of culturally diverse patients. It demonstrates that the organization recognizes and values members of the patient's ethnic group. According to CLAS Standard #2, diversity is measured not merely by numbers, but by an organization's ability to hire, promote and retain a staff that reflects the demographics of the service area. Staff diversity needs to be encouraged and supported throughout all ranks of the organization. While at this time it may not be possible to achieve exact parity between patients and staff at all job levels, a clear demonstration of good faith efforts to develop concise strategies for working toward this goal will be recognized as meeting this standard. (Note: The majority of this section should be the concern and responsibility of the Human Resources department of the healthcare organization.)

Section #5, Checklist #1: Utilizing patient and staff demographics to evaluate the organization's "Diversity Profile"

10. List the 5 largest racial/ethnic groups that comprise the patient populations and provide percentage of the total patient population that each sub-group represents in the space below. (See columns 2 and 3 of **Section #2, Checklist #1** for this information.)

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11. List the 5 main racial/ethnic groups in the organization's service area and the percentage of the total population that each sub-group represents in the space below. (See columns 5 and 6 of **Section #2, Checklist #1** for this information.) Are there any significantly large populations in the area who are not utilizing the organization's services? If so, has the organization considered this might indicate that members of these groups do not believe that the institution is a welcoming, comfortable place? Members of this group might be encouraged to seek the organization's services if they were better represented on the organization's staff. (Note: This information is available at http://www.census.gov/)

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12. Review the results of **Section #2, Checklist #2.** List the 5 largest racial/ethnic groups that comprise the staff populations and their percentage of the total staff population in the space below. How do these percentages compare with the percent of the total patient population represented by each ethnic/cultural group? Are members of other cultural groups within the service area represented as well? Analyze the breakdown of positions held throughout the institution. Is there a fairly balanced spread of culturally diverse employees at every level of the institution or do one or more groups fulfill primarily entry level positions?

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Section #5, Checklist #2: Evaluating the organization's efforts to attract and retain minority staff members

(Note: The purpose of these suggestions is to widen the applicant search to a larger population of quality caregivers, not to target minorities at the exclusion of majority groups).

10. Advertisement of Administrative Staff Openings

Through what venues does the organization publish administrative staff openings? Are these venues likely to recruit qualified minority as well as mainstream applicants? Consider the demographics of their readership. In addition to the current venues, one may wish to advertise in some publications that are targeted to specific groups, such as the Association of Hispanic Healthcare Executives. View the list below for further suggestions.

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2. Advertisement of Medical Staff Openings

What venue(s) does the organization use to advertise for a medical staff search? Are these venues likely to recruit minority as well as mainstream physicians and nurses? What are the demographics of their readership? Check the facility library and review the list below to identify other venues that are likely to reach culturally diverse medical staff.

_____

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_____

3. Selection and Interview Process

a. What is the racial/ethnic make-up of the last 5 search committees and reviewing teams for medical and non-medical staff? How many persons on each of the above committees or teams were of the same or similar racial/ethnic background as the candidate(s)?

_____

_____

_____

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_____

b. Make a list of everything that could be done at these meetings to make the applicant feel comfortable and/or welcomed. (Note: Remember that it can be as insulting to indicate that a person is being considered for a position *because* of belonging to a certain race or religion as it is to disqualify someone because of membership in that group! Try to consider ways to acknowledge persons for their professional and personal qualities rather than to *balance* staff demographics. *Qualifications*, not race and ethnicity, should be the main issue in hiring practices.)

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Sources for advertising openings to minority applicants for managerial and medical positions

1. **Management**
   The Institute for Diversity in Health Care Management provides a comprehensive venue for the posting of management positions and the reviewing of resumes of minority candidates. There is a very minimal fee for companies to advertise positions and no charge for candidates to post their resumes.
   http://www.diversityconnection.org

2. **Medical**
   The following is a list of web sites and/or telephone numbers of minority professional associations for many medical and nursing specialties. It is not known whether these sites have a venue for posting position openings. However, these agencies will aid the organization in broadening the search for qualified minority candidates.

   a. **African American**
      Association of Black Cardiologists
      http://www.abcardio.org

      Association of Black Nursing Faculty
      http://www.abnfinc.org

      Association of Black Psychologists
      http://www.abpsi.org

      Minority Health Professions Foundation
      http://www.minorityhealth.org

      National Black Nurses Association
      http://www.nbna.org

      National Dental Association (NDA)
      http://www.ndaonline.org

      National Medical Association (NMA)
      http://www.nmanet.org

      National Optometric Association
      http://www.natoptassoc.org

      National Organization of Blacks in Dietetics and Nutrition (NOBIDAN)
      Ph: 216-932-4796

      National Pharmaceutical Association
      http://www.npha.net

Student National Medical Association (SNMA)
http://www.snma.org

b. American Indian/Alaska Native

Association of American Indian Physicians
http://www.aaip.com

Association of Native American Medical Students
http://www.aaip.com

Indians Into Medicine
http://www.med.und.edu/depts/inmed/home.htm

Society for Advancement of Chicanos and Native Americans in Science (SACNAS)
http://www.sacnas.org

c. Asian and Pacific Islander Americans

Asian American Pacific Islander Nurses Association
Ph: 973-720-3215

Asian Pacific American Medical Student Association (APAMSA)
http://www.apamsa.org

Chinese American Medical Society
http://www.camsociety.org

Philippine Nurses Association of America
Ph: 415-468-7995

Samoan National Nurses Association
http://www.snna.org

d. Hispanic/Latino/Latina

Hispanic-Serving Health Professions Schools, Inc.
http://www.hshps.com

Interamerican College of Physicians and Surgeons (ICPS)
http://www.icps.org

National Association of Hispanic Nurses
http://www.thehispanicnurses.org

National Association of Puerto Rican and Hispanic Social Workers (NAPRHSW)
http://www.naprhsw.com

National Hispanic Medical Association
http://www.nhmamd.org

e. Multicultural/Multipurpose

American Public Health Association
http://www.apha.org

Intercultural Cancer Council (ICC)
http://www.iccnetwork.org

Minority Health Project
http://www.minority.unc.edu

National Center for Primary Care at Morehouse School of Medicine
http://www.msm.edu/ncpc/ncpc.htm

Department of Health and Human Services, Office of Minority Health
http://www.omhrc.gov

Section #5, Checklist #3: Evaluating job advancement options and opportunities for minority groups

1. Advancement policy and recent outcomes

a. Does the institution have a written (or unwritten) policy to fill position openings from within? **Yes No**

b. Check the number of positions that have opened within the past 12 months.

10) How many positions throughout the organization were actually filled? _____

11) How many of these positions were filled by staff/employees within the organization? _____

12) What number of internally filled positions resulted in an increase in salary for the person changing position? _____

13) What number represented a higher rank or position within the organizational structure? _____

5) State the total number of people from each racial/ethnic background who received promotions in salary and rank within the past year in the second column below. Then, specify the level of promotion.

Cultural Background	Total	Entry level to Supervisor	Supervisor to Manager	Low to Mid Level Administrator	Mid to High Level Administrator
White, Non-Hispanic					
Hispanic					
African American					
Asian					
Other Minorities					

c. List the ways that promotion opportunities are announced to current employees and staff.

_____

_____

o. List the types of educational opportunities provided to assist employees and staff to qualify for advancement.

_____

_____

p. List provisions that are made to assist immigrant employees improve their English. Next to each, note whether it is (1) during or after working hours, (2) on or off-site and (3) fully paid by the institution or partially paid by the employee.

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11. Retention

a. Refer back to **Section #2, Checklists #2 and #3** and check the hire date of every medical and non-medical minority employee. In the chart below, list the average length of employment for each racial/ethnic group at various levels of the organization.

Cultural Background	Senior Manager	Mid Manager	Non-Managerial	Entry Level	Physicians	Nurses	Technicians	Other
White, Non-Hispanic								
Hispanic								
African American								
Asian								
Other Minorities								

1) Is the average length of employment for any of the racial/ethnic groups significantly less than the others? Brainstorm to list the possible reasons for lack of retention (i.e. is the work environment less friendly? Are there fewer opportunities for advancement? Does lack of education or language ability prohibit opportunity for advancement?). Informal talks with members of these populations may help to identify the key factors in a short retention.

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2) List 3 steps that might be taken to improve retention. Informal talks with these populations may provide the best clues to improving retention.

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j. Does the institution encourage mentoring, especially at the managerial level?
Yes No

10) If mentoring is encouraged, what percentage of the mentors are minorities?
_____

11) What is the percentage of staff receiving mentoring that belongs to a minority group? ____

3) Some of the articles listed for Further Reading indicate that mentoring is an important asset to the retention of employees but that there is a reluctance for mentors to mentor those who belong to a racial/ethnic group different from their own. List 3 ways to encourage white senior level management to mentor promising minority staff and groom them for advancement.

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Section #5, Checklist #4: Developing a plan to improve minority representation throughout the organization

10. Internal/Current Staff

Responses to **Section #5, Checklist #3** should demonstrate the institution's "success ratio" in demonstrating to minority employees and staff that future opportunities for advancement, both financially and career-wise, exist within the organization. Improving this "success ratio" will encourage minority retention and loyalty.

j. List 3 steps that might be taken to encourage minorities to apply for promotions within the organization.

_____

_____

_____

k. List 3 steps that might be taken to help minorities improve their qualifications for higher level positions within the organization.

_____

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_____

11. Hiring of Staff

Increase minority representation through hiring strategies.

j. List 3 strategies that the institution will take to increase the representation of the specific minorities in its patient/service base within the **physician** staff or "preferred physicians."

_____

_____

_____

k. List 3 strategies to be implemented to build a **nursing** staff that mirrors the patient/community base.

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_____

l. List 3 strategies to be implemented to increase the pool of qualified minority applicants for non-medical positions **above entry level**.

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_____

_____

Further Reading

Chyna, Julie T, "Mirroring Your Community: A Good Reflection on You," *Healthcare Executive,* Vol. 16, #2, pp 18-23

Dreachslin, Janice L, Ph.D. "Diversity Leadership and Organizational Transformation: Performance Indicators for Health Service Organizations," *Journal of Healthcare Management,* Nov/Dec, 1999

Dreachslin, Janice L, Ph.D., *Diversity Leadership,* Health Administration Press, 1996

Evans, Rupert M., Sr., "Increasing Minority Representation in Health Care Management," *Health Forum Journal,* Nov/Dec, 1999, Vol. 42, #6

Weber, David O. "The Lack of Diversity at the Top," *Health Forum Journal,* Sept/Oct, 2000

Section #6: Guide to providing the language access services mandated by Title VI of the Civil Rights Act of 1964 (*CLAS Standards #4, 5, 6 & 7*)

The specific services outlined in CLAS Standards #4, 5, 6 and 7 relate to language access for limited English speaking patients. These services are mandated for all organizations receiving Federal Funds in Title VI of the Civil Rights Act in 1964. Policy Guidance for implementing these rulings was last revised in August, 2003. Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency) states that healthcare organizations must take "reasonable steps to ensure meaningful access" A Report to Congress on March 14, 2002 outlined the total benefits and assessed the costs involved in implementing this executive order (See Further Reading at the end of Section #6 to obtain documents referred to above).

This section of the guide offers practical suggestions as to how health care organizations can create and implement language access services to satisfy the recommended national CLAS standards and the above rulings in a timely and cost effective manner. Research shows that more than 300 languages are spoken in the United States today. According to the Report to Congress, the most popular, in order of frequency, are Spanish, French, German, Italian, Chinese, Tagalog, Polish, Korean, Vietnamese, Portuguese, Japanese, Greek, Arabic, Hindi, Russian, Yiddish, Thai, Persian, French Creole, and Armenian. Health care organizations serving patients of many different language backgrounds may need to implement on-site services to all groups served incrementally. However, during this transitional process, alternative language access (e.g. phone interpreting services) should be provided if they are to comply with the current OCR LEP guidance. As noted in the Congressional Report, the four factors that are used to determine whether a particular agency has met the requirements for interpreting services are: (1) the number or proportion of Limited English Proficiency (LEP) individuals, (2) the frequency of contact with the program or institution, (3) the nature and importance of the program, and (4) the resources available and costs.

(Note: This report estimates that the provision of adequate interpreter services to LEP patients in a hospital setting would only add 0.5% to operating costs. It does not include either information or estimated costs for the provision of signage in the patient's preferred language or the translation of written materials.)

The suggestions offered in the guide illustrate only a few of many strategies that a health care organization might utilize to provide appropriate and adequate language access and satisfy the mandates of Title VI as well as CLAS Standards #4, 5, 6 and 7. A number of health care organizations have developed other methods for providing interpreter services. The Commonwealth Fund Report has summarized other methods that some organizations have found successful (See Further Reading at the end of Section #6).

Implementation of the **Section #6 Checklists** will allow institutions to demonstrate their "good faith" effort to provide the full range of language services to all LEP individuals. Procedures include the initial establishment of a full range of on-site interpreting and translation services to the most populous language groups in the service area and

provides suggestions for appropriate alternative services to be provided to less populous language groups. It then offers a timetable for broadening and improving language services to less populous groups until the mandate is fully met.

In order to initiate and continue to provide adequate language services, it is important that the following information be included on the record of every patient.

- Preferred spoken language
- Preferred written language
- Whether or not the patient was informed of the right to interpreter services
- How this information was conveyed
- Whether the patient accepted or declined this service
- If accepted, how this service was provided

Section #6, Checklist #1: Informing patients of their right to language assistance

CLAS Standard #5 states that health care organizations must inform all patients/clients of Limited English Proficiency (hereafter referred to as LEP) in both verbal and written format (and in their preferred language) of their right to receive language assistance free of charge. This information is to be provided at all points of contact between the institution and the patient/client.

1. Refer to **Section #2, Checklist # 1** for the list of population groups currently living in the organization's service area. Copy this list onto the table below. Next to each group list the primary language(s) spoken by each group. (Note: Not all members of a population group necessarily speak or even read a single language or dialect.) In order to obtain accurate information, contact at least one community organization representing each of the population groups in the service area and ask them the following questions:

a. Is there is a language spoken and understood by <u>all</u> the members of your racial/ethnic group?

b. What is the language? If there is more than one language spoken/understood, what are these languages? (Note: If there is more than one language spoken, there is probably at least one community organization that represents speakers of each of these languages. Ask the primary contact for the name(s) of other organizations. Contact at least one of the community organizations to check the accuracy of this information.)

c. Can you recommend a professional interpreter of that language? (Note: This information will be required for **Section #6, Checklist #4**. If there is more than one language spoken by that population group, try to obtain the name and a contact for a community organization representing each language group.)

m. Is there a written language common to all members of that population? (Note: It is very possible for groups who speak different languages or dialogues to share a common written language.)

n. Write the name of the written language(s) in the space provided in the table.

o. Are you able and willing to provide an accurately written notice which would inform the patients from your community of their right to an interpreter in their language of preference free of charge? (Note: This information will be required to complete **Section #2, Checklist #2**.)

p. What is the estimated level of literacy (ability to read basic directions/instructions, ability to fill out simple written forms) of members of your community? Is it likely that all members will be able to read this written notice? Will some members of your community need pictorial signs to inform them of their rights?

(Complete the form at the top of the next page with the information gathered from community leaders.)

Population Group	Main Spoken Language	Other Spoken Languages	Main Written Language	Other Written Languages

12. Develop a procedure for determining the language of preference of patients/clients who have limited proficiency in English. Some institutions have developed a series of "I speak" cards, which allow patients to point to an icon (e.g. a map with the various languages of that country or region written in the script of that particular language). (Note: Do not insult the patient. These cards should only be used in cases where the patient has clearly demonstrated limited proficiency in English. When in doubt, ask the patient! A heavy accent does not constitute a lack of desire or ability to communicate in English.) It might also be helpful to place an icon of a book under each language with a smiling face and a frowning face to help the patient indicate whether or not he/she is able to read.

a. All staff working at entry points for patients should receive training in how to use these cards effectively.

b. The OCR Guidelines recommend recording information about the patient's primary spoken and written language in the person's file.

l. Keep track of the number of patients in each language group who require language assistance.

13. Once the patient's preferred language has been identified, provision should be made to inform the patient of the right to interpreter services at no cost. This information can be relayed to the patient through the following measures:

a. Written signs should be posted at intake points in a minimum of the 3-5 most populous languages in the service area. This information should also be conveyed

pictorially as a means to serve those unable to read and those who come from less populous language backgrounds.

b. Application forms, instructions and other institutional information should be translated into the languages of all groups in the service area. (Note: Institutions serving a large number of language groups may wish to proceed incrementally by translating the materials for the 3-5 most populous groups first. They can then add another translation every 6 months until all important literature has been translated into the preferred languages of the patients/clients in the organization's service area.)

c. Set up uniform procedures for timely and effective telephone communication with trained bilingual staff or a telephone interpreting service. They should be instructed to inform patients of their rights to interpreter services at no cost to themselves.

m. Brochures, booklets, and outreach materials should be translated into the written languages of all groups in the service area with notation of the patients' right to services in their preferred language.

n. Signage in the language of the patients should be displayed on the premises of the community organizations.

o. Notices to this effect should be published in newsletters, newspapers and other documents written in the languages of these groups in the service area.

5. According to the OCR Guidelines, institutions should:

a. Monitor the demographics of their service area and patient population using the latest census data. (Note: See **Section #2, Checklist #1**.)

b. Develop a written LEP plan that informs patients of their rights to an interpreter. This plan can also include tracking success in informing patients of their right to the services of an interpreter. (Note: See Section #9 of the guide.)

k. Update the information on the population groups living in the service area by the local institution. (Note: See Sections #2 and 9 of the guide.

l. Develop a written LEP plan of the language assistance services, and how staff and LEP persons can access those services. This can be done by including a question in the customer satisfaction survey given to each patient served regarding whether or not the patient was appropriately informed of his/her right to these services.

6. Include the following information in the file of each patient:

a. Preferred spoken language

b. Preferred written language

c. Whether or not the patient was informed of the right to interpreter services

m. How this information was conveyed

n. Whether the patient accepted or declined this service

o. If accepted, how this service was provided

Section #6, Checklist #2: Establishing adequate signage in other languages

1. Initially post signage regarding procedure for registering or receiving services in the languages of the 3-5 most populous groups in the institution's service area. Add signage in another language every 6 months until adequate signage exists for all language groups. (Note: These signs should be posted at all points of entry into different departments as well as entry into each of the buildings where services are offered.)

2. Provide directional signs to locate specific departments, waiting areas and services. Use the above procedure until all groups are served.

3. If the health care organization serves a large number of limited English-speaking patients, consider installing informational telephones and signs directing the patient to the telephone. This will allow patients who are lost or unsure of where they are going to pick up a telephone, press the appropriate language button and ask directions from someone who speaks their language.

4. Place pictorial signs to direct persons belonging to less populous client groups of the service area as well as persons who are not literate in their primary spoken language.

5. Check the accuracy of every written or pictorial sign before posting. This may be accomplished by requesting that a qualified employee or a member of a representative community group translate the sign or picture back into English.

6. Check the appropriateness of the sign by asking a member of the community group whether any of words in a particular language or pictures could be considered in any way inappropriate or insulting to members of that group.

Section #6, Checklist #3: Developing appropriately translated patient information and patient education materials for all patients in the service area

10. Use the list of written languages prepared in **Section #6, Checklist #1** to determine the languages for which patient information and education materials must be provided.

11. List all the materials that are provided to English speaking patients and their families in the table below.

12. Next to the name of each pamphlet or informational sheet, grade it as "essential to the quality of care," "important to the quality of care," or "of possible interest to the patient."

13. Indicate in the column provided whether this is material prepared by the health care institution itself or is prepared by an outside organization (e.g. a drug company or auxiliary health care group).

14. Use **Section #2, Checklist #1** to identify the 5 most populous language groups seen by the organization during the past 12 months.

15. Set up a timeline over the course of the next 6 months for the development or acquisition of all patient materials classified as essential in the 5 most populous written languages. Before arranging for materials to be translated into these languages, contact each of the organizations responsible for the preparation of any of the written materials on this list. Ask them the following questions:

a. Can you supply any of the translations required?

b. Would you be willing to either sponsor or subsidize the preparation of translated materials?

c. If your organization is listed as a co-sponsor, would you be willing to distribute the materials to other client organizations?

16. Arrange for the translation and preparation of all other essential materials into the 5 most populous languages. Work with a professional translating service that has had experience in medical translations.

17. Plan to have the materials listed as "important" to the quality of health of the patient to be translated into the appropriate languages and made available to these population groups within a 12 month period using the above procedure.

18. Translate the list of the materials categorized as "of possible interest" to the patient into the 5 most populous languages. Include a note stating that the patient has the

right to request that an interpreter (either by phone or in person) be made available to read and describe the contents of that written document.

19. Track requests for language assistance in languages other than the most populous language to obtain "essential" or "important" information. Ask the interpreters to also inform patients of their right to request a summary of the contents of the written materials that are categorized as "of possible interest to patient." Expand the translated materials in the order of the frequency of the languages for which help is requested. Follow the suggestions of #11 below.

Name of Pamphlet	Essential to the Quality of Care	Important to the Quality of Care	Of Possible Interest	Prepared by Institution	Prepared by Outside Source

11. Send all brochures or written materials in each classification to professional telephone interpreters of the languages of less populous groups (for which written materials have not been translated) in advance. Ask the interpreters to read the materials and be ready to orally translate the contents of these materials when telephoned by the patient. Utilize the telephone interpreter services to summarize the contents of these brochures when a patient in one of these language groups requires the information from that brochure.

Section #6, Checklist #4: Creating an efficient, cost effective system for medical interpretation

1. Delegate one person or department to be responsible for the interpreter service program. This person may be someone who is already on staff or someone hired specifically to develop and administer the program. *Establishing Interpreter Services in Health Care Settings* outlines the duties of this individual, which are listed below (See Further Reading for full reference):

a. Recruiting trained interpreters (e.g. on-staff professionals, bilingual staff serving in other capacities in the organization, contract interpreters and/or community volunteers)

b. Testing and assessment of interpreter skills in knowledge of medical terminology and general oral skills in both English and the second language

c. Training of bilingual staff who wish to serve as interpreters (Note: The training should include interpreter skills, cross-cultural issues and the ethics of patient confidentiality.)

l. Training of medical and non-medical staff in how to use interpreters effectively

m. Locating area resources for interpreters and interpreter training

n. Coordinating interpreter services, establishing procedures for receiving requests for interpreters, scheduling interpreters, contracting with interpreters and maintaining records

o. Keeping abreast with both patient and service area demographics as well as legal aspects of interpreting and interpreter certification

p. Managing the finances for the interpreter services

q. Serving as a liaison with community organizations

r. Working with departments to encourage the hiring of bilingual employees

2. Neither CLAS nor OCR give a specific method by which their mandates can be satisfied. The method chosen will depend on the size of the health care organization, the frequency of requests for interpreters and how successfully these requests are being met. However, both CLAS and OCR mention the inappropriateness and medical dangers of utilizing family or friends of the patient as interpreters and state that unless offers to provide the aid of interpreters are refused an interpreter designated by the institution should be assigned. Should the patient insist upon using a family member or friend to interpret, it is advised that institutions request that a trained interpreter listen to the exchange and correct any miscommunication that may

occur. Below is a partial list of the different types of interpreter services that health care organizations have successfully utilized:

a. Paid salaried professional medical interpreters on full or part time staff

b. Bilingual staff who have been certified in the knowledge of both medical and everyday language in English and their second language and have been trained in interpreting procedures and the ethics of confidentiality

c. Community volunteers who meet the same criteria as bilingual staff (Note: Official arrangements need to be made with the community organization in advance so that interpreters who meet this criterion are always available when needed.)

d. Contract interpreters from a professional interpreting service, which is arranged in advance

e. Remote simultaneous medical interpreting (Note: See Commonwealth Fund Report, p. 25)

f. Telephone interpreting services

(Note: Larger organizations located in more diversely populated areas will probably wish to utilize a combination of these methods. For example, these organizations may wish to hire some full or part-time professional interpreters for some languages and to hire and/or train some bilingual staff in medical interpreting for other languages. Smaller organizations and private practices may find it more cost effective to create official arrangements with community organizations, remote simultaneous interpreting services and/or telephone interpreting services.)

3. Identify qualified medical interpreters and medical interpreting services in advance and select qualified bilingual staff who may serve as interim interpreters until a professional interpreter arrives.

a. *The Immigrant and Refugee Health Task Force (Chicago, 1993*) listed the following as basic competencies for the Health Care Interpreter:

1) Demonstrates fluency in a minimum of two languages, one of which is English, in the skills of reading, writing, speaking and comprehension
2) Is familiar with the technical vocabulary associated with health care interpreting
3) Demonstrates an understanding of and sensitivity to cultural issues that impact the health interpreting situation
4) Is familiar with different types of interpreting styles such as simultaneous vs. consecutive interpreting

14) Is able to apply problem-solving skills to facilitate the interpreting process

15) Identifies and applies strategies and techniques to deal with interpersonal issues that may arise during health care interpreting situations
16) Demonstrates an understanding of ethical and professional codes of conduct for interpreters such as confidentiality, informed consent and privacy
17) Demonstrates an ability to apply ethical and professional conduct to health care interpreting situations
18) Demonstrates an understanding of local health service delivery systems
19) Demonstrates an understanding of and familiarity with the terminology of complex medical and ethical dilemmas of modern medicine such as "Do Not Resuscitate" orders, advance directives and termination of life support

b. Use the above list of competencies as a guide to the types of questions which should be asked when hiring either on-staff or contract interpreters. These guidelines will help the organization determine the qualifications of interpreter service companies. The following is a list of questions that might be asked:
10) What training or certification do you (or the interpreters in your service) hold?
11) How is proficiency in each language certified?
12) What training have you (or the interpreters whom you employ) have in medical terminology in English and the language(s) of specialty?
13) What training have you (or the interpreters whom you employ) have in the cultural issue apt to effect medical interpreting in these languages?
14) What training have you (or the interpreters whom you employ) have in different forms of interpreting?
15) What training have you (or the interpreters whom you employ) have in medical codes of conduct such as patient confidentiality?
16) Do you (or your agency) specialize in medical interpreting?
17) What hospitals or health care organizations that have used your services might be contacted as references?

c. These basic competencies can also serve as an outline to the organization's selection and training of bilingual staff who are willing to serve as part-time interpreters. (Note: Staff who interpret in addition to other duties should be compensated in some way for their time and increased work load. This compensation may be in a number of different forms such as monetary, extra vacation days, education, and/or job promotion.)
10) The fluency of bilingual staff in both English and whatever languages they agree to interpret for must be tested formally or informally. The institution may wish to try to locate a formal test. The institution may also simulate an interpreting situation between an objective staff member who speaks that language and the actual interpreter to check the accuracy of the interpretation. Analyze the appropriateness and accuracy of both everyday language and medical terminology.
11) Require a minimum of 40 hours of training and practice (on or off-site, during work hours or with "release time." Courses should be free or reimbursement should be provided to participants upon completion of the course. The

information gathered to complete **Section #6, Checklist #3** should represent the competency goals of interpreter training.

4. Identify and use qualified telephone interpreting services.

a. There are a number of companies which advertise their ability to provide telephone interpreters in one or several languages. Before contracting with any interpreter service it is important to ask the company representative:

1) Does your company supply interpreters in all sorts of fields or does it specialize in medical interpreting?
2) Where do you find your interpreters? Do they work for you full-time or are they contracted on an "as-needed" basis?

12) What are their qualifications? How is their fluency in English and the languages they interpret tested? Do they hold certificates in medical interpretation? Do they hold certificates in any other form of interpretation? Do you train them in medical ethics and confidentiality? Roughly how many years of experience does your average interpreter have? (Note: Check experience and training of interpreters in each of the languages in your service area.)

13) What do you do when you receive a request for an interpreter for a language that is not on your general list of interpreters? How do you locate an interpreter? Are each interpreter's skills tested before he/she is asked to interpret for a client?

b. In addition to the above questions, it is strongly advised that before establishing a contractual relationship with any interpreting service, that the organization "test" the service by asking several bilingual employees of different language backgrounds to "act" as patients. Rate the service on their speed and efficiency in connecting the "patient" to a suitable interpreter as well as the cultural appropriateness and language accuracy in terms of general language knowledge, medical terminology, and the ability to make medical terms and conditions comprehensible to the patient.

c. Following the section on Further Reading is a list of a few telephone interpreter services that advertise as performing medical interpretation over the telephone. This list should in no way be taken as an endorsement of any of the companies. (Note: This list does not imply a recommendation. Each company should be evaluated in the manner suggested above.)

Further Reading

Boyd, Jr. Ralph, Memorandum for Head of Departments and Agencies General Counsels and Civil Rights Directors, Subject: Executive Order 13166(Improving Access to Services for Persons with Limited English Proficiency) www.usdoj.gov/crt/cor/lep/Oct26Memorandum.htm

Durham, Maria, Ed.M., R.N., et. al, Establishing Interpreter Services in Health Care Settings, 1998, Amherst Educational Publishing, Amherst, MA

Office for Civil Rights, Policy Guidance: Title VI Prohibition Against National Origin Discrimination As It Effects Persons with Limited English Proficiency, www.hhs.gov/gov/ocr/lep/guidelhtml

Paez, Kathryn Paez, RN,MSN, MBA, Providing Oral Linguistic Services, A Guide for Managed Care Plans, Centers for Medicare & Medicaid Services (CMS). May be downloaded from the CMS Internet site at www.cms.gov/healthplans/quality/project03.asp>

Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: 13166 Improving Access to Services for Persons with Limited English Proficiency, March 14, 2002

Roat, Cynthia E. How to Choose and Use a Language Agency: A Guide for Health and Social Service Providers who wish to Contract with Language Agencies. The California Endowment, 2002. 62 pages.

Youdelman, Mara and Jane Perkins, Providing Language Interpretation Services in Health Care Settings: Examples from the Field, May 2002, Quality of Care for Underserved Populations, The Commonwealth Fund, New York, www.cmwf.org

A Partial List of Telephone Interpreter Services

(Note: This list does not constitute a recommendation. It is merely a partial list of organizations that provide telephone interpreting services. Each company should be thoroughly investigated for each of the languages contracted for prior to using the company's services.)

Language Line Services
Pacific Interpreters
Tele-interpreters
On-line Interpreters
CTS Language Link
Network OMNI
Cyracom
Certified Languages International

Section #7, Guide to on-going staff training throughout the organization (*CLAS Standard #3*)

This section will help the institution evaluate current training in cultural and linguistic competence and to plan to ensure that this training becomes an on-going process. It presents a list of core topics that should be included in the training. This list has been subdivided into three levels of competence according to job performance requirements and the amount of contact staff members are expected to have with diverse patients and colleagues. Employees who have little or no direct contact with diverse patients or staff (e.g. technicians, custodians and food service employees) might only be required to achieve and maintain **Basic Competence**. Those who have moderate contact with diverse patients and staff (e.g. telephone operators and bill collectors) should achieve and maintain **Intermediate Competence**. Those who have regular contact with or make decisions concerning diverse patients and staff (e.g. physicians, nurses, human resources personnel and administrators) should be expected to achieve and maintain **Advanced Competency**.

Organizations are encouraged to modify materials in this section to meet their unique needs. Large organizations may wish to further separate topics into workplace diversity and patient diversity. The suggested topics are only intended as guidelines. They are not all inclusive. They should help organizations:

1. Evaluate and/or enrich the content of training programs in diversity or cultural/linguistic competence already in use by the organization

2. Plan the content of future training

3. Evaluate the adequacy of the content of external training programs

Each list of topics is considered minimal for a comprehensive training course at the needed level of competence. Each has been based on a general concept of the roles and duties likely to be performed by persons who fulfill a particular role within the health care organization. Curriculum planners should feel free to rearrange content topics or to use them as brainstorming tools from which they build their own syllabi.

Section #7, Checklist #1: Evaluating current training in cultural and linguistic competence

(Note: The results of this checklist will indicate how well the organization currently complies with the recommendation for "on-going training throughout the organization" and assist in the development of a training schedule for each of the groups listed.)

1. Assess the organization's current training methods in cultural and linguistic competence.

a. The organization currently offers specific training in cultural competence to those employees who come into contact with and or care for people who are culturally different from themselves. **Yes No**

b. The organization currently offers specific training in workplace diversity for those who manage/supervise or work with other staff members who are culturally different from themselves. **Yes No**

c. The organization currently offers specific training in linguistic competence to improve the ability to communicate effectively with limited English speaking patients and/or staff. **Yes No**

2. Utilizing the chart below, evaluate the quantity and quality of the training received by <u>each</u> employee group. (Note: Some of the staff categories may be sub-divided to mirror the structure of the organization.)

a. Indicate the number of hours of training over the course of the last 2 years that was dedicated specifically to cultural and/or linguistic competence. If training in these areas was covered within the framework of a broader topic (e.g. quality care, avoiding medical mistakes, quality improvement and/or risk management), *only count* the number of hours specifically devoted to cultural and/or linguistic competence. (Note: As a general rule of thumb, <u>all</u> employees should receive some training in this area, with those who have the greatest contact with culturally and linguistically diverse patients and staff receiving the greatest number of training hours.)

b. Calculate the percentage of training hours spent per employee group out of the total amount of training hours.

c. Indicate the types of on-the-job application assignments that were utilized for practice purposes. Note the method of follow-up used to check for completion of these tasks.

d. List the dates of the completed training sessions.

e. List the dates of upcoming follow-up training sessions. (Note: It is recommended to schedule these follow-up sessions in cultural and linguistic competence every 6 months.)

4. The person or department conducting cultural competency training is:

a. A trainer who has received special training and/or certification in cultural and linguistic competence **Yes No**

b. A trainer who has not received specific training but whose major workload is devoted to cultural/linguistic competency training **Yes No**

c. A regular trainer who teaches other subjects as well **Yes No**

d. An external training specialist in cultural and linguistic competence **Yes No**

e. Not a face-to-face trainer but rather is a commercial self- teaching course or video **Yes No**

5. The content of the training:

a. Is the same for all groups of employees **Yes No**

b. Is modified to meet the to the job tasks and duties of the particular group of trainees **Yes No**

6. Training is followed up and reinforced by:

a. Internal internet reminders and tips **Yes No**

b. Regular meetings and lectures **Yes No**

c. Departmental reminders **Yes No**

d. An in-house newsletter **Yes No**

e. Case studies for department meetings **Yes No**

f. Best practice shared with other departments **Yes No**

g. Other (_____) **Yes No**

(Note: Training in cultural and linguistic competence is often emotional and is usually only as effective as the trainer himself. One goal of the institution should be to develop one or more highly competent trainers who are knowledgeable and comfortable with this topic.)

Employee Group	Hours of Specific Cultural Competence Training in the Last 2 Years and Percentage of Total Amount	Types of On-the-Job Application Assignments and Follow-up Methods	Date(s) of Completed Training Sessions	Date(s) of Upcoming Follow-up Training Sessions
CEO & Top Decision Makers*				
Department Heads & Supervisors*				
Physicians*				
Nurses*				
Human Resources*				
Non-Clinical Contact Staff (e.g. Receptionists, Telephone Operators, Accounting, Billing)**				
Behind-the-Scenes Clerical Staff and Technicians***				
Non-clinical support Employees (e.g. Food Service, Cleaning Staff, Maintenance)***				

*Advanced Competency is recommended for staff who have frequent contact with culturally diverse patients.
**Intermediate Competency is recommended for staff who have more limited contact with culturally diverse patients.
***Basic Competence is recommended for staff who have little or no direct contact with culturally diverse patients.

Section #7, Checklist #2: Planning for on-going training throughout the organization

Although all employees in a culturally and linguistically competent organization should be given some training, the amount and depth of training they receive may be adjusted according to their job descriptions and the amount of regular interaction they have with culturally and linguistically diverse patients and/or staff. Training should be prioritized according to the level of competency required by each employee group in the following order: **Advanced**, **Intermediate** and **Basic**. Furthermore, effective training in cultural and linguistic competence involves not only additions to participants' knowledge base, but often requires a shift in attitudes, increased awareness and sensitivity to others and the acquisition of a number of skills. Attitudinal changes and skills-improvement require repeated interventions.

1. Use the table below to evaluate the training needs of the various groups of staff at the institution. (Note: The human resource and training departments may wish to customize the table to fit the unique structure of the organization.)

a. Indicate the date of initial training for each employee group. These sessions should specifically address cultural and linguistic competence in the health care field. On-the-job application measures should be discussed and "homework" should be assigned.

b. Set up a group meeting to review the results of the on-the-job application assignment and to ensure its completion. It is strongly advised that all training be reinforced at the minimum of a 6 month interval.

c. Utilize daily reminders (e.g. email, newsletters, signs and memos) to increase knowledge as well as reinforce changes in basic attitudes and behavior of the institution's personnel. The content of these reminders may include dates and customs of different religious holidays and facts about values and beliefs of a particular cultural group.

d. Schedule monthly or bi-monthly peer or departmental discussions about cultural and language issues and/or problems that staff routinely face. The objective of these talks/lectures is to broaden institution-wide understanding of cultural diversity and develop strategies to improve the cultural competence of all employee groups. (These discussions can become part of departmental meetings or "brown bag" lunch affairs and can utilize peer or supervisor facilitators. Thus, the costs involved in traditional training can be avoided.)

e. Review patient satisfaction surveys on a quarterly basis. Identify areas of strength and weakness with each population group served and adjust the focus of future training sessions accordingly.

2. Although the following suggestions center upon training outside of the classroom environment, many in-class resources do exist to reinforce training. Self-teaching modules are currently being developed for clinical and non-clinical staff by various agencies and publishers and there are a number of excellent videos already available.

Employee Group	Date of Initial Training	Date of Group Meeting to Review On-the-Job Application Assignments	Daily Reminders (e.g. Email, Newsletters, Signs and Memos)	(Bi)Monthly Institution-wide Lectures on Cultural Competency	Department Meetings on Special Issues and/or Problems	Quarter Review of Patient Satisfaction Surveys
CEO & Top Decision Makers*						
Department Heads & Supervisors*						
Physicians*						
Nurses*						
Human Resources*						
Non-Clinical Contact Staff (e.g. Receptionists, Telephone Operators, Accounting, Billing)**						
Behind-the-Scenes Clerical Staff and Technicians*						
Non-clinical support Employees (e.g. Food Service, Cleaning Staff, Maintenance)*						

*Advanced Competency is recommended for staff who have frequent contact with culturally diverse patients.
**Intermediate Competency is recommended for staff who have moderate contact with culturally diverse patients.
***Basic Competence is recommended for staff who have little or no direct contact with culturally diverse patients.

Section #7, Checklist #3: The Three Levels of Cultural and Linguistic Competence

Each of the suggested curriculum for the three levels of cultural and linguistic competence (**Basic**, **Intermediate**, and **Advanced**) are divided into four learning categories: Knowledge, which lists definitions, facts, and information that a person achieving that level of competence should know, Awareness and Attitudes, which lists the sensitivity that the person at that level of competence should develop, Skills, which denotes the specific tasks that the person at that level should be able to perform and On-the-Job Application, though not an actual learning category, suggests ways in which the other three categories might be practiced in the work environment.

1. **Basic Competence**
   This level of competence consists of the knowledge, attitudes and skills that *all* employees in a culturally and linguistically competent organization should receive even if they do not interact with culturally and linguistically diverse patients and/or employees on a regular basis. These basic competencies should be included in the training curricula of all groups. The broad training content of the knowledge, awareness/attitudes and skills is essentially the same for all employees, regardless of level and function in the organization. However, the actual materials and methods used to develop these areas of competency might need to be modified to suit the way the particular groups may apply the training depending upon their level of education and job description. The suggested length of this training module is 4 to 6 hours.

2. **Intermediate Competence**
   This level of competence represents the additional knowledge, awareness/attitudes and skills needed by staff who have a higher degree of interaction with culturally diverse patients and/or employees. This training module has a suggested length of 4 to 6 hours in addition to the training in **Basic Competence** for a total of 8-12 hours.

3. **Advanced Competence**
   This level of competence requires a great deal of knowledge, awareness/attitudes and skills. It is highly recommended for staff who have daily contact with culturally diverse patients and/or employees. The suggested length of this training module is 4 to 6 hours after completion of training in both **Basic** and **Intermediate Competence** for a total of 12-24 hours. (Note: Due to differences in learning styles, focus and concerns, it is preferable that each group of physicians, nurses, other clinical staff, human resources personnel and administrators receive separate training in the initial stage. However, on-going practice and training is most helpful when it is organized within departments and multi-disciplinary work teams rather than by profession.)

Level One: Basic Competence
(Training for Entire Staff)
Suggested Length: 4 to 6 Hours

Knowledge	Awareness and Attitudes	Skills	On-the-Job Application
Definitions: Culture, race, ethnicity, sexual orientation, diversity, prejudice, stereotype, cultural competency, linguistic competency, cultural humility As needed knowledge of food and rules of cleanliness of other groups	Everyone is uniquely multicultural (i.e. belonging to many subgroups, which define the person's belief system, behavior, language and work ethic). Nonjudgmental attitude toward the food preferences and notions of cleanliness of other groups and willingness to accommodate whenever possible	How to ask other people about their needs and preferences How to perform one's duties without insult to or breaking religious and/or cultural rules of others	Adherence to dietary requirements (i.e. who can or cannot handle Kosher foods and the religious prohibition of pork for Jews and Muslims) If assisting in feeding, attention to using the right rather than the left hand for some cultures
Changing demographics and the impact on both the country and the organization • Primary Employee Populations • Primary Patient Populations • Effective relationships essential to workplace efficiency & institutional growth • Focus upon aspects of	Awareness and appreciation of differences in communication styles, cultural and spiritual values and work ethics How these effect patient and staff's behavior, expectations and satisfaction Ability to refrain from assuming that everyone is "just	Improved ability to understand and communicate with people of diverse language and cultural backgrounds • Understand heavily accented English • Speak more slowly and clearly with those of a different language background • Check comprehension by	Ability to observe and track improvement in one's skills in cross cultural communication Ability to recognize instances of miscommunication and correct the causes of confusion Application of appropriate and respectful behavior toward patients and staff different from

demographic change pertinent to group being trained.(e.g. methods of work, communication and healing beliefs)	like me" or judging others by one's own code of behavior • Recognition & modification of one's own biases, prejudices and stereotypes • Cultural curiosity rather than fear or avoidance of those who are different • Acknowledging one's own stereotypes of others and managing them	asking information questions rather than yes/no questions • Ability to treat others according to their standards of respectful and appropriate behavior rather than by one's own standards	oneself
Governmental and JCAHO stance on cultural and linguistic competence	How each employee's workplace behavior contributes to or detracts from compliance		Monitoring intercultural interactions and identifying successful ways of communicating across cultures
Components of cultural and linguistic competence as applied to oneself and the organization as a whole	Self-awareness of one's own values, beliefs, stereotypes and biases and how these dictate one's attitudes and behavior	Ability to refrain from stereotyping others and a reduction of cultural/ethnic biases. Ability to identify and check influence of biases on one's own behavior	Identification of instances where one's own cultural, ethnic biases impact decision-making and behavior Effort to reduce this bias
Basic etiquette (do's and taboos) of major patient groups served and major cultural/ethnic groups employed by the organization	Understanding of how cultural rules of behavior impact how we perceive others and how others perceive us Willingness to modify behavior accordingly	Identifying and using appropriate forms of address Following cultural rules for touching, distance, and other behaviors	Establishment, reinforcement, and enforcement of general behavioral guidelines throughout organization

Level Two: Intermediate Competence
(Training for Non-Clinical Contact Staff, Physicians, Nurses and Administrators)
Suggested Length: 4 to 6 Hours to be completed after Basic Competence has been achieved

Knowledge	Awareness and Attitudes	Skills	On-the-Job Application
The business case for cultural and linguistic competence • Changes in service • Area population • Quality of care • Medical Risk	Institutional growth and survival depends upon attracting and retaining culturally diverse patients. Access to and quality of care depends upon the cultural and linguistic competence of staff.	How to identify and correct cultural and linguistic problems and/or issues within the work area How to mentor, correct and coach across cultures How to problem solve and address grievances in culturally mixed settings.	Outreach to community organizations Making community needs and concerns an integral part of customer service
Cultural and linguistic competence and the law • CMS • CLAS • OCR • JCAHO How well the organization complies to these standards (e.g. Institutional self audits)	Personal commitment to supporting and promoting cultural/linguistic competence	How to track and increase compliance within department, administrative and personal domain Ability to explain legal aspects and regulations to diverse individuals and groups	
How different population groups in service area define health or wellness, illness and	Culture influences attitudes regarding quality and appropriateness of care and	Ability to balance legal requirements regarding care with culturally appropriate	Development of culturally and linguistically flexible approaches to work

quality of care For HR staff and supervisors: how different cultures may have very different ideas about work ethics, what constitutes a good employee and job advancement	these attitudes must be respected to meet the needs of all patients in the service area. Avoidance of the assumption that non-verbal communication (e.g. eye contact or body language) is the same for all cultures.	patient needs and expectations	
How clear communication is essential to quality of care in patients and quality of performance in staff Why using untrained persons to interpret is dangerous	Communication is a two way street equally dependant upon both interlocutors. What can I do to improve communication?	How to identify cases of miscommunication How to identify the language that the patient needs How to contact and engage an interpreter How to communicate effectively through an interpreter	Developing departmental protocols for identifying and dealing with language needs Tracking the frequency of language needs per population group Monitoring "successful" use of interpreters
The reputation of the institution within each patient population Holidays, customs and etiquette of cultural groups in the service area	Desire to learn more about these communities and apply this knowledge to the work place	Use of knowledge about a cultural group to make individuals feel welcomed and valued (i.e. how to greet someone in their own language)	Acknowledgement of holidays and special events within the department through signs and verbal greetings

Level Three: Advanced Competence
(Training for Physicians, Nurses and Administrators)
Suggested Length: 4 to 6 Hours to be completed after Intermediate Competence has been achieved

Knowledge	Awareness and Attitudes	Skills	On-the-Job Application
Health, illness and illness prevention beliefs and practices of populations in the service area Work styles and work ethics differ from culture to culture. (Note: This information might be substituted with information regarding work ethic and expectations with human resources personnel, administrators and supervisors.)	Other culture's beliefs are not "wrong," only different from Western medical beliefs. Ability to recognize pros and cons of every norm Not everyone believes that Western medicine is the best and most effective approach.	Questioning techniques, which "allow" diverse patients and/or staff to openly describe beliefs and practices How to acknowledge these beliefs and practices respectfully How to balance these diverse beliefs with one's own and with legal and/or institutional requirements	Flexibility to include these beliefs in medical and/or staff management
How power and ethnocentrism impact caring and access to care as well as job performance and work relationships	Lack of innovation or compliance does not always illustrate weakness or lack of compliance - it can be related to culture	How to empower patients and staff when they view you as the authority figure	Create a welcoming environment
Language as a factor in access to care and quality of care How using family members and/or untrained interpreters can lead to medical error and	How lack of a common language may make one feel incompetent and powerless	How to simplify language to communicate directly with LEP individuals How to effectively use an interpreter.	Track and measure patient and staff communication and interaction

negative outcomes		Other options when an interpreter is not available.	
Impact of race on genetic predisposition Common diseases and health problems of each group in the service area	For medical treatment or supervision to work it must be tailored to lifestyle and cultural beliefs.	How to tailor treatment plans and work orders to culture	
Impact of culture and language on health access and health system use	Appreciation/acceptance/ tolerance of differences in cultural and spiritual beliefs and values regarding delivery of health care		
Patient population: family structure, belief system, traditional medicine, community healers, diet & nutrition and decision-making practices	Understanding/sensitivity to patient's desire not to know or to participate in decision-making	How to ask questions to elicit patient beliefs regarding cause and cure definitions and prior interventions	Eliminate racial disparities in quality of care
	Recognition of one's own preferences and understanding that these may be different that that of others		
Knowledge of "toxic practices" in group to which patient belongs	Avoidance of stereotyping or making assumptions about unique individuals based upon race or ethnicity	How to take a culturally sensitive history and physical	Departmental list of references and cultural and linguistic information
Religious/cultural taboos to specific standard medical practices	Respect for beliefs contrary to "logic" or common medical practice	How to negotiate a culturally appropriate balance between patient beliefs and taboos and	Examination and search for possible modification of rules and procedures in the light of

		institutional and/or medical care and services	some of the beliefs and taboos of religious cultural communities in the service area
Impact of health disparities that may be caused by cultural and linguistic barriers to care	Acceptance of the concept that quality care must be determined by a definition of both the provider and the receiver of care	How to make the services provided accessible and acceptable to each of the groups served	Identification of barriers to care for groups in service area and design of protocols to make care more accessible to each group
Impact of culture and language on medical error, malpractice, patient satisfaction with services, staff retention/attrition and discrimination cases against institution	Barriers to communication between staff and patient can be a major factor in malpractice and medical error. Empathy and cultural humility (i.e. an understanding that one can never KNOW another culture completely) It's better to ask than make assumptions.	How to listen and communicate more effectively across cultural and linguistic barriers	Review of past instances of medical error and/or mal-practice to identify possible cultural or linguistic factors Examination of possible actions which might have prevented these problems Development of protocols to avoid repetition in the future
Local community organizations and leaders to consult as cultural brokers and for bringing members into the health system	Value of going out into the community and creating a view that the health care organization is approachable and helpful	Networking skills	Invitations to community leaders to serve on boards and committees Attempt to meet and mingle with major groups in the service area

Further Reading

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Dreher M & Macnaughton N: Cultural Competence in Nursing: Foundation or Fallacy? *Nurse's Outlook* 2002; 50(5):175.

Gardenswartz, L & Rowe A: *Managing Diversity in Health Care Manual: Proven Tools and Activities for Leaders and Trainers*. Jossey-Bass: San Francisco 1999.

Luna I: Diversity Issues in the Delivery of Healthcare. *Lippincotts Case Management* 2002; 7(4):138-43.

Mir G & Tovey P: Cultural Competency: Professional Action and South Asian Carers. *Journal of Management of Medicine* 2002; 16(1):7-19.

Rundle A, Carvalho M & Robinson M: *Cultural Competence in Health Care - A Practical Guide*. Jossey-Bass: San Francisco 1999.

Salimbene S: Cultural Competence: A Priority for Performance Improvement Action. *Journal of Nursing Care Quality* 1999; 13(3):23-35.

Salimbene S: Chapter 12: Methods for Improving Cultural Competence (Strategies for Developing a Culturally Competent Managed Care Organization). *Guide to Managed Care Strategies* 1999; 203-221.

Takayama JI, Chandran C & Pearl DB: A One Month Cultural Competency Rotation for Pediatrics Residents. *Academic Medicine* 2001; 76(5):514-5.

Section #8, Guide to the development of positive, participatory and collaborative partnerships with community organizations and support groups of culturally diverse populations in the service area *(CLAS Standard #12)*

These alliances will ensure that each group's health care needs and concerns are met in a culturally appropriate manner.

Section #8, Checklist #1: Strengthening ties with communities through contacts with grass root organizations

Part #2 of **Section #2, Checklist #6** has been repeated on this checklist. Fill it out again and refer back to the original to determine whether or not there has been an increase in the amount and type of general community involvement with the health care organization.

1. **Utilization of Community Organizations for Input and Support**

   a. List the important community and/or religious organizations affiliated with each patient population in the service area.

   b. Indicate the institution's ability to incorporate feedback from important community and/or religious organizations in the development of a culturally diverse environment.

Patient Population Groups in the Service Area	Important community and/or religious organizations	Direct Contact is established between the healthcare organization and the community organization	A member of the community organization serves on one of the institution's advisory boards and/or committees	Input on how to improve patient satisfaction has been requested from the community organization

2. Contact each of the organizations listed in the table above.
Request the following information from the community leaders:

a. Reputation of health organization in community and general information about population

10) How is your group's population changing within the service area of the organization?

_____ Increasing _____ Decreasing _____ Remaining Constant

11) What are your population's three primary health concerns?

_____

_____

_____

12) How well do the members of your organization feel the health care institution addresses these concerns?

_____ Very well _____ Well _____ Somewhat well _____ Not well at all

13) What steps might the health care organization take to better address these concerns?

_____

_____

_____

14) How might the healthcare institution and your community organization partner up to address these concerns?

_____

_____

15) In general, what is the reputation of the health care organization with members of your community?

_____

_____

16) How might the health care organization improve that general reputation?

_____

_____

17) Are there any policies or procedures practiced by the health care institution that are considered discriminatory to members of your population?

_____

_____

b. Evaluation of Services

Share patient satisfaction surveys with each of the community organizations. Ask members of these organizations the following questions:

1) Is the health care organization asking appropriate questions to elicit true patient opinions of the services that they received? **Yes No**
2) Is the translation of this form accurate and correct? **Yes No**
12) How will the health care organization get the majority of patients from your group to receive the form and complete it in an honest manner (i.e. by mail, phone, or in-person)?

_____

_____

c. Attracting and retaining patients from each population group

Approach the respective community organization and ask the following questions:

10) How do new members of your community usually make decisions regarding the choice of a physician or health service?

_____

_____

2) What are the 5 most important criteria in choosing a hospital or health service?

_____

_____

_____

_____

_____

3) What can the health care organization do to make this group of people choose to go to this health care institution?

_____

_____

13) What are the 5 major reasons that members of your community feel dissatisfied or leave a health care organization?

_____

_____

_____

_____

_____

14) To your knowledge, has anyone from your community left the health care organization for any of the reasons listed above? If so, for what specific reason?

_____

_____

6) How can the health care organization and your community organization partner up to:
   a) Improve health access for your community?

      _____

      _____

   j) Improve health outcomes?

      _____

      _____

   k) Reduce common illness or epidemiological problems through educational efforts?

      _____

      _____

   l) Build confidence and trust for the health care organization within your community?

      _____

      _____

   m) Other suggestions for partnering?

      _____

      _____

Further Reading

Andresen J: Cultural Competence and health care: Japanese, Korean, and Indian Patients in the United States. Journal of Cultural Diversity 2001; 8(4):109-21.

Section #9, Guide to annual self-assessment and evaluation

This final step in an organization's journey toward cultural and linguistic competence is linked to both the creation of a workable strategic plan and the constant revisiting of the institutional audit. These checklists should be redone each year as a means of evaluating the institution's progress in meeting its goals. It is recommended that all yearly self-assessments be saved as they will provide a comprehensive picture of the institution's journey toward cultural and linguistic competence and its ability to maintain the standards it has set. **Section #9, Checklist #4** suggests that these results be shared with the communities the institution serves as a means of encouraging suggestions from them as well as demonstrating the institution's commitment to offering the highest quality of services.

Section #9, Checklist #1: Annual Institutional Self-Audit

1. Copy and fill out **Section #2, Checklist #2**, using the most current figures. Compare the current staff demographics with those of last year. Decide whether the institution wishes to track the changes in these figures in percentiles or actual numbers. Be consistent from year to year.

a. What is the total increase in the diversity of the total staff? _____

b. Does this increase in staff diversity better match the patient population than it did one year ago? **Yes** **No** (If **yes**, by what percent? _____)

c. What is the increase in the diversity of management? _____

d. What is the increase in the diversity of physicians?_____

e. What is the increase in the diversity of nurses? _____

f. What is the increase in the diversity of clerical staff? _____

g. What is the increase in the diversity of all other staff? _____

h. List **at least** 2 steps the organization has taken during the past year to increase job satisfaction and retention of diverse employees.

1) _____

2) _____

3) _____

4) _____

i. Has at least one of the above steps towards increasing job satisfaction and retention of diverse employees been to increase the potential of job advancement through education and training? **Yes** **No**

j. Compare the employee attrition figures for this past year with those of the year before. How successful has the organization been in retaining diverse employees?

____ Very successful ____ Somewhat successful

____ About the same as last year ____ Worse than last year

2. Copy and fill out **Section #2, Checklist #4**, using the most current figures. Compare the current actions to enhance cultural and linguistic competence with those of the previous year.

a. What changes, if any, have been made in either the wording or the interpretation of the organization's mission statement?

_____

_____

b. Re-evaluate these changes to determine how (or if) they have demonstrated the organization's full commitment to cultural and linguistic competence.

c. List 3 ways internal organizational communication has supported this goal over the past year.

10) _____

11) _____

12) _____

d. What 5 changes/improvements have been made in the overall cultural diversity and competency education during the past year. (Note: Refer to the lists of suggested training topics in **Section #7, Checklist #3** of this guide. Check off all the topics in these lists which are now regularly included in training.)

1) _____

2) _____

3) _____

4) _____

5) _____

e. List any additional measures taken to insure that all patients receive culturally and linguistically competent care and services. (Note: See Part #5 in **Section #2, Checklist #4**.)

1) _____

2) _____

3) _____

f. Rate the organization's cultural/linguistic competency status at this time. (Note: After having spent a year on this journey to cultural and linguistic competency, it is natural for an organization's overall self-rating to *decrease* rather than *increase*. This is not due to a decrease in progress, but to an increased understanding of the complications involved in this process. This awareness of *how much one doesn't know or how far an institution has to go* on its journey to cultural and linguistic competence should be considered a major step toward progress.)

____ Fully competent ____ Moderately competent

____ Somewhat competent ____ Not competent

g. Note any changes to the physical environment to make it more appropriate and inviting to the patient populations served.

1) _____

2) _____

3) _____

h. Note any changes to the emergency room/walk-in and appointment services to make them more convenient and appropriate to the patient populations served.

1) _____

2) _____

3) _____

3. Copy and fill out Part #4 of **Section #2, Checklist #5**, using Section #6 of the guide as a resource.

a. Compare the current answers to Parts #4a and b to those answers in the original self-audit on language and interpreter access.

1) What has been the increase in the number of languages in which forms are translated? _____

2) What has been the increase in the number of languages in which signage is provided? _____

3) What has been the increase in the number of languages for which patient educational materials are provided? _____

4) What has been the increase in the number of languages for which on-site interpreters are provided? _____

5) What has been the increase in the number of languages for which telephone interpreters or other forms of interpreting services are provided? _____

b. Compare the current answers to the yes/no statements in Part #4c to the original evaluation of on-site interpreters. The quality of the interpreting services has:

____ increased greatly ____ has increased somewhat ___ has stayed the same

4. Copy and fill out Part #5 of **Section #2, Checklist #5**. Compare the current responses about food service and visitation with the previous answers.

a. List **at least** one improvement that has been made during the past year regarding the appropriateness and convenience of food service:

1) _____

2) _____

3) _____

b. List **at least** one improvement that has been made during the past year regarding the appropriateness and convenience of visitation:

1) _____

2) _____

3) _____

5. Review the institution's strategic plan. (Note: See Section #3 of the guide.)

a. The goals of the strategic plan set for this year been met. **Yes No**

b. The goals of the strategic plan have been exceeded? **Yes No**

c. List the goals of this year's strategic plan that the institution has not met, if applicable.

1) _____

2) _____

3) _____

d. List the goals of the strategic plan that the institution has met, if applicable.

1) _____

2) _____

3) _____

e. List the accomplishments that are in excess to the goals of this year's strategic plan, if applicable.

1) _____

2) _____

3) _____

Section #9, Checklist #2: Review of employee and patient grievances and patient satisfaction

1. Examination of Employee Grievances

a. Examine the list of employee grievances for the **year prior** to the year under current review.

1) How many complaints were filed by employees? _____
2) How many of the grievances are related to cultural, racial, or religious issues? _____
3) How many of the grievances involved an employee from a culturally, racially or religiously diverse background (either as complainant or as defendant)? _____

b. Examine the list of employee grievances from **the current year**.

1) How many complaints were filed by employees? _____
2) How many of the grievances are related to cultural, racial, or religious issues? _____
3) How many of the grievances involved an employee from a culturally, racially or religiously diverse background (either as complainant or as defendant)? _____

c. Compare the employee grievances from the current year under review to the year prior.

1) There were **(more/fewer)** grievances that involved cultural, racial or religious issues.
2) There were **(more/fewer)** complaints made by employees of culturally, racially or religiously diverse backgrounds.
3) There is a(n) **(increase/decrease)** of complaints made by white Caucasian employees against minority employees.
13) There is a(n) **(increase/decrease)** of complaints made by an employee of one ethnic/racial group about an employee/patient of another group.
14) The organization attributes the positive changes to:
    a) Increased awareness/consciousness of differences **Yes No**
    b) Increased sensitivity to those who are different from themselves **Yes No**
    c) Improved ability to communicate across cultures **Yes No**
    d) Other (_____) **Yes No**
15) The organization attributes the negative changes to:
    a) Decreased awareness/consciousness of differences **Yes No**
    b) Decreased sensitivity to those who are different from themselves **Yes No**
    c) Lessened ability to communicate across cultures **Yes No**
    d) Other (_____) **Yes No**

2. Examination of Employee Attrition

Examine the figures for employee attrition. (Note: It is recommended that this be done, if possible, by department or classification by level of employee.)

a. Identify culturally diverse employees.

b. Compare the number of culturally diverse employees in each department or classification with the number of White Caucasian employees who left the organization.

c. Compare the above figures with the percent of minority (culturally diverse) employees currently employed by the organization. (Note: Use **Section #2, Checklist #2** to obtain these figures.)

d. There is a higher percentage rate of employee attrition for minority (culturally diverse) employees than for majority (White Caucasian) employees. **Yes No**

e. If the answer is yes, identify the cultural groups with the highest attrition and arrange separate focus groups with a number of these employees to try to determine what, if anything, in the organizational environment causes members of their cultural group to leave. Ask for their help in changing the situation.

3. Examination of Patient/Client Grievances

Examine the list of patient/client grievances from **the current year**.

a. How many complaints were filed by a culturally diverse patient/client about a White Caucasian employee? _____

b. How many complaints were filed by a culturally diverse patient/client about a culturally diverse employee from a culture different from the complainant? _____

c. How many complaints were filed by White Caucasian patient/client against a culturally diverse employee? _____

d. Identify reoccurring patterns in patient/client grievances using the above answers.

e. What particular cultural, racial or language group of patients lodge the greatest number of complaints? _____

f. What are the primary issues surrounding the majority of the complaints by this particular group?

_____

_____

g. Consult community leaders for suggestions of ways to avoid these grievances.

h. List three steps the organization will take during the coming year to prevent or lower the possibility of the occurrence of these grievances in the future. (Note:

Include these steps in the strategic plan for next year. Check at the end of the year to see whether the number of occurrences have been reduced or eliminated.)

1) _____

2) _____

3) _____

4. Examination of Patient Satisfaction Figures

Compare the patient satisfaction figures from this year with those from the previous year. Identify those figures relating to the satisfaction of patients from other cultures. These figures should have identified race, culture, religious and language preference. (Note: If patient satisfaction by population groups have not been tracked, of diverse groups prior to this year, compare the results of the totals for both years and then examine those from this year.)

a. Patient satisfaction has ____ improved _____ remained the same ____ declined

b. List in decreasing order, the average satisfaction quota for each of the population groups served by the organization.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

c. If there is a particular cultural, racial or language group of patients who seem the least satisfied with care or services that they have received, list them below.

_____

d. If there is a common pattern or cause in their lack of satisfaction, list it below.

_____

e. Ask for the advice of community leaders and devise a plan for improving patient satisfaction in area served by the institution.

f. List three steps the organization will take during the coming year to improve patient satisfaction in the future. (Note: Include these steps in the strategic plan for next year. Check at the end of this year to make sure that patients from this population group have indicated improved satisfaction in this area.)

1) _____

2) _____

3) _____

Section #9, Checklist #3: Examining and re-evaluating short and long-term goals

(Note: Refer to Section #3 of this guide to complete this checklist.)

1. How many of the items on the implementation plan were actually accomplished? _____

2. How many of the items on the implementation plan were not accomplished? _____

3. The goals set were realistic (i.e. length of time to accomplish each task, necessary manpower and budgetary costs) **Yes No**

4. List any *tasks* or *objectives* that were overlooked during the initial planning or only surfaced as issues during the implementation of other goals.

_____

_____

_____

5. Identify any tasks that showed themselves to be unnecessary, unreasonable or impossible to accomplish after implementation began.

_____

_____

_____

6. How far has the organization come in implementing CLAS? Use the table below to indicate which of the standards the institution is now in full compliance, which of the standards the institution is now in partial compliance (i.e. implementation is in progress) and which of the standards the institution is now in non-compliance (i.e. has not yet begun to implement).

Full Compliance	Partial Compliance	Non-compliance

7. How *important* or *necessary* have the issues surrounding CLAS become to the entire organization?

_____

8. Consult the diverse communities served. Ask them if they feel that the institution's efforts have improved its ability to serve them. Ask for suggestions to further improve upon the institution's accomplishments. List the suggestions below:

_____

_____

_____

9. List any revisions that present findings show might make the 5-year plan more realistic and fiscally sound.

_____

_____

_____

10. List any revisions that should be made to next year's plan.

_____

_____

_____

11. List any insights the institution has gained that may help it implement CLAS in a more timely and effective manner.

_____

_____

_____

Assessment and evaluation of the effectiveness of the guide

This final portion of the guide has been included to assist the organization evaluate the helpfulness of this guide. It is only through learning about the actual experiences of each organization attempting to follow the guide in its ongoing journey toward cultural and linguistic competence that the author of the guide can identify weaknesses and omissions and *continue to improve* the guide's usefulness. The job of providing guidance in each institution's individual journey toward cultural and linguistic competence is on-going. The author hopes to continue to improve the guide in order to meet not only present, but also future questions and needs. She can only do this effectively if each organization fills out this evaluation and email, mail or fax these completed checklists, along with questions and criticisms to either of the following:

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Name of person submitting this form: _____

Person's position or title: _____

Organization: _____

Address: _____

_____

Telephone: _____ Fax: _____ Email Address: _____

Number of person's employed by the organization: _____

Number of patients/beds: _____

Please list the primary populations served in order of size (largest group first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please inform the author of the guide about whether:

1. The institution began its journey towards cultural competence prior to the use of the guide. **Yes No**

2. The institution began its journey towards cultural competence with the use of the guide. **Yes No**

3. The institution followed *all* 9 sections of the guide in the same order as they were presented. **Yes No**

4. The institution utilized the entire guide but rearranged the order of implementation to suit institution's needs. **Yes No**

5. The institution followed only those sections of the guide that were most pertinent to itself. **Yes No**

6. List the sections in the order that the institution used them: _____

7. In the table below, please list the sections that the institution omitted and the reason why this section was omitted.

Section Omitted	Reason Omitted

8. In general, how would the institution evaluate the usefulness of this guide to its particular needs?

_____ Extremely useful _____ Very helpful

_____ Somewhat helpful _____ Not helpful

Please elaborate on the reasons for the above evaluation. (Note: The author values the institution's feedback in future efforts to improve this guide.)

_____

_____

_____

12. How would you rate the overall clarity of the guide?

(lowest) 1 □ 2 □ 3 □ 4 □ 5 □ (highest)

13. How would you rate the overall ease of use of the guide?

(lowest) 1 □ 2 □ 3 □ 4 □ 5 □ (highest)

14. What suggestions does the institution have for making the guide clearer and easier to use in the future?

_____

_____

_____

15. Please list recommendations of this guide (or of CLAS) that the institution was unable to implement due to budget restraints.

_____

_____

_____

Please feel free to comment upon why the organization found these recommendations expensive. What did the organization do instead of the guide's recommendations? How might these recommendations be altered to make them more cost-effective?

_____

_____

_____

16. Please list recommendations of this guide (or of CLAS) that the organization was unable to or unwilling to implement because of fear of possible legal repercussions. Please explain why the organization felt that they involved legal risk.

_____

_____

_____

17. What other steps can OMH take to assist the health care institution in implementing CLAS specifically and cultural and linguistic competence in general?

_____

_____

_____

15. If the organization has any questions or would like to request the assistance of the author of this guide in implementing CLAS please write them below and/or contact the author Suzanne Salimbene, Ph.D. (Note: See contact information at beginning of this survey.)