Rural Hospitals and Spanish Speaking Patients with Limited English Proficiency

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At the Heart of Public Health Policy

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Executive Summary

There are more than 40 million Latinos in the United States, 14.2% of the population. Many of these individuals have limited English proficiency (LEP), which can lead to poor health outcomes in the absence of effective medical interpretation or translation services.

Our study explored how rural hospitals are meeting the needs of LEP patients, reflecting the Federal standards for culturally and linguistically appropriate services (CLAS standards). We identified hospitals in two types of rural counties: those with substantial growth in the Latino population between the 1990 and 2000 Censuses, and counties with large and stable Latino populations. We contacted 319 rural hospitals, most of which had fewer than 100 beds (67.4%) and were located in counties with large, stable Hispanic populations (68.0%). About half (54.5%) were located near metropolitan areas, with potential competition from other larger hospitals.

Findings:

- Seventy-eight percent of hospitals reported having a written policy related to language assistance and 91.7% reported having tools for patients to communicate their language needs, yet only 40% reported language assistance advertisements in Spanish.

- While almost every hospital (98.7%) reported providing oral interpretation to Spanish-speaking patients, only 19.6% used staff interpreters or those employees whose primary workforce responsibility is interpretation. A large percentage of hospitals (85.6%) reported having documents or materials available in Spanish.

- Hospitals in counties with newly growing Hispanic populations were more likely to report "high" or "very high" demand for Spanish interpretation in the emergency department (ED), outpatient (OP), and inpatient (IP) than those in counties with stable Hispanic populations. Hospitals in high-growth counties were also more likely to report having tools for patients to communicate their language needs and documents or materials in Spanish.

- Rural hospitals adjacent to a metropolitan area were more likely to report "high or very high numbers" of visits by Hispanic patients in need of interpretation services in the ED, OP, and IP and the highest demand for Spanish interpretation was in the ED.

- Lack of state agency resources (65.6%) and the lack of hospital funding for interpretation or translation (65.3%) were most often noted as potential barriers to effective language assistance. Hospitals that voluntarily reported sample or model programs stressed the importance of training interpreters in-house or collaborating with colleges and universities that offer nationally recognized programs.

Chapter 1: Introduction

Increasing health care access for minorities whose primary language is not English requires an examination of the provision of culturally and linguistically appropriate health care. Studies indicate that for Hispanic Spanish-speaking populations, limited English proficiency (LEP) is a barrier to quality health care[1].

There were 40.4 million Latinos in the United States in 2004, an increase of 14% since 2000 (US Census Bureau, 2004, Pew Hispanic Center, 2005). The total US population increased only 13.2% between 1990 and 2000 while the Hispanic population increased by 57.9% (Pew Hispanic Center/Kaiser Family Foundation, 2002). The largest percentage increases in the Hispanic population occurred in the South, with increases as high as 394% in North Carolina, 211% in South Carolina, and 173% in Kentucky (US Census Bureau, 2001). The Hispanic population, the largest and fastest growing minority group representing an estimated 14.2% of the population, is projected to rise to 47.7 million by 2010 and 60.4 million by 2020 (US Census Bureau, 2004; Pew Hispanic Center, 2005).

The Census Bureau estimates that approximately 47 million people speak a language other than English at home (US Census Bureau, 2000). Furthermore, 40% of Hispanics in the United States reported speaking little or no English (Pew Hispanic Center/Kaiser Family Foundation, 2002). Latino patients are often the most unsatisfied with their care due to the lack of interpreter services and studies have shown that only half of LEP patients in need of an interpreter are provided one (Flores & Mendoza, 2002; Brown, Gerzoff, Karter, Gregg, Safford,

[1] The literature on Latino health has no consensus regarding the preferred term to use referring to persons of Latin American heritage who live in the United States. Both Hispanic and Latino are used extensively, although U.S. government documents, including the census, use the term Hispanic. Given this mixed usage in the literature, this report uses the terms Latino and Hispanic interchangeably.

Policy Relevance

Several steps have been taken to ensure that federally-financed services reach all populations in the United States. Congress passed Title VI of the Civil Rights Act of 1964 stating:

> "No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (US DOJ, 1964).

In *Lau v. Nichols*, the Supreme Court ruled that LEP discrimination constituted a violation of the national origin clause in Title VI of the Civil Rights Act and that reasonable measures were needed to ensure equal access for those with primary languages other than English (414 U.S. 563 1974). On August 11, 2000 President Clinton issued the executive order 13166 entitled: "Improving Access to Services for Persons with Limited English Proficiency" (65 Fed. Reg. 50121). After a process of public comment and input, the HHS Office of Minority Health issued the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) on December 22, 2000 (65 Fed. Reg. 80865).

There are 14 CLAS standards, related to three different topics: culturally competent care, language access services and organizational supports for cultural competence (Perkins, 2003). Four of the 14 standards are related specifically to language access, and organizations receiving federal funds are mandated to comply with these standards. The organizations may adopt the remaining ten standards voluntarily, as they are only recommendations or guidelines (Shaw-Taylor, 2002). Hospitals that are not in compliance with CLAS standards are subject to fines and can lose their federal funding (Schroeder, 2002). In addition, hospitals not in compliance face increased legal risks, such as class action lawsuits by LEP patients for not providing translation and interpretation services.

Research Objectives

The objectives of this study are to:

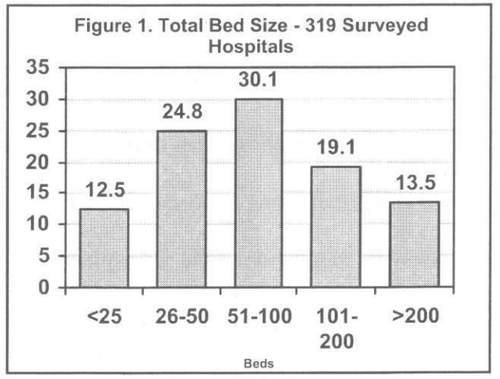
- Describe the institutional and environmental characteristics and conditions relevant to the provision of culturally and linguistically appropriate health care to LEP clients;
- Describe the areas where LEP patients receive care in rural hospitals by Hispanic growth and county location;
- Determine the extent to which rural hospitals have implemented language assistance programs;
- Compare the language assistance resources between hospitals located in counties with emergent (high Hispanic growth) or non-emergent Hispanic populations (large stable Hispanic population);
- Compare the language assistance resources between rural hospitals located in counties adjacent and those non-adjacent to metropolitan areas;
- Ascertain the factors (strengths and barriers) associated with the provision of language assistance to Hispanic clients;
- Identify sample programs in rural hospitals being used to facilitate the provision of linguistically and culturally competent health care to Hispanic clients;
- Describe the approaches that rural hospitals perceive to be most effective for the provision of linguistically and culturally competent health care to Hispanic clients.

Information on rural hospitals was collected using a mailed survey. Appendices provide (A) a detailed description of the methods, (B) the designed survey instrument used in the study, (C) detailed tables, (D) sample local programs, (E) a list of CLAS standards, and (F) a list of Joint

Chapter 2: Results

Characteristics of Responding Hospitals

We surveyed 841 rural hospitals, of which 319 (37.9%) responded after three mailings. The majority of responding hospitals (67%) have 100 beds or less (Figure 1) and about a third of the surveyed hospitals have more than 100 beds. Nearly all hospitals (92%) have emergency departments (Table C-2, Appendix C) and two thirds reported having hospital-based outpatient services. Seventy-two percent of the surveyed hospitals offer obstetric services and about 60% offer "uncomplicated" obstetric level of care. About two thirds (67%) of hospitals offer hospital-based outpatient services.



County Level Demographic Information

About half (52%) of responding hospitals were located in rural counties with urban populations between 2,500 and 19,999 and about half (55%) were located adjacent to a metropolitan area. Two of every five responding hospitals (40%) were the only hospital in the county, while approximately half (50%) were located in counties with two to three total hospitals and (10%) were located in counties with more than three hospitals. About a third of the hospitals (32%) were in counties with substantial Hispanic population growth between 1990 and 2000. According to the 2000 Census, the mean percent population in poverty in counties where the respondent hospitals were located, was about 13% (Table C-1, Appendix C).

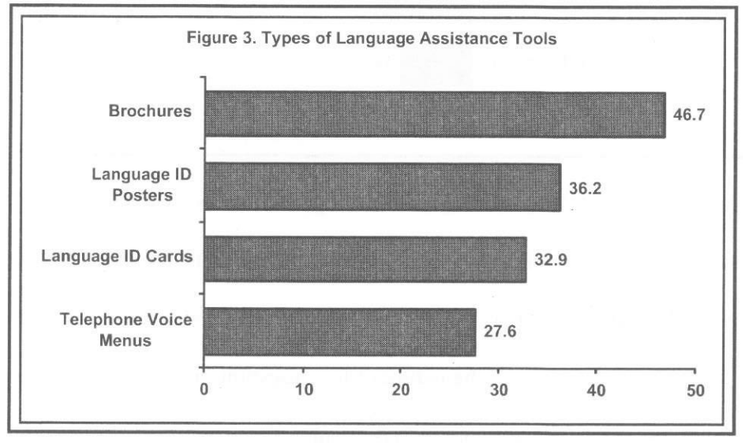
significantly ($p<0.05$) higher proportions of "high or very high" demand for Spanish interpretation than those in hospitals located in counties with stable Hispanic populations.

Table 1. Demand for Spanish Interpretation in the Emergency Department (ED), Outpatient Department (OP), and Inpatient Area (IP)

	ED		OP		IP	
	No.	%	No.	%	No.	%
High/Very High	111	50.3	73	33.2	64	28.2
Low	72	32.6	101	45.9	117	51.5
Almost never	35	15.8	42	19.1	42	18.5

Implementation of Language Assistance Programs

Virtually all hospitals have tools for their patients to communicate their language needs to the hospital's staff (91.7%;). The most commonly used tools by hospitals were brochures, posters, cards and telephone voice menus (Figure 3)



Note: Numbers add to more than 100% because the categories are not mutually exclusive

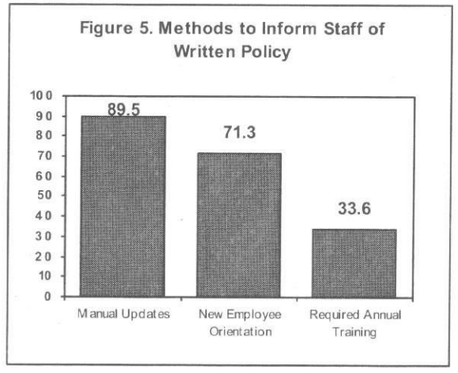
Almost every hospital reported providing oral interpretation to Spanish-speaking patients (98.7%). The most commonly used resources by hospitals to provide oral interpretation are bilingual employees whose primary role is not interpretation, telephone interpreter lines and

Language Assistance Services by Hispanic Growth and County Location

Compared to hospitals located in counties with stable Hispanic populations, a significantly ($p<0.05$) higher percentage of hospitals located in counties with high-growth populations reported having tools for patients to communicate their language needs and documents or materials in Spanish (Table C-6, Appendix C). Hospitals adjacent to metro areas reported a slightly higher percentage of documents and materials in Spanish compared to those not adjacent to metropolitan areas (Table C-6, Appendix C), but the difference was not statistically significant ($p<0.05$).

Hospital Policies

Seventy-eight percent of hospitals reported having a written policy related to language assistance. The majority informed the staff about the policy through policy and manual updates and during new employee orientation (Figure 5, right). The categories are not mutually exclusive because hospitals can employ more than one method of informing staff about language assistance. The vast majority of hospitals reported having the policy in place for more than 2 years (86.9%). Half (50.0%) responded that the Federal Guidelines were useful in writing that policy, while a quarter (25.2%) indicated the guidelines were not helpful and the remainder indicated either that Federal guidelines did not apply in their case or that they did not know. Those



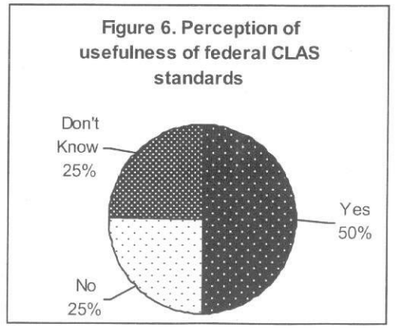


Table 2. Top 5 Strengths and Barriers for Providing Language Assistance to Spanish Speaking Patients

Rank	Strength	No.	%
1	Institutional Support	252	94.0
2	Access to telephone interpreter lines	237	89.1
3	Staff willingness to use interpreter	243	86.5
4	Quality of telephone interpreter lines	198	85.0
5	Bilingual staff	206	72.8
	Barrier		
1	State agency resources (e.g. Health Department)	103	65.6
2	Funding for interpretation or translation	141	65.3
3	Local language training programs	110	59.1
4	Access to bilingual volunteers	106	44.5
5	Interpreter response time	70	27.6

The top five strengths reported by hospitals included: institutional support (94%) for their language programs, access to telephone interpreter lines (89.1%), staff willingness to use interpreters to serve Spanish-speaking patients (86.5%), quality of telephone interpreter lines (85%) and bilingual staff (72.8%; Table 2).

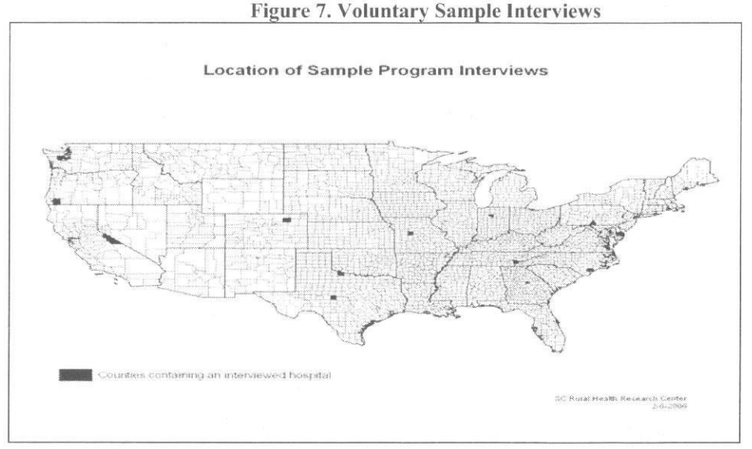
The rankings in Table C-12 (Appendix C) show that among hospitals in counties with high Hispanic growth, bilingual staff is not listed but "interpreter response time" appears among the top five strengths. Conversely, in hospitals located in counties with non-emergent Hispanic population, the interpreter response time is not among the top five strengths reported. Note that these non-emergent hospitals ranked higher quality of interpreter lines. The quality of telephone interpreter lines was not highly ranked as a strength among hospitals adjacent to metropolitan areas (Table C-13, Appendix C).

Chapter 3: Sample LEP Programs

Beyond the survey: looking for local approaches

There are variations among the approaches used by rural hospitals in providing linguistically and culturally competent health care for LEP patients in their communities. A follow-up interview was conducted with voluntary hospital representatives to capture the variety of programs being used. We asked if their individual hospitals had sample programs for interpreter services that could be shared with others. This follow-up interview was not intended as scientific qualitative research, rather as an investigative tool to elicit practical information for hospital administrators of rural hospitals in various states (Figure 7).

Figure 7. Voluntary Sample Interviews



We contacted thirteen hospitals that have, or were in the process of creating, a language assistance program for LEP clients. Hospitals in rural areas of Texas, Pennsylvania, Georgia,

diversity in its hiring practices. It was noted that her hospital displays flags representing all the nationalities and states of those on staff. The display was a symbol of the organization's commitment to diversity and cultural sensitivity.

The theme of the financial viability and cost-effectiveness of language assistance programs in resource limited environments emerged from the interviews. The respondents detailed the business case behind employing traditional solutions such as hiring interpreters in-house or using telephone language lines and outside contractors. A Washington hospital currently budgets approximately $85,000 annually for interpretation services. The hospital representative mentioned the hospital is small and has only had 24/7 interpreter service for three years. Small rural hospitals, often with less financial resources than other institutions, could face financial difficulties in their attempts to provide language assistance. Other respondents mentioned the cost of telephone language lines and that these services can potentially become a drain on the available resources. Some hospitals spend $70 to $2000 each month on the phone line. A Missouri hospital tallies the expenses of the language line, an estimated $1000-$2000 each month, separately from the interpreter services to monitor the usage of the line by individual departments. An Oregon hospital is currently hiring for in-house interpretation services due to expensive interpreter contracts which can cost $15,000-$18,000 each month.

Unencumbered access to Spanish interpreters was another theme to emerge from the key informant interviews. All hospitals have created systems to provide interpretation services 24/7. Some have full-time interpreters during the day and call lists during the nights and holidays. Language interpretation telephone lines are widely used but the majority of hospitals use them during the night, holidays or in case of emergency when the interpreter is not readily available. Interpreters in at least three hospitals said they lived close by and they did not have a problem

Hispanic Center in partnership with the hospital. Task force members worked with ministers in the community creating a cultural diversity kit that hospital employees can use with LEP patients. Other hospitals offer cultural sensitivity training to their employees and inform the Hispanic community about their employees trained in culturally appropriate techniques.

The local approaches to the provision of linguistically and culturally competent health care for LEP Spanish-speaking patients were varied. A regional pattern regarding the provision of such care was not observed. The hospitals did have commonalities, such as full-time staff interpreters, interpreter training and efforts to develop culturally competent staff familiar with linguistically appropriate care. The lack of regional specificity highlights the generalization of such programs to most rural hospitals with a significant LEP Spanish-speaking population.

Chapter 4: Conclusions and Practical Implications

Summary of Findings

Rural hospitals in the United States are adopting a variety of measures to serve the LEP Hispanic/Latino population. Although virtually all hospitals surveyed have tools for patients to communicate their language needs to the hospital's staff through hospital brochures, language identification posters, language identification cards or telephone voice menus, less than 40% have notices in Spanish about free language assistance. The remaining respondents have such notices in English or none at all. About three fourths of the hospitals reported having a written policy related to language assistance. The staff learns about the policy through policy and manual updates and during new employee orientation. This suggests that rural hospitals across the nation have made a commitment to language assistance programs despite differences in bed size, resources and the size of the Hispanic population in various counties.

Findings on Existence of Language Assistance Programs

Almost every hospital reported providing oral interpretation to Spanish-speaking patients. A large percentage of the surveyed hospitals are using bilingual employees, whose primary role is not interpretation, or telephone interpreter lines. Friends or family also interpret for patients; however, some of the hospitals mentioned that the use of family and friends as interpreters was the patients' choice, not the hospital's preference. Hospital administrators should be aware of the potential HIPAA violations of family and friends interpreting private health information. Another potential patient safety issue is the filtered transmission of information from the patient to health care provider via an interpreter. Also at issue is the problem of potential filtering of information by informal interpreters who might selectively decide which information is pertinent

services in the ED, OP, and IP than rural hospitals in counties not adjacent to a metropolitan area.

Strengths and Barriers to the Provision of Language Assistance Programs

The main strengths hospitals reported to be related to the provision of language assistance to Spanish speaking patients were, in decreasing order, institutional support, access to telephone interpreter lines, staff willingness to use an interpreter, quality of telephone interpreter lines and access to bilingual staff. About two thirds of the hospitals said that the most significant barriers to language interpretation for Latinos were the lack of state agency resources and the lack of hospital funding for interpretation or translation. Other barriers mentioned were the lack of local training programs and access to bilingual volunteers. Interpreter response time was a barrier for the provision of language assistance among a third of the hospitals.

Local Approaches to the Provision of Language Assistance Programs

Hospitals that voluntarily reported sample or model programs stressed the importance of training interpreters in-house or in colleges that offer nationally recognized programs. Partnerships with local colleges, agencies, and others are critical to the provision of high quality interpretation services. Several hospitals that have interpreters in-house are also developing outreach programs for Hispanics and training hospital staff on the best use of interpreters. The sample programs provide valuable information regarding the characteristics of successful language assistance programs and the adaptability to other areas.

The findings of this study validate previous recommendations for hospital interpreter services. The Language Task Force of Universal Health Care Action Network of Ohio has provided such recommendations in a blueprint for success. Their twelve recommendations are supported by the study findings and can be generally applied by hospital administrators. In an

the researchers to the participants with an earnest plea to complete the survey with the third and final mailing. This prompted the highest response rate of all the mailings.

The design of the survey also limits the responses of the participants to the demand for language assistance services and the types of services available. In an effort to gain as much information as possible, the survey was followed up by interviews with voluntary participants. While providing valuable qualitative data, this interview was not designed as a structural qualitative research instrument.

Practice Implications

Studies have indicated that Spanish-speaking LEP patients are most unsatisfied with their care and often experience poor outcomes when not able to access health care in a linguistically appropriate way; furthermore, when federally mandated linguistically appropriate care is provided, these outcomes often improve (Brown, et al., 2003; Wilson, et al., 2005). This study shows that rural hospitals with LEP Spanish-speaking patients are aware of the need for linguistically appropriate care and these hospitals have taken appropriate measures to improve the access to care for those patients.

Patient Safety and CLAS Compliance: Accreditation

Prior research indicates that the lack of linguistically appropriate care has been linked to negative health outcomes (Wilson, et al, 2005). Adherence to the CLAS standards is more than a regulatory exercise, but also a critical patient safety concern. Hospital administrators should implement or improve policies conducive to the CLAS standards in an effort to provide the best quality care for LEP patients and as a good business practice to prevent potential Title VI and HIPAA infractions.

A potential gap in the health care system could lie with rural hospitals who are not JCAHO accredited. One solution may be to have state hospital associations serve as a resource to unaccredited rural hospitals. In addition, the CLAS standards and JCAHO standards are available publicly and can be used to create language assistance programs. The CLAS mandates, JCAHO standards and the UHCAN Ohio blueprint provide a more than adequate basis for hospital administrators to create, implement and evaluate language assistance programs in rural hospitals.

Staffing and Development Issues

Hospital administrators in emergent Hispanic population counties should actively recruit quality medical interpreters; especially departments with high/very high demand, such as the emergency department. In hospitals with limited resources, the human resources department should actively recruit bilingual applicants for relevant job openings.

The hospitals in our study depend heavily on bilingual employees to meet the high or very high demand of Spanish interpretation in rural Hispanic emergent counties. Local institutions and administrators should consider recruiting and training bilingual and culturally competent health providers to work in rural counties with a high Hispanic population. The existence of a diverse workforce could positively impact the health of minority patients in an effort to reduce health disparities.

Hospitals administrators should also create a position for a supervisor of interpreter services. Hospitals using in-house or contracted interpreters should have an effective method for monitoring and evaluating the interpreting staff. Hospitals using bilingual employees should clearly articulate in the language assistance policy any additional compensation for those bilingual employees fulfilling dual roles. The interpreter coordinator or Human Resources

Areas for Future Research

Given that a large number of rural hospitals are using bilingual employees whose primary role is not interpretation, further research is needed to evaluate the quality of their interpretation services. The research should focus on the correlation, if any, between untrained interpreter quality and the primary workforce role (clerical, front desk staff) and quality of care.

Some studies have suggested that the lack of language assistance programs in hospitals leads to unnecessary clinical tests and complications (Wilson, et al, 2005; Manson, 1996). Further research should perform costs analyses of language line interpretation programs and patient outcomes to determine the cost of unnecessary services to LEP patients. A study of geographic variation could also provide information on a correlation, if any, between health disparities witnessed in rural and urban LEP patients dependent on the type of language assistance available to them.

Appendix A: Methods

Design and Procedure

We conducted a cross sectional study using a survey mailed to rural hospital administrators in the United States. The survey was developed based on the Federal standards for culturally and linguistically appropriate services. It was reviewed by experts (researchers and staff from the Office of Rural Health) and then pre-tested among several hospital administrators resulting in the final survey instrument (Appendix B).

The survey procedure was conducted using three mail-outs: an initial mailing on May 6, 2005, followed by a second mailing four weeks later and a final mailing three weeks after the second. A reminder postcard was also mailed four days after the final mailing. Each of the three survey mailings included the single-page survey instrument accompanied by a cover letter and a self-addressed envelope with prepaid postage. Also contained within the cover letter were instructions on how participants who chose to do so could complete the survey instrument online using an internet-hosted survey form, utilizing a private URL and a unique user identification code supplied within the cover letter. The final reminder postcard also contained this information. Secondary data pertaining to county characteristics used in sample selection and analyses came from the 2003 Area Resource File. Information about hospital characteristics, beyond that obtained by the survey, was drawn from the 2000 American Hospital Association Annual Survey Database.

Returned surveys were coded and entered into a database using EpiData with appropriate check fields and entry skip patterns to ensure proper data entry. Comment fields were also recorded and coded, with content reduction performed at a later date. After the conclusion of the data entry phase, every tenth completed print survey was selected for validation by checking the

After counties had been selected, we identified all hospitals in those counties using the 2000 AHA Annual Survey. All hospitals operated by the Federal government were excluded from the sample, including military hospital facilities. The sample of hospitals in the initial mailing contained 856 facilities.

Each survey mailing was addressed to the hospital administrator for each hospital in the sample as identified in the 2000 AHA Annual Survey file. In cases where mailings were returned by the postal service for any reason (insufficient address, no proper receptacle, person not known, etc.), a corrected name or address was sought using the 2005 AHA Hospital Guide or other online resources. If a correction was found, subsequent mailings were sent to the corrected name and address. If a hospital was positively identified as closed, it was removed from both subsequent mailings and the sample. Also, if mailed material addressed to any single hospital was returned on every mailing, the hospital was removed from the sample. Hospitals for which address information was initially incorrect, but for which correct information was obtained, were retained in the survey. Finally, one former hospital facility was removed from the sample upon confirmation that they were currently operating as an assisted-living facility. The table below shows the response rate for each mailing and the total response rate of 319 hospitals.

Response by Mailing Period

Mailout #	*Surveys Received by Completion Method*		*# Surveys Mailed*	*Mailout Response Rate*
1	*Print*	93		
	Online	23		
			841	13.8%
2	*Print*	47		
	Online	13		
			725	8.3%
3	*Print*	131		
	Online	12		
			665	21.5%

Final Response Rate = 37.9%

Results of the interviews were analyzed using qualitative analysis of the primary themes. The themes were (a) organizational structure/policy development, (b) financial viability, (c) access to interpreters for LEP patients, (d) interpreter training, and (e) community involvement.

Appendix B: Survey

Please circle the answer that best describes your hospital.

Demand for Services

1. On average, how many Spanish-speaking patients needing language assistance do you serve each month (all services, all departments)?

a. Less than 100 b. 100 – 999 c. 1,000 – 2,999 d. 3,000 or more

2. What is the demand for Spanish interpretation services in your hospital's:

	Very high	High	Low	Almost Never	Don't know
Emergency Department	4	3	2	1	DK
Outpatient Department	4	3	2	1	DK
Inpatient Area	4	3	2	1	DK

Services Available

3. What tools do you have that help Spanish-speaking patients communicate their language needs? *(Circle all that apply).*

a. We don't have any tools
b. Language identification cards
c. Hospital brochures
d. Language identification posters
e. Telephone voice menus
f. Other, specify:_____

4. Does your hospital provide oral interpretation for Spanish-speaking patients?
[ ] No [ ] Yes *(if Yes, please circle all the ways you provide oral interpretation):*

a. Contracted interpreters
b. Employee interpreters whose primary role is interpretation
c. Bilingual employees whose primary role is not interpretation (i.e. nurses, administrative assistants, housekeeping staff)
d. Volunteer community interpreters or community based organizations
e. Friends or family
f. Telephone interpreter services
g. Other, specify:_____

5. Does your hospital have documents or materials available in Spanish?
[ ] No [ ] Yes *(if Yes, please circle all the materials available in Spanish):*

a. Intake forms
b. Complaint forms
c. Consent forms
d. Eligibility forms
f. Health education materials
g. Notices about free language assistance
h. Applications to participate in a program or activity
i. Other. _____
e. Patients bill of rights

6. Does your hospital have a written policy regarding language assistance?

a. No If no, please skip to Question 10
b. Yes Please answer Questions 7 through 11

7. How does your hospital inform staff of the hospital's written policy? (Circle all that apply)

a. New employee orientation
b. Policy and procedure manual updates
c. Required annual training
d. Other. Specify _____

8. How long has your written policy regarding language assistance been in place?

a. less than 2 years b. 2 to 4 years c. More than 4 years

9. Were the Federal guidelines for Limited English Proficiency (LEP) patients helpful in writing your policy?

a. No b. Yes c. Does not apply

10. For each of the issues below, please circle if it is a strength or barrier for providing language assistance to your Spanish-speaking patients at your hospital.

a. Institutional support	Strength	Barrier	Does Not Apply
b. Funding for interpretation or translation	Strength	Barrier	Does Not Apply
c. Bilingual staff	Strength	Barrier	Does Not Apply
d. Access to bilingual volunteers	Strength	Barrier	Does Not Apply
e. Access to telephone interpreter lines	Strength	Barrier	Does Not Apply
f. Quality of telephone interpreter lines	Strength	Barrier	Does Not Apply
g. Local language training programs	Strength	Barrier	Does Not Apply
h. State agencies' resources (e.g., Health Dept.)	Strength	Barrier	Does Not Apply
i. Staff willingness to use interpreter	Strength	Barrier	Does Not Apply
j. Interpreter response time	Strength	Barrier	Does Not Apply

11. Please add any additional comments you believe will be of interest regarding translation or interpretation services for Spanish-speaking patients at rural hospitals

_____
_____
_____
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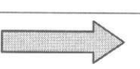

Appendix C: Detailed Tables

Study Sample Counties:
Rural Counties with >200% increase in Hispanic population (1990-2000), base Hispanic population of 300+, and at least 1 hospital

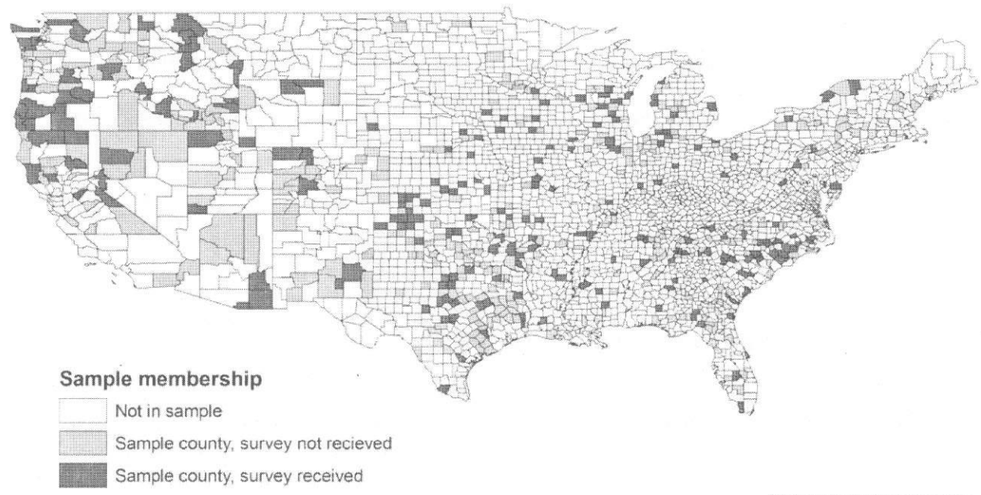

Table C-2. Characteristics of Sampled, Responding, and Non-responding Hospitals

	Original Sample		Responding Hospitals		P value
Characteristic	No.	%	No.	%	
Type of Services					
ED					0.7087
Yes	667	91.62	265	92.3	
No	61	8.38	22	7.7	
OB					0.9675
Yes	526	72.25	207	72.1	
No	202	27.75	80	27.9	
OB Level of Care					0.9215
Uncomplicated	296	60.41	123	61.5	
All Uncomplicated & Most Complicated	169	34.49	66	33.0	
Serious Illnesses & Abnormalities	25	5.10	11	5.5	
Free Standing OP Center					0.3046
Yes	134	18.41	45	15.7	
No	594	81.59	242	84.3	
Hospital-Based OP					0.7840
Yes	483	66.35	193	67.3	
No	245	33.65	94	32.7	
OP Surgery					0.7906
Yes	651	10.58	255	88.9	
No	77	89.42	32	11.1	

[1] 32 observations missing from the AHA Survey

Table C-4. Number of Spanish-Speaking Patients Served per Month - All Services, All Departments by Hispanic Growth

			High Growth Counties		Stable Population Counties	
	All Hospitals					
Number of Spanish-speaking Patients Served per month	No.	%	No.	%	No.	%
Less than 100	156	69.6	112	77.2	44	55.7
100 – 999	66	29.5	32	22.1	34	43.4
1,000 or more	2	0.9	1	0.7	1	1.3
Total	319	100.0	145	100	79	100

Chi-square (High vs. Stable Population), P=0.0036.
Fisher's Exact Test (High vs. Stable Population), p = 0.0015.

Table C-5. Demand for Spanish Interpretation by Department, by Hispanic Growth and County Location

	Total	**Population Change**		**Location**	
	all responding hospitals	**Rapidly growing Hispanic Population**	**Stable Hispanic Population**	**Adjacent to a Metro Area**	**Not Adjacent to a Metro Area**
Emergency Department	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
High/Very High	111 (50.92)	55 (70.5)	56 (40.0)	65 (50.8)	46 (49.5)
Low	72 (33.03)	18 (23.1)	54 (38.6)	43 (33.6)	29 (31.2)
Almost Never	35 (16.06)	5 (6.4)	30 (21.4)	18 (14.1)	17 (18.3)
Total	218 (100.00)	78 (100)	140 (100)	128 (100)	93 (100)
Outpatient Services					
High/Very High	73 (33.80)	41 (51.9)	32 (23.4)	39 (30.7)	34 (36.6)
Low	42 (19.44)	31 (39.2)	70 (51.1)	64 (50.4)	37 (39.8)
Almost Never	101 (46.76)	7 (8.9)	35 (25.5)	22 (17.3)	20 (21.5)
Total	216 (100.00)	79 (100)	137 (100)	127 (100)	93 (100)
Inpatient Services					
High/Very High	64 (28.70)	35 (43.8)	29 (20.3)	35 (26.7)	29 (30.2)
Low	42 (18.83)	36 (45.0)	81 (56.6)	73 (55.7)	44 (45.8)
Almost Never	117 (52.47)	9 (11.3)	33 (23.1)	21 (16.0)	21 (21.9)
Total	223 (100.00)	80 (100)	143(100)	80 (100)	96 (100)

Chi-square (Emergency Department: High vs. Stable), p<.0001.
Chi-square (Outpatient Services: High vs. Stable), p<.0001.
Chi-square (Inpatient Services: High vs. Stable), p=.0006.

Table C-8. Ways Hospitals Provide Oral Interpretation by Hispanic Growth and County Location

	Total	Population Change		Location	
	All Responding Hospitals (n=224)	Rapidly growing Hispanic Population (n=79)	Stable Hispanic Population (n=145)	Adjacent to a Metro Area (n=126)	Not Adjacent to a Metro Area (n=98)
Contracted interpreters	61 (27.2)	23 (29.1)	38 (26.2)	36 (28.6)	25 (25.5)
Employee interpreters (primary role)	44 (19.6)	26 (32.9)	18 (12.4)	27 (21.4)	17 (17.4)
Bilingual employees (not primarily interpreters)	177 (79.0)	57 (72.2)	120 (82.8)	102 (81.0)	75 (76.5)
Volunteer community interpreters	85 (38.0)	34 (43.0)	52 (35.2)	46 (36.5)	39 (39.8)
Friends or family	107 (47.8)	40 (50.6)	67 (46.2)	60 (47.6)	47 (48.0)
Telephone interpreter services	154 (68.8)	61 (77.2)	93 (64.1)	91 (72.2)	63 (64.3)
Other	8 (3.8)	3 (3.8)	5 (3.5)	8 (6.4)	0 (0.0)

Chi-square (Has Employee Primary-Role Interpreters: High vs. Stable), p=.0002.
Chi-square (Has Telephone Interpreter Services: High vs. Stable), p=.0436.
Chi-square (Has Other Interpretation Services: Adjacent vs. Non-adjacent), p=.0111.

Table C-9. Documents/Materials Available in Spanish by Hispanic Growth and County Location

	Total	Population Change		Location	
	All responding hospitals (n=196)	Rapidly growing Hispanic Population (n=76)	Stable Hispanic Population (n=120)	Adjacent to a Metro Area (n=114)	Not Adjacent to a Metro Area (n=82)
Intake forms	90 (45.9)	39 (51.3)	51 (42.5)	50 (43.9)	40 (48.8)
Complaint forms	54 (17.6)	25 (32.9)	29 (24.2)	25 (21.9)	29 (35.4)
Consent forms	142 (72.5)	57 (75.0)	85 (70.8)	83 (72.8)	59 (72.0)
Eligibility forms	63 (32.1)	29 (38.1)	34 (28.3)	36 (31.6)	27 (32.9)
Health education materials	141 (71.9)	59 (77.6)	82 (68.3)	84 (73.7)	57 (69.5)
Notices about free language assistance	76 (38.8)	26 (34.2)	50 (41.7)	43 (37.7)	33 (40.2)
Applications for programs or activities	46 (23.5)	19 (25.0)	27 (22.5)	31 (27.2)	15 (18.3)
Patient's bill of rights	159 (81.1)	64 (84.2)	95 (79.1)	87 (76.3)	72 (87.8)
Other	26 (13.3)	14 (18.4)	12 (10.0)	18 (15.8)	8 (9.8)

Chi-square (Has Complaint Forms in Spanish: Adjacent vs. Non-adjacent), p=.0378.
Chi-square (Has Patient's Bill of Rights in Spanish: Adjacent vs. Non-adjacent), p=.0426.

Table C-12. Top 5 Strengths and Barriers for Providing Language Assistance to Spanish Speaking Patients by Hispanic Growth

	Emergent Hispanic Population	Non-emergent Hispanic Population
Category	Rank (%)	Rank
Strengths		
Institutional support	1 (94.4)	1 (93.8)
Access to telephone interpreter lines	2 (90.0)	3 (88.6)
Staff willingness to use interpreters	3 (84.1)	4 (87.6)
Quality of telephone interpreter lines	4 (77.4)	2 (89.3)
Interpreter response time	5 (68.2)	-
Bilingual staff	-	5 (77.0)
Barriers		
State agencies resources (e.g. Hlth Dept)	1 (66.1)	2 (65.3)
Funding for interpretation/translation	2 (63.3)	1 (66.4)
Local language training programs	3 (53.4)	3 (62.8)
Access to bilingual volunteers	4 (44.6)	4 (44.5)
Bilingual staff	5 (35.9)	-
Interpreter response time	-	5 (25.3)

Table C-13. Top 5 Strengths and Barriers for Providing Language Assistance to Spanish Speaking Patients Hospital Adjacency to Metropolitan Areas

	Adjacent to a Metro Area	Not Adjacent to a Metro Area
Category	Rank (%)	Rank (%)
Strengths		
Institutional support	1 (95.3)	1 (92.5)
Access to telephone interpreter lines	2 (90.7)	3 (87.0)
Staff willingness to use interpreters	3 (84.0)	2 (89.6)
Interpreter response time	4 (73.7)	-
Bilingual staff	5 (72.0)	5 (72.0)
Quality of telephone interpreter lines	-	4 (82.2)
Barriers		
State agencies resources (e.g. Hlth Dept)	1 (71.6)	3 (58.0)
Funding for interpretation/translation	2 (66.9)	1 (63.2)
Local language training programs	3 (57.7)	2 (61.0)
Access to bilingual volunteers	4 (41.2)	4 (48.6)
Bilingual staff	5 (28.0)	-
Interpreter response time	-	5 (29.1)

Appendix D: Sample Programs

Colorado Plains Medical Center: Committee and Staff Volunteer

Hospital Contact and Information:
Alida C. Patiño
Staff Accountant / Interpreter
Colorado Plains Medical Center
1000 Lincoln Street
Fort Morgan, CO 80701
Tel: 970 542 3358
Fax: 970 542 3315
e-mail: alida_Patino@prhc.net

Hospital Responsibilities:
Alida Patiño is the chair of the LEP committee. The committee holds quarterly meetings. She also meets with interpreters to discuss the problems they have encountered in their interpretation. She mentioned that not all Spanish speakers are suitable for interpretation because they are not proficient enough in English.

Alida is a certified medical interpreter. She attended the 40 hour "Bridging the Gap" medical interpretation training at the Spring Institute in Denver, Colorado. Alida and her husband are putting together a plan for on-site Spanish classes for clinical personnel only.

Alida lives 5 minutes from the hospital and she is on call after hours. This is a volunteer activity and she does not receive compensation for this extra work. She is happy to do that because she empathizes with the feelings of immigrant people in her state. She comes from Europe and knows how it feels to be an immigrant.

Hospital Policy:

Mammoth Hospital
Mammoth Lakes, CA 93546
Policy on Interpreter Services

PURPOSE:
It is the purpose of Mammoth Hospital to ensure adequate and speedy communication between LEP (LEP) patients (and their appropriate family members) and hospital staff in order to provide quality health care services. LEP individuals are those who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

Mammoth Hospital shall maintain compliance with State and Federal legislation and accrediting agency guidelines pertaining to interpreter services, and shall have an established mechanism to provide interpreter services to patients with language or communication barriers. A language or communication barrier results from speaking different languages or visual languages.

POLICY:

- Signage relating to interpreter services shall be posted throughout Mammoth Hospital and the Sierra Park Clinics. The signage shall include:
  - Notification that interpreter services are available upon request.
  - List of languages for which interpreter services are available.
  - How to obtain an interpreter.
  - Internal and State department numbers where complaints may be filed concerning interpreter service problems including Telecommunications Device for the Deaf (TDD) or Teletypewriter (TTY) – see policy on Communicating with the Hearing-impaired Patient.
  - Local address and telephone number to the Licensing and Certification Division of the State Department.
- An interpreter will be provided if the patient indicates the need for an interpreter, or if a health care professional determines that an interpreter is necessary.
- Hospital Staff shall identify the language needed for a client who requests interpreter services by using the Language Indicator Card, the desk-top posters, or the "I Speak Card."
- Dual-role and full-time dedicated site interpreters (see criteria below) within the department should be utilized first. If the department is unable to provide language coverage, contact the Interpreter Services Supervisor, Monday – Friday 0800 – 1600, by calling extension 2640, by paging overhead or by calling 1-877-209-4708 (pager). For interpreter services coverage 24 hours/7 days a week, see Outlook's "Interpreter Services Calendar" for contact information. ***All dual-role and full-time interpreters will be identified with an ORANGE ID badge.***
- If an interpreter is unavailable, contact Language Line Services for assistance – see Language Line Services guidelines attached or access on the hospital Intranet system.
- To provide continuity of care, the patient's primary language and/ or dialect (other than English) shall be recorded in the patient's medical record and the Dairyland Healthcare Solutions System.
- The name of the interpreter providing interpretive services must be documented in the patient's medical record.
- If a LEP patient refuses Mammoth Hospital interpreter assistance, he/she must sign a waiver releasing Mammoth Hospital from interpreter responsibilities.

Mammoth Hospital Interpreter Program Criteria

A) Bilingual Ambassadors - bilingual staff are our Hispanic ambassadors for the hospital. They provide direct service; they do not provide interpretive services. Bilingual staff are our points-of-contact for the Hispanic patients until an interpreter is called. They assist with scheduling appointments, talk with family members, help comfort patients, and direct

Memorial Hospital: Documenting the Business Case

Hospital Contact and Information:
Brian T. Shockney, MHA, CHE
President & CEO
Memorial Hospital
Logansport, IN 46947
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Fax: 574-753-1402
bshockney@mhlogan.org

Responsibilities:

Mr. Shockney was appointed by the governor to represent the health sector on the state commission for interpreters and translators. The goal of the commission is to educate providers and legislators on the importance of adequate interpretation and create a certification program in Indiana. This will be a program similar to "Bridging the Gap" where people get certified before they start their work as medical interpreters. There was a bill before the Indiana General Assembly in 2005 to make the Commission's recommendations law. However, a budget battle in the Indiana General Assembly killed this bill and many others. The Commission's hope is to see legislative approval in Indiana in January 2006.

Hospital Background:

The hospital is located in a rural county where Tyson established a plant and created 1,200 jobs that are being filled by Hispanics mainly. The hospital started to prepare for that large influx of Spanish speaking population. Mr. Shockney met with staff in other hospitals from other states where they have had the same experience. A community task force called Diversity Dynamics was created to help assure successful assimilation of the new residents to the community. The task force created plans to include how they were going to embrace the new community and how their needs would be met. The hospital's mission is to ensure that every citizen receives access to quality care regardless of race, nationality, color, or creed, economic, or social status.

The hospital began with a language telephone line but discussed that this tool was not appropriate because it was impersonal and they could not verify the credentials of the interpreter. Therefore, they hired a full-time interpreter and then another one. They also started several activities:

- Medical Spanish classes to physicians
- Diversity trainings
- Partnered with a school to do health screenings. A Pediatric clinic in a school that has the largest growth of Hispanic population
- Worked with a pastor in local Latino congregation
- Created a scholarship program to pay for bilingual persons to study nursing (addressing the health professionals shortage areas)
- Started bilingual billing
- Childbirth classes

        - No only alleviated the liability, availability, quality, and communication issues, but provided less anxiety for the providers and staff when caring for non-English speaking patients.
    - Developed Policies & Procedures to Ensure Qualifications
    - Added Second Full-time Interpreter
    - Partners In Education with Columbia Elementary
        - School activities with students, families, and faculty
        - Tours of hospital to promote health and health careers
    - Pediatric Clinic in Columbia Elementary
        - Health is the key to classroom learning
        - Connecting kids with community resources (programs and services such as Medicaid, clinic, medicine, etc.)
        - Education to students and parents regarding the U.S. health system and linking with a primary care provider
    - Link with local Latino Congregations
        - Health scholarship program for identified health care worker shortage areas
        - Linking patients with providers
        - Facilitating care delivery (surgeries, medicine, etc.)
- Statistical Progress
    - In 2004 Memorial Hospital spent $67,632 to employ two full-time interpreters including benefits, educational assistance, training and certifications.
    - Memorial reduced its language interpretation costs from two dollars ($2.00) per minute for the interpretation line to twenty-seven cents (.27) per minute for two full-time interpreters.
    - Memorial has been able to contract its interpreters to other healthcare providers on the campus on an as needed basis, thus improving the quality of care for our citizens at every health care encounter. Memorial also recoups its costs for contracting out these services through reimbursement from these providers and the provider receive quality interpretation and translation services for a minimal fee per fifteen minute increments. *Sharing the costs among the medical community makes this feasible for everyone.*
    - The costs of translation (not interpretation) of documents, forms, signage, etc. that are required by the Federal Regulations are included in this cost as our qualified interpreters do this during their normal working hours between interpretation services. This represents an additional reduction in costs to Memorial of over one thousand and five hundred dollars ($1,500) per year.
    - By ensuring quality interpretation and thus quality care for non-English speaking persons and their families, a reduction in health care costs is experienced as evidenced by a higher compliance rate with prescribed treatment plans and thus reductions in future health care costs that often times are born by the state Medicaid program or the health care provider themselves.
- Organizational Effects
    - Have experienced increase total bad debts and community care as a whole.
    - Memorial Hospital has experienced financial rewards from the implementation of a quality interpretation services.
    - Memorial sends its interpreters to the manufacturing plants and businesses that employ the non-English speaking citizens to provide education regarding health insurance and its importance. This has increased the number of non-English speaking patients that have health insurance from approximately three percent (3%) to over forty percent (40%) today.
    - Memorial has been able to collect co-payment and deductibles as well as work with non-English speaking patients regarding payment of their healthcare bills.
    - Memorial provides health education classes (childbirth, smoking cessation, etc.) in Spanish which are fee for service classes.

Oconee Regional Medical Center: Bilingual Employees

Hospital Contact and Information:
Mollie Thomas
VP/Administrative Services
Oconee Regional Medical Center
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Milledgeville, GA 31061
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Hospital Background:
Oconee Regional Medical Center (ORMC) has 2-3 staff members who speak Spanish and are in charge of interpretation. There are also two Spanish-speaking physicians on the Medical Staff.

ORMC is also able to use the AT&T interpretation line (Language Line) through the Sheriff's Department without charge. At this point, the Hispanic population in Milledgeville is not large, but Hispanics do come to the hospital from surrounding areas, as well. Frequently those who speak no English are accompanied by someone who does know English well.
When there is no one accompanying a patient who speaks no English, one of the Spanish-speaking staff members is called or the Language Line is used.

ORMC's greatest need is for translation of written documents. Although a number of the basic documents used by the hospital have been translated, there is still a definite need in this area. Some areas have translations for basic documentation needed (such as Registration), and the Cancer Treatment Center has flashcards of basic commands to use with an unaccompanied patient who speaks no English. Same Day Surgery and the OB Unit have translations of various documents, including discharge instructions.

The hospital staff is very interested in learning Spanish. However, it is important to remember that it takes years to learn Spanish well, and that there is danger in possible overconfidence with regard to medical interpretation.

Appendix E: Office of Minority Health CLAS Standards

Federal Standards for Culturally and Linguistically Appropriate Health Care Services

Preamble: Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers can:

Culturally Competent Care:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning

Language Access Services:

4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served. (Mandate)

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery. (Mandate)

6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services. (Mandate)

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge. (Mandate)

Organizational Supports for Cultural Competence

8. Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities
10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff

Appendix F: Office of Minority Health CLAS Standards Crosswalked to Joint Commission Standards

Office of Minority Health National CLAS Standards Crosswalked to Joint Commission 2004 Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care

Note: The entire text of the Joint Commission standard was not included. Please reference the appropriate Joint Commission Accreditation Manual for the full text of the standards.

Chapter/Manual Title Acronym	Manual/Chapter Title Expansion
RI	Rights, Responsibilities, and Ethics
PC	Provision of Care, Treatment, and Services
PS	Behavioral Health Promotion and Disease Prevention
LD	Leadership
HR	Management of Human Resources
PI	Improving Organization Performance
IM	Management of Information

OMH CLAS Standard	JCAHO Standards	Comments
Standard 1. Health care organization 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.	**RI.2.10** The organization respects the rights of (patients/residents/clients). **EP.2** **RI.2.20** Patients receive information about their rights. **EP 15 (Applicable only to BHC-OTP)** **RI.2.100** Organization respects the [patient's/resident's/client's] right to and need for effective communication. **EP.2, 3, 4** **RI.2.220 (LTC only)** Residents receive care that respects their personal values, beliefs, cultural and spiritual preferences, and life-long patterns of living. **PC.2.20 (AHC, HAP, LTC, OME only)** The organization defines in writing the data and information gathered during assessment and reassessment.	Standard 1 is the foundation on which other CLAS standards are based and incorporates a variety of the JCAHO standards. OMH provides the following suggestions for implementing this standard: • Cross-cultural education and training for staff • Assessment of staff learning skills through testing, direct observation, monitor patient/personnel encounter

	services, and recommend a sufficient number of qualified and competent staff to provide care, treatment, and services. **EP.1** **LD.3.20** Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital. **EP.1,2,3**	rather than specific outcomes. Organizations should encourage retention by fostering a culture of responsiveness toward the challenges and ideas that a culturally diverse staff offers and should incorporate the goal of staff diversity into the organization's mission statement, strategic plans, and goals.
Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.	**HR.2.10** Orientation provides initial job training and information. **EP. 5** **HR.2.30** Ongoing education, including in-services, training, and other activities, maintains and improves competence. **EP. 3, 7**	JCAHO standards address orientation on cultural diversity and sensitivity, and expect ongoing in-services and other education and training offered to be appropriate to the needs of the population(s) served and in response to learning needs identified through performance improvement findings and other data analysis. If an organization incorporates data regarding the CLAS standards in their regular performance improvement activities the educational needs may be addressed. However, the Joint Commission does not require ongoing education and training specific to culturally and linguistically appropriate service delivery. OMH suggests organizations involve community representatives in the development of CLAS education and

assistance services.		OMH suggests informing patients/consumers by using the following: • Using language identification cards • Posting and maintaining signs with regularly encountered languages at all entry points • Creating uniform procedures for timely and effective telephone communication between staff and patients • Including statements about services available and right to free language assistance services
Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).	**HR.3.10** Competence to perform job responsibilities is assessed, demonstrated, and maintained. **EP.1**. **RI.2.100** Organization respects the [patient's/resident's/client's] right to and need for effective communication. **EP 1, 2, 3,4**	The Joint Commission expects that staff are able to perform job responsibilities. Although not specific to the competence of interpreters, organizations are expected to define the competencies and have a mechanism to assess competency. This OMH standard would also be supported with the Joint Commission standard that addresses the appropriateness of communication. OMH suggestions include: • Patient/consumer may choose family member after being informed of free services available • Suggest trained interpreter be present

organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, and operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.	department has effective leadership. **EP.1, 2, 3, 4, 5** **LD.3.10** The leaders engage in both short-term and long-term planning. **EP.1, 2** **LD.4.10** The leaders set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities. **EP.1,2,3,4,5**	organizational leadership to engage in long and short term planning there is no requirement for a written strategic plan to provide culturally and linguistically appropriate services. OMH suggests the following activities to meet the intent of this standard: • Designated personnel or department should have authority to implement CLAS specific activities as well as monitor responsiveness of whole organization • Strategic plan developed with participation of consumers, community and staff • Results of data gathering and self assessment processes should informed the development and refinement of goals, plans, and policies.
Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their	**PS.2.10 (BHC ONLY)**The organization's behavioral health promotion services are appropriate to the needs of the community or population served. **EP.1, 2** **PI.1.10** The organization collects data to monitor its performance.	The Joint Commission standards do not directly address this OMH standard. However, an organization may choose to conduct assessments of these activities as part of their performance improvement activities. OMH standards note that surveys are a good tool for collecting data however the surveys should be culturally and linguistically appropriate. Findings

		requesting this information and emphasize with patients/consumers that this information is confidential and not intended to be used for discriminatory practices.
Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.	**PS.2.10 (BHC ONLY)** The organization's behavioral health promotion services are appropriate to the needs of the community or population served. **EP.1, 2** **LD.3.10** The leaders engage in both short-term and long-term planning. **EP.1**	The Joint Commission Behavioral Health Care program is the only program that requires a needs assessment of its community or population served. Specifically, the needs assessment should include : • A definition of the community or population served • The number of people in the community or population served • The distribution of community or population by age or age group, gender, socioeconomic status, ethnic and cultural background, and/or level of functioning • An inventory of behavioral health promotion services appropriate to the age, gender, community need, and level-of functioning distributions of the population or community served The only other related Joint Commission standard is the leadership planning standard. OMH suggests an HCO involve the

		conflict issues • Provide notice in other languages about the right to file a complaint or grievance • Provide name and number of individual responsible for disposition of grievance • Offer ombudsperson services • Include oversight and monitoring of culturally or linguistically related complaints/grievances are part of organization quality program
Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.		The Joint Commission standards do not require an organization to publish this type of information, nor does the Joint Commission expect organizations to make public any of their performance improvement information. OMH suggests organizations can report CLAS standards implementation progress in a standalone document or existing organizational reports or documents. In order to provide information to the public about their progress organizations may use newsletters, newspaper articles, television, radio or posting on a website

http://www.jcaho.org/about%2Bus/hlc/hlc_omh_xwalk.pdf

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