## GOVERNANCE, LEADERSHIP, AND SYSTEMS
### DEI STEERING COMMITTEE

### CONDUCT ONGOING SELF-ASSESSMENT & EVALUATION (GLOBAL)

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

NQF Preferred Practice 20: Regularly assess attitudes, practices, policies, and structures of all staff as a necessary, effective, and systematic way to plan for and incorporate cultural competency within an organization.

**NCQA MHC 4 Element B:** There is an annual written evaluation of the culturally and linguistically appropriate services program that includes the following:
1. A description of completed and ongoing activities for culturally and linguistically appropriate services
2. Trending of measures to assess performance
3. Analysis of results of initiatives, including barrier analysis
4. Review and interpretation of the results by community representatives
5. Evaluation of the overall effectiveness of the program.

**NCQA MHC 5 Element B:** The organization assesses the following at least annually:
1. Utilization of language services for organization functions
2. Eligible individual experience with language services for organization functions
3. Staff experience with language services for organization functions
4. Eligible individual experience with language services during health care encounters.

**NCQA MHC 5 Element C:** Based on the results of measurement of health care disparities and language services, the organization annually:
1. Identifies and prioritizes opportunities to reduce health care disparities
2. Identifies and prioritizes opportunities to improve CLAS
3. Evaluates the effectiveness of an intervention to reduce a disparity
6. Evaluates the effectiveness of an intervention to improve CLAS.

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

TJC #20 How are data used to improve cultural and linguistic (C&L) services?

TJC #24. What is the baseline for the cultural and linguistic (C&L) services we currently provide?
- Can we use this baseline to compare our progress as we improve cultural and linguistic (C&L) services?

TJC #25. How do we measure the quality of our cultural and linguistic (C&L) services?
- What systems are in place to collect feedback from patients and staff?
- Are we asking the right questions to obtain information regarding the care we provide to patients with cultural and linguistic (C&L) needs?
- How do we obtain feedback from patients with language needs?
  - Do patient satisfaction surveys include questions about cultural and linguistic (C&L) services?
  - Is there a mechanism in place to translate written surveys and patient responses?
  - Are focus groups and patient interviews used to obtain patient satisfaction data?
- Are our patients satisfied with the communication services, resources, and tools provided to them?

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SEEK AND RETAIN DIVERSE REPRESENTATION IN LEADERSHIP
(NAPH IIA). The hospital's governing bodies and executive leaders represent, and are responsive to, the diverse populations served by their organizations.

- Commit to seeking opportunities for underrepresented racial and ethnic minority professionals to serve on boards and in executive positions.
- Identify pools of talented individuals from diverse racial and ethnic groups through networking and proactive outreach to professional associations, chambers of commerce, corporations, community leaders, and advocacy groups.
- Provide a support system that will help new hospital board members evolve and enhance their competency in board matters through education, training, and mentoring.

**CLAS Standard 2**: Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

NQF Preferred Practice 28: Recruit and hire ethnically diverse providers and staff at all levels including management levels.

NQF Preferred Practice 4: Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.

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**IDENTIFY AND DEVELOP DEI CHAMPIONS**

(NAPH IIB) Create a matrix of key leaders within the hospital who are committed to decreasing disparities and who will detail activities and responsibilities to ensure that all patients receive the highest quality care, regardless of race or ethnicity.

NQF Preferred Practice 2: Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.

TJC #1: How does our leadership currently support the provision of culturally competent care?

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**ENSURE DEI COORDINATION IS BROAD AND INCLUSIVE OF ALL INTERNAL STAKEHOLDERS**

TJC #7. Which members of our organization are responsible for coordinating cultural and linguistic (C&L) initiatives?
- In what ways does leadership support those in charge of cultural and linguistic (C&L) initiatives?

TJC #8. Is there a dedicated staff position for coordinating cultural and linguistic (C&L) initiatives?
- What are the position’s specific responsibilities?
- Does this position report to an executive in the organization?
- Is there a high-level task force that coordinates cultural and linguistic (C&L) initiatives?
  - Who serves on the task force?
  - How many members are internal or external to the organization?
  - Are there a range of staff levels and disciplines represented?
  - How often does the task force meet?
  - How does the task force review policies and procedures to ensure they address the diverse needs of patients and staff?
  - How does the task force support efforts for ongoing cultural competence training for staff at all levels?
  - What is the process for implementing task force recommendations?

TJC #38. How are activities and initiatives related to culturally competent care being coordinated within our organization?
- How are we involving different stakeholders from across the organization to collaborate in cultural and linguistic (C&L) efforts?
  - Committees may consist of:
- Staff (clinical and administrative leadership, nursing, medical staff, pastoral care, interpreting services, social work, human resources, patient safety/risk management, quality improvement staff, cultural brokers, community outreach/marketing, etc.)
- Patients
- Community leaders
- Religious leaders

- Do stakeholders represent varying perspectives within the organization (including various departments, positions, professional levels)?
- Do stakeholders represent the varying perspectives within the community (e.g., cultures, religions)?
- What activities are stakeholders overseeing?
  - How are these cultural and linguistic (C&L) activities being centrally coordinated?
- How are stakeholders addressing patient and/or staff concerns related to cultural and linguistic (C&L) issues?

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### INCLUDE DEI IN ORGANIZATIONAL VISION, MISSION, AND VALUES

NQF Preferred Practice 3: Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.

TJC #2: In what ways does our mission statement or other guiding principles (e.g., vision, values) reflect an organizational commitment to providing culturally competent care?

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### DEVELOP A STRATEGIC PLAN

(NAPH IIB) The hospital ensures that healthcare equity is integral to its strategic plan.
- Incorporate equity into a hospital strategic plan that is accepted and promoted by both the executive leadership and the governance body.
  - State explicitly any organizational intent to close racial and ethnic quality gaps where they exist.
  - Develop a plan that is appropriate to the population served by the hospital.
- Include in the strategic plan specific strategies for ensuring that all patients have access to high-quality services and affordable medications.
Develop efforts to ensure that patients have access to continuous and high quality care.

- Establish equity as a standard of care equal to the other aims for improvement identified by the Institute of Medicine in *Crossing the Quality Chasm* (i.e., safety, effectiveness, patient-centeredness, timeliness, and efficiency).
- Identify key hospital leaders who can help build equity into the strategic goals of the hospital.
- Ensure that diversity and cultural competence training programs integrate community context as part of the strategic planning process.

(NAPH VC) The hospital develops external and internal resources for healthcare language access.
- Strategize within the hospital and advocate outside the hospital for improved healthcare financing of language access for LEP populations.

**CLAS Standard 8:** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

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

NQF Preferred Practice 3: Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.

NQF Preferred Practice 7: Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

NQF Preferred Practice 8: Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.

NCQA MHC 4 Element A: The organization has a written program description for improving culturally and linguistically appropriate services that includes the following:
1. A written statement describing the organization’s overall objective for serving a culturally and linguistically diverse population
2. A process to involve members of the culturally diverse community in identifying and prioritizing opportunities for improvement
3. A list of measurable goals for the improvement of Culturally and Linguistically Appropriate Services (CLAS) and reduction of health care disparities
4. An annual work plan
5. A plan for monitoring against the goals
6. Annual approval by the governing body.
TJC #4. In what ways have we used the National Standards for Culturally and Linguistically Appropriate Services (CLAS) or other guidance to incorporate cultural competence into organizational planning?

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

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**CREATE AND IMPLEMENT POLICIES, PROCEDURES, GOALS AND ACCOUNTABILITY**

(NAPHD ID) Equitable healthcare for diverse populations becomes part of the hospital’s environment, policies, and practices and is supported with effective operational and administrative infrastructure supports.

- Develop strategic goals to measure and increase workforce diversity in the hospital.
- Establish cultural competence assessment teams to evaluate policies addressing the hospital’s responsiveness to its diverse workforce and patient population.
- Develop recommendations and implementation plans for culturally and linguistically appropriate services in accordance with the National Standards for Culturally and Linguistically Appropriate Services in Healthcare (CLAS Standards) developed by the U.S. Department of Health and Human Services’ Office of Minority Health.
- Create accountability measures designed to improve customer service and quality of care.
- Redesign the hospital’s physical plant, including exterior and interior signage, to help LEP patients access services.

**CLAS Standard 9**: Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
**NQF Preferred Practice 1:** Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.

**NQF Preferred Practice 6:** Commit to cultural competency through systemwide approaches that are articulated through written policies, practices, procedures, and programs.

**NQF Preferred Practice 29:** Actively promote the retention of a culturally diverse workforce through organizational policies and programs.

**NQF Preferred Practice 8:** Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.

**NQF Preferred Practice 10:** Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.

**NCQA MHC 1 Element C:** The organization has policies and procedures for managing access to and use of race/ethnicity and language data, including:
1. Controls for physical and electronic access to the data
2. Permissible uses of the data
3. Impermissible uses of the data, including underwriting and denial of coverage and benefits.

**TJC #3.** How have we operationalized our commitment to the provision of culturally competent care into organizational actions, procedures, services, and resources?

**TJC #5.** Which organizational policies and procedures, if any, set expectations for staff for providing culturally and linguistically appropriate care?

- Do we have policies and/or procedures that address the following:
  - Reinforcing the importance of cultural sensitivity and effective communication in the provision of care
  - Supporting the use of professional health care interpreters
  - Discouraging the use of family, minors, or other untrained individuals as interpreters
  - Suggesting which types of language services are appropriate for certain situations (e.g., on-site, telephone, video)
  - Requiring the use of language services throughout the continuum of care
  - Resolving or mediating any cross-cultural conflicts that may arise

- How is compliance with these policies and procedures monitored?
TJC #19. What are our policies and/or procedures that address the systematic collection of data?

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INCLUDE DEI IN BUSINESS AND RESOURCE PLANNING

(NAPH IIC) The hospital’s business planning includes an organizational assessment, strategic planning, implementation, and monitoring process to evaluate progress and results on interventions to ensure equity.

- Include in the hospital’s planning process strategic objectives that focus on equitable care, processes, and services, as well as a strategy to develop the necessary resources.
- Incorporate healthcare equity into the hospital’s budgetary planning and implementation process.
- Commit to a plan to recruit and retain a hospital workforce that represents the diversity of the patient population.
- Identify and develop a sustainable funding source for culturally and linguistically competent care, including provision of quality medical interpreters and translation services for all patients.
- Collaborate with other hospitals and healthcare organizations in the community on developing strategies for leveraging available financial and infrastructure resources to improve culturally and linguistically competent care.

NQF Preferred Practice 5: Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.

TJC #3: What resources (e.g., financial, staff) have we dedicated to cultural and linguistic (C&L) activities?

- Which internal resources have been identified to support cultural and linguistic (C&L) activities and improve patient-provider communication?
- Which external resources have been explored to provide or pay for cultural and linguistic (C&L) activities and improve patient/provider communication?

TJC #7. Which members of our organization are responsible for coordinating cultural and linguistic (C&L) initiatives?

- In what ways does leadership support those in charge of cultural and linguistic (C&L) initiatives?
TJC #8. Is there a dedicated staff position for coordinating cultural and linguistic (C&L) initiatives?
   o What are the position's specific responsibilities?
   o Does this position report to an executive in the organization?

TJC #9. What types of financial systems are in place to remove barriers to using cultural and linguistic (C&L) services?
   • How do we budget funds for the provision of culturally appropriate services?
     o How do we budget funds for the provision of language services?
     o Can we manage costs by cancelling/rescheduling interpreter appointments when patients cancel/reschedule appointments?

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**PLAN TO RECRUIT AND RETAIN A DIVERSE WORKFORCE**

(NAPH IIC) Commit to a plan to recruit and retain a hospital workforce that represents the diversity of the patient population.

**CLAS Standard 2:** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

NQF Preferred Practice 28: Recruit and hire ethnically diverse providers and staff at all levels including management levels.

NQF Preferred Practice 29: Actively promote the retention of a culturally diverse workforce through organizational policies and programs.

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

TJC #42. What opportunities have we identified to partner with educational institutions to recruit and train a diverse workforce?
- What opportunities are available for training current staff?
- What types of recruitment opportunities are available in the surrounding community?
- What incentives are we providing to recruit and train a diverse, bilingual staff?
- Are there opportunities for developing a future diverse workforce?

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**REPORT DATA AND PROGRESS INTERNALLY AND EXTERNALLY**

(NAPH IIB) Develop a dashboard report on equity for presentation to the hospital’s governance body and make it available to staff, patients, and the community. Integrate an equity dashboard report and other quality indicators by race and ethnic group into the regular governance body and management reports, as well as on the balanced scorecard for the hospital.

**CLAS 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.

NQF Preferred Practice 41: Publicly report data for the applicable NQF-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care stratified by race/ethnicity and primary written and spoken language.

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**BUILD BRIDGES AND COLLABORATE EXTERNALLY**

(NAPH IA) Collaborate with other organizations to improve the capacity to obtain and update data for understanding the communities served and to accurately plan and implement services that respond to diverse needs.

- Use this information to plan, develop, and implement healthcare services that are responsive to the community served.
- Determine the costs involved in developing and implementing these services, the organizational barriers to be overcome, and strategies to overcome them.
TJC # 39. What existing resources can we share with other organizations or local, state, and national associations?
   o Are there best practices related to implementing culturally competent care that we could share with other organizations?
   o Are there any lessons learned from implementing culturally competent care that would be useful to share with other organizations?
   o What types of information would we like to learn from other organizations?
   o What resources are available that other organizations can share with us?
   o What organizations or types of organizations do we want to share information or resources with?

TJC # 40. What resources or materials do we want to develop in collaboration with other organizations?
   o Are there specific types of resources we want to develop with other organizations (e.g., a multi-hospital interpreter network, educational resources, or translations of vital documents such as consent forms, complaint forms, patient rights information, intake forms, etc.)
   o Which languages should we target?
   o Which hospitals or other health care organizations should we collaborate with?

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(1) DATA COLLECTION & ANALYSIS, AND (2) COMPLIANCE WITH NATIONAL STANDARDS

DEI COMPLIANCE TASK FORCE

## MAINTAIN A DEMOGRAPHIC PROFILE OF THE COMMUNITIES SERVED

**CLAS Standard 11:** Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

NQF Preferred Practice 38: Utilize indirect data collection methodologies (e.g., geocoding, surname analysis) to characterize the race, ethnicity, and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.

NQF Preferred Practice 39: Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.

TJC #18. How have we assessed the cultural and linguistic (C&L) needs of the community?

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

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Contact: Susana Rinderle, MA ~ Manager, Diversity, Equity & Inclusion ~ SRinderle@salud.unm.edu
IMPLEMENT DATA GUIDELINES (IOM OR OTHER)

(NAPH IID) Utilize technology to standardize the hospital's collection of race, ethnicity, language, and socioeconomic status (SES) data; where possible, analyze data for quality measures by each of these factors to quantify the hospital's progress towards eliminating these demographic differences in quality of care.

(NAPH IVA) The hospital acknowledges the need for data on patient race, ethnicity, and primary language. Ensure that every patient is identified accurately by race/ethnicity and primary language by using standard definitions on admission and in contacts with hospital services. It is highly recommended that hospitals standardize:

- Who provides information, patient (self-identification is best)
- When data are collected,
- Which racial and ethnic categories are used,
- Why race/ethnicity data are being collected,
- How data are stored, and
- How patients’ concerns are addressed.

It is recommended that hospitals utilize the Health Research and Educational Trust’s (HRET) Disparities Toolkit—(www.hretdisparities.org)

CLAS Standard 10: Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

NQF Preferred Practice 36: Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner.

NQF Preferred Practice 37: Ensure that, at a minimum, data on an individual patient’s race and ethnicity (using the Office of Management and Budget categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.

NQF Preferred Practice 44: Any surveys created by or conducted by the organization must collect race, ethnicity, and primary written and spoken language, and analysis and results must be stratified by race, ethnicity, and primary written and spoken language.

NCQA MHC 1 Element A: The organization’s methods to assess the race/ethnicity of its eligible individuals include the following:
1. Direct collection of data from eligible individuals
2. Estimation of race/ethnicity using indirect methods
3. Validation of estimation methodology
4. Process to roll up race/ethnicity data to Office of Management and Budget (OMB) categories
5. System for data storage and retrieval of individual-level data
6. Reporting HEDIS Diversity of Membership measure (race/ethnicity component), if applicable.

NCQA MHC 1 Element B: The organization’s methods to assess the language needs of its eligible individuals include the following:
1. Direct collection of language needs from its eligible individuals
2. A system for data storage and retrieval of language data
3. Assessment of the population’s language profile at least every three years
4. Determination of threshold languages (those spoken by 5 percent of the population or 1000 eligible individuals)
5. Determination of languages spoken by at least 1 percent of the population or 200 eligible individuals, whichever is less
6. Reporting the HEDIS Diversity of Membership measure (language component), if applicable.

NCQA MHC 1 Element D: When the organization collects data, it discloses to eligible individuals its policies and procedures for managing access to and use of race/ethnicity and language data, including:
1. Controls for physical and electronic access to the data
2. Permissible uses of the data
3. Impermissible uses of the data, including underwriting and denial of coverage and benefits.

TJC #19. How have we assessed the cultural and linguistic (C&L) needs of our patients?
- What type of patient-level demographic data do we collect (e.g., age, gender, race/ethnicity, primary spoken and/or written language, religion, sexual orientation, disabilities, cultural needs, dietary needs, health literacy level, etc.)?
- How do we ensure the accuracy of the data?
  - Do we collect data directly from our patients?
  - Are staff trained on the best way to obtain data in a manner that is respectful to the patient and comfortable for the staff?
  - Has the organization utilized tools such as the Health Research and Educational Trust (HRET) Toolkit for collecting data on race, ethnicity, and primary language to aid their data collection efforts?
ANALYZE AND MONITOR “REALS” AND OTHER DATA

(NAPH IID) Utilize technology to standardize the hospital’s collection of race, ethnicity, language, and socioeconomic status (SES) data; where possible, analyze data for quality measures by each of these factors to quantify the hospital’s progress towards eliminating these demographic differences in quality of care.

(NAPH IVB) The hospital’s focus on measurement in reducing disparities is to ensure that all patients receive the appropriate standard of care. If this standard is not met, the hospital ensures that data is available in a format that allows stratifying by race, ethnicity and language to determine if gaps in quality care are present.

Determine whether patients receive all recommended care in a timely fashion and how patients perceive their care:

- Compare the hospital’s service population by race, ethnicity, and language data with those of the catchment community to identify disparities in access or accessibility.
- Analyze clinical quality indicators for all patients to determine if gaps in quality exists by race, ethnicity, or primary language.
- Link patient demographic information to patient satisfaction surveys and analyze grievances and complaints filed to determine if differences in satisfaction fall along racial or ethnic lines.
- Analyze medical errors by patient race, ethnicity, and primary language to identify and address patterns.

(NAPH IVC) The hospital analyzes performance in providing timely patient access to culturally and linguistically competent services.

- Determine the percent of clinical staff trained in culturally and linguistically competent care.
- Evaluate the percent of completed race, ethnicity, and language data fields completed.
- Analyze the demand and supply of language services.
- Analyze time to bedside for supplying language services when needed.

NCQA MHC 5 Element A: The organization uses race/ethnicity and language data and the following methods to determine if health care disparities exist.

1. Analyze one or more valid measures of clinical performance, such as HEDIS, by race/ethnicity
2. Analyze one or more valid measures of clinical performance, such as HEDIS, by language
3. Analyze one or more valid measures of eligible individual experience, such as CAHPS, by race/ethnicity or language

TJC #23. How are data regarding the use of cultural and linguistic (C&L) services reviewed and compared to the C&L needs identified through demographic data collection?

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**USE THE RESULTS OF DATA ANALYSIS TO DRIVE IMPROVEMENTS**

(NAPH IVD) Feedback on performance is provided to the hospital’s clinical and administrative leadership for needed design change or improvement activities.
- Create a timely feedback and learning process to ensure that data on clinical quality and service performance are communicated to clinical and administrative leaders.
- Consider using report cards or dashboards to measure organizational performance on eliminating disparities by applying evidence-based guidelines of care and language services. (See Massachusetts General Hospital’s *Creating Equity Reports: A Guide for Hospitals* at <www.mghdisparitiesolutions.org>.)
- Consider provider level report cards on clinical quality indicators and appropriate utilization of language services that are stratified by patients’ race, ethnicity, and language data.
- Evaluate clinical quality and service performance data over time to measure the impact of process changes.
- Use data to determine gaps in individual patient care (or experience of care) and study the process leading to gaps in care or service delivery or quality. Apply this knowledge to system redesign or improvement.

(NAPH IVE) The hospital establishes a goal of no disparities in care based on race, ethnicity, language, or SES.
- Undertake small scale tests of change to improve process gaps identified above until performance goals are achieved.
- Apply reliability principles to ensure that improved processes are spread reliably throughout the organization.

NQF Preferred Practice 40: Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.

NCQA MHC 5 Element C: Based on the results of measurement of health care disparities and language services, the organization annually:
3. Implements at least one intervention to address a disparity
4. Implements at least one intervention to improve CLAS

TJC #20. How are data used to create cultural and linguistic (C&L) initiatives?

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

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**BENCHMARK RESULTS OF DATA ANALYSIS**

(NAPHRIVE) The hospital establishes a goal of no disparities in care based on race, ethnicity, language, or SES.
- Use data to benchmark the gaps in care based on race, ethnicity, language, and SES.
- Benchmark performance and goals on best known results nationally.

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COMMUNITY ENGAGEMENT AND PARTNERSHIP
DEI COMMUNITY TASK FORCE

ASSESS COMMUNITY NEEDS

(NAPH IA). The hospital understands that effective alliances and partnerships require an accurate assessment of community needs and productive community engagement. The hospital relates to the community as not just a recipient or consumer of healthcare, but as a partner in identifying needs, establishing priorities, developing programs, and promoting improved health status and effective healthcare for all.

- Determine the resources both in the hospital and the community (formal and informal) that can be used to retrieve and update data on the needs of various racial, cultural, ethnic, linguistic, and socio-economic groups within the service area.
  - Identify the sources of information that other organizations in the community use to determine the diverse factors related to patient needs, attitudes, behaviors, health practices, and concerns among the patient populations.
  - Potential resources include: marketing enrollment, and termination data; census and voter registration data; school enrollment profiles; focus groups, interviews, and surveys; county and state health status reports; data from other community agencies and organizations; collaboration and consultation with faith-based and community organizations, providers, and leaders on conducting outreach, building provider networks, providing service referrals, and enhancing public relations; and community-member participation on hospital governing boards, advisory committees, ad hoc advisory groups, and hospital-community meetings.

- Collaborate with other organizations to improve the capacity to obtain and update data for understanding the communities served and to accurately plan and implement services that respond to diverse needs.
  - Use this information to plan, develop, and implement healthcare services that are responsive to the community served.
  - Determine the costs involved in developing and implementing these services, the organizational barriers to be overcome, and strategies to overcome them.

NQF Preferred Practice 31: Engage communities to ensure that healthcare providers (individual and organizational) are aware of current and changing patient populations and cultural and communication needs and provide opportunities to share resources and information.

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COLLABORATE WITH THE COMMUNITY TO STRATEGIZE AND IMPLEMENT CHANGE

(NAPH IB). The hospital establishes and maintains forums for meeting with the community (local leaders and organizations) to identify key concerns, strategies for improving the public’s health, and available community resources.

- Identify local leaders, as well as community resources.
  - Form alliances and collaborative relationships with key leaders and organizations.
  - Meet with these leaders to identify solutions for improving the provision of quality healthcare.
  - Create alliances and collaborative relationships with local, state, and national hospital associations that are working to reduce disparities in healthcare.

(NAPH VC) The hospital develops external and internal resources for healthcare language access.

- Strategize within the hospital and advocate outside the hospital for improved healthcare financing of language access for LEP populations.

CLAS Standard 12: Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

NQF Preferred Practice 32: Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.

NQF Preferred Practice 33: Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating the effectiveness of cultural competency activities.

NQF Preferred Practice 34: Healthcare professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.

NQF Preferred Practice 35: Use the methodology of community-based participatory research when conducting research in the community as a collaborative approach to research that equitably involves all stakeholders in the research process and fosters the unique strengths that the community brings to the process.
TJC #42. What opportunities have we identified to partner with educational institutions to recruit and train a diverse workforce?
- What opportunities are available for training current staff?
- What types of recruitment opportunities are available in the surrounding community?
- What incentives are we providing to recruit and train a diverse, bilingual staff?
- Are there opportunities for developing a future diverse workforce?

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**PARTNER WITH COMMUNITY ORGANIZATIONS/RESOURCES TO DIRECTLY BENEFIT PATIENTS**

(NAPH IC). The hospital identifies and establishes linkages to community resources for patients, families, and staff.  
- Form alliances and partnerships with community service providers and social service agencies to facilitate seamless, appropriate referral processes.
- Form alliances and partnerships with homeless shelters, faith-based organizations, and other community advocates to promote the provision of quality healthcare.
- Collaborate with community organizations and advocacy groups to provide access to quality language services for limited English proficient (LEP) populations (See Category V)

(NAPH IIIC). Collaborate with other healthcare organizations to improve workforce training and education programs in the community.

(NAPH VA). Collaborate with other hospitals in the area to improve language access and interpreter services in the community.

TJC # 43. Which community resources exist that could help us better meet cultural and linguistic (C&L) needs?
- What community organizations or networks can we collaborate with to help bridge cultural barriers?
- What religious leaders or chaplains have we developed relationships with to meet patient needs?
- Are there traditional healers within the community to whom we can reach out?
- How have we trained staff to be aware of and access these external resources?
TJC # 44. How have we reached out to the community and/or facilitated access to both internal and external services?
  o Are patients aware of the community programs or services available that relate to patients’ continuum of care?
  o Are there public assistance programs that we could help patients become more aware of as part of their overall care?
  o What adult learning programs could we partner with to help with issues of health literacy?

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**COLLABORATE & DIALOGUE WITH PATIENTS AND FAMILIES**
(NAPH ID). The hospital engages patients and families as both a cornerstone and a catalyst for improvement in the organization (patient and family advisory council, ombuds program)

- Establish a patient and family advisory council that is representative of the community and institutionalizes healthcare equity issues as part of the regular agenda.

**CLAS Standard 12:** Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

**NQF Preferred Practice 33:** Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating the effectiveness of cultural competency activities.

TJC #41. How many community representatives are involved in our cultural and linguistic (C&L)-related committees?
  o On what other committees would having community representatives be helpful?
  o Do the community representatives currently involved provide perspectives of the diverse needs of the populations we serve?

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**ESTABLISH EQUITABLE, INCLUSIVE CONFLICT AND GRIEVANCE RESOLUTION PROCESSES**
The hospital engages patients and families as both a cornerstone and a catalyst for improvement in the organization (patient and family advisory council, ombuds program)

- Create an ombudsman program to ensure that grievance resolution processes are culturally and linguistically appropriate and capable of identifying, preventing, and resolving crosscultural conflicts or complaints by patients/consumers.

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

NQF Preferred Practice 45: Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.

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**DISSEMINATE DATA, MARKET SERVICES, AND REPORT PROGRESS EXTERNALLY**

(NAPH IIB). Develop a dashboard report on equity for presentation to the hospital’s governance body and make it available to staff, patients, and the community. Integrate an equity dashboard report and other quality indicators by race and ethnic group into the regular governance body and management reports, as well as on the balanced scorecard for the hospital.

**CLAS 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.

NQF Preferred Practice 11: Market culturally competent services to the community to ensure that communities that need services receive the information.

NQF Preferred Practice 41: Publicly report data for the applicable NQF-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care stratified by race/ethnicity and primary written and spoken language.

NQF Preferred Practice 42: Regularly make available to the public information about progress and successful innovations in implementing culturally competent programs (especially the NQF endorsed preferred practices for cultural competency), and provide public notice in communities about the availability of this information.
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### (1) LANGUAGE ACCESS & SERVICES, AND (2) "CULTURAL COMPETENCE" TRAINING AND DEVELOPMENT

#### DEI COMPETENCE TASK FORCE

#### CONDUCT ONGOING SELF-ASSESSMENT & EVALUATION ("CULTURAL COMPETENCE")

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

NQF Preferred Practice 43: Assess and improve patient- and family-centered communication on an ongoing basis.

TJC # 22. How are language issues incorporated into patient care?
- Are the different forms of interpreters (e.g., on-site, telephone, video) evaluated for efficiency, cost, and quality?

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#### ENSURE THE ACCURACY, READABILITY, AND CULTURAL APPROPRIATENESS OF TRANSLATED MATERIALS

(NAPH VA). The hospital communicates with patients and families in the patients’ own language and is responsive to the patients’ cultural needs. This may involve using interpreter services, offered by trained and competent staff, and distributing well translated written materials.

- Inform patients of guidelines pertinent to their care in a culturally and linguistically appropriate manner.
- Organize language access and interpreter services to ensure the availability of interpreters and translated materials as needed for safe and high quality patient care.
- Ensure that translated materials and signs accurately convey the meaningful substance of materials written in languages other than English.

(NAPH VB) The hospital provides oral and written educational and community resource materials in a culturally appropriate manner, in the appropriate language, and at the correct level of literacy.

- Develop a process to create mass customization of written patient information, based on collected race, ethnicity, language, and socio-
provide opportunities to amend these prepared documents at the point of care (e.g., hospital ward, procedure room for consent).

Establish written follow-up instruction and support as a standard part of every clinical interaction, including the patient verbalizing understanding and agreement with the plan.

**CLAS Standard 7:** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

NQF Preferred Practice 15: Translate all vital documents, at a minimum, into the identified threshold languages for the community that is eligible to be served.

NQF Preferred Practice 16: Translate written materials that are not considered vital when it is determined that a printed translation is needed for effective communication.

NQF Preferred Practice 17: Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document.

NCQA MHC 2 Element A: The organization has a documented process for providing vital information in threshold languages (see MHC 1 Element B) that includes:
1. Use of competent translators
2. A mechanism for providing translations in a timely manner
3. Specifying when translations will be written and when sight translation (oral interpretation) of written information will be provided
4. A mechanism for evaluating the quality of the translation.

TJC #17. What types of written materials (e.g., informed consent, medication information, discharge instructions) does our organization create or have translated into patients’ primary languages?

- Are professional translators used to translate materials?
- Is there a formal quality review process for these materials?
- Is there a central repository for translated documents to minimize duplication and control the quality of the documents?
- How are health literacy and cultural issues addressed by written materials?
- Are other options available for patients with low literacy or low health literacy skills (e.g., video or audio instructions)?
- What is the process for tracking print materials for revisions and updates?

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<td>(NAPH VA). The hospital communicates with patients and families in the patients’ own language and is responsive to the patients’ cultural needs. This may involve using interpreter services, offered by trained and competent staff, and distributing well translated written materials.</td>
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<td>- List in a visible and accessible manner the local options for culturally appropriate medical interpreters (e.g., telephone or in person interpreters).</td>
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<td>- Create a language and interpretation plan that follows the patient through all healthcare interactions (e.g., assign a medical interpreter when diagnostic test, procedure, or family meeting is scheduled).</td>
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<td>- Organize language access and interpreter services to ensure the availability of interpreters and translated materials as needed for safe and high quality patient care.</td>
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<td>(NAPH VC). The hospital develops external and internal resources for healthcare language access.</td>
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<td>- Hire appropriately-trained bi-and multi-lingual staff, including those fluent with American Sign Language.</td>
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<td>- Provide competency training for medical interpretation.</td>
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<td>- Ensure that all visual and written signs and materials are in the specified languages of the hospital's patient population.</td>
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<td>- Use promotoras, navigators, and care managers trained in the language and culture appropriate to the patient population.</td>
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<td>- It is recommended that hospitals utilize the following premier resources in the area of health care language access: Hablamos Juntos <a href="http://www.hablamosjuntos.org">www.hablamosjuntos.org</a>; Speaking Together &lt;www.speakingtogether.org</td>
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**CLAS Standard 4:** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

**CLAS Standard 5:** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

NQF Preferred Practice 12: Offer and provide language access resources in the patient’s primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.

NQF Preferred Practice 14: Maintain sufficient resources for communicating with patients in their primary written and spoken languages through
qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.

NCQA MHC 2 Element B: The organization uses competent interpreter or bilingual services to communicate with eligible individuals who need to communicate in a language other than English.

NCQA MHC 2 Element C: The organization supports practitioners in providing competent language services, including:
3. Providing practitioners with language assistance resources
4. Making in-person, video or telephone interpretation services available to practitioners

NCQA MHC 2 Element D: Annually, the organization distributes written notice in English and any languages spoken by 1 percent or 200 eligible individuals, whichever is less, up to a maximum of 15 languages, that the organization provides free language assistance, and how the eligible individual can obtain the service.

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**DEVELOP AND IMPLEMENT STAFF & PROVIDER TRAINING ON EFFECTIVELY SERVING DIVERSE PATIENTS**

(NAPH IIIC). The hospital’s administrative and clinical leadership implements staff development programs that support culturally and linguistically appropriate evidence-based care.

- Determine what workforce training and education programs are needed for staff to achieve cultural and linguistic competence.
- Organize the hospital's workforce training and education programs to ensure that they:
  - Are tailored to the particular functions of the trainees and the needs of the specific populations served;
  - Educate staff on the effects of cultural differences between staff and patients within clinical settings;
  - Include the hospital’s language access policies and procedures (e.g., relevant laws and how to access interpreters and translated written materials);
  - Successfully train staff on the elements of effective communication between staff and patients of different cultures and languages (e.g., working respectfully and effectively with interpreters; improving awareness of cultural differences such as religion, diet, and male-female relations); and
  - Educate staff on strategies and techniques for recognizing and resolving racial, ethnic, or cultural conflicts with patients and other staff.
At times of transitions in care, the hospital's leadership and staff ensure both that communication with patients, families, and caregivers and coordination with clinical providers are handled consistently and effectively.

- Provide training for clinical staff to understand which family or community members are appropriate to invite to family meetings or to be present at time of discharge.

The hospital communicates with patients and families in the patients’ own language and is responsive to the patients’ cultural needs. This may involve using interpreter services, offered by trained and competent staff, and distributing well translated written materials.

- Identify the primary language during interaction with patient (e.g., identify language preferences of patients using existing materials such as the "I Speak" card).

**CLAS Standard 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.

**CLAS 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.

NQF Preferred Practice 18: Use "teach back" as a patient engagement tool to enhance communication between the healthcare provider and the patient during clinical encounters.

NQF Preferred Practice 19: Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.

NQF Preferred Practice 21: Include family members in healthcare decisions, when requested by the patient, when providing care for culturally diverse populations.

NQF Preferred Practice 24: Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.

NQF Preferred Practice 30: Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.

NCQA MHC 2 Element C: The organization supports practitioners in providing competent language services, including:

1. Sharing data with practitioners on language needs of eligible individuals
2. Sharing organization or service area population data on language needs
3. Offering training to practitioners on the provision of language services.
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<th>TJC #5. Which organizational policies and procedures, if any, set expectations for staff for providing culturally and linguistically appropriate care?</th>
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<td>o What training have staff received regarding these policies and procedures and how to abide by them?</td>
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<th>TJC # 12. What tools are provided to staff to determine the appropriate language services?</th>
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<td>o What resources are available to identify language needs (e.g., &quot;I Speak&quot; cards, telephone interpreting services)?</td>
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<td>o What training have staff received to understand and use the resources available to identify language needs?</td>
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<th>TJC #13. What tools and resources are available to staff to help them meet patients’ cultural needs?</th>
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<td>o How are staff made aware of these tools?</td>
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<td>o What type of training have staff received to help them meet the unique cultural needs of the patient population?</td>
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<th>TJC #14. How are staff made aware of the availability of cultural and linguistic (C&amp;L) services?</th>
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<td>o Are interpreter services incorporated at the patient care level to ensure visibility?</td>
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<tr>
<td>o What type of training have staff received regarding the appropriate use of cultural and linguistic (C&amp;L) services?</td>
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<th>TJC #15. What type of training have staff received regarding how to access cultural and linguistic (C&amp;L) services?</th>
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<td>o Are staff aware of the regulatory requirements, mandates, and national standards regarding the provision of language services?</td>
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<tr>
<td>o What internal materials are available on how to access cultural and linguistic (C&amp;L) services during hours, after-hours, and for certain departments (e.g., the emergency room)?</td>
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<td>o How are cultural and linguistic (C&amp;L) services accessed (e.g., on-site interpreters, contract interpreters, telephone or video language services, chaplain, religious and spiritual services, dietary services, etc.)?</td>
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<th>TJC # 21. How are cultural issues incorporated into patient care?</th>
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<td>• How often do cultural issues have an impact on patient care?</td>
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<td>• Do staff consider religious and spiritual beliefs, cultural beliefs, folk remedies, traditions, rituals, and alternative medicine when providing care?</td>
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<td>• What skills do staff have to explore patients’ perspectives including cultural and religious beliefs related to health, illness, and treatment?</td>
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<td>• Do staff document situations in which cultural issues arise?</td>
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<td>o Do chaplains record encounters with patients?</td>
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<td>o Are dietary considerations regarding culture and/or religion recorded?</td>
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<th>TJC # 22. How are language issues incorporated into patient care?</th>
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<td>• Is there formal documentation of interpreter encounters?</td>
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<td>o Where is the encounter documented (e.g., interpreter log, patient’s medical record)?</td>
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<td>o Is the type of interpreter documented (e.g., on-site, telephone, video)?</td>
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<td>TJC #27. How does staff training address the importance of effective communication in the provision of care?</td>
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<tr>
<td>Does training address the roles that language, literacy, and culture play?</td>
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<td>Are these issues addressed during orientation and ongoing training?</td>
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<td>Are staff provided training on how to access available resources to meet the cultural and linguistic (C&amp;L) needs of patients?</td>
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<tr>
<td>o Are they trained to access on-site interpreters, telephone, or video interpreters?</td>
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<td>What type of training have staff received on how to work with interpreters?</td>
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<tr>
<th>TJC #28. How are staff educated on the unique cultural and linguistic (C&amp;L) needs of the patients served?</th>
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<tr>
<td>Do staff receive cultural competence training?</td>
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<tr>
<td>o When does training occur?</td>
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<td>o Is the training required or optional?</td>
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<td>o How often is training provided (e.g., during orientation, annually to all staff)?</td>
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<tr>
<td>o What issues are addressed in the training?</td>
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<tr>
<td>o Who provides the training?</td>
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<th>TJC #29. What educational materials and tools are staff provided regarding the cultural and linguistic (C&amp;L) issues of the service community?</th>
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<tr>
<td>Are there any online applications or intranet resources that provide cross-cultural information?</td>
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<tr>
<td>Do staff have an opportunity to dialogue about the cultures and languages encountered?</td>
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<tr>
<td>Are staff required to demonstrate competency regarding the use of cultural and linguistic (C&amp;L) resources and tools?</td>
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<th>TJC #30. How can technology enhance or better facilitate existing language services?</th>
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<tr>
<td>Are staff trained to properly use telephone or video medical interpreting services?</td>
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<tr>
<td>Is the appropriate equipment present in patient rooms (e.g., speakerphone, dual handset telephones, video equipment)?</td>
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<tr>
<td>Are speech output devices and/or bilingual communication boards made available to supplement language services?</td>
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DEI Comprehensive Self-Assessment: Competence  
Contact: Susana Rinderle, MA ~ Manager, Diversity, Equity & Inclusion ~ SRinderle@salud.unm.edu
ASSESS AND ENSURE INTERPRETER COMPETENCE

(NAPH VA) The hospital communicates with patients and families in patients’ own language and is responsive to the patients’ cultural needs. This may involve using interpreter services, offered by trained and competent staff, and distributing well translated written materials.

- Assess and ensure the training and competency of interpreters.

(NAPH VC) The hospital develops external and internal resources for healthcare language access.

- Hire appropriately-trained bi-and multi-lingual staff, including those fluent with American Sign Language.
- Provide competency training for medical interpretation.

CLAS 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).

TJC #16. What type of training is required for those providing language services?

- If using staff to interpret:
  - Is there a policy that ensures staff are proficient in English and the target language, including relevant medical terminology?
  - Is there a policy that ensures staff understand the role of the interpreter, Health Insurance Portability and Accountability Act (HIPAA) and confidentiality issues, and interpreter codes of ethics and standards of practice?
  - Are there requirements for ongoing testing and training?
  - Have guidelines been developed for dual-role interpreters?

- If using an outside vendor for language services:
  - Are there standards for training and competency that agency interpreters have to meet?
  - Does the hospital ensure that outside vendors comply with hospital policies and procedures related to such issues as language proficiency, the role of interpreters, HIPAA, confidentiality, ethics, and standards of practice?
  - How do we ensure that contract interpreters are meeting those standards?

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(1) PATIENT INVOLVEMENT, AND (2) CULTURALLY & LINGUISTICALLY APPROPRIATE CARE MODEL
DEI CARE TASK FORCE

CONDUCT ONGOING SELF-ASSESSMENT & EVALUATION (CARE & SERVICES)

CLAS Standard 11: Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

TJC #25. How do we measure the quality of our cultural and linguistic (C&L) services?
- What systems are in place to collect feedback from patients and staff?
- Are we asking the right questions to obtain information regarding the care we provide to patients with cultural and linguistic (C&L) needs?
- How do we obtain feedback from patients with language needs?
  - Do patient satisfaction surveys include questions about cultural and linguistic (C&L) services?
  - Is there a mechanism in place to translate written surveys and patient responses?
  - Are focus groups and patient interviews used to obtain patient satisfaction data?
- Are our patients satisfied with the communication services, resources, and tools provided to them?
  - How are these data used to improve cultural and linguistic (C&L) services?

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INVOLVE PATIENTS AND FAMILIES IN THEIR PLAN OF CARE

(NAPH IE). The hospital engages patients and families in their plan of care.
- Establish a shared understanding between the clinician and patient about the clinical condition and the recommended plan of care, including tests, medications, diet, and activity recommendations, based on the application of cultural competency training.
- Provide self care support and engage in collaborative decision making with patients.
- Develop a self management care process for patients.
NQF Preferred Practice 21: Include family members in healthcare decisions, when requested by the patient, when providing care for culturally diverse populations.

NQF Preferred Practice 22: If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.

NQF Preferred Practice 27: Explore, evaluate, and consider the use of multimedia approaches and health information technology to enable the provision of healthcare services that are patient and family centered and culturally tailored to the patient.

TJC # 34. What programs do we have that help patients understand and navigate the health care system?
- Do we have educational resources that explain the health care system?
- What mechanism is in place for patients to ask questions about the health care system?
- Are staff available to assist patients with insurance, payment, and logistical issues?

TJC # 35. What types of patient education and training do we provide that help patients make informed decisions and actively participate in their care?
- Does our in-house pharmacy translate prescription and warning labels into the most common patient languages?
- Do discharge instructions take into account such factors as a patient’s language, health literacy, cultural beliefs, access, child care, family support, etc.?
- How can technology be used as a tool to provide patient education?
  - Are electronically translated patient education materials assessed for accuracy?
- Are patients given an opportunity to ask questions regarding their instructions?
- How are patients assessed for comprehension of their instructions (e.g., asked questions, teach-back processes)?

TJC # 44. How have we reached out to the community and/or facilitated access to both internal and external services?
- Are patients aware of the community programs or services available that relate to patients’ continuum of care?
- Are there public assistance programs that we could help patients become more aware of as part of their overall care?
- What adult learning programs could we partner with to help with issues of health literacy?

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DEVELOP AND IMPLEMENT AN EVIDENCE-BASED, CULTURALLY & LINGUISTICALLY APPROPRIATE CARE MODEL

(NAPH IIIA). The hospital ensures that all patients receive high quality, evidence-based care.
- Adopt standard order sets and/or treatment guidelines, with automated reminders for conditions, that have published as best practices for various conditions (e.g., acute myocardial infarction, congestive heart failure, community-acquired pneumonia, stroke, hypertension, diabetes, immunizations, as well as for preventive care).
- Adopt a set of orders that provides evidence-based treatment guidelines to the provider. If a provider judges that the patient should not be offered a recommended treatment, test, or procedure, allow the provider to opt out of following that particular best practice only with documented justification.
- Create systems to ensure that timely interpreter services are available at the bedside (See Category V).

(NAPH IIIB) The hospital’s leadership and staff understand that equitable care for diverse populations requires that cultural and linguistic competence be an essential element in the design, administration, and delivery of effective services. Administrators and clinicians need to identify:
- Effects of cultural and linguistic differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative end-of-life care;
- The impact of socio-economic status (SES), race and racism, ethnicity, and socio-cultural patient factors on access to care, utilization, quality of care, and health outcomes;
- Differences in the clinical management of preventable and chronic diseases and conditions by differences in the race or ethnicity of patients; and
- The effects of cultural differences between patients and staff, and develop strategies to address these within the design, administration, and delivery of services.

Steps to implement the above might include the following:
- Collaborate with other hospitals and healthcare training resources in the community to improve clinician training and capacity in this area.
- Provide an environment in which patients from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices when negotiating treatment options with their providers.
- Engage consumer, family, and community participation in the planning and delivery of services. Establish effective linkages and partnerships with other healthcare providers and community resources.
NQF Preferred Practice 9: Implement language access planning in any area where care is delivered.

NQF Preferred Practice 13: Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.

NQF Preferred Practice 23: Develop and implement a comprehensive care plan that addresses cultural concerns.

NQF Preferred Practice 24: Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.

TJC #3. How have we operationalized our commitment to the provision of culturally competent care into organizational actions, procedures, services, and resources?
- How do our cultural and linguistic (C&L) services reflect an understanding of the needs of the population?

TJC # 10. Are we effectively using staff across disciplines to provide culturally and linguistically appropriate care?

TJC # 11. What formal systems do we have for identifying patients’ cultural and linguistic (C&L) needs?
- Have we determined the first points of contact at which cultural and linguistic (C&L) needs are best identified?
- How do staff handle phone calls from patients with language needs?
- How does the phone system handle calls from patients with language needs (e.g., automated system, operator)
- How do we ensure that information regarding cultural and linguistic (C&L) needs follows the patient throughout the continuum of care?

TJC # 33. How have we adapted our patient care services to incorporate cultural beliefs?
- Is there a need to modify visitation hours to accommodate patient needs?
- How can we adjust our policies and procedures to accommodate cultural considerations?
- Do our dietary menus reflect our commitment to diversity and culturally competent care?

TJC # 36. What culturally centered programs have been developed to address the needs of our larger populations?
- Are there any current programs that could be more culturally focused?

TJC # 37. What programs have been built around religious and spiritual beliefs?
- Is our chaplaincy service diverse and inclusive of multiple religions?

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Contact: Susana Rinderle, MA ~ Manager, Diversity, Equity & Inclusion ~ SRinderle@salud.unm.edu
ENSURE SMOOTH TRANSITIONS IN CARE

(NAPH IIID). At times of transitions in care, the hospital’s leadership and staff ensure both that communication with patients, families, and caregivers and coordination with clinical providers are handled consistently and effectively.

- Develop a treatment summary as part of the patient record and make it available to providers and patients, in the patient’s language and at the appropriate level of health literacy, during every care interaction.
- Provide and/or facilitate the use of culturally and linguistically competent patient advocates.
- Include information related to language, culture, literacy, and SES issues in treatment plans, transitions, and reports.

(NAPH VD). The hospital measures performance in communication at times of transitions.

- Develop processes to communicate with ambulatory providers at clinical transitions (e.g., admission, discharge, and end of life).
- Upon discharge, provide patients and families with written information on clinical status, follow-up plans, and who to call if clinical deterioration occurs.
- Ensure that ambulatory follow-up visits are scheduled at time of discharge and included in the patient’s follow-up plan.
- Ensure that ambulatory providers receive a sufficiently detailed clinical summary to facilitate meaningful follow-up in the post-acute care setting.
- Include information related to language, culture, literacy, and SES issues in treatment plans, transitions, and reports.

NQF Preferred Practice 26: Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.

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MAINTAIN A PROVIDER NETWORK THAT CAN MEET PATIENTS’ CULTURAL & LINGUISTIC NEEDS
NCQA MHC 3 Element A: To enable members to choose practitioners best able to meet their cultural and linguistic needs, the organization:
1. Collects information about languages in which a practitioner is fluent when communicating about medical care
2. Collects information about language services available through the practice
3. Collects practitioner race/ethnicity data
4. Publishes practitioner languages in the provider directory
5. Publishes language services available through the practice in the provider directory
6. Provides practitioner race/ethnicity on request.

NCQA MHC 3 Element B: At least every three years, the organization:
1. Analyzes the capacity of its network to meet the language needs of its members
2. Analyzes the capacity of its network to meet the needs of its members for culturally appropriate care
3. Develops a plan to address any gaps identified as a result of analysis, if applicable
4. Acts to address any gaps based on its plan, if applicable.

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**ADAPT THE PHYSICAL ENVIRONMENT & SIGNAGE**

(NAPH IID). Equitable healthcare for diverse populations becomes part of the hospital’s environment, policies, and practices and is supported with effective operational and administrative infrastructure supports.

- Redesign the hospital’s physical plant, including exterior and interior signage, to help LEP patients access services.

(NAPH VA). The hospital communicates with patients and families in the patients’ own language and is responsive to the patients’ cultural needs. This may involve using interpreter services, offered by trained and competent staff, and distributing well translated written materials.
- Ensure that ... signs accurately convey the meaningful substance of materials written in languages other than English.

(NAPH VC). The hospital develops external and internal resources for healthcare language access.
- Ensure that all visual and written signs...are in the specified languages of the hospital’s patient population.

**CLAS Standard 7**: Health care organizations must ...post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

NQF Preferred Practice 25: Adapt the physical environment where the healthcare is being delivered to represent the culture of the populations who access their healthcare in that environment.

TJC # 31. What aspects of the physical environment have been evaluated to determine whether they meet specific patient needs?
  - Is signage readable, in appropriate languages, and available throughout the organization?
  - Is it easy for patients to identify and access the organization’s entry points?

TJC # 32. What changes have we made to the physical environment that support patient diversity?
  - Are there rooms available for special patient needs such as prayer, family conferences, and individual consultations?
  - Do we have patient rights and responsibilities documents translated into our most dominant languages and posted in clear view of all major entry points?
  - Have we considered ways to accommodate patients with large families?

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