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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<td>Press-Ganey has some information. Other surveys will need to be designed to collect this information.</td>
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<td>More comprehensive training, review of complaints for equity issues</td>
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<td>Press-Ganey patient satisfaction surveys are sent out in Spanish and English; these are assessed to drive changes in policy, procedures, and guidelines, and structure of programs.</td>
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<td>Need formal community assessment (can start with feedback rec’d through focus groups). How does this information filter to the</td>
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- PG survey is translated into Spanish and goes out to Spanish speakers automatically. Patient responses stratified by language of survey, and/or use of interpreter during stay. Four custom questions exist on the PG survey specifically aimed at satisfaction with interpreter services. Spanish comments on surveys PDF copied and forwarded to Interpreter Language Services for translation.
- Staff satisfaction and culture of safety surveys are proctored in Spanish for LEP staff.
- PSN and Patient Advocate/Grievance process links Language Services when complaints arise that include cultural competence failure or language access failure.
- Discussions are occurring with NMMRA with regarding to aligning forces in the area of diabetes regarding culturally competent reporting. Active participation by UNMH with AF4Q initiative through NMMRA.
- PAC, IAC, Native American Services Subgroup, CBOC, Patient Advisory Boards in Primary Care, among others. PAC dashboard developed by community members and reported monthly to community.
- Board of Trustees, CEO decide how/when/what data we report to the public.
- Registration includes race/ethnicity bedside? Is this information available on the intranet (how does it get on the radar to help drive improvements in patient care?)
  - Consider an annual report to the community.
  - Analysis of survey data not done according to Race/Ethnicity or Language.
(single category), language, address, zip, etc. Data collected by self-report. Training on Race/Language data collection tool mandatory for all Frontline Staff. Training includes: if patient leaves section blank, scripted prompting by front-end staff aims at ensuring a complete document.

- Accuracy: annual post-completion audit of race/language data collection tool checking 1) agreement between what is marked on the tool and what is captured in Cerner (Accuracy); 2) completion rate by patient. Feedback provided based upon audit, to Office Supervisors by department.

- Annual updates to Native American Community; Quarterly updates to Indian Health Service; Annual report from DOH based upon hospital discharge data (HEDIS, outcomes, TJC reports, etc); monthly dashboard report to Patient Access Committee (Community); Quarterly dashboard to Interpreter Advisory Committee (Community).

- BOT and CBOC meetings include time for public input.

### 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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UNMH is beginning to develop champions of cultural competency through the Health Literacy Task Force & DEI.

UNM Hospitals has a core group of Language Access Coordinators who work at each primary building site across UNMH to facilitate access to linguistically appropriate care. This group has met since 2007.

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?
  o 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?

TJC Road Map: Organization Readiness: Leadership
  □ Demonstrate leadership commitment to effective communication, cultural competence, and patient- and family-centered care.

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Reflected in Core value of HSC “Diversity in people and thinking.” No actionable plan identified.

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<td>(NAPH IIB) The hospital ensures that healthcare equity is integral to its strategic plan.</td>
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<td>- Incorporate equity into a hospital strategic plan that is accepted and promoted by both the executive leadership and the governance body.</td>
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<tr>
<td>o State explicitly any organizational intent to close racial and ethnic quality gaps where they exist.</td>
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<tr>
<td>o Develop a plan that is appropriate to the population served by the hospital.</td>
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<tr>
<td>- Include in the strategic plan specific strategies for ensuring that all patients have access to high-quality services and affordable medications.</td>
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<tr>
<td>o Develop efforts to ensure that patients have access to continuous and high quality care.</td>
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<tr>
<td>- Establish equity as a standard of care equal to the other aims for improvement identified by the Institute of Medicine in <em>Crossing the Quality Chasm</em> (i.e., safety, effectiveness, patient-centeredness, timeliness, and efficiency).</td>
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<tr>
<td>- Identify key hospital leaders who can help build equity into the strategic goals of the hospital.</td>
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<tr>
<td>- Ensure that diversity and cultural competence training programs integrate community context as part of the strategic planning process.</td>
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<td>(NAPH VC) The hospital develops external and internal resources for healthcare language access.</td>
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<tr>
<td>- Strategize within the hospital and advocate outside the hospital for improved healthcare financing of language access for LEP populations.</td>
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**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?

TJC Road Map: Organization Readiness: Leadership

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<td>□ UNMH Strategic plan presented at Management Coffee, August 20, 2009 – &quot;Our patient care mission encompasses serving as an accessible, high quality, safety focused, and comprehensive care provider. Our vision is that UNMH will be the leader in improving New Mexico’s health outcomes. A mission enhancer is to ensure equity in outcomes across all</td>
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<td>Health literacy &amp; cultural competence training (once defined) are needed in addition to the strong focus on language access already in place.</td>
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<td>Not all operational procedures address this component. Need to adopt a definition for cultural competence.</td>
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| o Most line staff job descriptions indicate preferred candidates have a second language.  
| o Targeted, community-based recruitment occurs for NAHS & ILS positions.  
| o Since 2005 New Employee Orientation covers language services & diversity.  
| o Frontline Education includes mandatory section on communication/language.  
| o OPD offers two courses on diversity & intercultural competence, two levels of Spanish, and ongoing ESOL classes.  
| o Since 2007, staff take annual competencies on language access and use of interpreter services, and cultural diversity.  
| o 2009 semi-annual awareness campaigns for ILS through communication, buttons, posters, presentations on access to language services.  
| o Access of ILS services is strong, > 4,000 interpreted events each month (does not include direct services provided in another language) and > 1,000 documents translated.  
| o ILS dashboard reviewed with Interpreter Advisory committee each 2 months at standing meeting.  
| o Bridging the Gap 40 hour training conducted monthly for staff qualified through testing.  
| o Health literacy online competency effective 2010  

Leadership (and nurse) demographics not reflective of staff ethnic diversity.
CREATE AND IMPLEMENT POLICIES, PROCEDURES, GOALS AND ACCOUNTABILITY

(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.

- 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?

TJC Road Map: Organization Readiness: Leadership
- Integrate unique patient needs into new or existing hospital policies.

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<td>o Core Value: Diversity in people and thinking.</td>
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<td>A plan to review and update policies and procedures should be put in place.</td>
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<td>o Some policies and procedures address</td>
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<td>Improved culturally competent care coordination for LEP and patients facing possible equity barriers, aside from Native Americans. We cannot quantify how often cultural issues impact care –</td>
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cultural competency (UNMH Board of
Trustees Patient Grievance Policy,
Interpreter Language Services
Procedure). ILS Procedure commended
by Office of Civil Rights.

- Cultural exchange/Inservice provided
  annually with ongoing education 1:1
  available to Care Management Discharge
  Planners & Clinical Social Workers from
  the Office of Native American Health.
- Contract Health coordinators for Indian
  Health Service share information,
  services, and cultural implications for
  consideration during the discharge
  planning process (strong).
- SE Heights Clinic is a strength, especially
  regarding care of Vietnamese patients.
  Vietnamese Interpreters at SE Heights
  Clinic are permitted to wear traditional
dress in performance of their job duties.
- Active Health Literacy Task Force.
- We meet this (TJC #5) through our
  Standards of Performance, which must
  be signed off by anyone applying for a
  job at UNMH, and appear on every job
  description for sign-off by staff. The
  "Service" Pillar under SOP states:

  **Dignity and Respect:** We recognize,
  value, and respect the diversity of our
  co-workers, patients, and customers by
  honoring their perspectives, choices,
  and differences. This commitment is
  reflected in our conduct by ensuring
  their knowledge, values, beliefs, and
  cultural backgrounds are incorporated

  data not collected.

  Targeted programs and policies aimed
  at retention for members of
  underrepresented cultural groups.

  Explore what indirect data
  methodologies are out there that could
  be adopted? Leah Steimel might be a
  good resource.

  -
into staff interactions, care planning, and decision-making.

- Stipend program available for qualified bilingual staff who also serve as interpreters.
- Required annual competency on diversity for all staff.
- Registration includes race/ethnicity (single category), language, address, zip, etc. Data collected by self-report. Training on Race/Language data collection tool mandatory for all Frontline Staff. Training includes: if patient leaves section blank, scripted prompting by front-end staff aims at ensuring a complete document.
- Accuracy: annual post-completion audit of race/language data collection tool checking 1) agreement between what is marked on the tool and what is captured in Cerner (Accuracy); 2) completion rate by patient. Feedback provided based upon audit, to Office Supervisors by department.

- Language Access and Patient Grievance policies include section requiring that any complaints which include issues around LEP, language access, or discrimination are also handled by the Director of Call Center & Interpreter Services in addition to the Unit Director. All grievances funnel through the Patient Advocate’s office for reporting, data tracking, and loop closure. This practice was cited by the Office of Civil Rights as
a best practice.
• Patient Advocate reports to Administrators, Quality Committee, and Board of Trustees.

INCLUDE DEI IN BUSINESS AND RESOURCE PLANNING
(NAPHI 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?
  o Which internal resources have been identified to support cultural and linguistic (C&L) activities and improve patient-provider communication?
  o 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?
  o 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?
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**PLAN TO RECRUIT AND RETAIN A DIVERSE WORKFORCE**

(NAPPH 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?
What are our strategies for staff recruitment?
- 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?

TJC Road Map: Organization Readiness: *Workforce*
- Target recruitment efforts to increase the pool of diverse and bilingual candidates.
- Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.

<table>
<thead>
<tr>
<th>Current Compliance</th>
<th>Weak</th>
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<th>Opportunities</th>
<th>Priority/Timeline</th>
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<tbody>
<tr>
<td>Current data are reflective of a diverse staff.</td>
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<td>Action plan may need to be developed that discusses an overall plan</td>
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<tr>
<td>Most line staff job descriptions indicate preferred candidates have a second language.</td>
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<td></td>
<td>Leadership (and nurse) demographics not reflective of staff ethnic diversity.</td>
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<tr>
<td>Targeted, community-based recruitment occurs for NAHS &amp; ILS positions.</td>
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<td>Targeted programs and policies aimed at retention for members of underrepresented cultural groups.</td>
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<tr>
<td>Most line staff job descriptions indicate preferred candidates have a second language, and line staff demographics resemble patient population.</td>
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<tr>
<td>Targeted, community-based recruitment for NAHS &amp; ILS positions.</td>
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<tr>
<td>#6 TJC: We meet this through our Standards of Performance, which must be signed off by anyone applying for a job at UNMH, and appear on every job description for sign-off by staff. The &quot;Service&quot; Pillar under SOP states: <em>Dignity and Respect:</em> We recognize,</td>
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value, and respect the diversity of our co-workers, patients, and customers by honoring their perspectives, choices, and differences. This commitment is reflected in our conduct by ensuring their knowledge, values, beliefs, and cultural backgrounds are incorporated into staff interactions, care planning, and decision-making.

- Vietnamese Interpreters at SE Heights Clinic are permitted to wear traditional dress in performance of their job duties.
- Stipend program available for qualified bilingual staff who also serves as interpreters.
- Required annual competency on diversity for all staff.

**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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<th>Priority/Timeline</th>
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<tbody>
<tr>
<td>Board of Trustees, CEO decision on how/when/what data we report to the public.</td>
<td>X</td>
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DEI Comprehensive Self-Assessment: Steering

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3/8/11
o Registration includes race/ethnicity (single category), language, address, zip, etc. Data collected by self-report. Training on Race/Language data collection tool mandatory for all Frontline Staff. Training includes: if patient leaves section blank, scripted prompting by front-end staff aims at ensuring a complete document.

o Accuracy: annual post-completion audit of race/language data collection tool checking 1) agreement between what is marked on the tool and what is captured in Cerner (Accuracy); 2) completion rate by patient. Feedback provided based upon audit, to Office Supervisors by department.

**BUILD BRIDGES AND COLLABORATE EXTERNALLY**

(NAPHA) 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?

- Are there best practices related to implementing culturally competent care that we could share with other organizations?
- Are there any lessons learned from implementing culturally competent care that would be useful to share with other organizations?
- What types of information would we like to learn from other organizations?
- What resources are available that other organizations can share with us?
- What organizations or types of organizations do we want to share information or resources with?

TJC # 40. What resources or materials do we want to develop in collaboration with other organizations?

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

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<tr>
<td>Most work currently being done through ILS.</td>
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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?

### TJC Road Map: Organization Readiness: *Data Collection and Use*

- Conduct a baseline assessment of the hospital’s efforts to meet unique patient needs.
- Use available population-level demographic data to help determine the needs of the surrounding community.

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DEI Comprehensive Self-Assessment: Compliance

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3/8/11
| Discussions are occurring with NMMRA with regarding to aligning forces in the area of diabetes regarding culturally competent reporting. **Active participation** by UNMH with AF4Q initiative through NMMRA. | x | Need formal community assessment (can start with feedback rec’d through focus groups). How does this information filter to the bedside? Is this information available on the intranet (how does it get on the radar to help drive improvements in patient care?)

- PAC, IAC, Native American Services Subgroup, CBOC, Patient Advisory Boards in Primary Care, among others. PAC dashboard developed by community members and reported monthly to community.
- Registration includes race/ethnicity (single category), language, address, zip, etc. Data collected by self-report. Training on Race/Language data collection tool mandatory for all Frontline Staff. Training includes: if patient leaves section blank, scripted prompting by front-end staff aims at ensuring a complete document.
- Accuracy: annual post-completion audit of race/language data collection tool checking 1) agreement between what is marked on the tool and what is captured in Cerner (Accuracy); 2) completion rate by patient. Feedback provided based upon audit, to Office Supervisors by department.
- Interpreter Advisory Committee includes input from Catholic Social Services & from major community (SE Heights); this area is most often targeted for settlement by various immigrant groups. Known & upcoming immigration

- Need to obtain and maintain demographic data. Epidemiological profile could be worked on with DOH and infection control depts. (Add to Pam Iwamoto’s Infection Control Plan for 2010.) Develop Cultural profiles handbook.

- Consider an annual report to the community.
settlement is planned for within the IAC to ensure language is needed.
- Board of Trustees, CEO decision on how/when/what data we report to the public.
- Annual updates to Native American Community; Quarterly updates to Indian Health Service; Annual report from DOH based upon hospital discharge data (HEDIS, outcomes, TJC reports, etc); monthly dashboard report to Patient Access Committee (Community); Quarterly dashboard to Interpreter Advisory Committee (Community).
- BOT and CBOC meetings include time for public input.

**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?

TJC Road Map: Organization Readiness: *Data Collection and Use*
- Conduct a baseline assessment of the hospital’s efforts to meet unique patient needs.
- Develop a system to collect patient-level race and ethnicity information.
- Develop a system to collect patient language information.
- Make sure the hospital has a process to collect additional patient-level information.

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<tbody>
<tr>
<td>o Cerner collects this information and Quality Outcomes can pull data. More work.</td>
<td>x</td>
<td>x</td>
<td></td>
<td>We do not use the HRET toolkit. Compare existing Race/Language Tool (which was developed based upon research and best practices). If determined to be a comparable tool, then this is not an area weakness. Allow committee to investigate this.</td>
<td></td>
</tr>
<tr>
<td>o Race and language are collected, however, no differentiation between spoken/written language is present. Current practice includes the question “what language would you prefer to receive your health services in?” which we believe to be the key question. Committee to decide if this meets criteria.</td>
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<tr>
<td>o Ethnicity is collected as part of ‘Race’ (Hispanic), not differentiated.</td>
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<td></td>
<td>Explore what indirect data methodologies are out there that could be adopted? Leah Steimel might be a good resource.</td>
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</tbody>
</table>
Committee to determine if this meets criteria.
- Registration includes race/ethnicity (single category), language, address, zip, etc. Data collected by self-report. Training on Race/Language data collection tool mandatory for all Frontline Staff. Training includes: if patient leaves section blank, scripted prompting by front-end staff aims at ensuring a complete document.
- Accuracy: annual post-completion audit of race/language data collection tool checking 1) agreement between what is marked on the tool and what is captured in Cerner (Accuracy); 2) completion rate by patient. Feedback provided based upon audit, to Office Supervisors by department.

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.
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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<tbody>
<tr>
<td>Data, particularly language, is being collected, but not currently analyzed or translated into disparities-reducing initiatives</td>
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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.mghdisparitiessolutions.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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<tr>
<td>o Need to employ methodology to collecting of data and auditing of records to determine what improvement opportunities exist. Then take steps to address disparities, etc.</td>
<td>x</td>
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<td></td>
<td>Define Cultural competence. We do not separately collect written vs. spoken language preference from patients.</td>
</tr>
<tr>
<td>o AF4Q multidisciplinary team looking at disparity as it relates to Diabetes care. UNMH shares resources, data, and best practices.</td>
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<tr>
<td>o Current Practice (Daily): Interpreter rounding twice daily to all LEP inpatients; communication needs</td>
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facilitated with unit staff and providers. Native American liaisons round twice daily on NA inpatients and facilitate communication based upon family or patient needs. This is ongoing, hard-wired. Nursing assessments upon admission (nursing assessment database).

### BENCHMARK RESULTS OF DATA ANALYSIS

(NAPH IVE) 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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<tr>
<td>Networking being done – little data available as of yet.</td>
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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.

TJC Road Map: Organization Readiness: Patient, Family, and Community Engagement
☐ Collect feedback from patients, families, and the surrounding community.

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<td>Need formal community assessment (can start with feedback rec’d through focus groups). How does this information filter to the bedside? Is this</td>
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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
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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<td>x</td>
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<td>o Community Benefits Oversight Committee (Subcommittee of the Board of Trustees) and Performance Oversight Committee receives quarterly report and data dashboards; data is set to include race and outcomes data.</td>
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<td>o Pathways Program – 1% of mil levy funds goes to community to shore up services/opportunities that drive the overall health of a community.</td>
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<td>o NAHS outreach is extensive; liaison in place since 2004, growth from dept of 1 to 9 in 2010. Trends bear out the results of marketing and outreach</td>
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through departmental liaisons showing a steep upward trend in access to both inpatient and outpatient services. Language outreach to the community includes assessments of language access services at UNMH by an independent field specialist in 2005 and 2008. Language Access is becoming hard-wired with new awareness campaigns, increased standards for quality interpreting, and new equipment aimed at ease of practice.

- Driving patients towards programs for assistance is part of the fabric of how we do business. Discharge planners and social workers are heavily involved in coordination of follow-up care for inpatients. They involve NAHS office for native Americans returning to rural areas for healthcare to ensure their communities or personal living situation can support follow-up care needs.
- Office of Community Affairs/Leah, Ivette
- Nursing Research – Community Based, on obesity, hyperlipidemia, and ______(check w/Kathy Lopez-Bushnell)?
- Pathways Program
- Patient Satisfaction Focus Groups in each Primary Care Site
- Interpreter Advisory (Community) Committee; includes a research and publication subcommittee working on publishing our work to date.
- Patient Access Committee
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?
- 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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DEI Comprehensive Self-Assessment: Community
Driving patients towards programs for assistance is part of the fabric of how we do business. Discharge planners and social workers are heavily involved in coordination of follow-up care for inpatients. They involve NAHS office for Native Americans returning to rural areas for healthcare to ensure their communities or personal living situation can support follow-up care needs.

NAHS outreach is extensive; liaison in place since 2004, growth from dept of 1 to 9 in 2010. Trends bear out the results of marketing and outreach through departmental liaisons showing a steep upward trend in access to both inpatient and outpatient services. Language outreach to the community includes assessments of language access services at UNMH by an independent field specialist in 2005 and 2008. Language Access is becoming hard-wired with new awareness campaigns, increased standards for quality interpreting, and new equipment aimed at ease of practice.

Driving patients towards programs for assistance is part of the fabric of how we do business. Discharge planners and social workers are heavily involved in coordination of follow-up care for inpatients. They involve NAHS office for native Americans returning to rural areas for healthcare to ensure their communities or personal living situation can support follow-up care needs.
can support follow-up care needs.
- Office of Community Affairs/Leah, Ivette
- Nursing Research – Community Based, on obesity, hyperlipidemia, and _____ (check w/Kathy Lopez-Bushnell)?
- Pathways Program
- Patient Satisfaction Focus Groups in each Primary Care Site
- Interpreter Advisory (Community) Committee; includes a research and publication subcommittee working on publishing our work to date.
- Patient Access Committee
- Native American Subcommittee of the PAC

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<tr>
<th>COLLABORATE &amp; DIALOGUE WITH PATIENTS AND FAMILIES</th>
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<tr>
<td>(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)</td>
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<tr>
<td>- Establish a patient and family advisory council that is representative of the community and institutionalizes healthcare equity issues as part of the regular agenda.</td>
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**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?
- On what other committees would having community representatives be helpful?
- Do the community representatives currently involved provide perspectives of the diverse needs of the populations we serve?

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PAC, IAC, Native American Services Subgroup, CBOC, Patient Advisory Boards in Primary Care, among others. PAC dashboard developed by community members and reported monthly to community.

**Opportunity:** It does not appear that we are evaluating the effectiveness of cultural competency activities.

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**ESTABLISH EQUITABLE, INCLUSIVE CONFLICT AND GRIEVANCE RESOLUTION PROCESSES**

*(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)

- 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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<tr>
<td>Language Access and Patient Grievance policies include section requiring that any complaints which include issues around LEP, language access, or discrimination are also handled by the Director of Call Center &amp; Interpreter Services in addition to the Unit Director. All grievances funnel through the Patient Advocate’s office for reporting, data tracking, and loop closure. This practice was cited by the Office of Civil Rights as a best practice.</td>
<td>x</td>
<td></td>
<td></td>
<td>No ombuds programs</td>
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<tr>
<td>Bilingual (Spanish-English) Patient Advocate reports to Administrators, Quality Committee, and Board of</td>
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<td></td>
<td>No evaluation of cross-cultural effectiveness of grievance resolution process</td>
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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.

TJC Road Map: Organization Readiness: Patient, Family, and Community Engagement

- Share information with the surrounding community about the hospital’s efforts to meet unique patient needs.

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<td>o Since 2005, 90% of Centralized Scheduling staff are bilingual English/Spanish speakers. This is a critical entry point for patients accessing appointment services.</td>
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<td>Assessing and improving culturally competent behaviors by line staff and patient care providers.</td>
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<td>o Phone trees and ACD messages are multi-lingual for all lead #’s called by the</td>
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<td>Consider an annual report to the community.</td>
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Very large effort underway since 2008 from Patient Financial Services on access to financial assistance; inservices conducted in community centers in Spanish.
- Ads on Spanish radio stations & on Singing Wire Radio to advertise services to Spanish and Navajo – speaking listeners.
- Navajo video describes access to services, system navigation, financial assistance, interpreters, and liaison services.
- Active marketing campaign for Native American Health Services underway since 2008 (billboards, booths annually at state fair, health fairs four times per year, Gathering of Nations.)
- Frontline Education mandatory training on Native American Health and access to services, appropriate billing.
- Patient brochures in multiple languages, co-created by the community.
- Patient Education materials translated; good example is diabetes handbook in English and Spanish written at a 6th grade level with simple pictures and diagrams to walk patients through & facilitate participation in their own care plans.
- Board of Trustees, CEO decision on how/when/what data we report to the public.
- Registration includes race/ethnicity
(single category), language, address, zip, etc. Data collected by self-report. Training on Race/Language data collection tool mandatory for all Frontline Staff. Training includes: if patient leaves section blank, scripted prompting by front-end staff aims at ensuring a complete document.

- **Accuracy**: annual post-completion audit of race/language data collection tool checking 1) agreement between what is marked on the tool and what is captured in Cerner (Accuracy); 2) completion rate by patient. Feedback provided based upon audit, to Office Supervisors by department.

- **Annual updates** to Native American Community; Quarterly updates to Indian Health Service; Annual report from DOH based upon hospital discharge data (HEDIS, outcomes, TJC reports, etc); monthly dashboard report to Patient Access Committee (Community); Quarterly dashboard to Interpreter Advisory Committee (Community).

- BOT and CBOC meetings include time for public input.
**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?

TJC Road Map: Organization Readiness: *Workforce*
- Identify staff concerns or suggested improvements for providing care that meets unique patient needs.

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<tr>
<td>Current Practice (Daily): Interpreter rounding twice daily to all LEP inpatients; communication needs facilitated with unit staff and providers. Native American liaisons round twice daily on NA inpatients and facilitate communication based upon family or patient needs. This is ongoing, hard-wired. Nursing assessments upon admission (nursing assessment database).</td>
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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-economic characteristic data of the hospital patient population.
- 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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<tr>
<td>o All vital documents are translated into Spanish (a threshold language) and many vital documents are also translated into Vietnamese (not a threshold language).</td>
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<td>Identify which items must be translated and which may simply be reserved for sight translation as needed. Revisit identification of vital documents to be translated, articulate them as such, and address any gaps in translation. Update and formal review of forms should be improved; archival database is in development.</td>
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<tr>
<td>o Neither federal law nor our Consultant, Cindy Roat, recommends that all documents be translated.</td>
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<td>Also needed are options for LHL patients.</td>
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<td>o Methodology exists to archive forms; retrieval is through direct link on hospital intranet or internet websites.</td>
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<tr>
<td>o Sight translation available via Pacific Translators or via second language interpreters.</td>
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**DEVELOP AND PROVIDE LANGUAGE ACCESS RESOURCES**

(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.

- List in a visible and accessible manner the local options for culturally appropriate medical interpreters (e.g., telephone or in person interpreters).
- 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).
- Organize language access and interpreter services to ensure the availability of interpreters and translated materials as needed for safe and high quality patient care.
(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.
- Ensure that all visual and written signs and materials are in the specified languages of the hospital’s patient population.
- Use promotoras, navigators, and care managers trained in the language and culture appropriate to the patient population.
- It is recommended that hospitals utilize the following premier resources in the area of health care language access: Hablamos Juntos www.hablamosjuntos.org; Speaking Together < www.speakingtogether.org

**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.
TJC Road Map: Organization Readiness: *Provision of Care, Treatment, and Services*

- Develop a system to provide language services.
- Address the communication needs of patients with sensory or communication impairments.
- Integrate health literacy strategies into patient discussions and materials.

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<td>Strong ILS Department</td>
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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.

(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.
- 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.

(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.
- 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
5. Offering training to practitioners on the provision of language services.

.. Which organizational policies and procedures, if any, set expectations for staff for providing culturally and linguistically appropriate care?
   o What training have staff received regarding these policies and procedures and how to abide by them?

TJC #12. What tools are provided to staff to determine the appropriate language services?
   o What resources are available to identify language needs (e.g., “I Speak” cards, telephone interpreting services)?
   o What training have staff received to understand and use the resources available to identify language needs?

TJC #13. What tools and resources are available to staff to help them meet patients’ cultural needs?
   o How are staff made aware of these tools?
   o What type of training have staff received to help them meet the unique cultural needs of the patient population?
TJC #14. How are staff made aware of the availability of cultural and linguistic (C&L) services?
   - Are interpreter services incorporated at the patient care level to ensure visibility?
   - What type of training have staff received regarding the appropriate use of cultural and linguistic (C&L) services?

TJC #15. What type of training have staff received regarding how to access cultural and linguistic (C&L) services?
   - Are staff aware of the regulatory requirements, mandates, and national standards regarding the provision of language services?
   - What internal materials are available on how to access cultural and linguistic (C&L) services during hours, after-hours, and for certain departments (e.g., the emergency room)?
   - How are cultural and linguistic (C&L) services accessed (e.g., on-site interpreters, contract interpreters, telephone or video language services, chaplain, religious and spiritual services, dietary services, etc.)?

TJC #21. How are cultural issues incorporated into patient care?
   - How often do cultural issues have an impact on patient care?
   - Do staff consider religious and spiritual beliefs, cultural beliefs, folk remedies, traditions, rituals, and alternative medicine when providing care?
   - What skills do staff have to explore patients’ perspectives including cultural and religious beliefs related to health, illness, and treatment?
   - Do staff document situations in which cultural issues arise?
     - Do chaplains record encounters with patients?
     - Are dietary considerations regarding culture and/or religion recorded?

TJC #22. How are language issues incorporated into patient care?
   - Is there formal documentation of interpreter encounters?
     - Where is the encounter documented (e.g., interpreter log, patient’s medical record)?
     - Is the type of interpreter documented (e.g., on-site, telephone, video)?
     - Is there a policy for documenting interpreter encounters?
     - Are staff educated on the importance of documenting interpreter encounters?
   - Are encounters documented when an interpreter has been offered but has been refused by a patient?
     - Is there a policy for documenting the refusal of interpreter services?
     - Are staff educated on the importance of documenting the refusal of interpreter services?

TJC #27. How does staff training address the importance of effective communication in the provision of care?
   - Does training address the roles that language, literacy, and culture play?
   - Are these issues addressed during orientation and ongoing training?
   - Are staff provided training on how to access available resources to meet the cultural and linguistic (C&L) needs of patients?
     - Are they trained to access on-site interpreters, telephone, or video interpreters?
• What type of training have staff received on how to work with interpreters?

TJC # 28. How are staff educated on the unique cultural and linguistic (C&L) needs of the patients served?

• Do staff receive cultural competence training?
  o When does training occur?
  o Is the training required or optional?
  o How often is training provided (e.g., during orientation, annually to all staff)?
  o What issues are addressed in the training?
  o Who provides the training?

TJC #29. What educational materials and tools are staff provided regarding the cultural and linguistic (C&L) issues of the service community?

• Are there any online applications or intranet resources that provide cross-cultural information?
• Do staff have an opportunity to dialogue about the cultures and languages encountered?
• Are staff required to demonstrate competency regarding the use of cultural and linguistic (C&L) resources and tools?

TJC #30. How can technology enhance or better facilitate existing language services?

• Are staff trained to properly use telephone or video medical interpreting services?
• Is the appropriate equipment present in patient rooms (e.g., speakerphone, dual handset telephones, video equipment)?
• Are speech output devices and/or bilingual communication boards made available to supplement language services?

TJC Road Map: Organization Readiness: Workforce

□ Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.

TJC Road Map: Organization Readiness: Provision of Care, Treatment, and Services

□ Create an environment that is inclusive of all patients.
□ Address the communication needs of patients with sensory or communication impairments.
□ Integrate health literacy strategies into patient discussions and materials.
□ Incorporate cultural competence and patient- and family-centered care concepts into care delivery.

TJC Road Map: Include elements from Checklist on Admission, Assessment, Treatment, End-of-Life and Discharge & Transfer (p.5)

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- Some policies and procedures address cultural competency (UNMH Board of Trustees Patient Grievance Policy, Interpreter Language Services Procedure). ILS Procedure commended by Office of Civil Rights.
- Since 2005 New Employee Orientation covers language services & diversity.
- Frontline Education includes mandatory section on communication/language.
- OPD offers two courses on diversity & intercultural competence, two levels of Spanish, and ongoing ESOL classes.
- Since 2007, staff take annual competencies on language access and use of interpreter services, and cultural diversity.
- 2009 semi-annual awareness campaigns for ILS through communication, buttons, posters, presentations on access to language services.
- Access of ILS services is strong, > 4,000 interpreted events each month (does not include direct services provided in another language) and > 1,000 documents translated.
- ILS dashboard reviewed with Interpreter Advisory committee each 2 months at standing meeting.
- Bridging the Gap 40 hour training conducted monthly for staff qualified through testing.
- Health literacy online competency effective 2010
- Nurses use teach back with interpreters,

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- A plan to review and update policies and procedures should be put in place.
- Health literacy & cultural competence training (once defined) are needed in addition to the strong focus on language access already in place.
- Not all operational procedures address this component. Need to adopt a definition for cultural competence.
- Outreach training in language access to College of Nursing. More work with other staff is necessary on “teach back” besides nurses.
- Health Literacy & cultural competence training (once defined) is needed in addition to the strong focus on language access already in place.
- Improved culturally competent care coordination for LEP and patients facing possible equity barriers, aside from Native Americans. We cannot quantify how often cultural issues impact care – data not collected.
- Standards of Performance reinforce expectations, but ‘cultural competence’ has not been well-defined for our staff, or assessed, so this is an expectation without a clear goal. OPD offers two courses on effective communication, but
**if applicable.**

**Tools:**
- Pacific Interpreters ‘point to’ posters with 20+ top languages help identify which language patient speaks
- I-speak cards
- Multi-lingual notices posted regarding availability of interpreters to empower patients to ask for them if not immediately offered.

**Training:**
- Pacific Interpreters and phone equipment, video equipment training conducted house-wide during 2009 training blitz
- Incorporated into mandatory Frontline Education training for phone/intake staff.
- Opportunity for MA’s and Nurses to receive language access training in orientation.
- Part of mandatory curriculum for residents of UNM School of Medicine residency programs,
- Part of New Resident orientation.

Informed consent is translated into Spanish and Vietnamese.

Families are included as part of decision making, when appropriate. Interpreters are used.

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<th>these are not geared towards intercultural issues.</th>
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<td>- Educating internally about health literacy challenges and equipping our staff to identify them and how to manage/navigate them.</td>
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“Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.” – Part of nursing assessment.

- Cultural exchange/Inservice provided annually with ongoing education 1:1 available to Care Management Discharge Planners & Clinical Social Workers from the Office of Native American Health.
- Contract Health coordinators for Indian Health Service share information, services, and cultural implications for consideration during the discharge planning process (strong).
- SE Heights Clinic is a strength, especially regarding care of Vietnamese patients.
- Active Health Literacy Task Force.
- #21 TJC: Patient or family may request adjunct healing services (i.e. curandera, medicine man, add'l family at bedside for support, etc.)
- #27 TJC: Training for Medical Students/Residents now includes mandatory course on language, importance of and working with interpreters, how to access interpreters, the role language and culture plays in healthcare.
- IOM Health Literacy video available to UH providers and nursing staff via intranet.
- Discussions are occurring with NMMRA with regarding to aligning forces in the area of diabetes regarding culturally
competent reporting. Active participation by UNMH with AF4Q initiative through NMMRA.

- Driving patients towards programs for assistance is part of the fabric of how we do business. Discharge planners and social workers are heavily involved in coordination of follow-up care for inpatients. They involve NAHS office for Native Americans returning to rural areas for healthcare to ensure their communities or personal living situation can support follow-up care needs.

- Office of Community Affairs/Leah, Ivette

  - Language Access and Patient Grievance policies include section requiring that any complaints which include issues around LEP, language access, or discrimination are also handled by the Director of Call Center & Interpreter Services in addition to the Unit Director. All grievances funnel through the Patient Advocate’s office for reporting, data tracking, and loop closure. This practice was cited by the Office of Civil Rights as a best practice.

### 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?

**TJC Road Map: Organization Readiness: Workforce**
- Ensure the competency of individuals providing language services.

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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 (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?

TJC Road Map: Organization Readiness: *Workforce*
- Identify staff concerns or suggested improvements for providing care that meets unique patient needs.

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<td>o Press-Ganey has some information. Other surveys will need to be designed to collect this information.</td>
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<td>o PG survey is translated into Spanish and goes out to Spanish speakers automatically. Patient responses stratified by language of survey, and/or use of interpreter during stay. Four custom questions exist on the PG survey specifically aimed at satisfaction with interpreter services. Spanish comments</td>
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<td>Data analysis not done according to Race/Ethnicity or Language.</td>
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on surveys PDF copied and forwarded to Interpreter Language Services for translation.
  O Staff satisfaction and culture of safety surveys are proctored in Spanish for LEP staff.

### INVOKE 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?
o Are patients given an opportunity to ask questions regarding their instructions?

o 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?

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?

TJC Road Map: Organization Readiness: *Provision of Care, Treatment, and Services*

- Create an environment that is inclusive of all patients.
- Address the communication needs of patients with sensory or communication impairments.
- Integrate health literacy strategies into patient discussions and materials.

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- Active marketing campaign for Native American Health Services underway since 2008 (billboards, booths annually at state fair, health fairs four times per year, Gathering of Nations.)
  - Patient brochures in multiple languages, co-created by the community.
  - Patient Education materials translated; good example is diabetes handbook in English and Spanish written at a 6th grade level with simple pictures and diagrams to walk patients through & facilitate participation in their own care plans.
  - When requested by the patient, at any time, all resources may be sight-translated via phone or in-person interpreter.
  - Use of community *promotoras*, Native American Health liaisons, Care One Program, and participation in the Pathways Program help to carry messages regarding access to services and system navigation.
  - Health plan provider directories include an indicator when providers are multilingual.
  - Community was active in providing input regarding BBRP architecture and icon system.
  - BBRP signage and navigation brochures are good and include Braille
  - New clinics (SE Heights) have excellent multi-lingual signage.
  - At all entry points system-wide,

- Educating internally about health literacy challenges and equipping our staff to identify them and how to manage/navigate them.
- Need to obtain and maintain demographic data. Epidemiological profile could be worked on with DOH and infection control depts. (Add to Pam Iwamoto’s Infection Control Plan for 2010.) Develop Cultural profiles handbook.
- Multilingual signage announces access to interpreters and financial assistance.
  - Multilingual brochures explain our healthcare system.
  - TJC #35. No electronic translation is used, as this is contraindicated for effective translation. But in-person translation occurs through qualified, trained translation staff. Translation accuracy is validated through a systematic, 3-person process in ILS prior to being posted.
  - Community Benefits Oversight Committee (Subcommittee of the Board of Trustees) and Performance Oversight Committee receives quarterly report and data dashboards; data is set to include race and outcomes data.
  - Pathways Program – 1% of mil levy funds goes to community to shore up services/opportunities that drive the overall health of a community.
  - NAHS outreach is extensive; liaison in place since 2004, growth from dept of 1 to 9 in 2010. Trends bear out the results of marketing and outreach through departmental liaisons showing a steep upward trend in access to both inpatient and outpatient services. Language outreach to the community includes assessments of language access services at UNMH by an independent field specialist in 2005 and 2008. Language Access is becoming hard-wired with new awareness.
campaigns, increased standards for quality interpreting, and new equipment aimed at ease of practice.
- Driving patients towards programs for assistance is part of the fabric of how we do business. Discharge planners and social workers are heavily involved in coordination of follow-up care for inpatients. They involve NAHS office for native Americans returning to rural areas for healthcare to ensure their communities or personal living situation can support follow-up care needs.
- Office of Community Affairs/Leah, Ivette
- Patient Access Committee
- Native American Subcommittee of the PAC
- Interpreter Advisory Committee includes input from Catholic Social Services & from major community (SE Heights); this area is most often targeted for settlement by various immigrant groups. Known & upcoming immigration settlement is planned for within the IAC to ensure language is needed.

**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?

TJC Road Map: Organization Readiness: Provision of Care, Treatment, and Services
- Create an environment that is inclusive of all patients.
- Develop a system to provide language services.
- Address the communication needs of patients with sensory or communication impairments.
- Integrate health literacy strategies into patient discussions and materials.
- Incorporate cultural competence and patient- and family-centered care concepts into care delivery.

TJC Road Map: Include elements from Checklist on Admission, Assessment, Treatment, End-of-Life and Discharge & Transfer (p.5)

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public.
  - Very large effort underway since 2008 from Patient Financial Services on access to financial assistance; inservices conducted in community centers in Spanish.
  - Ads on Spanish radio stations & on Singing Wire Radio to advertise services to Spanish and Navajo – speaking listeners.
  - Navajo video describes access to services, system navigation, financial assistance, interpreters, and liaison services.
  - Active marketing campaign for Native American Health Services underway since 2008 (billboards, booths annually at state fair, health fairs four times per year, Gathering of Nations.)
  - Frontline Education mandatory training on Native American Health and access to services, appropriate billing.
  - Patient brochures in multiple languages, co-created by the community.
  - Patient Education materials translated; good example is diabetes handbook in English and Spanish written at a 6th grade level with simple pictures and diagrams to walk patients through & facilitate participation in their own care plans.
  - Nursing admission database includes information on the patient nationality, ethnicity and cultural preferences.
  - “Consider cultural, spiritual, and
religious beliefs that may complement or conflict with standard medical care.” – Part of nursing assessment.

- Brochures, advertising materials, health fair booths/written materials, and websites for the public carry a multicultural message through representative pictures.
- Community was active in providing input regarding BBRP architecture and icon system.
- SE Heights clinic is a good example of community involvement, and serves as the model for future ambulatory clinic sites.
- Native American Health Services office (artwork, hospitality cart) is another good example of adapting the physical environment to represent the culture of populations served.
- Visiting hours and the option to stay overnight have become more flexible to accommodate family needs and preferences.
- Dietary Services offers a blend of many ethnic cuisines both on its menu choices for inpatients and in the cafeteria.
- When requested, provision is made for curanderas or Medicine Men in addition to accommodations for more family support at the bedside.
- Native American Health Services and Language Services have expanded hours in 2009-2010.
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.

TJC Road Map: Include elements from Checklist on Admission, Assessment, Treatment, End-of-Life and Discharge & Transfer (p.5)
- Cultural exchange/Inservice provided annually with ongoing education 1:1 available to Care Management Discharge Planners & Clinical Social Workers from the Office of Native American Health.
- Contract Health coordinators for Indian Health Service share information, services, and cultural implications for consideration during the discharge planning process (strong).
- SE Heights Clinic is a strength, especially regarding care of Vietnamese patients.
- Active Health Literacy Task Force.
- UNMH Strategic plan presented at Management Coffee, August 20, 2009 – “Our patient care mission encompasses serving as an accessible, high quality, safety focused, and comprehensive care provider. Our vision is that UNMH will be the leader in improving New Mexico’s health outcomes. A mission enhancer is to ensure equity in outcomes across all populations”

**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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<td>When requested by the patient, at any time, all resources may be sight-translated via phone or in-person interpreter.</td>
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<td>NQF suggests developing a directory that is available for patients that list bilingual providers.. Signage needs to be revisited. Indicator of multilingual providers is lacking in the Find-a-doc directory published by UNM and inconsistently marked on the UH primary care provider panels website. UH Main signage needs work, older clinic signage needs work, 933 Bradbury signage is very inadequate. It would be helpful to have a dual language internet website, aside from CarePages.</td>
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o Native American Health Services office (artwork, hospitality cart) is another good example of adapting the physical environment to represent the culture of populations served.

o Visiting hours and the option to stay overnight have become more flexible to accommodate family needs and preferences.

o Dietary Services offers a blend of many ethnic cuisines both on its menu choices for inpatients and in the cafeteria.

o When requested, provision is made for curanderas or Medicine Men in addition to accommodations for more family support at the bedside.

o Native American Health Services and Language Services have expanded hours in 2009-2010.