



MEDICAL BOARD OF CALIFORNIA
Licensing Operations



**Cultural and Linguistic Physician Competency Program
(CLC) Workgroup Meeting**

Lake Tahoe Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

May 11, 2010

MINUTES

Agenda Item 1 Call to Order/Roll Call

The CLC of the Medical Board of California was called to order by Chair Jorge Carreon, M.D., at 10:05 a.m. A quorum was present and due notice had been mailed to all interested parties.

The workgroup attendees were welcomed by Dr. Carreon. He stated that nothing solid has been done with this issue and he might like to see legislation implemented in the future which would require cultural and linguistic CME programs, these would give physicians a better understanding cultural and linguistic issues.

Members Present:

Jorge Carreon, M.D., Chair
Shelton Duruisseau, Ph.D.
Barbara Yaroslavsky

Staff Present:

Linda Whitney, Executive Director
Jennifer Simoes, Chief of Legislation
Abbie French, Staff Services Manager, Licensing Operations
Jeffrey Breen, Licensing Operations Analyst

Members of the Audience:

Sheryl Horowitz, Ph.D.
Ron Joseph
Yvonne Choong, CMA
Don Schinske, CHIA/CAFP
Marty Martinez, CPEHN

Agenda Item 2 Review of Background and History of CLC

Abbie French, Manager, briefly went over the history of the CLC workgroup. Assembly Bill 801 added Business and Professions (B&P) Code Section 2198 (Cultural and Linguistic Competency of Physicians Act of 2003) (Act). This law is operated by local medical societies of the California Medical Association and is monitored by the Board. The Board has the responsibility to convene a workgroup, including but not limited to, representatives of affected patient populations, medical societies engaged in program delivery, and community clinics. The goal of this workgroup is to evaluate the progress made in the achievement of the intent of B&P Section 2198 (Section 2198), determine the means by which achievement of the intent of Section 2198 can be enhanced, evaluate the reasonableness and the consistency of the standards developed by those entities delivering the program, and to determine and recommend the credit to be given to participants who successfully complete identified programs. Ms. French indicated that funding for this will be provided by fees charged to physicians who elect to take the educational classes and any other funds that local medical societies may secure for this purpose.

Ms. French reported that in 2006 CLC became a required component of CME courses (B&P Code Section 2190.1), and workshop meetings have been held since 2005. The most recent workgroup members were appointed during the summer of 2009.

Linda Whitney, MBC Executive Director, reported that back in 2003, when the Act was implemented, there was concern about MBC's attitude and physicians being competent to speak or understand the culture of their patients. At the same time, there was substantial discussion of interpreters and if physicians were using interpreters. Legislation was moving forward encouraging non California licensed physicians from Mexico to come work in California. The Board opposed the bill and was perceived to be negative.

The first few committee meetings brought people together and ensured that all parties were on the same page. Attendees understood that MBC was not opposed to or against physicians learning about and understanding cultural differences. Our workgroup is to focus on the educational component.

Barbara Yaroslavsky asked if there are minutes from the prior workshop meetings. Linda Whitney stated that the meetings were taped, but she is not sure if minutes were created. Sheryl Horowitz stated that many of her PowerPoint slides go over some of the past CLC Workshop meetings and she believes minutes were created from past meetings. She said she would gather the past meeting minutes for us so we can share them at the next CLC meeting.

Agenda Item 3 Presentation Regarding Cultural and Linguistic Competency for Practicing Physicians; Consideration of Next Steps

Sheryl Horowitz, Ph.D, with the Institute for Medical Quality, walked the workgroup through her PowerPoint presentation. (See slide printout for presentation detail on the internet.)

Agenda Item 4 Identification of Future Workgroup Goals

Dr. Carreon went over the list of future ideas and asked if anyone had comments. Dr. Duruisseau suggested that the workgroup consider finding out what the schools of medicine in California are

doing with respect to meeting CLC requirements for their physicians. There are national standards for this kind of activity, and physicians and hospitals must comply with the standards if they are a federal contractor. This national program is monitored and reviewed by the Joint Commission on Accreditation of Hospitals. Dr. Horowitz has information on the Joint Commission standards and she can give this information to us to bring to the next workshop meeting.

Barbara Yaroslavsky asked about interpreters and how they get called on when needed. Don Schinske, with the California Healthcare Interpreting Association, stated that there is a state law that requires acute care hospitals in California to provide adequate language assistance. Standards are constantly evolving. Hospitals are free to solve language access challenges as they deem to be best (phone services, medical/non-medical staff, contract interpreters). Any physician that works at a facility where the federal government is the payer has an obligation to provide language assistance. You must do your best, given the resources you have, and ensure you make a good faith effort to address the language problem. Barbara Yaroslavsky asked if physicians are aware of this. Should MBC be doing a better job to inform physicians? Mr. Schinske believes there are some barriers and physicians do need more information on this topic. Mrs. Yaroslavsky asked Sheryl Horowitz if she has any documented stories, by a physician, that can be used in the MBC Newsletter. Ms. Horowitz will provide the workgroup with a few stories to help with this subject. Mr. Schinske added that many physicians will use the phone service or an interpreter if it is right there and available. If the service is not available then they will muddle through the visit. Dr. Carreon stated that the window of liability is opened when good quality of care is not given.

Barbara Yaroslavsky asked what community clinics do and do they train their staff? Linda Whitney stated that this is why there are so many discussions on best practices, such as diabetes care. Ron Joseph stated that some clinics have very well developed systems and have a very good way to track their patients, others do not. There is a lack of consistent regulation of requirements in California.

Dr. Carreon stated that one of the workgroup's missions is to have medical education for physicians, in culture and linguistic studies. He suggested that MBC should examine a requirement of this type of CME prior to renewal.

Yvonne Choong stated that in many cases we have non-minority physicians dealing with a minority patient. In California we are beginning to see more of the reverse, more minority physicians. She suggested the committee might want to think about cultural and linguistic training programs being done during residency.

Barbara Yaroslavsky stated that every medical school has courses on communication and/or cultural competency now. Many of the cultural and linguistic issues come after medical school. Mrs. Yaroslavsky asked if there is a cultural and linguistic requirement when you go for Board Certification.

Sheryl Horowitz talked about the PACE program in San Diego and how IMQ has been talking to them about potentially introducing cultural/language communication studies into that program.

Dr. Duruisseau asked if maybe the workgroup could look into a way to incentivize providers.

Linda Whitney stated that current law provides for this potential process of a reduced license fee or a credit for cultural and linguistic CME. Other ideas presented were to conduct the courses in a place that people want to be; mold the programs to what the physician wants.

The goal is to never treat this as a separate subject topic; as this topic should be part of normal quality of care.

Agenda Item 5 Development of Workgroup Action Plan

This group hopes to address the below at future CLC workgroup meetings:

- ee Review the rules and regulations of Federal Government
- ee Invite GME and Deans from the Medical Schoolsee
- ee Create a focus groupee
- ee Invite medical leaders to discuss what current groups are doing to address CL trainingee
- ee Encourage physicians to attend theseworkgroup meetings
- ee Discuss possible incentives that willencourage cultural and linguistic training
- ee Include liability carriers as part of these meetings.
- ee Accomplish the goals of existing law and come up aeeith written workgroup action plan

Agenda Item 6 Schedule of Future Meetings

The Committee set the next meeting date for Wednesday, July 28, 2010, for a period of two hours.

Agenda Item 7 Public Comments on Items Not on the Agenda

None

Agenda Item 8 Adjournment

Meeting adjourned at 12:05 p.m.

WELCOME TO
THE MEDICAL BOARD OF CALIFORNIA
Department of Consumer Affairs

Wellness Committee

Mission: *To further the Board's consumer protection mission by encouraging and guiding licensees to promote a sound balance in their personal and professional lives so that healthy physicians offer quality care to their patients.*

At the July 2007, meeting of the Medical Board, Dr. Shelton Duruisseau, one of the board members, presented an issue paper addressing physician wellness. His paper was entitled, "Physician Wellness as Constrained by Burnout."

Dr. Duruisseau's paper outlined the purpose, background, conclusion, and recommendations to enhance physician wellness. The focus of the review centered on the benefits that might be derived from the implementation of a program to assist with licensees' well-being. Since the mission of the board is to protect health care consumers, it must be recognized that this best can be achieved by having healthy physicians care for their patients. Dr. Duruisseau recommended the board establish a Wellness Committee, comprised of three board members and three to five public members. Each appointee should represent strategic partners to further consider the board's role in addressing programs to improve licensees' well-being.

The Board took action, and, on July 27, 2007, the Wellness Committee was established.

To learn more about the Wellness Committee, please follow these links:

- [Dr. Duruisseau's paper on Physician Wellness](#)
- [Members of the Committee](#)
- Minutes
 1. [September 26, 2007 meeting](#)
 2. [January 16, 2008 meeting](#)
 3. [July 24, 2008 meeting](#)
 4. [November 6, 2008 meeting](#)
 5. [January 29, 2009 meeting](#)
 6. [May 7, 2009 meeting](#)
 7. [July 23, 2009 meeting](#)
- [October 29, 2009 meeting](#)
- [Role and responsibilities](#)
- Articles in the Board's *Newsletter*
 1. [November 2007 edition, please see cover article, page 1](#)
 2. [January 2008 edition, please see page 7](#)
 3. [April 2009 edition, please see page 7](#)
- [Article in OBG Management, Dowden Health Media, Dec 2008, Vol. 20, No. 12 The Unbearable Unhappiness of the ObGyn: A crisis looms](#)
- [A summary of published peer-reviewed studies which support the connection between physician wellness and patient safety](#)

While the Medical Board of California may provide links to web sites, wellness activities, and/or articles, these links are provided solely for convenience and as a resource for our licensees. These other sites do not reflect the official policy of the Board and the link should not be construed as an endorsement of the site. We encourage you to check back for future updates.

We also welcome your suggestions on appropriate items or additional programs for the Wellness Committee to consider. For further information, or to offer suggestions, please contact Kevin A. Schunke, Committee Manager, at kevin.schunke@mbc.ca.gov or call (916) 263-2368.



Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings

This report provides unique insight into the challenges, activities and perspectives of 60 hospitals across the nation and a snapshot of their current situation. These findings cannot be generalized to all hospitals, but they provide detailed information about many ways that culture and language issues are being addressed in hospitals.

Key Findings

- Hospitals are challenged to meet the cultural and language needs of their patient populations, and efforts to address language are more concrete than those to address culture.
- There are a wide range of practices for meeting the cultural and language needs of patients. There also exists varied interpretation of “good” versus “poor” practice.
- There is a gap between current practice and desired practice, particularly related to the provision of language services. While this may be attributable to missing resources, in some cases the resources are available, but are not being used or processes are not being followed.
- Collection of patient demographic data is inconsistent across and within hospitals, and few hospitals use these data to improve services for diverse patients.

Related Recommendations

- Hospitals should consider establishing a centralized program with executive-level reporting to coordinate services relating to language and culture as part of the organization's commitment to quality.
- Hospitals should have policies in place regarding the provision of language services and should not rely on patients' friends, family or other “ad hoc” interpreters.
- Interpreters should be assessed for their language proficiency in both English and the target language and should be trained on the practice of interpreting for health care.
- Staff and physicians should be provided ongoing training on how to access language services and should be trained on how to work with an interpreter.
- Safety and quality leaders need to dialogue with language service coordinators, diversity officers, and pastoral care workers about the impact of culture and language on patient safety.
- Hospitals should implement a uniform framework for the collection of data on race, ethnicity, and language and should stratify service and technical quality measures such as those reported through the Hospital Quality Alliance by language, race, and ethnicity.

Please visit www.jointcommission.org/PatientSafety/HLC to download a free copy of the report.



One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations

As the diversity of our nation continues to grow, the multiplicity of languages, dialects, and cultures that hospitals and their staff encounter can be overwhelming. *Hospitals, Language, and Culture: A Snapshot of the Nation* (HLC) is a cross-sectional qualitative study, funded by The California Endowment, designed to explore how 60 hospitals across the country provide health care to culturally and linguistically diverse patient populations. Their latest report, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations* provides a framework for hospitals to develop and employ practices for meeting diverse patient needs.

There is no “one size fits all” solution, and the road map to cultural competence is unique for each organization. However, based on data gathered from the HLC study, this report recommends that organizations:

- Identify the needs of the patient population being served and assess how well these needs are being met through current systems
- Bring people across the organization together to explore cultural and language issues by sharing experiences, evaluating current practices, discussing barriers, and identifying gaps
- Make assessment, monitoring, and evaluation of cultural and language needs and services a continuous process
- Implement a range of practices spanning all four themes in a systemic manner aligned with patient needs and organizational resources

Framework Overview

The thematic framework presented in this report was derived from *current practices* that hospitals are employing to provide care and services to diverse patients.

<p style="text-align: center;">Building a Foundation</p> <p>Policies and procedures that systemically support efforts to meet the needs of diverse patients can help elevate the priority of these issues within the organization, drive efforts, and draw staff support</p>	<p style="text-align: center;">Collecting and Using Data to Improve Services</p> <p>Data collection and use allows the effectiveness and utilization of cultural and language services to be monitored, measured, and evaluated, which can be useful for planning and designing services</p>
<p style="text-align: center;">Accommodating the Needs of Specific Populations</p> <p>Developing practices that address the challenges of certain populations contributes to providing safe, quality care and decreasing health disparities</p>	<p style="text-align: center;">Establishing Internal and External Collaborations</p> <p>Collaborations can provide hospitals with additional opportunities for developing cultural and language programs and services when resources are limited or help them engage the community to share information and resources</p>

To help hospitals and other health care organizations tailor initiatives to meet the needs of their diverse patient populations, this report includes a self-assessment tool that organizations can use to initiate discussions about the needs, resources, and goals for providing the highest quality care to every patient served.

Please visit www.jointcommission.org/PatientSafety/HLC to download a free copy of the report.



Hospitals, Language, and Culture

PROJECT UPDATE

October 2009

The Joint Commission Revises Mission and Vision Statements

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*Hospitals,
Language, and
Culture: A Snap-
shot of the Nation*
is a research study
of The Joint
Commission funded
by a grant from
The California
Endowment

The Joint Commission recently revised its mission and vision statements to emphasize its role in health care.

The Joint Commission's new mission statement is:

"To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value."

The Joint Commission's new vision statement is:

"All people always experience the safest, highest quality, best-value health care across all settings."

There are two points worthy of note related to these new mission and vision statements. First, the new vision and mission statements recommit The Joint Commission to work toward the equitable treatment of patients. Second, The Joint Commission is committed to achieving this goal not simply through "accreditation and related activities," as stated in the previous mission statement, but "by evaluating...and inspiring [health care organizations] to excel..." It is within the context of these newly revised statements that The Joint Commission is now considering its work to improve language access.

The Joint Commission is developing standards to advance effective communication, cultural competence, and patient- and family-centered care in hospitals. These standards are being developed under a grant from The Commonwealth Fund and plan to set forth, among other things, more specific requirements for language access services.

Under the direction of Paul Schyve, MD, and Amy Wilson-Stronks, MPP, this 18-month project will increase national attention to cultural competence, highlight its intersection with patient- and family-centered care, and improve the safety and quality of care for all patients. The development

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Each issue of the HLC Update will feature project-specific updates and other information related to cultural and linguistic competency. We welcome your comments, which can be addressed to hlc-info@jointcommission.org.

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Resources from the HLC Study

The Joint Commission is developing hospital accreditation standards that aim to advance effective communication, cultural competence and patient- and family-centered care. These standards will be released in 2010 and will go into effect in 2011. The resources featured here can help health care organizations begin to examine these issues and prepare to meet the new requirements. To access any of these resources, please visit the Hospitals, Language, and Culture study website: www.jointcommission.org/PatientSafety/HLC/

Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings

This report, by Amy Wilson-Stronks, MPP and Erica Galvez, MA, recommends targeted strategies to address language and cultural needs that currently pose challenges to hospitals seeking to deliver safe, effective care to the diverse populations they serve. Key findings from the report include:

- Hospitals face a variety of challenges in meeting the cultural and language needs of their patient populations.
- Efforts to address language are more concrete than those to address culture.
- There are a wide range of practices for meeting the cultural and language needs of patients. There also exists varied interpretation of “good” versus “poor” practice.
- There is a gap between current practice and desired practice, particularly related to the provision of language services. This may be attributable to missing resources or, in some cases, the resources are available but are not being used or processes are not being followed.
- Collection of patient demographic data is inconsistent across and within hospitals, and few hospitals use these data to improve services for diverse patients.

One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations

This report, by Amy Wilson-Stronks, MPP, Karen K. Lee, MS, Christina L. Cordero, PhD, MPH, April L. Kopp, MFA, and Erica Galvez, MA, provides a thematic framework that was derived from current practices that hospitals are employing to provide care and services to diverse patients. As the range of practices mentioned in the report illustrates, there is no “one size fits all” solution, and the road map to cultural competence is unique for each organization. However, based on data gathered from the HLC study, this report recommends that organizations:

- Identify the needs of the patient population and assess how well these needs are being met through current systems.
- Bring people across the organization together to explore cultural and language issues by sharing experiences, evaluating current practices, discussing barriers, and identifying gaps.
- Make assessment, monitoring, and evaluation of cultural and language needs and services a continuous process.
- This report includes a self-assessment tool that organizations can use to initiate discussions about the needs, resources, and goals for providing the highest quality care to every patient served.

Relevant Joint Commission Standards

Several resources are available that highlight Joint Commission standards that support the provision of care, treatment, and services in a manner that is conducive to the communication, cultural, language, health literacy, and spiritual/religious needs of individuals, including:

- A crosswalk of the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) and The Joint Commission's 2009 Standards for the Hospital Accreditation Program
- Overviews of 2009 Joint Commission standards and elements of performance (EPs) that support effective communication, cultural competence, and patient- and family-centered care for the ambulatory health care (AHC), behavioral health care (BHC), critical access hospital (CAH), hospital (HAP), long term care (LTC), and home care (OME) accreditation programs.



Ongoing HLC Projects

From the Perspective of the CEO: What Drives Hospitals to Provide Culturally and Linguistically Appropriate Care?

Amy Wilson-Stronks, MPP, Sunita Mutha, MD

The *Hospitals, Language, and Culture* (HLC) study provided a unique opportunity, allowing researchers to sit down with sixty hospital CEOs and other top members of leadership to discuss issues related to the provision of culturally and linguistically appropriate care. This investigation examines CEO perspectives on providing health care to culturally and linguistically diverse patient populations. It explores what drives some to embrace cultural and linguistic services as “the right thing to do” while others see it as a “burden” on an already taxed health system. Our goal with this effort is to better understand what motivates hospital leaders (CEOs) to embrace and or champion efforts to improve the delivery of health care for culturally and linguistically diverse populations, while others remain ambivalent, resistant or, worse, unaware.

How are Patients’ Cultural Health Beliefs Addressed in the Emergency Department?

Amy Wilson-Stronks, MPP, Karen K. Lee, MS, Christina L. Cordero, PhD, MPH, Erica Galvez, MA, Romana Hasnain-Wynia, PhD, Elizabeth Jacobs, MD, MPP

Cultural health beliefs and language barriers can have a profound impact on the provision of health care, yet little is known about how well clinicians recognize and address these issues. One component of the *Hospitals, Language, and Culture* (HLC) study was to complete a simulated “patient-centered assessment” at each institution in which clinical and support staff were presented a hypothetical patient case. The project promises unique insight into how clinicians address patients’ cultural health beliefs. This investigation uses the hypothetical scenario of a limited English proficient patient who believes that his abdominal pain is the result of a hex to examine how emergency department clinicians would respond to a patient’s cultural health belief and for any sources of additional information about or assistance with this type of belief.

How do Emergency Department Practitioners Communicate with Limited English Proficient (LEP) Patients?

Amy Wilson-Stronks, MPP, Erica Galvez, MA, Romana Hasnain-Wynia, PhD, Elizabeth Jacobs, MD, MPP

Overcoming communication barriers with limited English proficient (LEP) patients is critical to rapid triage, accurate assessment and diagnosis in the emergency department (ED). This manuscript focuses on the use of specific language access services used by physicians in the Emergency Department to communicate with a hypothetical LEP patient.



RECENTLY PUBLISHED

Improving Patient-Provider Communication: A Call to Action

Lance Patak, MD, MBA, RN, Amy Wilson-Stronks, MPP, Ruth Kleinpell, PhD, RN, RAAN, MaryBeth Happ, PhD, RN, John Costello, MA, CCC-SLP, Colleen Person, MMA, SBN, RN, Elizabeth A. Henneman, PhD, RN

Journal of Nursing Administration. September 2009

This perspective piece, developed in collaboration with is featured in the September 2009 issue of the *Journal of Nursing Administration*. The authors call for policymakers, accrediting bodies, healthcare organizations, and other key stakeholders to prioritize issues of effective communication.

Coming Soon from the HLC Study:

Video on Improving Patient-Provider Communication

The U.S. Department of Health and Human Services' Office for Civil Rights and The Joint Commission are committed to supporting effective patient-provider communication. To that end, our organizations are collaborating for the first time to bring national attention to the issue of language access. A video entitled *Improving Patient-Provider Communication: Joint Commission Standards and Federal Laws* has been co-produced by our organizations to help educate health care providers and organizations about the role that language access plays in supporting effective communication and relevant federal and Joint Commission standards.

In the video, Tamara Miller, Deputy Director for Civil Rights at the Office for Civil Rights at the U.S. Department of Health and Human Services and Amy Wilson-Stronks, Project Director in the Division of Standards and Survey Methods at The Joint Commission and Principal Investigator for the *Hospitals, Language, and Culture* study, discuss what federal civil rights laws and Joint Commission accreditation standards require in terms of language access. They provide examples of the types of language access services that health care organizations should provide in order to comply with these requirements and emphasize some key considerations when planning for these services.

To help organizations better meet these requirements and the needs of the limited English proficient, deaf, or hard of hearing populations they serve, the video will be accompanied by a downloadable list of practical resources. The video will stream from the *Hospitals, Language, and Culture* study's website www.jointcommission.org/patientsafety/hlc. Running time is 33 minutes and the video is closed captioned. This video was developed as part of The Joint Commission's *Hospitals, Language, and Culture* study, with funding from The California Endowment.

We hope that you will find the video useful in promoting language access services as a means to support increased understanding and effective communication in health care.

Podcast on the Role of Professional Chaplains in Promoting Culturally Competent, Patient-centered Care

This podcast features Amy Wilson-Stronks, MPP, Project Director in the Division of Standards and Survey Methods at The Joint Commission and Principal Investigator of the *Hospitals, Language, and Culture* Study and Jon Overvold, MDiv, BCC, Director of Pastoral Care & Education North Shore University Hospital, discussing the critical role that professional chaplains play in promoting culturally competent, patient-centered care within health care organizations.

This podcast will be available for download from the *Hospitals, Language, and Culture* study's website www.jointcommission.org/patientsafety/hlc along with a full transcript of the podcast and a set of accompanying slides.

For additional
information,
contact:
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Continued from front page

of these accreditation standards, however, is only part of The Joint Commission's efforts to support language access. In order to inspire hospitals to implement practices that improve equitable care, The Joint Commission is developing a guide that will accompany the standards. The Joint Commission, in collaboration with the National Health Law Program, is developing this implementation guide to prepare Joint Commission surveyors and accredited hospitals for the potential release of proposed requirements to advance effective communication, cultural competence, and patient- and family-centered care. The purpose of this guide is to provide practical information and examples of processes that hospitals can use to meet the needs of the diverse patient populations they serve. The guide will include recommendations and practices that go above and beyond what the accreditation standards will require, with the hope that hospitals will be inspired to find better ways of meeting their patients' language, cultural, and individual needs. The duration of the project is August 2008 through January 2010. At the earliest, any implementation of the proposed requirements would occur in January 2011.

For more information about the development proposed requirements to advance effective communication, cultural competence, and patient-centered care for the hospital accreditation program, please visit www.jointcommission.org/PatientSafety/HLC/

If you have a question pertaining to existing standards, visit www.jointcommission.org/Standards/FAQs/ or call (630) 792-5900.



Your Voice

*Education, support and collaboration to advance
cultural competence in health care*

DiversityRx invites professionals working in the field of culturally and linguistically competence health care to network, collaborate, and learn from each other. Our goal is to bridge distance and institutional isolation, unearth the practice innovations and challenges faced by those on the front lines, and share those experiences to help others move forward.

Our Communities of Practice and Peer Learning Networks are a great place to start. Small groups of professional colleagues with a common interest "meet" through online learning platforms and email discussion groups to discuss practice challenges and share information about strategies and resources. We are currently running groups on cultural competence training, CLAS/health disparities policy, and collecting race/ethnicity/language data. Several new groups are slated to start in the next few months.

You're also welcome to participate in our monthly series of free webinars and online mini-conferences on a variety of cross cultural health topics. We've had two very popular sessions on health care reform and using patient demographic data to improve care for diverse populations, and look forward to upcoming presentations on the soon-to-be-released Joint Commission standards on CLAS, health literacy, interpreter certification, and more.

Full details about the Your Voice project and a sign-up for our upcoming events email notification service are online at www.diversityrxconference.org/Your-Voice/

Since 1997, the mission of DiversityRx has been to educate, support and expand the growing field of health care providers, policymakers, researchers and advocates working to deliver health services that are responsive to the cultural and linguistic needs of minority, immigrant, and indigenous communities. The mission of DiversityRx is carried out through a website (www.diversityRx.org), a listserv (CLAS-talk), and as a co-producer of a biennial national conference series (www.diversityRxconference.org).

The Your Voice project is sponsored by The California Endowment.

Hospitals, Language, and Culture

Resource Update

The Advisory Committee on Minority Health's Report on Health Reform

The Advisory Committee on Minority Health advises the Secretary of Health and Human Services on ways to improve the health of racial and ethnic minority populations, and on the development of goals and program activities within the Department. The advisory committee recently submitted their report to Secretary Kathleen Sebelius with suggestions ensuring that health care reform meets the health care needs of minority communities and eliminates health disparities. The report proposes 14 Principles that encompass scientifically well-established areas of health care policy and health care reform including the need for a diverse health care workforce, equitable access to comprehensive health care coverage and services, the key roles of public health and the safety net, and the need for transparent, accessible, and comprehensive data systems. The Joint Commission's *Hospitals, Language, and Culture* study is mentioned in the report.

To download or access this report, please visit: www.omhrc.gov/Assets/pdf/Checked/1/ACMH_HealthCareAccessReport.pdf

Expecting Success Toolkit

Expecting Success was a national program aimed at improving the quality of cardiac care while reducing racial, ethnic and language disparities. Ten hospitals with racially- and ethnically-diverse patient populations participated in the program, and improved the quality of care being provided to their heart failure and heart attack patients. Although the hospital collaborative component of the program came to a close in May 2008, the program and its lessons continue to inform other efforts. The program has released a toolkit that provides tips for hospitals on improving the quality of care and reducing disparities.

To access the toolkit or reports on the program, please visit: www.expectingsuccess.org

The Patient Provider Communication Forum

The Patient Provider Communication Forum is a national and international effort to promote information sharing, cooperation and collaboration among individuals who are committed to seeking improvements in patient-provider communication across the entire health care continuum—from a doctor's office, emergency room, clinic, ICU, acute care and rehabilitation hospital, home health service and hospice. Members of the group bring together a range of perspectives and experience in the area of patient-provider communication. The group works to share knowledge and resources and to raise awareness at both the practice and policy levels of the need to overcome existing communication barriers and to increase communication access across health care settings.

To access the website, please visit: www.patientprovidercommunication.org

Talking with Patients: How Hospitals Use Bilingual Clinicians and Staff to Care for Patients with Language Needs

This report presents findings from a survey conducted by researchers at The George Washington University, with funding from The California Endowment, that aimed to learn more about the individuals in a hospital setting who interact with patients who speak a language other than English. The study focuses in particular on the ways that bilingual clinicians and staff are used, how policies are developed, and how these practices affect the provision of language services. The report describes practices across the country, as well as policies and practices across hospitals located in the state of California. By increasing and sharing knowledge about how bilingual clinicians and staff can be effectively utilized, health systems will be able to modify and improve strategies for meeting the needs of their linguistically diverse communities.

To access the website, please visit: www.calendow.org/Collection_Publications.aspx?coll_id=22&ItemID=312

October is Health Literacy Month

A Focus on Health Literacy Resources

Health Literacy: A Prescription to End Confusion

This seminal report from the Institute of Medicine examines the body of knowledge that applies to the field of health literacy and provides recommendations for promoting a more health literate society.

To read the report online or to purchase a copy, please visit: <http://www.iom.edu/?id=19750>

The Health Literacy Environment of Hospitals and Health Centers

This guide provides tools for analyzing literacy related barriers to healthcare access and navigation. It is designed to help health care organizations consider the health literacy environment of their facilities and find ways to reduce health literacy demands.

To download or access the guide, please visit: www.hsph.harvard.edu/healthliteracy/HealthLiteracyEnvironment.pdf?id=1163

Informed Consent and Authorization Toolkit for Minimal Risk Research

This toolkit was developed by AHRQ to provide greater meaning of informed consent and Health Insurance Portability and Accountability Act (HIPAA) authorization for potential research subjects. The toolkit is designed to help both researchers and IRBs ensure that potential subjects are well informed. Some of the features of the toolkit include: a model process for obtaining written consent and authorization, examples of easy-to-read consent documents for informed consent and authorization, a certification tool to promote the quality of the consent process, and links to resources from the Department of Health and Human Services.

To download or access the toolkit, please visit: www.ahrq.gov/fund/informedconsent/

Is Our Pharmacy Meeting Patients' Needs? Pharmacy Health Literacy Assessment Tool User's Guide

This tool, developed with funding from AHRQ and The Robert Wood Johnson Foundation is designed to measure the "health literacy friendliness" of pharmacies by gathering information on the perspectives of objective auditors, pharmacy staff, and patients. The three parts of the assessment complement each other and are designed to work together to form a comprehensive assessment. The assessment was designed to be used in outpatient pharmacies of large, urban, public hospitals that primarily serve a minority population, however it can be adapted for use in other pharmacy and non-pharmacy environments.

To download or access the assessment, please visit: www.ahrq.gov/qual/pharmlit/index.html

Teaching Patients with Low Literacy Skills

This book, which is considered a "classic" in health literacy explores educational theories, testing for literacy skills, and assessing and creating the suitable materials. The book discusses assessments including the Fry formula, the REALM, and the Suitability Assessment of Materials (SAM). The book is now available for viewing or downloading through the Harvard School of Public Health's Health Literacy Studies website.

To download or access the book, please visit: <http://www.hsph.harvard.edu/healthliteracy/doak.html>

Unified Health Communication 101

The on-line training course was developed by HRSA for health care professionals focuses on improving communication skills, understanding key barriers to communicating, and implementing patient-centered communication practices that address health literacy, low English proficiency, and cultural competence.

To access the training course, please visit: www.hrsa.gov/healthliteracy/training.htm

"What Did the Doctor Say?:" Improving Health Literacy to Protect Patient Safety

The Joint Commission convened a Health Literacy and Patient Safety Roundtable, which was charged with framing the issues related to low health literacy and its impact on patient safety. The Roundtable discussions culminated in the publication of this white paper, which describes interventions to improve the ability of patients to understand complex medical information, and provide recommendations for a broad range of health care stakeholders and policymakers to mitigate the risks to patients with low health literacy and/or low English proficiency.

To download or access the white paper, please visit: http://www.jointcommission.org/PublicPolicy/health_literacy.htm

'Speak Up' Campaign Helps Prevent Errors in Care

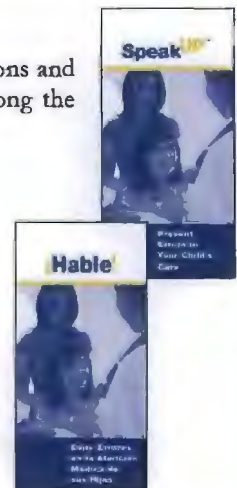
In March 2002, The Joint Commission, together with the Centers for Medicare and Medicaid Services, launched a national campaign to urge patients to take a role in preventing health care errors by becoming active, involved and informed participants on the health care team. The program features brochures, posters and buttons on a variety of patient safety topics. Free downloadable files of all Speak Up brochures and posters (including Spanish language versions of the brochures) are available on The Joint Commission Web site at www.jointcommission.org/PatientSafety/SpeakUp/

Organizations can download and print as many copies as they would like to distribute to patients, staff and community members. The brochures include a blank panel for organizations to insert their own patient safety information, logo and contact information. Speak Up materials also are available for purchase through Joint Commission Resources at (877) 223-6866 or online at www.jcrinc.com.

Preventing Errors in Your Child's Care

The new Speak Up™ brochure "Preventing Errors in Your Child's Care" offers parents questions and answers that can help them navigate many common, yet complex health care situations. Among the topics are:

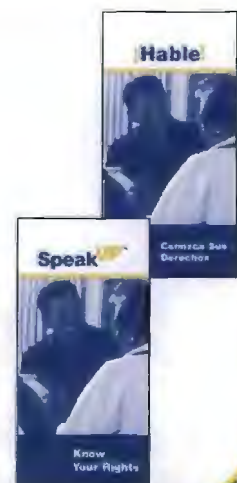
- Preparing for your child's visit to the doctor's office
- Symptoms that mean you need to take your child to the doctor or hospital immediately
- What you should ask the doctor
- Taking medicine safely
- Having a medical or laboratory test
- Going to the hospital
- Having a safe operation

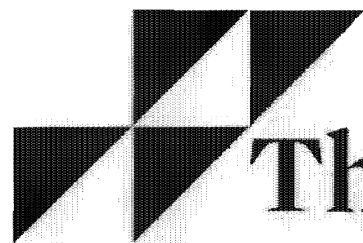


Know Your Rights

The Speak Up™ brochure "Know Your Rights" has questions and answers to help patients find out about their rights and role as a patient. Knowing about their rights and role can help patients make better decisions about their care. Among the topics are:

- What are your rights?
- What is your role in your health care?
- Can your family or friends help with your care?
- How can an advocate help with your care?
- Can your advocate make decisions for you?
- Can other people find out about your disease or condition?
- What is "informed consent?"
- What happens if something goes wrong during treatment or with my care?
- How do you file a complaint?
- Questions to ask before you enter the health care facility





The Joint Commission

New & Revised Standards & EPs for
Patient-Centered Communication

Accreditation Program: Hospital

The bold requirements indicate the new and/or revised Standards & EPs for patient-centered communication.

Standard HR.01.02.01

The hospital defines staff qualifications.

Elements of Performance for HR.01.02.01

1. The hospital defines staff qualifications specific to their job responsibilities. (See also IC.01.01.01, EP 3)
Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).
Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at <http://wwwn.cdc.gov/clia/regs/toc.aspx>.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital.
Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. (Inclusion of these qualifications will not affect the accreditation decision at this time.)
19. For hospitals that use Joint Commission accreditation for deemed status purposes: If blood transfusions and intravenous medications are administered by staff other than doctors of medicine or osteopathy, the staff members have special training for this duty.

Standard PC.02.01.21

The hospital effectively communicates with patients when providing care, treatment, and services.

Note: This standard will not affect the accreditation decision at this time.

Rationale for PC.02.01.21

This standard emphasizes the importance of effective communication between patients and their providers of care, treatment, and services. Effective patient-provider communication is necessary for patient safety. Research shows that patients with communication problems are at an increased risk of experiencing preventable adverse events,* and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients.** ***

Identifying the patient's oral and written communication needs is an essential step in determining how to facilitate the exchange of information with the patient during the care process. Patients may have hearing or visual needs, speak or read a language other than English, experience difficulty understanding health information, or be unable to speak due to their medical condition or treatment. Additionally, some communication needs may change during the course of care. Once the patient's communication needs are identified, the hospital can determine the best way to promote two-way communication between the patient and his or her providers in a manner that meets the patient's needs. This standard complements RI.01.01.01, EP 5 (patient right to and need for effective communication); RI.01.01.03, EP 2 (provision of language interpreting and translation services); and RI.01.01.03, EP 3 (meeting needs of patients with vision, speech, hearing, or cognitive impairments).

Footnote *: Bartlett G, Blais R, Tamblyn R, Clermont RJ, MacGibbon B: Impact of patient communication problems on the risk of preventable adverse events in acute care settings. CMAJ 178(12):1555-1562, Jun. 3, 2008.

Footnote **: Divi C, Koss RG, Schmaltz SP, Loeb JM: Language proficiency and adverse events in U.S. hospitals: A pilot study. Int J Qual Health Care 19(2):60-67, Apr. 2007.

Footnote ***: Cohen AL, Rivara F, Marcuse EK, McPhillips H, Davis R: Are language barriers associated with serious medical events in hospitalized pediatric patients? Pediatrics 116(3):575-9, Sep. 2005.

Elements of Performance for PC.02.01.21

1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1)
Note 1: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.
Note 2: This element of performance will not affect the accreditation decision at this time.
2. The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. (See also RI.01.01.03, EPs 1-3)
Note 1: This element of performance will not affect the accreditation decision at this time.

Standard RC.02.01.01

The medical record contains information that reflects the patient's care, treatment, and services.

Elements of Performance for RC.02.01.01

1. The medical record contains the following demographic information:
 - The patient's name, address, and date of birth, and the name of any legally authorized representative
 - The patient's sex
 - The legal status of any patient receiving behavioral health care services
 - The patient's language and communication needs
1. **The medical record contains the following demographic information:**
 - **The patient's name, address, date of birth, and the name of any legally authorized representative**
 - **The patient's sex**
 - **The legal status of any patient receiving behavioral health care services**
 - **The patient's communication needs, including preferred language for discussing health care (See also PC.02.01.21, EP 1)**

Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record.
2. The medical record contains the following clinical information:
 - The reason(s) for admission for care, treatment, and services
 - The patient's initial diagnosis, diagnostic impression(s), or condition(s)
 - Any findings of assessments and reassessments (See also PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8)
 - Any allergies to food
 - Any allergies to medications
 - Any conclusions or impressions drawn from the patient's medical history and physical examination
 - Any diagnoses or conditions established during the patient's course of care, treatment, and services
 - Any consultation reports
 - Any observations relevant to care, treatment, and services
 - The patient's response to care, treatment, and services
 - Any emergency care, treatment, and services provided to the patient before his or her arrival
 - Any progress notes
 - All orders
 - Any medications ordered or prescribed
 - Any medications administered, including the strength, dose, and route
 - Any access site for medication, administration devices used, and rate of administration
 - Any adverse drug reactions
 - Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EPs 1 and 23)
 - Results of diagnostic and therapeutic tests and procedures
 - Any medications dispensed or prescribed on discharge
 - Discharge diagnosis
 - Discharge plan and discharge planning evaluation

(See also PC.01.02.03, EPs 6-8)

Patient-Centered Communication Standards & EPs -- Hospital Accreditation Program

4. As needed to provide care, treatment, and services, the medical record contains the following additional information:
 - Any advance directives (See also RI.01.05.01, EP 11)
 - Any informed consent, when required by hospital policy (See also RI.01.03.01, EP 13)

Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies.

 - Any records of communication with the patient, such as telephone calls or e-mail
 - Any patient-generated information
5. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are recorded by the following individuals involved in the active treatment of the patient:
 - The doctor of medicine or osteopathy responsible for the care of the inpatient
 - A nurse
 - A social worker
 - Others involved in active treatment modalities.

The above individuals record progress notes at least weekly for the first 2 months of a patient's stay and at least monthly thereafter.
6. The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following:
 - The time and means of arrival
 - Indication that the patient left against medical advice, when applicable
 - Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services
 - A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services
7. **The medical record contains the patient's race and ethnicity.**

Note: This element of performance will not affect the accreditation decision at this time.

Standard RI.01.01.01

The hospital respects, protects, and promotes patient rights.

Elements of Performance for RI.01.01.01

1. The hospital has written policies on patient rights.
2. The hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1-3)
4. The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.
5. The hospital respects the patient's right to and need for effective communication. (See also RI.01.01.03, EP 1)
6. The hospital respects the patient's cultural and personal values, beliefs, and preferences.
7. The hospital respects the patient's right to privacy. (See also IM.02.01.01, EPs 1-5)

Note: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, please refer to Standard IM.02.01.01.

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8. The hospital respects the patient's right to pain management. (See also HR.01.04.01, EP 4; PC.01.02.07, EP 1; MS.03.01.03, EP 2)
9. The hospital accommodates the patient's right to religious and other spiritual services.
10. The hospital allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.
28. **The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.**
Note 1: The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EPs 6-8.)
Note 2: This element of performance will not affect the accreditation decision at this time.
29. **The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.**
Note: This element of performance will not affect the accreditation decision at this time.

Standard RI.01.01.03

The hospital respects the patient's right to receive information in a manner he or she understands.

Elements of Performance for RI.01.01.03

1. The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. (See also RI.01.01.01, EPs 2 and 5; PC.04.01.05, EP 8)
2. The hospital provides interpreting and translation services, as necessary. (See also RI.01.01.01, EP 2)
2. **The hospital provides language interpreting and translation services. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.21, EP 2; HR.01.02.01, EP 1)**
Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.
3. The hospital communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. (See also RI.01.01.01, EP 2)
3. **The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.21, EP 2)**