

Cultural Competency Assessment of Health Care Providers across Nebraska: A Survey of Limited English Proficient (LEP) Individuals



Nebraska Department of Health & Human Services
Office of Minority Health and Health Equity

April, 2009

ACKNOWLEDGMENTS

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Executive Summary

Limited English proficient (LEP) patients have long faced difficulties in accessing healthcare due to the lack of language interpretation services. LEP persons are individuals for whom English is not their primary language and who have a limited ability to read, write, speak, or understand English (LEP, 2008). Because minority, including LEP, population rates are on the rise, barriers in healthcare services may exist for those who do not speak English or do not fully understand the United States healthcare system. According to the American Journal of Public Health, persons who have limited English proficiency are less likely to have a regular source of primary care and are less likely to receive preventive care. They also are less satisfied with the care that they do receive, are more likely to report overall problems with care, and may be at increased risk of experiencing medical errors (Jacobs, 2004).

Nearly 47 million U.S. residents aged five or older speak a language other than English at home, and more than 21 million speak English less than “very well” (U.S. Census Bureau, 2000). Communication between providers and patients is critical for discussing issues such as diagnoses, treatment plans, medication instructions, and disease management techniques. The importance of language services for LEP patients is undeniable. The lack of language services can affect access to healthcare services as well as preventive care. The inability of patients to access proper care causes increased reliance on emergency rooms, resulting in greater costs to the healthcare system (AAPCHO, 2008).

The legal responsibility to provide language access applies across all federal program areas and activities, including healthcare. Any agency that accepts any federal funds (e.g., Medicaid payments), is responsible for ensuring language access to all the clients. Despite the federal right to language access for LEP patients in healthcare settings, the reality is that many healthcare providers are not aware of their responsibility, have not prioritized the issue, or have not been held accountable through consistent enforcement of these laws (Chen, 2007). Moreover, these healthcare providers fail to take into account both the consequences of not providing the services and the potential cost benefits of improving communication with their patients (Jacobs, 2004).

To further address these issues, the Office of Minority Health and Health Equity conducted a survey among limited English proficient healthcare clients throughout the state of Nebraska. The objective of the survey was to ascertain the quality of culturally and linguistically appropriate services and the standard of care received by respondents. This section briefly highlights the results detailed in section four.

Highlights

- The majority of the survey respondents were Hispanic/Latino. In general, respondents were Spanish-speaking (73.9%), between the ages of 25-54 (72.1%), had completed middle school or less (65.7%), and had a monthly household income of \$2,000 or less (72.5%).
- Of the survey respondents whose primary language was not English, less than 5% spoke English “very well.”
- Of the survey respondents whose primary language was not English, over 94% read English less than “very well.”
- Sixty-three percent of survey respondents “never” or “almost never” talked to their healthcare providers in their primary language.
- Sixty-two percent of Asian respondents “never” felt comfortable speaking with their healthcare providers in their primary language.
- Nearly half (46.7%) of Hispanic respondents “almost always” or “always” did not like to ask questions during medical appointments.
- More than half (52%) of survey respondents “always” or “almost always” needed an interpreter when visiting a healthcare provider.
- Forty percent of survey respondents had “never” or “almost never” been told by their healthcare provider that they had the right to an interpreter.
- Less than 6% of Asian respondents “almost always” or “always” saw signs and information printed in their primary language.
- Nearly thirty percent of survey respondents had “never” or “almost never” received information or instructions on how to use medications in their primary language.
- Thirty-eight percent of survey respondents reported that their healthcare providers were “always” or “almost always” disrespectful to them and their culture.
- Seventy-four percent of Hispanic respondents “sometimes,” “almost always,” or “always” had problems with their health insurance as it did not pay enough of their bills.
- Thirty percent of survey respondents were living without health insurance.
- In the 12 months prior to the survey, 39.4% percent of Hispanic respondents needed to see a doctor but could not because of cost.

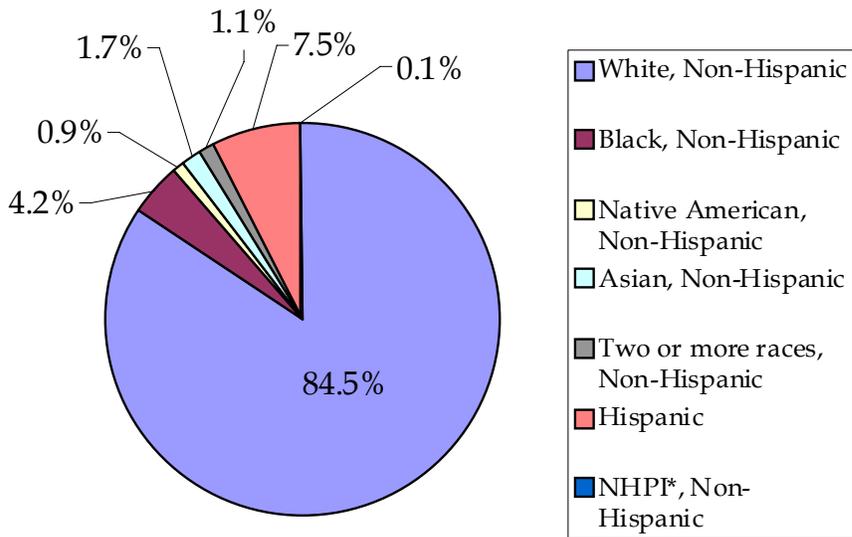
Background

Nebraska Statistics

Nebraska continues to become a more diverse state. In 2007, the total population of Nebraska was 1,774,571, with racial ethnic minorities comprising 15.5%. Hispanics comprised 49% of the total 274,191 minority population; while African Americans, Asians, and Native Americans comprised 27%, 11%, and 5.5%, respectively. According to the U.S. Census Bureau, from 2000-2007, Nebraska's racial ethnic population took a 28% jump from 214,152 to 274,191 (2007).



Figure 2.1: Percent Distribution of Nebraska Population by Race/Ethnicity 2007



*Native Hawaiian and Other Pacific Islander
Source: U.S. Census Bureau, 2007 Population Estimates Program

Hispanics are the fastest-growing minority group in Nebraska. The Hispanic/Latino population increased from 36,969 in 1990 to 94,425 in 2000, and to 133,820 in the year 2007. These numbers represented a 262% increase of the Hispanic population in the state between 1990 and 2007; a 155.4% increase between 1990 and 2000, and a 41.7% increase between 2000 and 2007. In 1990, the population of Nebraska was 1,578,385. Of that number, the Hispanic population accounted for 2.3%. In 2000, the population of Nebraska was 1,711,265 and the Hispanic population accounted for 5.5%. The population in Nebraska increased

to 1,774,571 in 2007 and the Hispanic population accounted for 7.5% of total Nebraska population (U.S. Census Bureau, 2007).

Did You Know?
 The median age of the Hispanic population in the U.S. in 2006 was 27.4, as compared with 36.4 years for the population as a whole.

Asians were the second fastest-growing minority group, with a 34.6% population increase between 2000 and 2007. In 2000, the Asian population accounted for 1.34% of the total Nebraska population, and by 2007, it was 1.7% (U.S. Census Bureau, 2007).



Among Asians in Nebraska, Vietnamese were the largest group with a population of 9,163, or 30.7% of the Asian-alone population. Chinese were the second-largest group, with a population of 6,465, or 21.7% of the Asian-alone population. Asian Indians were the third-largest group, numbering 5,558 and accounting for nearly 18.6% of the population (U.S. Census Bureau, 2007).

Table 2.1: Nebraska Population by Race and Ethnicity: 2000 and 2007

Race/Ethnicity	Population* Apr. 1, 2000	% population (2000)	Population Jul. 1, 2007	% population (2007)	Change (00-07)	% change (00-07)
Nebraska Total	1,711,265		1,774,571	100.0	63,306	3.7
White Alone	1,585,619	92.7	1,625,144	91.6	39,525	2.5
African American Alone	70,043	4.1	78,581	4.4	8,538	12.2
Native American Alone	15,634	0.9	17,576	1.0	1,942	12.4
Asian Alone	22,528	1.34	30,317	1.7	7,789	34.6
NHPI** Alone	993	0.1	1,270	0.1	277	27.9
Hispanic	94,425	5.5	133,832	7.5	39,407	41.7
White Non-Hispanic	1,497,113	87.5	1,500,380	84.5	3,267	0.2
Minority Population	214,152	12.5	274,191	15.5	60,039	28.0

Source: U.S. Census Bureau, 2007 population estimates (Release date: May 1, 2008), 2000 census estimates base.
 *2000 Population Estimates base reflects changes to the Census 2000 population from the Count Question Resolution program and geographic program revisions. ** NHPI: Native Hawaiian and Other Pacific Islander.

LEP Individuals and Public Policies

Public policies have been put into place to bridge the gap between the healthcare system and limited English proficient patients. These policies were created to help eliminate obstacles facing racial ethnic minorities. Examples of public policies affecting racial ethnic minorities include Title VI of the Civil Rights Act of 1964, Executive Order 13166, and the standards for culturally and linguistically appropriate services (CLAS).

Title VI of the Civil Rights Act of 1964 states that “no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance” (Office of Civil Rights, 2000). This piece of legislation specifically outlaws racial segregation in schools, public places, and employment. Please see the Appendices for a copy of this document.

Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency, was signed on August 11, 2000. It requires federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services to ensure that LEP people have meaningful access to them (LEP, 2008). Please see the Appendices for a copy of this document.

The standards for culturally and linguistically appropriate services (CLAS Standards) were issued by the U.S. Department of Health and Human Services Office of Minority Health (2001). The standards are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all consumers. The CLAS standards are primarily directed at healthcare organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). The ultimate goal of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans. Please see the Appendices for a listing of all the CLAS Standards.

In recent years, there has been little movement on the federal front towards improving or increasing language access. As a result, most legislative and regulatory activity to address language barriers in healthcare settings has occurred at the state level. Notable state legislative initiatives have occurred in

three broad areas: continuing education for health professionals, certification of healthcare interpreters, and reimbursement for language services for Medicaid/SCHIP enrollees (Chen, 2007).

Final Piece of the Puzzle

This is the third in a series of surveys designed to assess the cultural competence of healthcare in Nebraska. The first survey targeted healthcare providers, and the second targeted interpreters. In 2006, the Medical Translation and Interpretation (MTI) Leadership Group, a community task force based in Lincoln, Nebraska, created a ten-question survey to assess the attitudes of Lancaster County medical providers about the use of interpreters and translators. Over 550 surveys were sent to physician clinics, hospitals, dental clinics, and pharmacists in Lincoln and Lancaster County. A total of 173 responses were received.

Results of the survey indicated that a significant portion of medical providers were unclear or unaware of standards concerning interpretive services. Over 65% of the providers stated that they generally used patients' family and friends to provide interpretation services. Of the providers who used patients' family and friends to interpret, 49% felt that this method was probably or definitely adequate. Respondents were asked if they provided written health information such as forms, teaching sheets, and discharge instructions in languages other than English. Thirty-eight percent of respondents reported that they offered written health information and forms in other languages, and 62% of respondents reported that they did not.

Respondents were also asked what their greatest barrier was to communicating with LEP individuals. Twenty-eight respondents reported that lack of time was their greatest barrier to communicating with LEP individuals, 44 reported the lack of accessible interpreters as their greatest barrier, 43 reported cost as their greatest barrier, 24 reported that they were not responsible for being able to communicate with LEP individuals, and 14 could not define their greatest barrier (MTI, 2006).

The second survey, *Interpreters Speak Out: Nebraska Language Access Survey*, was conducted in 2007 on behalf of the Office of Minority Health and Health Equity. One hundred and seventy-nine persons completed the 30-question survey. The purpose of the survey was to expand the overall understanding of the quality of language services available in Nebraska's healthcare settings.

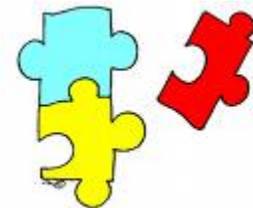
Thirty-one percent of respondents were born in the U.S., and 69% were born outside the U.S. Nineteen languages were spoken among the respondents (excluding English), and 71% of the respondents were Spanish language interpreters. Sixty percent of respondents were hired as interpreters and/or

translators, and 40% were not hired with the position of interpreter in their primary title or were in a dual-role position (OMH, 2008).

Interpreters were asked about their experiences as well as educational background and knowledge of ethics related to healthcare interpretation. Ninety-four percent of respondents had a high school diploma, 86% had some college education, 29% had a Bachelor's Degree, and 10% had a Master's Degree. In terms of medical interpreter training, nearly 80% of respondents reported that they had some medical interpreter training, yet it was unclear what the extent of their training was (OMH, 2008).

One question in the survey addressed standards of practice or guidelines, which are in place to define what an interpreter does while performing their job. Fifty-five percent of survey respondents indicated that they followed professional guidelines, while 45% either did not respond or reported that they did not follow any professional standards. Another question asked whether organizations were informing limited English proficient patients of their right to an interpreter free of charge. Of the respondents who answered the question, 55% rated the organizations as "excellent" or "very good" in this effort, and 45% of respondents felt that their organizations' effort to inform patients of their right to language access services was "fair," "inadequate," or "poor" (OMH, 2008).

The current survey is the final piece of the puzzle, as it assessed the clients' experiences and perspective. The survey was created to help identify issues of cultural competence, language access, and the overall standard of care for limited English proficient patients. Moreover, the survey was designed to find out how effectively these issues are being addressed from the perspective of the client.



Cultural competence refers to an ability to interact effectively with people of different cultures. Cultural competence requires that organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally. Cultural competence comprises many components and includes elements such as: (a) awareness of one's own cultural worldview, (b) attitude towards cultural differences, (c) knowledge of different cultural practices and worldviews, and (d) cross-cultural skills (NCCC, 2008). A culturally competent healthcare organization continually strives to create a healthcare system that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency (Betancourt, 2002). Nebraska's changing demographics have had a significant impact on the

healthcare system. Limited English patients encounter language barriers at many points in their search for healthcare, from the moment they try to make an appointment through their entire visit including discharge and referrals. These communication challenges affect access to quality health care; patients often delay treatment until their health needs become urgent (Hablamos Juntos, 2008). The goal is to combine the different perspectives from the three completed surveys and use the information to help bridge the gap within healthcare. Efforts will be made to improve the quality of health services for all LEP populations. This means creating organizations that promote an environment committed to serving patients who speak little or no English and adopting creative solutions to increase the number of professional interpreters and other language services available to LEP individuals.

Methodology

Telephone survey method was used to collect data for this project. The survey was conducted by the University of Nebraska Medical Center (UNMC). The questionnaire was first designed in English, and later translated it into Spanish, Vietnamese, and Chinese.

The Spanish Sample came from the 2008 BRFSS data. People who are Hispanic were identified and pulled from the first nine months of data collection. The Genesys Marketing Systems Group generated the sample for the Chinese and Vietnamese. They used their Listed Database and Targeted Surnames for these two groups. They have a proprietary list of Surnames they can reference. The Genesys Listed Database provides researchers with access to all available listed telephone households in the U.S. The listed household samples provide the ability to improve both sample efficiency and incidence rates when the research challenge faced calls for it. With the targeted demographics available to the household level, a listed database can provide sample households with the specific characteristics your research project demands. Geographic selections are available down to the ZIP+4 or census block level and includes tightly defined areas such as a radius around a point (address), retail trading areas, and other non-standard geographic areas that can be easily targeted. Selection criteria include numerous demographic variables; including income, age, and gender of adults and children, race, ethnic surnames, home ownership, etc.

The majority of survey data were weighted based on the 2006 Nebraska Asian and Hispanic population distribution regarding gender (see table). Demographic data was unweighted.

Data was weighted to the following proportions:

	Age	Gender	Total (%)
Hispanic	18+	Male	55.8%
		Female	44.2%
Asian	18+	Male	49.5%
		Female	50.1%

Results

Demographic Information

Age of Survey Respondents

Demographic data was collected about the respondents. Seven hundred and seven individuals took part in the survey. Survey respondents varied in age from 18 to 75 and over, with 58.7% of female respondents and 50.9% of male respondents between the ages of 25 to 44. Just over 7% of respondents were between the ages of 18 and 24, 16.1% were 45 to 54, 13.9% were 55 to 64, 5.4% were 65 to 74, and 1.4% were 75 and over. The majority (61.7%) of Hispanic respondents were between the ages of 25 to 44, while 74.9% of Asian respondents were between the ages of 35 to 64.

Figure 4.1: Age of Survey Respondents

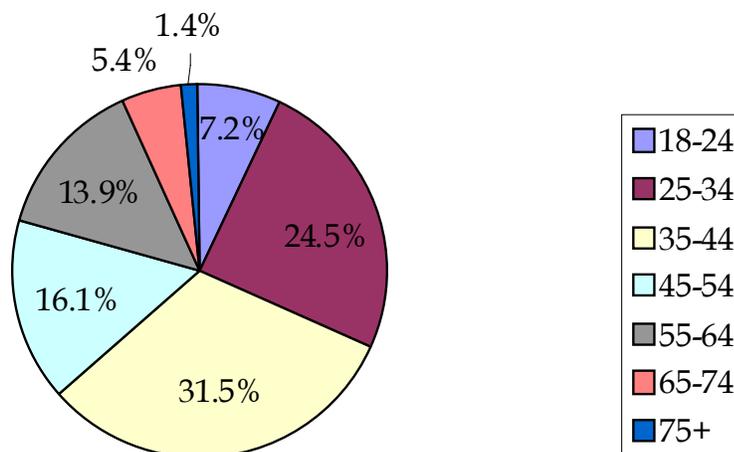
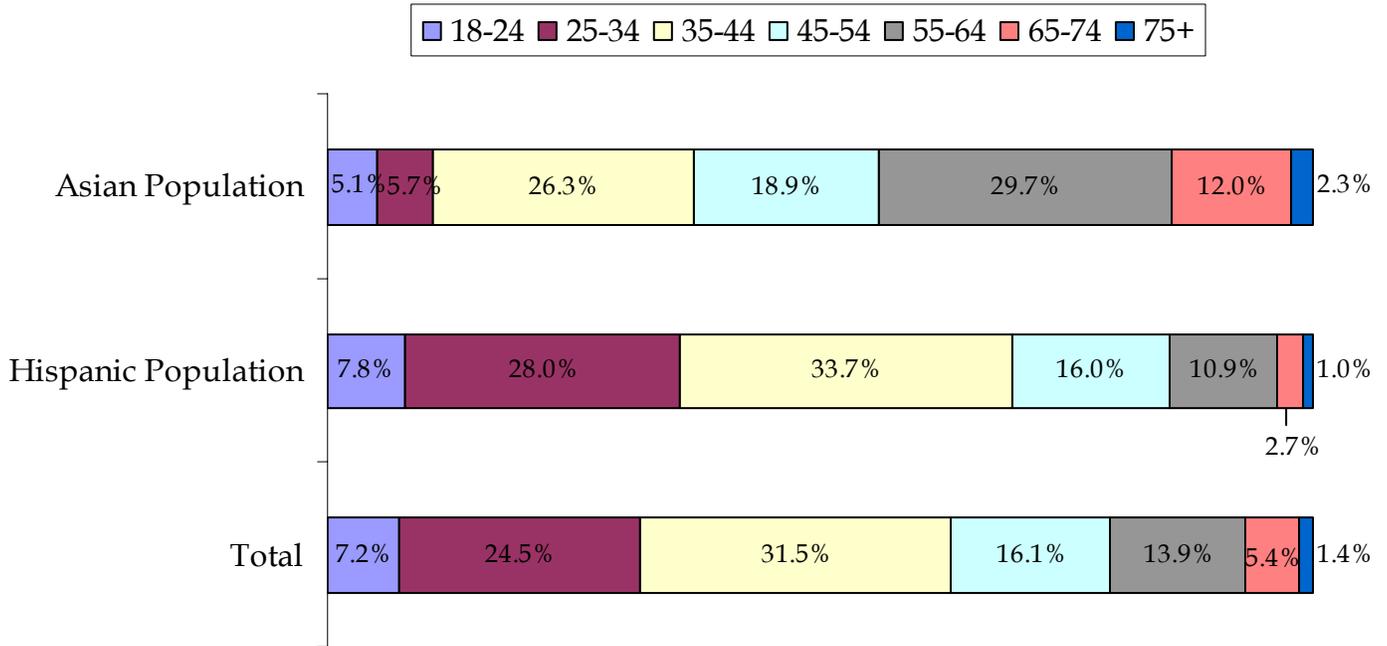


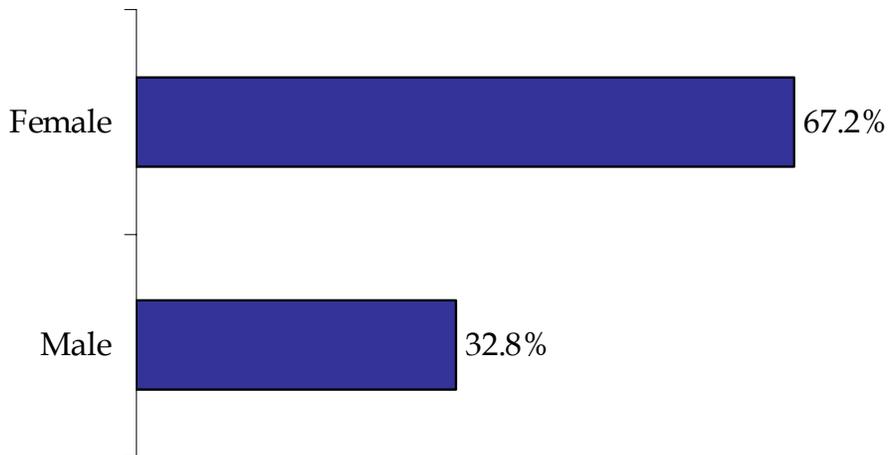
Figure 4.2: Age of Respondents by Race



Gender of Survey Respondents

Of the respondents, 32.8% were male, and 67.2% were female. Fifty-six percent of Hispanic respondents were male and 44% were female. The percentages for Asian respondents were similar, as 49.4% were male and 50.6% were female.

Figure 4.3: Gender of Respondents



Race and Ethnicity of Survey Respondents

This report targeted Hispanics and Asians throughout the state of Nebraska. Nearly 74% of respondents reported that they were Hispanic. Those who reported that they were Hispanic were then asked to further specify if they were Mexican or “Other.” Nearly 76% of Hispanic respondents stated that they were of Mexican heritage, and 24.2% stated that they were “Other.” Twenty-six percent of respondents reported that they were Asian. Eighteen percent reported that they were Vietnamese and 8.2% reported that they were Chinese.



Country of Origin

When asked about their country of origin, survey respondents offered a total of twenty-one different responses. Over 55% were born in Mexico. Vietnam, Guatemala, and China were also common responses; with 123, 55, and 53, respectively.

Table 4.1: Respondents’ Country of Origin

Country	Frequency
Argentina	1
Cambodia	2
Central America	3
China	53
Columbia	1
Costa Rica	1
Cuba	1
Dominican Republic	2
El Salvador	26
Guatemala	55
Honduras	9
Japan	1
Malaysia	1
Mexico	404
Nicaragua	1
Panama	1
Peru	1
Puerto Rico	2
South America	1
United States	7
Vietnam	123

Level of Education



In terms of education, over 65% of survey respondents had completed middle school or less. Only 8.2% had completed college, and 2.9% had received their postgraduate degree. The majority (78.6%) of Hispanic respondents' education

level was middle school or less. Twenty-one percent of Asian respondents had a college graduate degree, and 11.4% had completed a postgraduate degree.

Did You Know?

In 2006, 56% of the U.S. population (ages 3 to 34) was enrolled in school.

Figure 4.4: Highest Level of Education

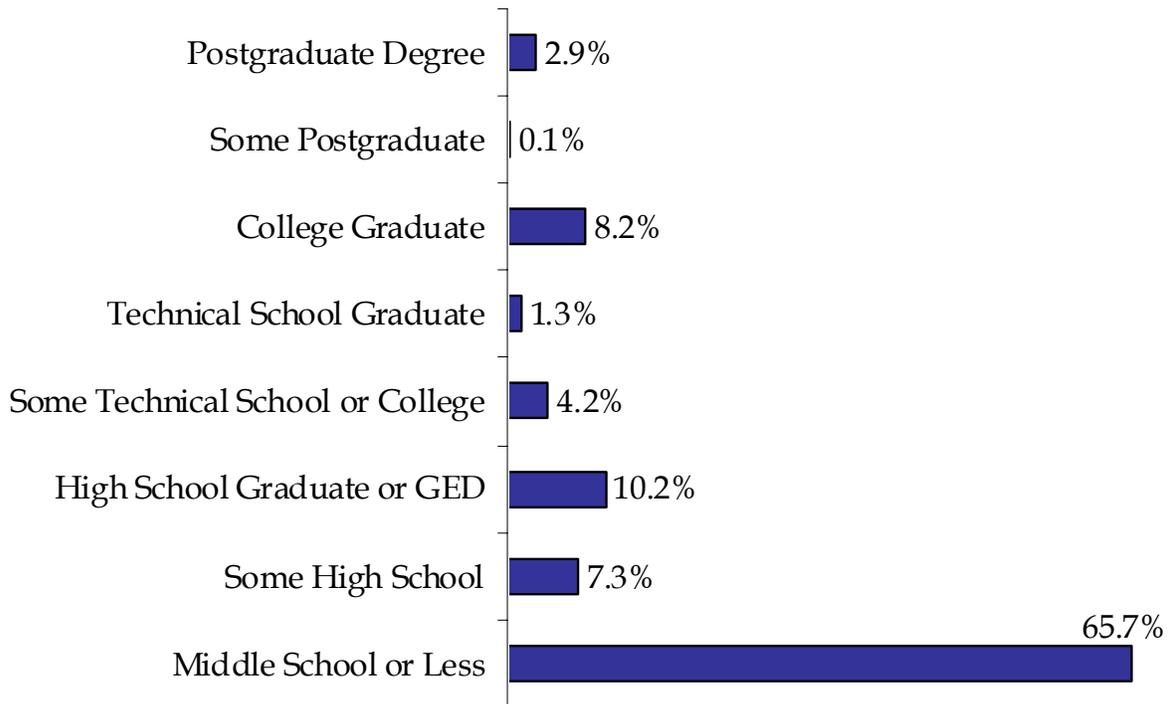
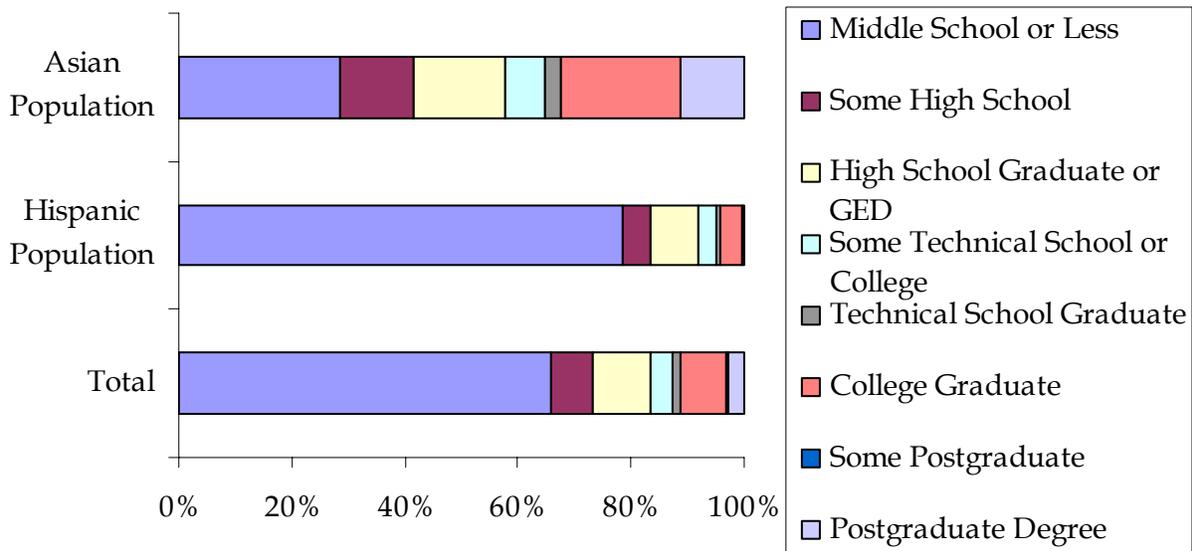


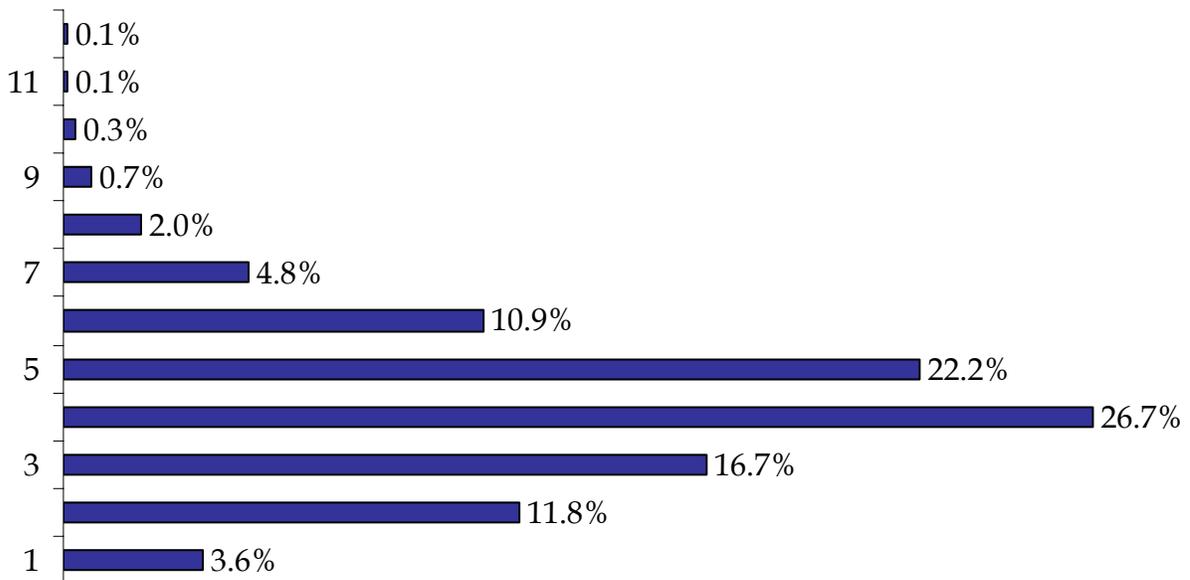
Figure 4.5: Highest Level of Education by Race



Number of People per Household

Survey respondents were asked how many people were in their household. Of those who responded, the most common answer was between three to five people per household. Others responses included two (11.8%), and six (10.9%).

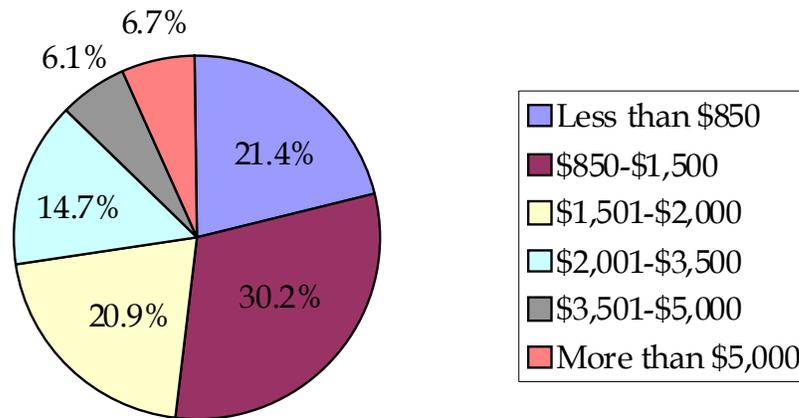
Figure 4.6: Number of People in a Household



Monthly Household Income

The total monthly household income varied from less than \$850 to more than \$5,000. The majority of respondents' household income ranged from \$850 to \$2,000 each month. Less than 15% of survey respondents brought home more than \$3,500 per month. The majority of female respondents (73.2%) reported that their monthly income ranged from less than \$850 to \$2,000. Nearly 73% of male respondents reported that their monthly income ranged from \$850 to \$3,500. Twenty-five percent of Asian respondents reported that their monthly household income was more than \$5,000.

Figure 4.7: Total Monthly Household Income



Counties of Survey Respondents

Survey respondents lived in 29 different counties in Nebraska. Douglas, Lancaster, and Dakota counties represented over half (54.6%) of the participants; with 219, 101, and 86, respectively. Other counties with significant numbers included Dawson (54), Colfax (51), and Hall (51).

Table 4.2: Counties of Survey Respondents

County	Number of People
Adams	16
Buffalo	8
Butler	1
Cheyenne	1
Clay	2
Colfax	51
Cuming	7
Dakota	86
Dawson	54

Dixon	4
Dodge	5
Douglas	219
Furnas	1
Hall	51
Hamilton	1
Holt	2
Lancaster	101
Lincoln	19
Madison	18
Otoe	3
Platte	4
Saline	7
Sarpy	11
Saunders	1
Scotts Bluff	7
Seward	1
Sioux	2
Wayne	1
Webster	1

Primary Language/Communication

Communication may be the biggest barrier to providing and receiving culturally competent services. Over the years, the number of U.S. residents who speak a language other than English has increased, as has the number of U.S. residents with limited English proficiency (LEP). The same is true of Nebraska, as the minority populations continue to increase while the non-Hispanic White population has stagnated or decreased.

The Marriam-Webster Dictionary defines communication as a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior (2008). It is a process by which we assign and convey meaning in an attempt to create shared understanding. Moreover, communication requires that all parties have an area of communicative commonality (Bergeson, 2008).

Communication between patients and their healthcare providers is essential for ensuring quality healthcare and developing trusting relationships. It is an important component of patient satisfaction, compliance, and outcomes.

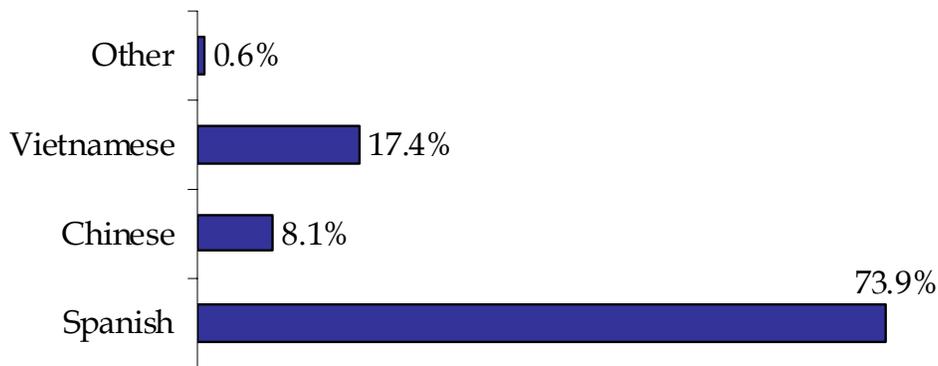
Although challenging for all populations, communication is especially a barrier for limited English proficient (LEP) patients, and the lack of accurate oral interpretation with this population results in decreased quality of care, increased medical errors, greater disparities, and diminished access (AAPCHO, 2008).

In this section of the survey, respondents were asked to answer questions about literacy levels in their primary language as well as the English language. In addition, respondents answered questions regarding their communication with healthcare providers.

Primary Language

A person's primary language is the language that one feels the most comfortable speaking. When queried about their primary language, 73.9% reported Spanish, 8.1% Chinese, and 17.4% Vietnamese.

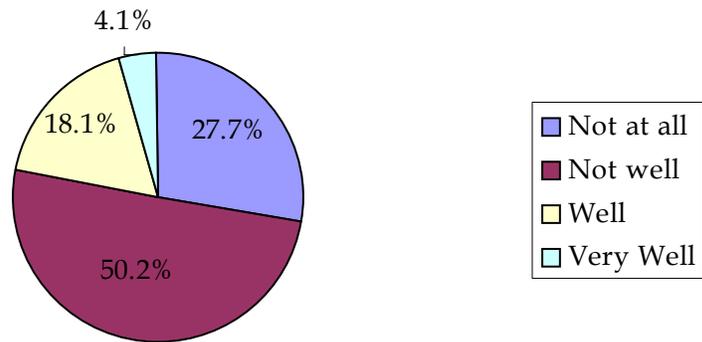
Figure 4.8: Primary Language of Respondents



English Speaking Proficiency

When asked how well they spoke English, over 25% of survey respondents stated that they did not speak English at all, and 50.2% of respondents spoke a little English, but "not well." Nearly 35% of female respondents and 22.8% of male respondents did not speak English at all. A small portion of survey respondents (4.1%) could speak English "very well," and 18.1% said that they spoke English "well." Almost 40% of Asian respondents spoke English "very well" or "well," while less than 16% of Hispanic respondents spoke English "very well" or "well."

Figure 4.9: How Well Do you Speak English?



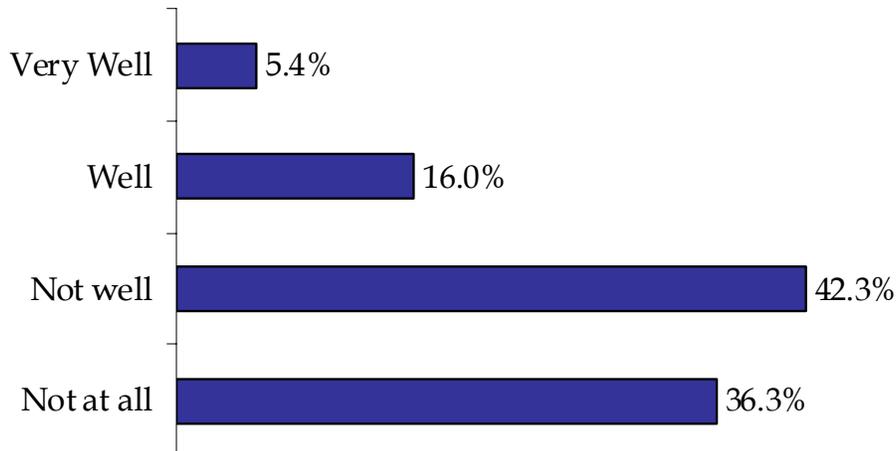
English Reading Proficiency

Survey respondents were asked how well they could read English. Over 36% reported that they could not read English at all. Nearly 40% of female respondents were not able to read English at all. Of the respondents who were able to read English, 42.3% did not read the language “well,” compared to the 16% who read English “well,” and 5.4% of survey respondents who read English “very well.” Less than 14% of Hispanic respondents could read English “well” or “very well,” while 39.5% of Asian respondents were able to read English “well” or “very well.”

Did You Know?

Fundamental Literacy is defined as follows: In one’s primary language, the ability to read, write, speak, and work with numbers (Zarcadoolas, 2005).

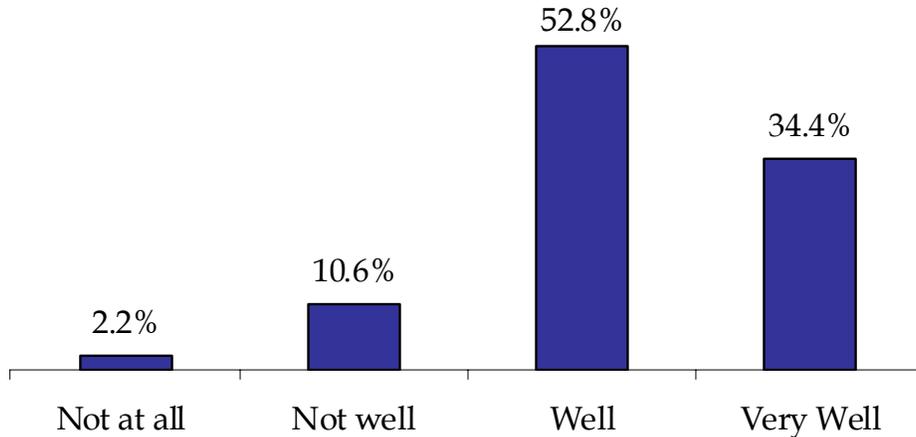
Figure 4.10: How Well Do you Read English?



Primary Language Reading Proficiency

In order to get a better understanding of literacy levels, survey respondents were also asked to report how well they could read in their primary language. Over 85% reported that they were able to read their primary language “very well” or “well.” Less than three percent reported that they were not able to read in their primary language at all.

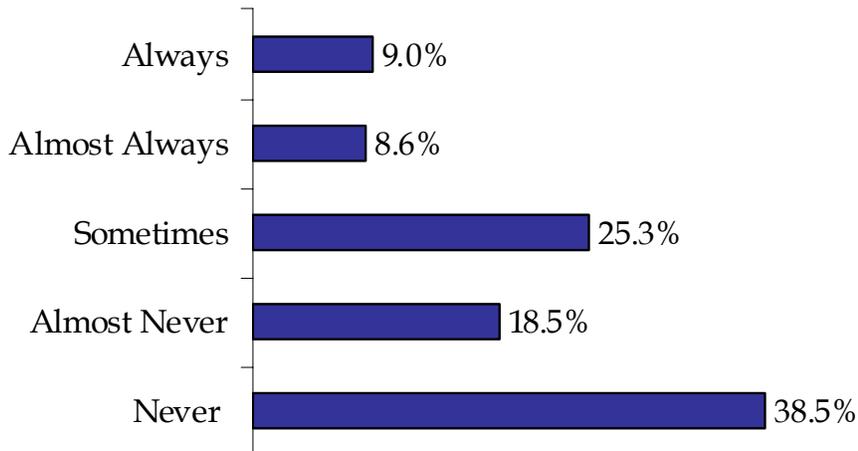
Figure 4.11: How Well Do you Read in your Primary Language?



Communicating in English

Survey participants were asked how often they talked to their healthcare providers in English. Less than 20% of respondents “almost always” or “always” talked to their healthcare providers in English. Almost 40% of survey respondents “never” talked to their healthcare providers in English, while 43.8% “sometimes” or “almost never” talked to their healthcare providers in English. Over 44% of Hispanic respondents and 21.9% of Asian respondents reported that they “never” talked to their healthcare providers in English.

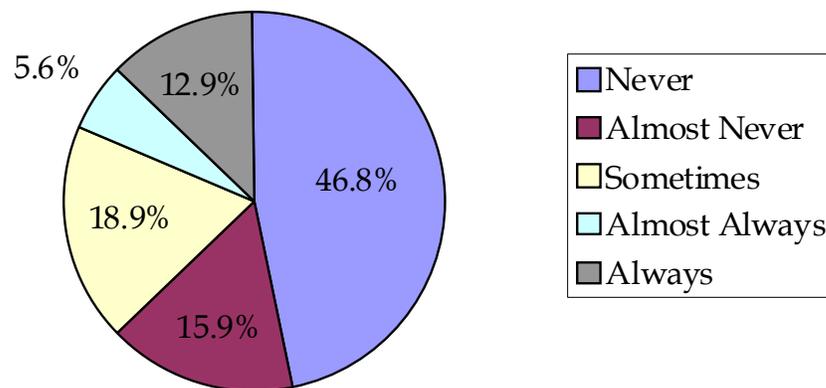
Figure 4.12: How Often Do you Talk to your Healthcare Providers in English?



Communicating in Primary Language

Respondents were asked how often they talked to their healthcare providers in their primary language. More than 18% “always” or “almost always” talked to their healthcare providers in their primary language, and 18.9% were “sometimes” able to talk to their healthcare providers in their primary language. Female respondents talked to their healthcare providers in their primary language more often than males, as 23.6% of female respondents and 14.2% of male respondents “always” or “almost always” talked to their healthcare providers in their primary language. Sixteen percent of Hispanic respondents “always” talked to their healthcare providers in their primary language, while only 3.8% of Asian respondents “always” talked to their healthcare providers in their primary language. Over 60% of respondents “never” or “almost never” talked to their healthcare providers in their primary language.

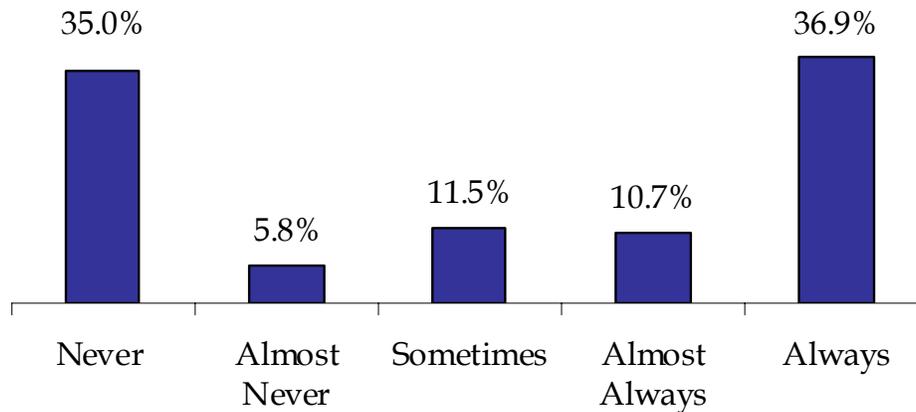
Figure 4.13: How Often Do you Talk to you Healthcare Providers in your Primary Language?



Level of Comfort

When asked how often they felt comfortable speaking with their healthcare providers in their primary language, 36.9% of survey respondents “always” felt comfortable, and 35% “never” felt comfortable. Nearly 6% “almost never” felt comfortable, 11.5% “sometimes” felt comfortable, and 10.7% “almost always” felt comfortable when speaking with their healthcare providers in their primary language. Nearly 45% of Hispanic respondents and 14% of Asian respondents “always” felt comfortable.

Figure 4.14: How Often Do you Feel Comfortable Speaking with your Healthcare Providers in you Primary Language?



Use of Interpreters

Interpreters work to enable cross-cultural communication by conveying the message from one language into another. To avoid misinterpretation, interpreters must thoroughly understand the subject matter in which they work in order to accurately convert information from one language into another language (U.S. Department of Labor, 2007). This is especially true when it comes to medical interpreters, as their primary job is to help patients communicate with doctors, nurses, and other medical staff. Inaccurate information or misinterpretation between the two parties can lead to serious or even fatal health complications.

According to the American Medical Translators, a medical translator or interpreter is a specially trained professional who has proficient knowledge and skills in a primary language or languages, and who employs that training in medical or health-related settings to make possible communications among parties speaking different languages. The skills of a medical interpreter or translator include cultural sensitivity and awareness of and respect for all parties, as well as mastery of medical terminology, which make possible conditions of mutual trust and accurate communication (American Family Physician, 2004).

The use of bilingual physicians and professional interpreters results in optimal communication and improved medical outcomes and has been linked with increased use of screening tests, an increased number of office visits, higher rates

of prescriptions being filled, fewer laboratory tests ordered, and increased patient satisfaction. In contrast, the use of ad hoc interpreters (untrained staff or family members, friends, and strangers from the waiting room), is associated with poorer self-reported understanding of diagnoses, increased numbers of interpreter errors, and higher rates of testing and admission from emergency departments (Kuo, 2007).

Did You Know?

Although no federal standards for health care interpreters exist, some states require or are initiating state certification. Washington has the oldest certification program.

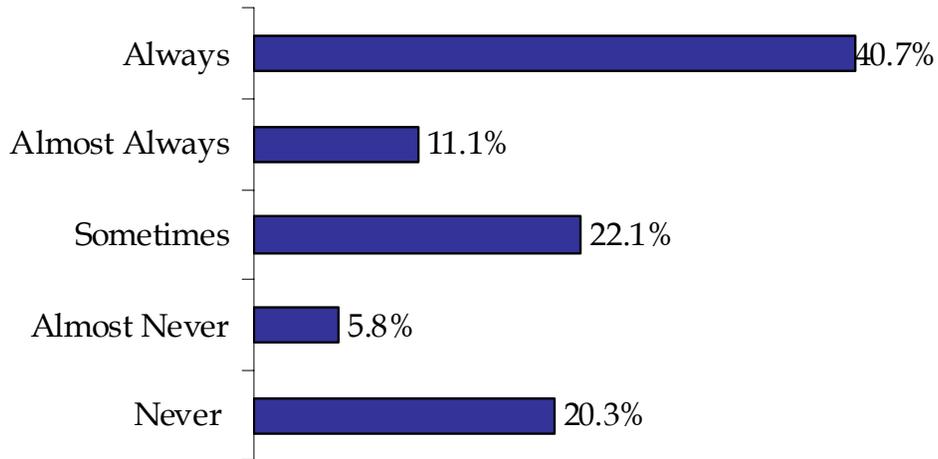
While any healthcare provider who receives federal funds must provide meaningful access to services for individuals with limited English proficiency, states are not required to reimburse providers for these expenses. However, states can choose to reimburse providers for language services for individuals enrolled in Medicaid and State Children's Health Insurance Programs (SCHIP). Currently there are only a few states that provide direct reimbursement to providers for language services. Nebraska does not utilize Medicaid or SCHIP funds for language service reimbursement for medical visits. Instead, they consider the costs of language services as part of providers' overhead or administrative costs, and include the costs in providers' payment rates (National Health Law Program & Access Project, 2004).

Many health centers take it upon themselves to provide language services to the best of their ability. However, there is increasing diversity among the languages spoken by LEP communities across the country and in the state of Nebraska, which pose more challenges in finding interpreters who can speak uncommon languages and in financing arrangements to support access for a wide variety of languages (AAPCHO, 2008).

Interpreter Use

Respondents were asked if they needed an interpreter when they visited their healthcare providers. Over 40% stated that they "always" needed an interpreter when they visited a healthcare provider, 11.1% "almost always" did, and 22.1% "sometimes" needed an interpreter. Over 43% of female respondents stated that they "always" needed an interpreter. Less than 30% of respondents "never" or "almost never" needed an interpreter when they visited a healthcare provider.

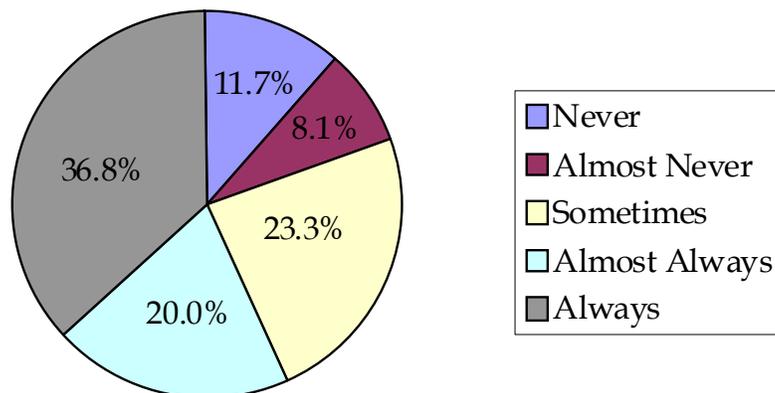
Figure 4.15: Do you Need an Interpreter when you Visit a Healthcare Provider?



Interpreter Availability

When asked about interpreter availability, 36.8% of survey respondents stated that an interpreter was “always” available when they needed one, and 11.7% of respondents said an interpreter was “never” available. Another 20% said that interpreters were “almost always” available, 23.3% said they were “sometimes” available, and 8.1% reported that they “almost never” had an interpreter available to them when they needed one. Nearly 33% of male respondents and 43.2% of female respondents reported that they “always” had an interpreter available to them when they needed one. Forty-five percent of Hispanic respondents reported that they “always” had an interpreter available to them. Over 33% of Asian respondents also reported that they “almost never” or “never” had an interpreter available to them when they needed one.

Figure 4.16: Is there an Interpreter Available when you Need One?

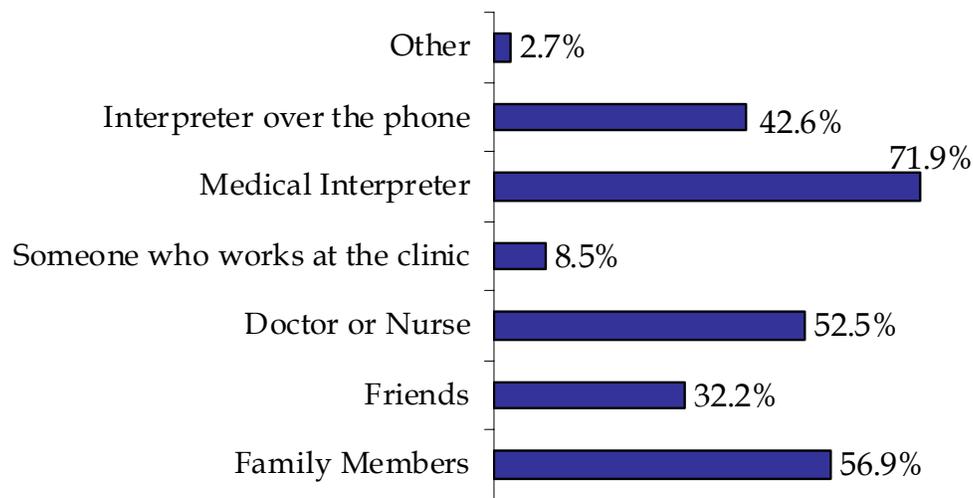


Who Interprets

Survey respondents were asked who interpreted for them in healthcare settings. Multiple responses were allowed. Of the survey respondents who needed an interpreter, 56.9% utilized a family member to interpret for them, 32.2% made use of a friend to help with interpretation, 52.5% had a doctor or nurse interpret for them, and 8.5% had someone who worked at the clinic interpret for them.

Professional interpreter services were also used. Over 70% of survey respondents used a professional medical interpreter, and 42.6% communicated with an interpreter over the phone.

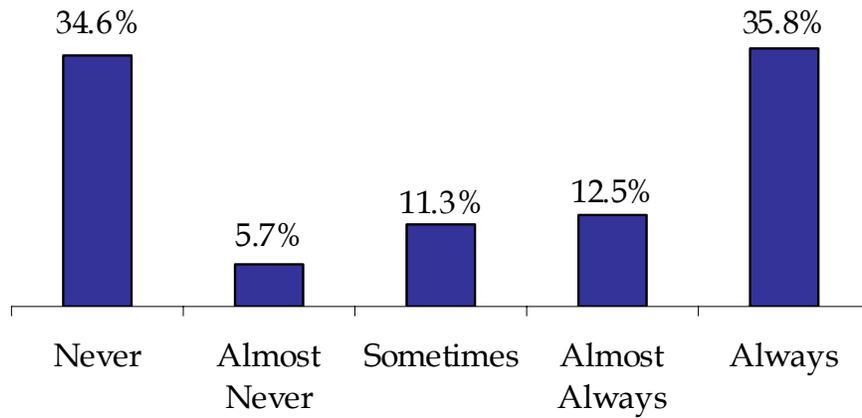
Figure 4.17: Who Interprets for you?



Right to an Interpreter

When asked if their healthcare provider had ever told them that they had a right to an interpreter, 59.6% reported that they were “always,” “almost always,” or “sometimes” notified of this right. Over 42% of Hispanic respondents and less than 16% of Asian respondents reported that they were “always” notified that they had a right to an interpreter. The right to an interpreter was not presented to all healthcare patients. Forty percent of survey respondents reported that they had “never” or “almost never” been told they had the right to an interpreter.

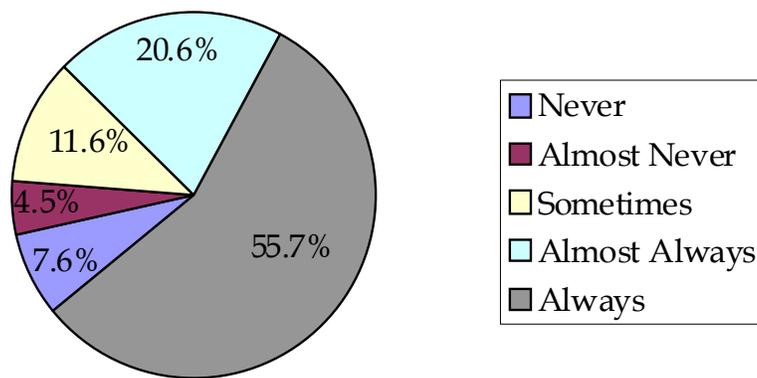
Figure 4.18: Have you Ever Been Told by your Healthcare Provider that you have the Right to an Interpreter?



Understanding One Another

When working with an interpreter, it is essential that the interpreter and patient understand each other. To get a better understanding of communication barriers between LEP individuals and interpreters, survey respondents were asked if they felt their interpreter understood what they were saying. Over 55% of survey respondents felt that their interpreter “always” understood what they were saying, 20.6% “almost always,” and 11.6% “sometimes”. Less than 13% of survey respondents “never” or “almost never” felt that their interpreter understood what they were saying. Seventeen percent of Asian respondents “never” felt their interpreter understood them, and 4.7% of Hispanic respondents felt the same.

Figure 4.19: Do you Feel that your Interpreter Understands what you are Saying?



How Interpreters Help

Interpreters are needed for various reasons. In the survey, respondents who needed an interpreter were asked how the interpreter helped them. Respondents were given several options and were able to select more than one answer. A majority of survey respondents used an interpreter to interpret what the doctor or nurse said (96.6%) and/or what they said to the doctor or nurse (95.9%). Over 65% of respondents used an interpreter to read information on medicine packages/bottles, and 71.1% used an interpreter to explain how to take/use medicine. Interpreters helped 57.4% make medical appointments, and assisted 54.2% with calling or going to the pharmacy to fill their prescriptions.

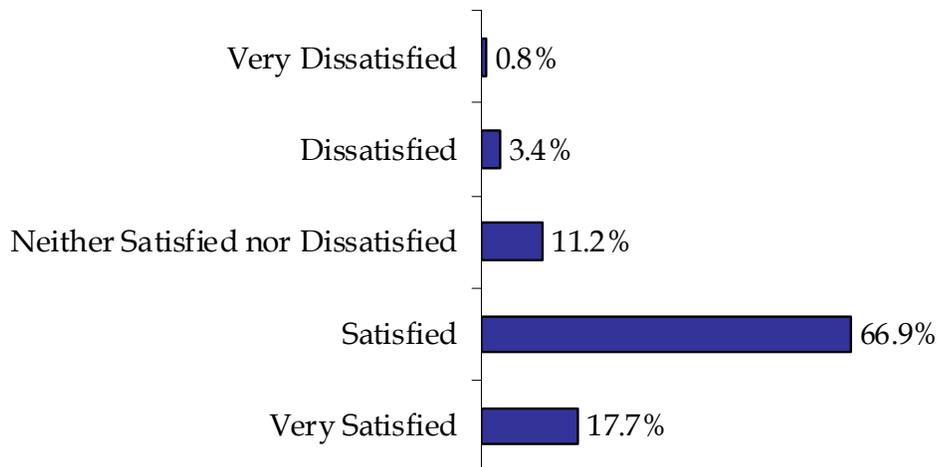
Table 4.3: How does the Interpreter help you?

Make medical appointments	57.4%
Interpret what they doctor or nurse say	96.6%
Interpret what you say to the doctor or nurse	95.9%
Call or go to the pharmacy to fill your prescription	54.2%
Read information on medicine packages/bottles	67.4%
Explain how to take/use medicine	71.1%
Other	2.8%

Satisfaction with Communication

In terms of satisfaction with the communication between respondents and their healthcare providers, over 84% responded that they were either “very satisfied” or “satisfied.” Less than 5% were “dissatisfied” or “very dissatisfied,” and 11.2% were “neither satisfied nor dissatisfied.”

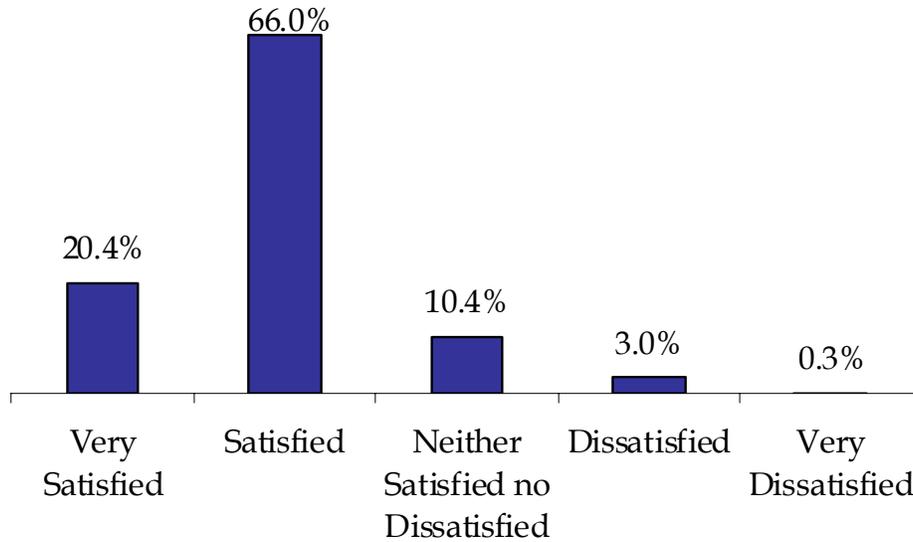
Figure 4.20: How Satisfied are you with the Communication Between you and your Healthcare Providers?



Satisfaction with Care

When respondents were asked about their satisfaction with the care that they received, over 85% reported that they were “very satisfied” or “satisfied.” The remaining 15% of respondents reported that they were either “dissatisfied,” “very dissatisfied,” or “neither satisfied nor dissatisfied” with the care they received.

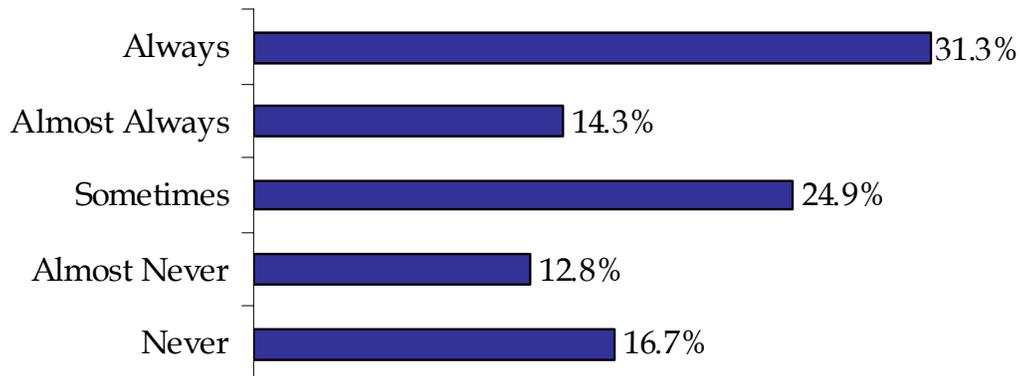
Figure 4.21: How Satisfied are you with the Care that you Receive?



Information in Primary Language

Survey respondents were asked how often they saw signs and information printed in their primary language. Almost 32% of survey respondents “always” saw signs or information in their primary language while 45.6% “almost always” or “sometimes” saw signs or information in their primary language. The percentage of those who “never” or “almost never” saw signs or information in their primary language was slightly under 30%. Nearly 84% of Hispanic respondents “always,” “almost always,” or “sometimes” saw signs and information printed in their primary language, while 94.5% of Asian respondents reported that they “never,” “almost never,” or “sometimes” saw signs and information in their primary language.

Figure 4.22: How Often Do you See Signs and Information Printed in your Primary Language?



Healthcare Decisions

All patients have the right to make healthcare decisions about the medical care they receive. Making healthcare decisions should be a collaborative effort. Healthcare providers should supply enough information to assist individuals in making medical decisions. Many limited English proficiency patients come from different cultural backgrounds; thus, their health beliefs and practices may differ from what is common and acceptable in the United States. Miscommunication and mistrust may occur if patients feel they are not being respected or being forced into a healthcare decision without sufficient information. Culture, language, and communication barriers have great potential to lead to mutual misunderstandings between patients and their healthcare providers.

Health Beliefs

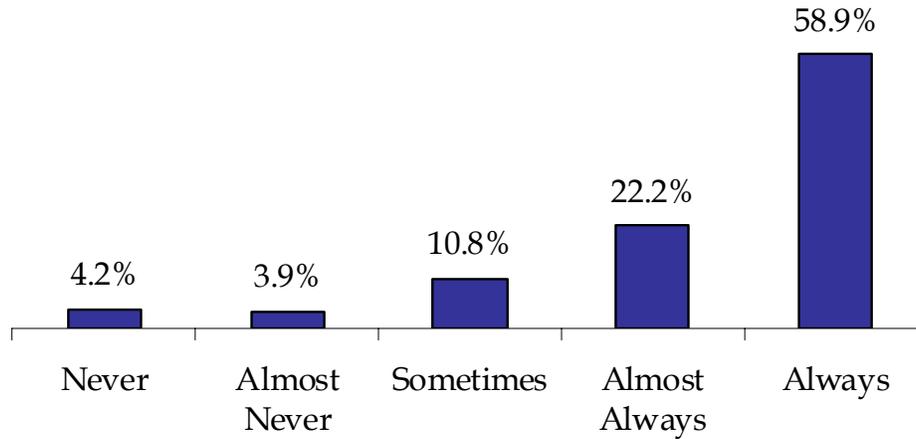
Survey respondents were asked how often they felt their healthcare providers respected their health beliefs. Over 80% of respondents “almost always” or “always” felt that their healthcare provider respected their health beliefs, while 8.1% “almost never” or “never” felt their health beliefs were

respected. Seventy-eight percent of male respondents and 84.4% of female respondents reported that their healthcare providers “always” or “almost always” respected their health beliefs.

Did You Know?

In many cultures, elders have a prestigious status in the family because of their experience. Family members look to elders for advice. An individual who becomes sick will turn first to family members, especially elders, for support, comfort and advice. They may recommend safe, simple home remedies.

Figure 4.23: How Often Does your Healthcare Provider Respect your Health Beliefs?

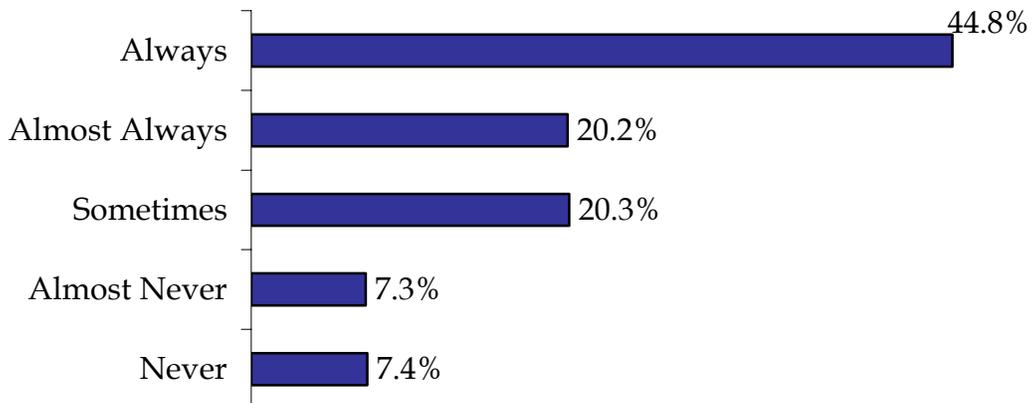


Collaborative Healthcare Decisions

Respondents were asked how often they and their healthcare providers made decisions together regarding their health. Of those who responded, 44.8% “always” and 20.2% “almost always” made decisions about their health together with their healthcare providers. Fifty-four percent of Hispanic respondents and less than 19% of Asian respondents “always” made collaborative healthcare decisions with their healthcare providers. Over 20% of survey respondents reported that they “sometimes” made health decisions together, while 7.3% “almost never” and 7.4% “never” made health decisions together with their healthcare providers.



Figure 4.24: How Often Do you and your Healthcare Providers Make Decisions Together about your Health?

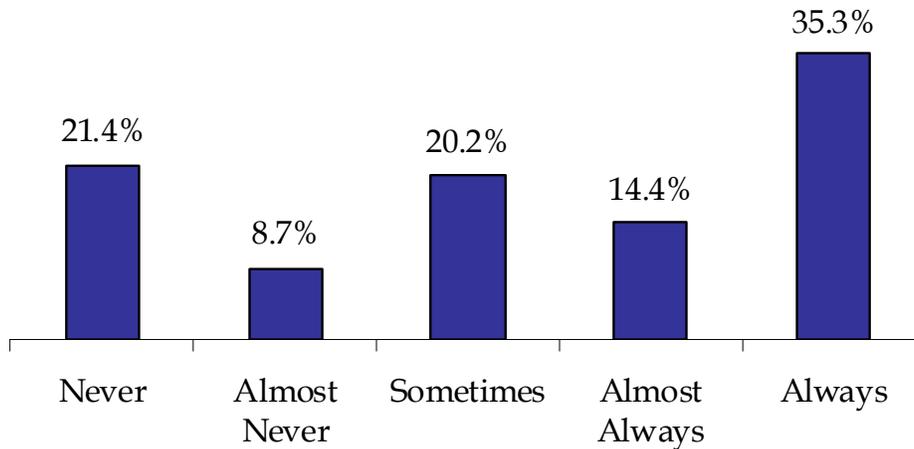


Information on Medication Use

When taking medications, it is important to know and understand the information or instructions in order to take the medication correctly. Respondents were queried about how often they received information and instructions on how to use medications in their primary language. Just over half (50.3%) of respondents reported that they “never,” “almost never,” or “sometimes” received information or instructions on how to use medications in their primary language. The other half (49.7%) “almost always” or “always” received information or instructions in their primary language. Forty-seven percent of Hispanic respondents “always” received information or instructions in their primary language, while 57.6% of Asian respondents “never” received information or instructions in their primary language.



Figure 4.25: How Often Do you Receive Information or Instructions on how to Use Medications in your Primary Language?



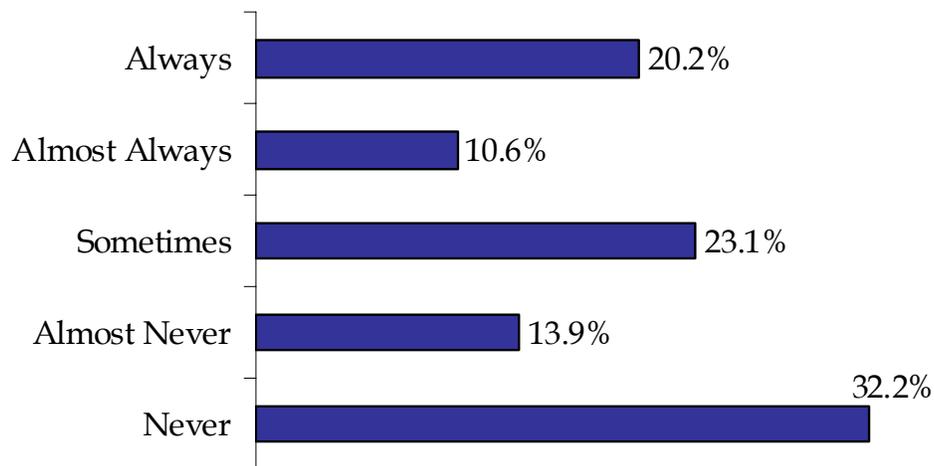
Barriers

A barrier can be classified as something that impedes, stands in the way of, or holds up progress (Merriam-Webster, 2008). People who are of limited English proficiency may experience different barriers than those who are able to speak English fluently. The limited English proficiency population may face many barriers including lack of materials in specific languages, availability and cost of interpreters and translators, interpreter’s lack of certification or adequate training in related terminology, low literacy levels, and messages that are too complex.

Interpreter Services

In terms of interpreter availability, survey respondents were asked how often interpreter services were not available when they visited their healthcare providers. Over 45% of survey respondents “never” or “almost never” had difficulties finding an available interpreter to assist them when speaking with healthcare providers. Thirty-one percent of female respondents and 33.6% of male respondents “never” had difficulties finding an available interpreter. Over 30% of respondents “almost always” or “always” found themselves in situations where interpreters were not available when visiting their healthcare providers.

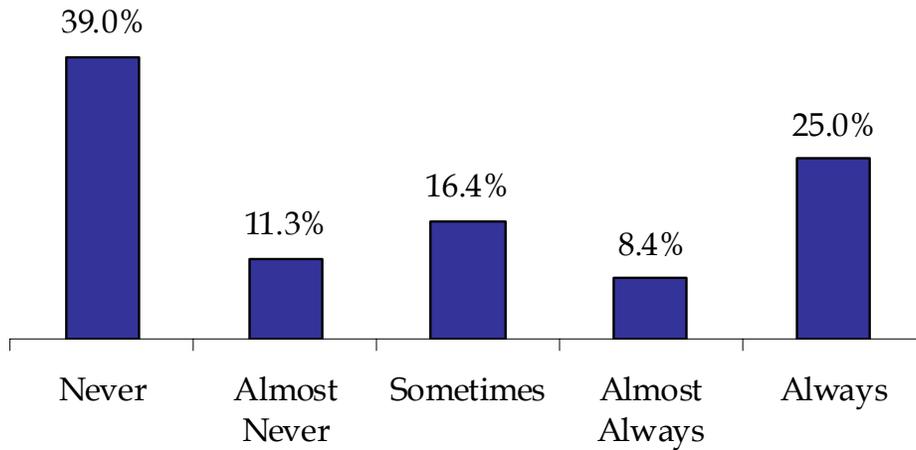
Figure 4.26: Interpreter Services are Not Available when I Visit my Healthcare Providers



Healthcare Providers and Primary Language

When asked to respond to the statement, “my healthcare providers do not speak my primary language,” 25% of survey respondents reported that their healthcare providers did not speak their primary language. More female than male respondents reported that they “always” or “almost always” experienced this barrier (36.5% and 29.7%, respectively). Almost 40% of respondents never experienced this barrier, as they chose to use healthcare services where the providers spoke their primary language.

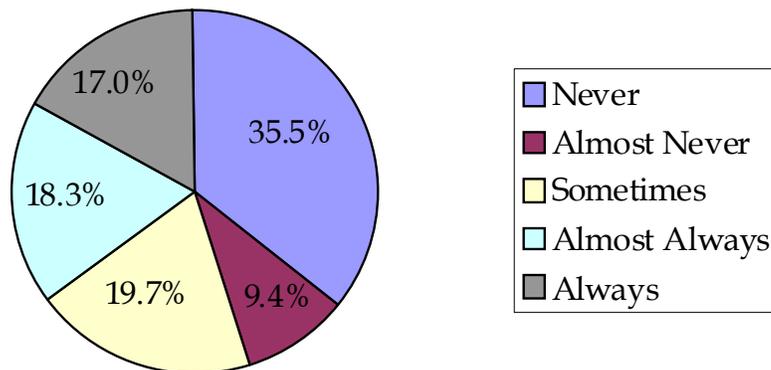
Figure 4.27: My Healthcare Providers Do Not Speak my Primary Language



Health Insurance

When asked about health insurance, 30.3% of survey respondents indicated that they had no health insurance. Of the respondents who had health insurance, 35.3% “almost always” or “always” incurred problems making payments as their health insurance did not pay enough of their bills. Almost 20% of survey respondents reported that their health insurance “sometimes” paid enough of the bills, and 44.9% “almost never” or “never” had difficulties with their health insurance paying enough of their bills. Nearly 70% of Asian respondents “never” had problems with their health insurance paying enough of their bills, while 74.2% of Hispanic respondents “sometimes,” “almost always,” or “always” experienced this barrier.

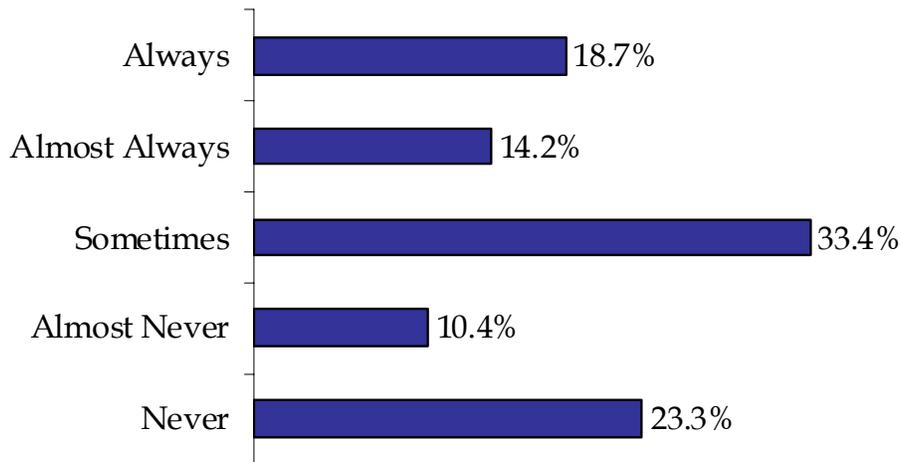
Figure 4.28: My Health Insurance Does Not Pay Enough of my Bills



Primary Language and Health Information Availability

More than 30% of survey respondents reported that they “never” or “almost never” had difficulties finding health information in their primary language. Conversely, over 30% of survey respondents said they “always” or “almost always” experienced the barrier of not having health information materials available in their primary language. Another 33.4% “sometimes” had health information available to them in their primary language.

Figure 4.29: There are No Health Information Materials Available in my Language

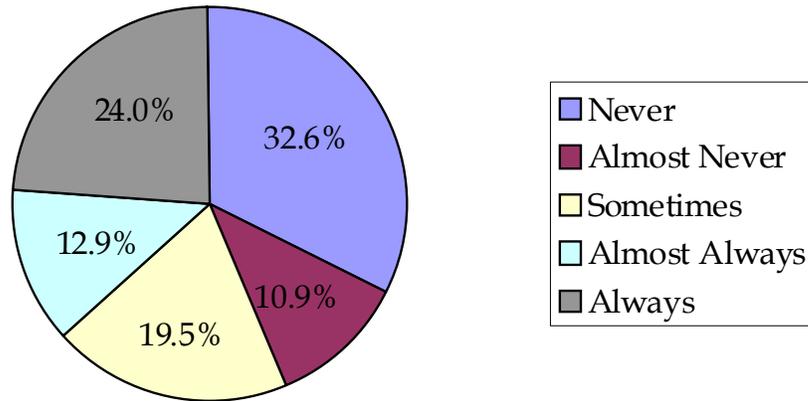


Asking Questions

Many respondents did not feel comfortable enough in a healthcare setting to ask questions. Over 35% of respondents “almost always” or “always” experienced this barrier and felt uncomfortable asking questions. Nearly 20% of survey respondents “sometimes” felt comfortable asking questions, and 43.5% “never” or “almost never” hesitated to ask questions when visiting with a healthcare provider. Seventy percent of Asian respondents “never” hesitated to ask questions, while over half (54.3%) of Hispanic respondents “sometimes,” “almost always,” or “always” felt uncomfortable asking questions.



Figure 4.30: I Do Not Like to Ask Questions

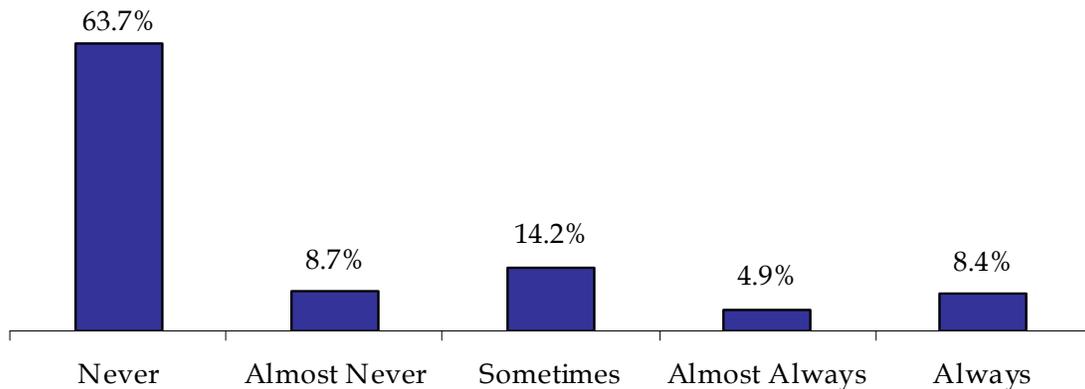


Threat of Being Deported

Undocumented immigrants may hesitate to or avoid visiting a healthcare provider as the threat of being sent back to their home country is intimidating. According to the World Health Organization (WHO), national healthcare plans often discriminate against undocumented immigrants by making only emergency care available for non-citizens (Hansen, 2007). Fear of immigration authorities or beliefs that their children do not qualify for services may also prevent undocumented parents from seeking healthcare for their native-born children.

Less than 10% of survey respondents reported being scared of getting sent back to their home country as a barrier, and 63.7% of respondents were “never” scared that they will be sent back to their home country. Over 96% of Asian respondents and 52.3% of Hispanic respondents were “never” scared of getting sent back to their home country. Other responses indicated that 8.7% were “almost never” scared, 14.2% were “sometimes” scared, and 4.9% were “almost always” scared of getting sent back to their home country.

Figure 4.31: I am Scared that I will be Sent Back to my Home Country

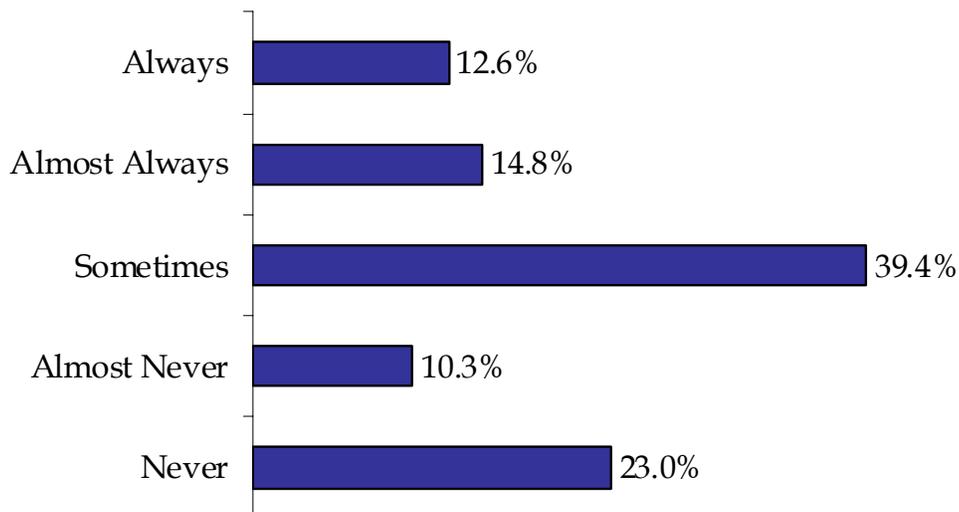


Medical Knowledge

When responding to the statement “I do not have enough medical knowledge to understand what my healthcare providers say to me,” 39.4% of respondents stated that they “sometimes” came across this situation and perceived it as a barrier. Over 25% of survey respondents “always” or “almost always” felt that they did not have enough medical knowledge to understand what their healthcare providers were saying to them, and 33.3% “never” or “almost never” felt that they lacked the medical knowledge to understand their healthcare providers.



Figure 4.32: I Do Not Have Enough Medical Knowledge to Understand what my Healthcare Providers Say to Me



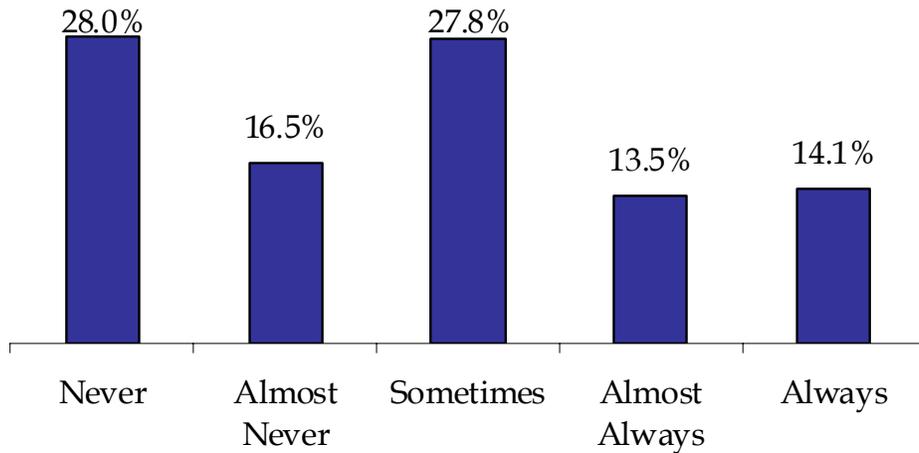
Affordable Healthcare

Affordable healthcare may also be a barrier for some LEP individuals. Survey responses indicated that less than 30% of survey respondents “always” or “almost always” experienced problems affording healthcare, and 44.5% “never” or “almost never” lacked the funds for healthcare coverage. Over 27% were able to afford healthcare some of the time. Nearly 17% of Hispanic respondents and 6.6% of Asian respondents “always” experienced problems affording healthcare.

Did You Know?

In 2007, health care spending in the United States reached \$2.3 trillion, or \$7,600 per person, and was projected to reach \$3 trillion in 2011.

Figure 4.33: I Cannot Afford Healthcare

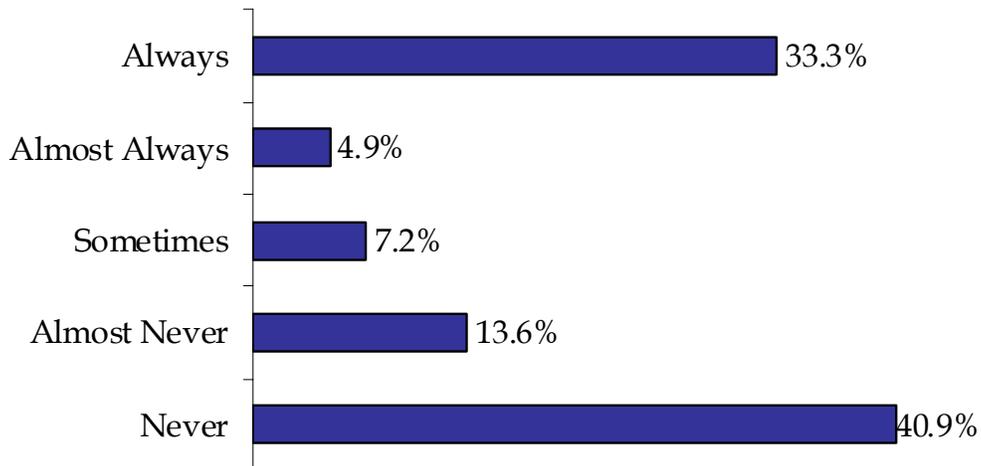


Culture and Respect

Culture, defined by the Merriam-Webster Dictionary, is the customary beliefs, social forms, and material traits of a racial, religious, or social group. It is a way of life shared by people in a place or time. When asked how often they felt healthcare providers were disrespectful to them and their culture, 54.5% of respondents reported that they “never” or “almost never” experienced this barrier. Over 38% felt their healthcare providers “always” or “almost always” disrespected them and their culture. Another 7.2% “sometimes” encountered situations where they felt their healthcare providers were not respectful to them and their culture. Over 42% of Hispanic respondents “always” felt that their healthcare providers disrespected them and their culture, while 45.3% of Asian respondents “never” felt disrespected.



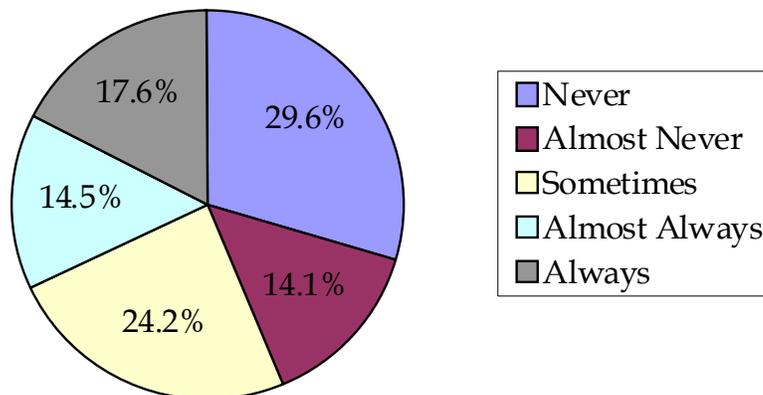
Figure 4.34: My Healthcare Providers are Not Respectful to me and my Culture



Knowledge of Available Health Services

Respondents were asked how often they knew of services or programs that could provide them assistance. Of those who responded, 32.1% stated that they were “always” or “almost always” unaware of health services or programs that could help them. Another 43.7% felt the exact opposite, as they were “never” or “almost never” unaware of health services or programs that could help them, and an additional 24.2% sometimes knew of services or programs available to assist them. Nearly 70% of male respondents were “sometimes,” “almost never,” or “never” unaware of services or programs that could help them, while 60.9% of female respondents were “sometimes,” “almost always,” or “always” unaware of services that could help them.

Figure 4.35: I Do Not Know of Any Services or Programs that Can Help Me

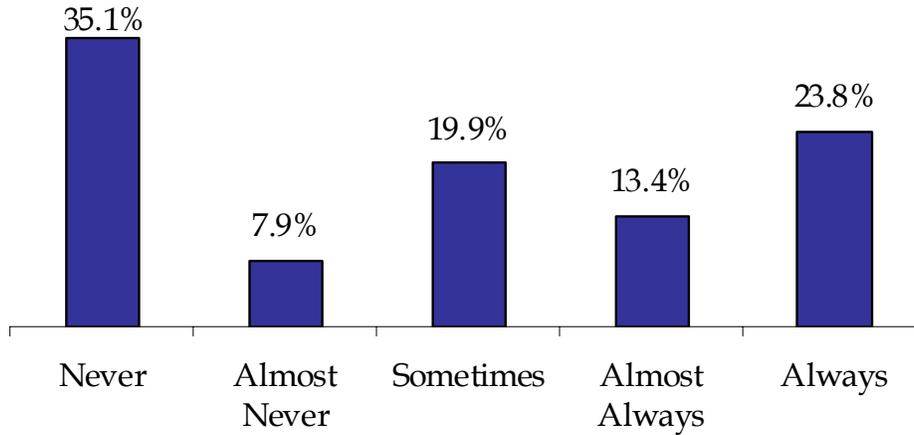


Transportation

Transportation issues may also be a barrier for LEP individuals when trying to travel to appointments. Over 55% of survey respondents “sometimes,” “almost always,” or “always” had difficulties getting to appointments because they did not have transportation. Transportation was not an issue for some others, as 35.1% “never” and 7.9% “almost never” missed appointments due to transportation issues. Nearly half (48.9%) of Hispanic respondents “always” or “almost always” had trouble making it to appointments because of transportation issues, while 63.9% of Asian respondents “never” experienced this barrier.



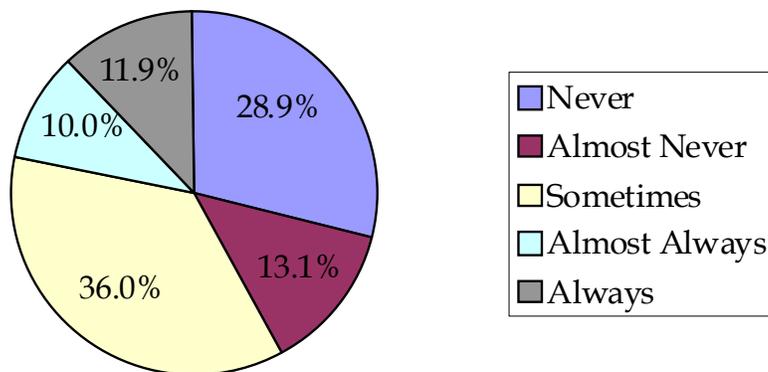
Figure 4.36: I Do Not have a Ride (Transportation) or way to get to Appointments



Work Conflicts

Scheduling appointments can be difficult due to work conflicts. Respondents were asked if their inability to leave work was a barrier to accessing healthcare. Over 25% of survey respondents reported that they were unemployed. Of the respondents who were employed, less than 22% “almost always” or “always” experienced problems seeing their healthcare providers because they were unable to miss work. Thirty-six percent “sometimes,” and 42% “almost never” or “never” missed appointments with their healthcare providers due to work conflicts.

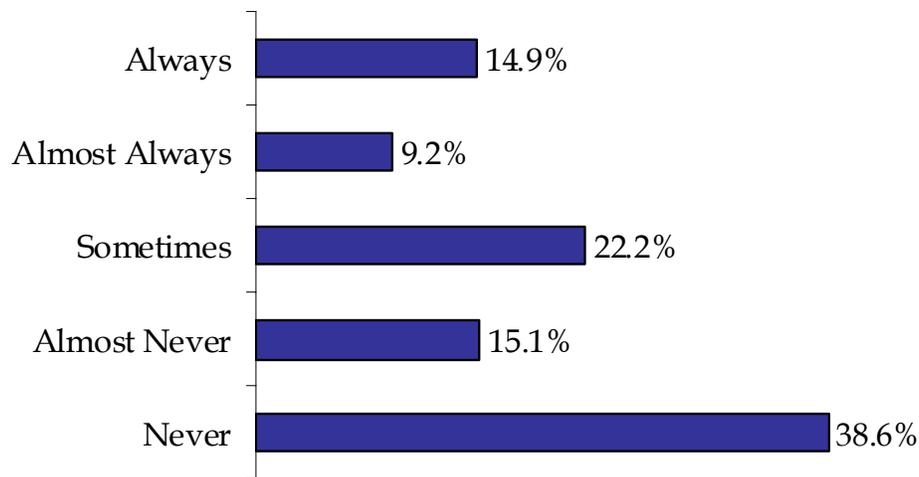
Figure 4.37: I am Unable to Miss Work



Family Conflicts

Responsibility to family can also be a barrier, as LEP individuals may have difficulty in finding someone to care for their family while at an appointment. Over 50% “never” or “almost never” missed healthcare appointments because they were unable to find someone to care for their family. Twenty-two percent “sometimes,” 9.2% “almost always,” and 14.9% “always” had difficulties making it to their healthcare appointments because they were unable to find someone to care for their family. Thirty percent of Hispanic respondents and 6.6% of Asian respondents “always” experienced this barrier.

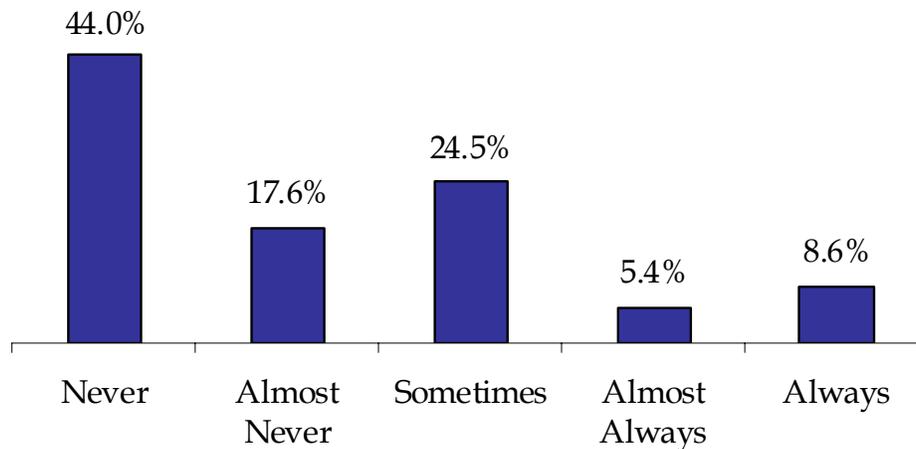
Figure 4.38: I am Unable to Find Someone to Care for my Family



Understanding the Healthcare Provider

It is important for individuals to fully understand what their healthcare provider says to them. At times, people may pretend to understand when in reality they do not. Less than 15% of respondents “almost always” or “always” pretended to understand what their healthcare providers were saying when they did not fully understand. Forty-four percent of survey respondents “never,” 17.6% “almost never,” and 24.5% “sometimes” pretended they understood what their healthcare providers were saying. Over 70% of Asian respondents and 34.6% of Hispanic respondents “never” pretended to understand their healthcare provider.

Figure 4.39: I Pretend to Understand what my Healthcare Provider is Saying when I Do Not Understand



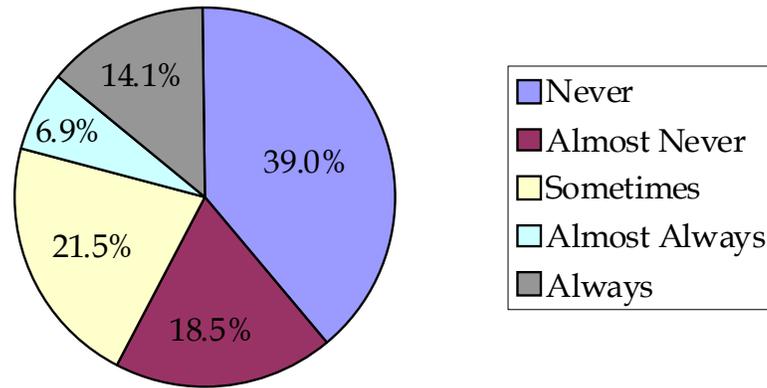
Providing Interpreters

When asked if they believed it was the healthcare providers' responsibility to provide interpreters, 77.9% responded "Yes," and 22.1% responded "No." Nearly 93% of Asian respondents and 72.5% of Hispanic respondents felt it was the healthcare provider's responsibility to provide interpreters.

Differences in Dialect

Another barrier that one may experience is that the interpreter may speak a different dialect of their primary language than they do, causing confusion and misinterpretation. Twenty-one percent of survey respondents "almost always" or "always" experienced this barrier. Nearly 22% "sometimes," 18.5% "almost never," and 39% "never" had problems understanding their interpreter due to different dialects. Seventy percent of Asian respondents "never" had problems understanding their interpreter, while 50.6% of Hispanic respondents "sometimes," "almost always," or "always" had difficulties understanding their interpreter because they spoke a different dialect of their primary language.

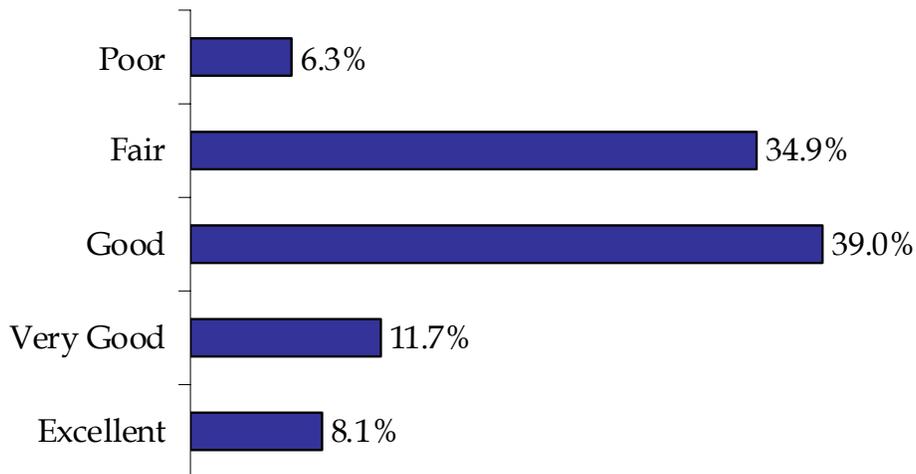
Figure 4.40: The Interpreter Speaks a Different Dialect of my Primary Language than I Do, so I Do Not Understand Very Well



Health Status

Respondents were asked to rate their current health status. Less than 10% reported that their health was “excellent,” 11.7% reported “very good” health, and 39% reported “good” health. Less than 10% of male respondents and 6% of female respondents reported that their health was “excellent.” Forty-one percent of Hispanic respondents and 41.3% of Asian respondents reported that their health was either “fair” or “poor.”

Figure 4.41: Would you say that in General you Health is?



Healthcare Coverage

When asked if they had any kind of healthcare coverage, including health insurance, prepaid plans such as Health Maintenance Organizations (HMO), or government plans such as Medicare, 56.4% of survey respondents stated that they did have some form of healthcare coverage, and 43.6% did not. Over 91% of Asian respondents had some kind of healthcare, while over half (55.9%) of Hispanic respondents did not have any coverage.

Cost

Cost may be another barrier affecting those who need to see a doctor. Respondents were asked if there was a time in the past 12 months when they needed to see a doctor but could not because of cost. Over 33% of survey respondents reported “Yes,” and 66.9% reported “No.” In the past 12 months, 39.4% of Hispanic respondents needed to see a doctor but could not because of cost, while 84.3% of Asian respondents were not affected by this barrier.

Did You Know?

In a Wall Street Journal-NBC Survey, almost 50% of the American public said the cost of health care is their number one economic concern.

Discussion and Recommendations

While awareness of culture and the increased emphasis on the importance of cultural competence has grown significantly over the past decades, there is still much to be done. Health centers may recognize the importance of language services for LEP patients; however, they also are experiencing numerous challenges in providing these services. Today, patients with limited English proficiency confront multiple barriers to healthcare access in the United States. The respondents in this survey reported a variety of barriers that affect their access to healthcare.

The majority (96%) of respondents in this survey were limited English proficient individuals as they spoke English less than “very well.” Respondents reported communication differences as well as differentiations in cultural backgrounds, which in turn, contributed to various barriers in their healthcare experience.

Sixty-two percent of Asian respondents “never” felt comfortable speaking with their healthcare providers in their primary language and nearly half (46.7%) of Hispanic respondents “almost always” or “always” did not like to ask questions during medical appointments.

Other barriers that stuck out included communication problems, not being notified of the right to an interpreter, the lack of available interpreters, usage of friends and family as interpreters, health insurance not paying enough of their bills, no healthcare coverage, feeling disrespected by healthcare providers, lack of signs, instructions, or information printed in their primary language, and the cost of healthcare.

Throughout the survey, we learned much about how limited English proficient individuals view the Nebraska healthcare system and what experiences they have had or barriers they have faced.

Successfully navigating the healthcare system is not only a struggle for many ethnic minority groups; it is also a struggle for many native-born Americans as well. Although ethnic minority groups are disproportionately affected by low literacy, the majority of those with low literacy skills in the United States are white, native-born Americans. According to the Institute of Medicine, nearly half of all American adults (90 million people) have difficulty understanding and using health information. Moreover, up to 80% of patients forget what their

doctor tells them as soon as they leave the office, and nearly 50% of what they do remember is recalled incorrectly (Pfizer, 2008).

It is critical for LEP individuals to be able to communicate with their healthcare providers. As complicated as it may be for English speakers to navigate the complex healthcare system, the difficulties increase for LEP individuals (National Health Law Program & Access Project, 2004). Fundamental literacy is defined by Zarcadoolas as one's ability to read, write, speak, and work with numbers in their primary language. These skills include the ability to: read consent forms, medicine labels and inserts, and other written healthcare information; understand written and oral information given by physicians, nurses, pharmacists and insurers; and act upon necessary procedures and directions such as medication and appointment schedules (Kickbusch, 2001). Survey results revealed that over twenty-five percent of respondents did not have enough medical knowledge to understand what their healthcare providers were saying to them.

General literacy and health literacy do not necessarily go hand in hand. Therefore, like LEP individuals, English speaking patients are also lacking when it comes to medical knowledge. Many patients have limited health vocabulary. Moreover, some patients, LEP or English speaking, may be too embarrassed to indicate to their healthcare providers that they have not really understood their instructions. People with low health literacy are often less likely to comply with prescribed treatment and self-care regimens, fail to seek preventive care and are at higher risk for hospitalization, remain in the hospital nearly two days longer than adults with higher health literacy, and require additional care that results in annual healthcare costs that are four times higher than for those with higher literacy skills (Pfizer, 2008).

Physicians routinely take for granted patients' ability to read and understand all types of health-related materials. In reality, many patients have difficulty communicating with their healthcare providers and following up with self-care instructions due to poor understanding of basic health vocabulary, limited background health knowledge, and trouble assimilating new information and concepts (Kickbusch, 2001).

Much health promotion and patient education information has traditionally used printed materials written at reading levels at or above the 10th grade. The average adult American reading level is 8th to 9th grade. However, nearly 1 in 5 adults read at or below the 5th grade level; and nearly 2 out of 5 older Americans and minorities read at or below that level (Pfizer, 2008).

To effectively communicate, regardless of language or cultural differences, physicians should ask patients about their needs and preferences. Often, LEP patients will use an interpreter to help them communicate with their healthcare providers. Over fifty percent of survey respondents “always” or “almost always” needed an interpreter when they visited their healthcare providers. Providers who accept Medicare and Medicaid payment for their services to LEP patients are required by law to provide them with effective language assistance. This may include hiring bilingual staff who are trained and competent interpreters, hiring staff interpreters, contracting with an outside interpreter service, arranging for the services of voluntary community interpreters, and using a telephone language interpreter service (AAPA, 2008).

Using an interpreter is a great way to help ensure that all patients receive quality medical care, even in circumstances where a healthcare professional and a patient speak different languages (AAPA, 2008). Over forty percent of respondents reported that they had “never” or “almost never” been told that they had the right to an interpreter. Physicians and clinics have a responsibility to ensure that their policies and procedures do not deny their patients access to healthcare services because of a language barrier. Healthcare providers who fail to notify their LEP patients of their right to an interpreter are not only hindering the patient, they are also setting themselves up for legal complications. By providing better access, healthcare providers can greatly improve health outcomes, patient care, and the quality of care.

The lack of available professional interpreters poses another problem for LEP individuals and healthcare providers. Survey results showed that over thirty percent of respondents “always” or “almost always” found themselves in situations where they needed an interpreter when visiting their healthcare provider; however, one was not available to them at the time of their appointment. The lack of interpreter availability only increases the usage of ad hoc interpreters. Thirty-two percent of respondents had a friend interpret for them and 56.9% utilized a family member as their interpreter. As stated before, the usage of untrained staff or family members, friends, and strangers from the waiting room, is associated with poorer self-reported understandings of diagnoses, increased numbers of interpreter errors, and higher rates of testing and admission from emergency departments (Kuo, 2007).

Cultural misunderstandings can exist between health professionals and their clients and patients. These misunderstandings further affect the ability of health professionals to help their clients and patients achieve optimal health. Over thirty-eight percent of respondents felt their healthcare providers “always” or “almost always” disrespected them and their culture. However, when asked how often their healthcare providers respected their health beliefs, over 80% of

respondents reported that they “almost always” or “always” felt that their healthcare provider respected their health beliefs. Patients may have beliefs about causes and cures that do not fit with established medical views. Cultural competency requires that healthcare providers be aware and respectful of race, culture, age, sex, and religious beliefs. A healthcare worker can show respect for the individual by offering the patient explanations and involving them in decisions about their care, rather than making demands on them or issuing unexplained information (NAHO, 2008).

Encouraging LEP individuals to ask questions during an appointment will help clear up misunderstandings and increase accurate compliance. Many people do not want to embarrass themselves by admitting they do not understand, and may feel uncomfortable questioning their healthcare providers. For many reasons, they may say yes when in fact they mean no, or no when in fact the answer is yes (NAHO, 2008). Moreover, people may pretend to understand when in reality they do not. Over thirty-five percent of respondents “almost always” or “always” experienced the barrier of feeling uncomfortable asking questions in a healthcare setting.

Results of the survey also revealed that Hispanic respondents were more likely to hesitate when asking questions as 54.3% of Hispanic respondents and 20.6% of Asian respondents “sometimes,” “almost always,” or “always” felt uncomfortable asking questions. In the Hispanic culture, it is common for people to trust and not question a doctor’s decision in regards to their health and wellbeing. For that reason, it represents a cultural issue when a doctor asks for their participation in the decision-making process. A doctor asking a patient to help make a decision is offensive to some and may cause the patient to question the doctor’s competence.

Survey respondents were asked how often they saw signs and information printed in their primary language. The percentage of those who “never” or “almost never” saw signs or information in their primary language was slightly under thirty percent. However, 94.5% of Asian respondents reported that they “never,” “almost never,” or “sometimes” saw signs and information printed in their primary language, while nearly 84% of Hispanic respondents reported that they “always,” “almost always,” or “sometimes” saw signs and information printed in their primary language. These results indicate that there is a lack of signs and available information in languages other than Spanish. In order to keep up with the changing population in Nebraska, there is a need for health related material and information to be printed in other languages. Cards, handouts, diagrams, posters, signs, and other basic resources that are printed in their primary language enable limited English proficient patients to overcome language barriers. Useful materials are simple to read, easy to access, and might

include step-by-step instructions that can be handed out to patients to help them navigate the health care system. Poster boards, diagrams, and pictures can be used to reinforce concepts described in written materials (Hablamos Juntos, 2008).

At this point in time, no federal standards for healthcare interpreters exist. Some states require or are at the beginning stages of requiring state certification in order to interpret for medical purposes. Some state governments, such as California and Washington, created certifications that are related to specific areas of healthcare interpreting, but do not necessarily cover the broad scope of knowledge and skills that make up the entire field. For example, the State of Washington's program is run by the Department of Social and Health Services, and serves as a basic screening for mental health and social services interpreters (Kelly, 2007).

Not surprisingly, language and cultural barriers are reflected in how LEP individuals perceive their healthcare experiences. Increasing cultural competency and reducing language barriers should be an important component of efforts at every level of the healthcare system to improve quality of care, reduce the risk of medical errors, and increase access to services. The continuous growth in the number of people who need language services is making it a necessity for Nebraska healthcare providers to address the issue.

Recommendations

1. Continue to work towards statewide certification for the purpose of quality assurance in the competencies of medical interpreters within our state's healthcare facilities.
2. Identify and implement federal and state reimbursement strategies to cover healthcare organization costs for providing **trained** interpreters.
3. Require the usage of a trained professional interpreter instead of ad hoc interpreters (family members, friends, strangers, or other untrained individuals serve as interpreters).
4. Train all staff in healthcare organizations to recognize and respond appropriately to patients with literacy and language needs.
 - a. Notify patients of their right to meaningful language access.
 - b. Require that healthcare organizations provide patients with information and instructions in their primary language and post notices to let them know that interpreters are available and can be requested.
 - c. Supply health information and material written at or below an 8th grade reading level.
5. Provide financial assistance for interpreters and employees to attend mandatory cultural competency trainings.

6. Collect data on patients' race and ethnicity so quality of care for patients from different racial or ethnic groups can be assessed.
7. Eliminate “barriers to entry” in the care system by educating patients, particularly those with low health literacy, about when and where to seek healthcare.
8. Refer patients to resources for healthcare coverage that will help them pay their healthcare costs.
9. Hire and promote minorities in the healthcare workforce.

In the end, providing culturally competent care and interpreter services to LEP individuals may not be as financially burdensome as a number of providers think. A federal report by the Office of Management and Budget estimated that the cost of interpreter services for LEP persons, when averaged over all inpatient, outpatient, and dental visits, would be an average of \$4.04 more per visit, equivalent to 0.5% of the average cost per healthcare visit (\$4.04/\$865) (Ku, 2005). We can either pay a small amount up front to ensure that all patients receive equitable, high-quality care, or pay a lot more later for unnecessary tests and procedures, preventable hospitalizations, medical errors and injuries, and expensive lawsuits.

Cultural competence and linguistically appropriate care is not a destination. The work of bridging cultures and creating responsive services is never completely done. Communities, service providers, and individuals continue to change. A culturally and linguistically competent healthcare organization is engaged in a continuous process of learning about different cultures and the individuals within the communities it serves. Because of this, the development of cultural competence and linguistically appropriate care may be best thought of not as arriving at a set of skills and knowledge, but rather as a journey (Olsen, 2006).

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Appendices

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 provides, "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Title VI of the Civil Rights Act of 1964 is the Federal law that protects individuals from discrimination on the basis of their race, color, or national origin in programs that receive Federal financial assistance. This means that elders cannot be denied access to federally funded health care, public assistance, or other social services based on race, color, or national origin.

Programs Covered by Title VI

Approximately 30 Federal agencies provide Federal financial assistance in the form of funds, training, and technical and other assistance to State and local governments, and non-profit and private organizations. These recipients of Federal assistance, in turn, operate programs and deliver benefits and services to individuals (known as "beneficiaries") to achieve the goals of the Federal legislation that authorizes the programs.

Federally assisted programs address such broad and diverse areas as:

- elementary, secondary, and higher education
- health care, social services, and public welfare
- public transportation
- parks and recreation
- natural resources and the environment
- employment and job training
- housing and community development
- law enforcement and the administration of justice
- agriculture and nutrition

Discrimination that is Prohibited by Title VI

There are many forms of illegal discrimination based on race, color, or national origin that can limit the opportunity of minorities to gain equal access to services and programs. Among other things, in operating a federally assisted program, a

recipient cannot, on the basis of race, color, or national origin, either directly or through contractual means:

- Deny program services, aids, or benefits;
- Provide a different service, aid, or benefit, or provide them in a manner different than they are provided to others; or
- Segregate or separately treat individuals in any manner related to the receipt of and service, aid, or benefit.

Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1: Goals

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Section 2: Federally Conducted Programs and Activities

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be

consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Section 3: Federally Assisted Programs and Activities

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order. The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Section 4: Consultations

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Section 5: Judicial Review

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON, THE WHITE HOUSE, August 11, 2000.

CLAS Standards

The following national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

- CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).
- CLAS **guidelines** are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- CLAS **recommendations** are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

The standards are also intended for use by:

- Policymakers, to draft consistent and comprehensive laws, regulations, and contract language. This audience would include Federal, State and local legislators, administrative and oversight staff, and program managers.
- Accreditation and credentialing agencies, to assess and compare providers who say they offer culturally competent services and to assure quality for

diverse populations. This audience would include the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, professional organizations such as the American Medical Association and American Nurses Association, and quality review organizations such as peer review organizations.

- Purchasers, to advocate for the needs of ethnic consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.
- Patients, to understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them.
- Advocates, to promote quality health care for diverse populations and to assess and monitor care being delivered by providers. The potential audience is wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant, and other community-focused organizations; and local and national nonprofit organizations that address health care issues.
- Educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include educators from health care professions and training institutions, as well as educators from legal and social services professions.
- The health care community in general, to debate and assess the applicability and adoption of culturally and linguistically appropriate health services into standard health care practice.

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

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.

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.

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.

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.

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).

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.

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.

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.

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.

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.

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.

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.

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.